

INFORMATION FOR NEW CLIENTS

Important Phone Numbers

- Lisa Kendall cell phone: (607) 351-1313 FAX: (844) 804-5605
- If you are unable to reach Lisa in case of emergency (or her appointed colleague providing vacation coverage), please contact **"All Hours Connect"** at (607) 272-1838. Alternatively, you may contact the crisis center at (607) 272-1616, call 911, or proceed to the Emergency Room.

Before your visit:

- Please complete the form at www.obriensbilling.com/contact-us/patients/ or call O'Brien's Billing Service at (315) 437-1451 to review your coverage.

At the time of your visit:

- Please remember to present your insurance member ID card.
- Your payment is due.

Responsibility of the Therapist

- To provide respectful, positive, sensitive policies and interactions
- To make clear policies and procedures to assure confidentiality, increase awareness, and decrease confusion

Responsibility of the Client

Payment is made at the time of the visit. If we do not participate with your plan, we will submit a claim to your insurance company as a courtesy.

If you are unable to keep an appointment, please notify us immediately. If an appointment is cancelled without 24-hour notice, you will be billed for the session. If you fail to show up for your appointment, you will also be billed for the session.

Sessions are 45 minutes in length; shorter visits may be suggested, and longer visits are possible in case of emergency.

CONFIDENTIALITY

Responsibility for Records and Rights

Confidentiality is a very critical issue. Any personal information that you share with us may be entered into your records in written form. Your records routinely include appointment dates and progress notes. Every effort is made to avoid any entry of information which may be sensitive or embarrassing. No outside person is allowed to access our files without your written consent.



All records are kept in locked file cabinets. All closed cases are stored in inaccessible files. In our practice we have passwords to protect databases, and virus/intrusion detection software. Access to your history and psychotherapy progress notes is limited to Lisa Kendall and professional staff who may be covering for her absence from the office; insurance information is handled by:

O'Brien's Billing Service
4309 E. Genesee St., Syracuse, NY 13214
(315) 437-1451
www.obriensbilling.com
obb@obriensbilling.com

Insurance claims forms and monthly statements identify you, your diagnosis, procedures, and cost.

Although your record is the physical property of Lisa Kendall, the information belongs to you. You have rights as defined by federal HIPAA law as well as New York State law. Please see the HIPAA privacy policy for detailed information about your rights under HIPAA.

Social Media and Electronic Communications

It is the policy of this practice to maintain a therapeutic relationship free of undue influence and respectful of the privacy of both therapist and client. For this reason, I will not pursue nor allow connections on social media, such as Facebook or Linked In. In a small town, this may be difficult; please discuss your concerns with Lisa Kendall.

E-mail and texting may be used for routine communications. In spite of all possible precautions, no computer system is guaranteed to be 100% private. Please indicate your preferences concerning contact via email, text messaging, and the appropriateness of leaving messages at specific phone numbers.

I have a received a copy of this letter and an opportunity to have my questions answered:

_____ Client Signature (or responsible party)	_____ Date
_____ Client Name	_____ Date
_____ Responsible Party name	_____ Date
_____ Therapist	_____ Date



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Client Signature (or responsible party)	Date
_____	_____
Client Name	Date
_____	_____
Responsible Party name	Date
_____	_____
Therapist	Date



Name:
 Address:

Date of Birth:

Date:

	Contact	OK to use?	OK to leave message?
Home Phone			
Work Phone			
Cell Phone			
Text			
e-mail			
Other			

Gender: (circle) Male Female Other:

Primary Care Physician's Name/Number _____

Have you had previous counseling? _____ When _____ with whom? _____

Has anyone in your family been seen by a counselor _____

Are you presently on medication? _____ If so, what medications? _____

Any drug/alcohol use/abuse in family of origin or present family? _____

Do you ever think of committing suicide? _____ Do you presently have suicidal thoughts? _____

Contact person for emergencies: Name _____ Phone # _____

TARGET COMPLAINT: What is the primary concern that you would like to address in counseling?

How has this concern affected: (circle 1-not at all → 5-very much)

Marriage / Partner	1	2	3	4	5
Family	1	2	3	4	5
Job / School Performance	1	2	3	4	5
Friendships	1	2	3	4	5
Finances	1	2	3	4	5
Health	1	2	3	4	5
Anxiety Levels	1	2	3	4	5
Mood	1	2	3	4	5
Sexuality	1	2	3	4	5
Eating Habits	1	2	3	4	5
Sleep	1	2	3	4	5





THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (“HIPAA”), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.



Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child or Elder Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child or Elder abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of



preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Education. We may send you communications about Educational materials and opportunities at one time or another. You have the right to opt out of such communications with each notification you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Provider and Privacy Officer, Lisa A. Kendall at 416 N. Tioga St., Ithaca, NY 14850.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.



- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Provider and Privacy Officer, Lisa A. Kendall, at 401 E. State St., Ste. 400, Office #1, Ithaca, NY 14850, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 23, 2013.

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name: _____
Date of Birth: _____
SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Lisa A. Kendall’s Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Lisa A. Kendall at (607) 351-1313.

Signature of Client _____ **Date** _____

Signature or Parent, Guardian or Personal Representative * _____ **Date** _____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Client Refuses to Acknowledge Receipt _____
Signature of Staff Member _____



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Notice of Privacy Practices
Receipt and Acknowledgment of Notice

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Date of Birth: _____
SSN: _____

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Signature of Client _____ **Date** _____

Signature or Parent, Guardian or Personal Representative * _____ **Date** _____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Client Refuses to Acknowledge Receipt _____
Signature of Staff Member _____



Adult Checklist of Concerns

Name _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- I have no problem or concern bringing me here
- Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- Aggression, violence
- Aging
- Alcohol use
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration, distractibility
- Career concerns, goals, and choices
- Caregiving
- Childhood issues (your own childhood)
- Children, child management, child care, parenting
- Chronic illness
- Chronic pain
- Codependence
- Confusion
- Compulsions
- Custody of children
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Drug use—prescription medications, over-the-counter medications, street drugs
- Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- Elder Care
- Emptiness
- Failure
- Family problems, family conflict
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income
- Friendships
- Gambling
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Inferiority feelings

(cont.)



Adult Checklist of Concerns (p. 2 of 2)

- Interpersonal conflicts
- Impulsiveness, loss of control, outbursts
- Irresponsibility
- Judgment problems, risk taking
- Legal matters, charges, suits
- Loneliness
- Marital conflict, distance/coldness, infidelity/affairs, remarriage
- Memory problems
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension
- Obsessions, compulsions (thoughts or actions that repeat themselves)
- Oversensitivity to rejection
- Panic or anxiety attacks
- Perfectionism
- Pessimism
- Physical pain
- Procrastination, work inhibitions, laziness
- Relationship problems
- School problems (see also "Career concerns . . .")
- Self-centeredness
- Self-esteem
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- Shyness, oversensitivity to criticism
- Sleep problems—too much, too little, insomnia, nightmares
- Smoking and tobacco use
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness
- Suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Trauma, accident
- Weight and diet issues
- Withdrawal, isolating
- Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues:

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

