Debra Caplowe
131 W. Great Falls St., Suite 101
Falls Church, VA 22046
703-795-4226

Confidential Client Information

Name: _____
Preferred Nickname, if applicable: _____
Age and Date of Birth: _____
Street Address: _____
City/State/Zip Code: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

If discretion is necessary when leaving a message for you with someone else or on your voice mail, please specify? _____

_____

Marital Status: Single Married Separated Divorced Widowed
Spouse/partner: Name _____ Age _____
Occupation: _____ Years together: _____
Number/Ages/Names of children: _____

Education: # of years _____ Highest degree: _____ Occupation: _____
Place of Employment: _____

Who raised you: _____
Mother's name: _____ Age: ____ Occupation: _____
Father's name: _____ Age: ____ Occupation: _____
Names and ages of siblings:

_____

Who referred you to my practice? _____
Briefly describe what brings you in today: _____

_____

_____

Have you before seen a mental health professional or a psychiatrist? If so, please briefly specify for what and when: _____

_____

_____

Please list any significant medical problems you are having:

_____

_____

What prescribed and over-the-counter medications are you currently taking (please include dosage):

_____

_____

Have you ever been hospitalized for depression, suicidal behavior, substance abuse, alcoholism, eating disorders, or any other psychiatric reason? If so, please specify for what and when.

_____

_____

_____

Please indicate, by circling, if any of the following are concerns for you:

Relationship with spouse, partner, children, friends, boss, coworkers, family of origin, peers.	Depression	Body image
	Mood swings	Weight gain or loss
	Irritability	Eating disorder
	PMS	Physical illness
Social anxiety	Post-partum depression	Head trauma
Social isolation	Suicidal thoughts	Pain
Stress	Homicidal thoughts	Fertility
Job loss or problems	Anxiety	Sexuality
Financial concerns	Excessive worry	Libido
Housing concerns	Panic attacks	Religion
Domestic violence	Troubling or racing thoughts	Spirituality
Past abuse: emotional, sexual, and physical	Dissociation	Fear of confrontation
	Trauma	Excessive drinking
Current abuse: emotional, sexual, and physical	PTSD	Drug use
	Loss of self	Codependence

In your family of origin, is there a history of: ☐ Alcoholism ☐ Substance abuse
☐ Mental illness, including anxiety, depression, eating disorders, psychosis
☐ Psychiatric hospitalization ☐ Suicide or attempts
☐ Physical abuse ☐ Emotional abuse ☐ Sexual abuse
☐ Violence between adults ☐ Prolonged physical illness
If so, please elaborate: _____

_____

_____

POLICIES AND FEES

CONFIDENTIALITY:

Everything we talk about is confidential with a few exceptions. Your written permission is required to release information regarding your case except when there is a possibility of danger to yourself or others. I am required by law to report any suspected child or elder abuse. In the interest of providing you with the best possible care, I might consult on occasion with other mental health professionals concerning your case.

SESSIONS:

Sessions are 50 minutes long. **Cancellations must be made with at least 24 hours notice to avoid being charged for the missed session.** Exceptions may be made due to illness or an unexpected event.

FEES:

Payment is due at every session either by Venmo or Zelle. I do not accept credit cards. I do not participate directly with any insurance companies. I will provide you with a statement to submit to your insurance company for reimbursement. Many insurance companies will reimburse for out-of-network services. You are responsible for contacting your insurance company to determine your reimbursement rate for outpatient mental health services.

CONTACT OUTSIDE OF SESSION:

I periodically check my voice mail weekday and weekends. I do my best to return all phone calls in a timely manner. Most calls are returned the same day with the exception of the weekend. If you are having a mental health medical emergency and I can't be reached please call 911 or go to your nearest emergency room.

I have read your policies and about your fees and am in agreement.

_____

Signature

_____

Date

DEBRA CAPLOWE, L.C.S.W.
131 West Great Falls Street, Suite 101
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HIPAA, Confidentiality, and Client Rights – Signature Page

This page verifies that you have received a copy of the **HIPAA, Confidentiality, and Client Rights** form, that you have read, understood, and agree to the terms, and that any questions you have were adequately answered. Please initial the lines below and provide your signature. Thank you.

_____ I have read and understand the **HIPAA, Confidentiality, and Client Rights** form and agree to these terms.

_____ I understand that I can ask for clarification at any time if I have questions or concerns.

_____
Client name

_____ _____
Client signature Date

_____ _____
Debra Caplowe, L.C.S.W. Date

DEBRA CAPLOWE, LCSW
131 W. Great Falls Street, Suite 101
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HIPAA, Confidentiality, and Client Rights

This form provides you with important information about confidentiality and the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights regarding the information that you share with me. Please note that although HIPAA dictates a number of ways that I may share your PHI, only under the most unusual circumstances will I release any information without your prior knowledge and authorization. Please read this over carefully and notify me if you have any questions or concerns. Each health care provider is required to appoint a Privacy Officer. Given that I am a solo practioner, I serve as the Privacy officer for my practice. Additionally, please sign the last page, indicating that you understand and agree to these terms of services. Thank you.

Ψ HIPAA NPP and NPP RECEIPT FORM

HIPAA was designed to improve the efficiency of health care services by standardizing electronic data and to protect privacy of this data by imposing uniform procedures and standards. HIPAA requires that I provide you with Notice of Privacy Practices (NPP) for use and disclosure of your Protected Health Information (PHI) for treatment, payment, and health care operations. The NPP, which is attached to this form, explains HIPAA and its application to your personal health information in greater detail. I understand that these documents are long and complex. If you have any questions, we can discuss them at any time. Furthermore, by law, I must obtain your signature acknowledging that I have provided you with the NPP. Please sign the NPP receipt form, indicating that you have received a copy.

Ψ CONFIDENTIALITY AND LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a therapist. In most situations, I can only release information about your treatment to others with your written consent. However, there are some limits to confidentiality that you need to be aware of. Please understand that if any situation as described below arises, I will make every effort to fully discuss the situation with you before taking any action and I will limit my disclosure as much as possible.

1.) If a patient threatens to harm himself or herself, I may be obligated to seek hospitalization for him or her, or to contact family members or others who can help provide protection.

2.) If a patient communicates a specific threat of immediate serious physical harm to an identifiable victim, and I believe he or she has the intent and ability to carry out the threat, I am required to take protective actions. These actions may include notifying the potential victim or his or her guardian, contacting the police, or seeking hospitalization for the patient.

3.) If a patient is involved in a court proceeding and a request is made for information, I cannot provide any information without written authorization, or a court order. However, if a subpoena is served on me with appropriate notices, I may have to release the information requested.

4.) If a government agency is requesting information for health oversight activities, I may be required to provide it for them.

5.) If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

6.) If a patient files a worker's compensation claim, I must, upon appropriate request, provide a copy of any mental health report.

7.) I may occasionally find it helpful to consult with other mental health professionals about my work with a client. During a consultation, names and other identifying information are not used.

Discussion is limited to general information, diagnosis, and treatment. The other professionals are also legally bound to keep the information confidential. Although I do not customarily tell clients about these consultations, I will note all consultations in your Clinical Record.
8.) HIPAA requires me to inform you that the modes of communication that I use in my practice (i.e., a cordless phone, a cellular phone, e-mail, and a fax machine) may not be completely secure. That is, medical information may be accessible by someone other than the intended recipient of the information. Confidentiality is paramount, however, so safeguards have been implemented. Please ask me if you have any questions about this.

Furthermore, there are some situations in which I am legally obligated to take actions to attempt to protect others from harm. Although these situations are unusual in my practice, they may require me to reveal some information about a patient's treatment.
1.) If I have reason to suspect that a child is abused or neglected, the law requires that I file a report with the appropriate governmental agency, usually the Department of Social Services. Once such a report is filed, I may be required to provide additional information.
2.) If I have reason to suspect that an adult is abused, neglected or exploited, the law requires that I file a report to the Department of Welfare or Social Services. Once such a report is filed, I may be required to provide additional information.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Ψ CLIENT RIGHTS

As a patient of mine, you have certain rights regarding your health information. In fact, HIPAA provides you with several new or expanded rights with regard to your PHI. I am happy to discuss any of these rights with you.
1.) You have the right to ask me to communicate with you about your health and related issues in a particular way or place that affords you the most privacy. For example, you can ask that I do not call you at work, or that I do not identify myself when I call you at home, etc. I will do my best to accommodate your requests.
2.) You have the right to ask me to limit what I tell others involved in your care or in the payment of your care, such as family members and friends. Although your request does not necessitate agreement on my part, I will try to be most reasonable while also acting in the most legal and ethical manner. Either way, I will inform you about my intentions and the reasons for them.
3.) You have the right to request access to your clinical or psychotherapy records. Should you care to do so, I will discuss with you that process upon your request.
4.) You have the right to ask me to amend your record. Should you care to do so, you would have to submit your request in writing.
5.) You have the right to request an accounting of most disclosures of your PHI that you have neither consented to nor authorized
6.) You have the right to determine the location to which protected information disclosures are sent.
7.) You have the right to file any complaints you make about my policies and procedures in your records. You also have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint, in writing, with me and with the Secretary of the Department of Health and Human Services. Filing a complaint will not change the health care that I provide for you.
8.) Lastly, you have the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.