Stephnie Thomas, LCPC
77 East Main Street, Suite 204
Westminster, MD 21157
Cell: 410-236-1470

Client Information Sheet: Family

PAYMENT MUST BE MADE AT TIME OF SERVICE

Date Case Opened: _____ Permission to call home and leave message? **Y N**

Child's Name: _____ Date of Birth: _____ Age: ___

Mother's Name: _____ Date of Birth: _____ Age: __

Marital Status: _____ Address: _____

Home Phone: _____ Cell Phone: _____

Employer:_____ Address: _____

Father's Name: _____ Date of Birth: _____ Age: ___

Marital Status: _____ Address: _____

Home Phone: _____ Cell Phone: _____

Employer:_____ Address: _____

Who does the child live with? Please circle the appropriate response:
Both parents in one household, One parent household Shared custody arrangement

Mother and other adult parental figure(s) , Father and other adult parental figure(s)

If both parents share custody, which parent does the child spend most time with? _____

Emergency Contact for Adult: _____ Relation:_____

Phone number of emergency contact: _____

Permission for counselor to speak with contact in an emergency:

***(please sign here):*_____ Date: _____**

Two Emergency Contacts for **Juvenile**:

#1 Name: _____ Relation: _____ Phone: _____

#2 Name: _____ Relation: _____ Phone: _____

Permission for counselor to speak to contacts in an emergency:

***(please sign here):* _____ Date: _____**

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INSURANCE INFORMATION

Note that I am a non-participating provider. Therefore, PLEASE FILL OUT THE INFORMATION BELOW ONLY IF YOU PLAN TO REQUEST REIMBURSEMENT FOR SERVICES FROM YOUR INSURANCE COMPANY

Your Name: _____ **Date of Birth:___/___/_____**
(or Child's Name First Name MI Last Name
if the child's insurance will be used)

Name of Insured Member: _____ **Insured's DOB: __/___/___**
First Name MI Last Name

Address: _____ _____ ___ _____
Street Address City State Zip

Name of Insurance Company: _____

Address: _____ _____ ___ _____
Street Address City State Zip

Phone Number for Mental Health Providers: _____
(*Usually found on the back of the card)*

Member ID of the person requesting services: _____

Group Number: _____

Health Plan Number (*if applicable):* _____

Do you have "out-of-network" health care benefits? YES NO

Note that once I release information to your insurance company I can no longer guarantee confidentiality of such information.

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Please fill in and specify all that apply (ask your therapist if you are unsure)

Primary Care Physician: _____ Phone: _____

Address: _____

School Child Attends: _____ Phone: _____

Address: _____

Other Treating Professional: _____Phone: _____

Address: _____

Previous Treatment Provider: _____Phone: _____

Address: _____

I, _____, request and authorize exchange of information between the
(Print your name here)

Individual(s) or organization(s) shown above and Stephnie Thomas, LCPC.

This authorization expires on ____/____/_____ *(If not specified, this authorization expires six months after treatment ends).*

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based on my request. There are three ways to cancel this authorization: 1) Sign and date a revocation form, available from Stephnie Thomas 2) Write, sign and date a letter to Stephnie Thomas to cancel this authorization; 3) Sign, date and write "cancel" on this original form. Once information is given out, Stephnie Thomas no longer has control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.

I agree to the release of health care information (testing, diagnosis, and/or treatment) when applicable for: ☐ **Psychiatric disorder/mental health** ☐**Drug/alcohol use**
☐ **Sexually-transmitted disease** ☐ **HIV/AIDS**

_____ _____ ___/___/__ ___/__/____
Patient's signature **Printed Name** **DOB** **Date**

_____ _____ ___/___/__ ___/__/____
Authorized individual's signature **Printed Name** **DOB** **Date**
Relationship to patient if signed on behalf of patient: ☐ **Parent** ☐ **Guardian** ☐ **Personal representative**

Witness Signature: _____ Date: ___/____/____

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Patient Copy

NOTICE OF PRIVACY PRACTICES

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

As a licensed professional counselor, I am required by applicable federal and state law to maintain the *privacy* of your health information. I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice (which may be amended from time to time). I may also follow State law which may be MORE stringent for your protection. .

For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information listed in Section II G of this notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures without Your Written Authorization

I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and 'state law.

1. **Treatment:** I may use and disclose PHI in order to provide treatment to you. For example, we *may* use PHI to diagnose and provide counseling service to you. In addition, we may disclose PHI to other health care' providers involved in your treatment.
2. **Payment**: 'We may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.
3. **Health Care Operations**: I may use and disclose PHI in connection with our health care operations, including, quality improvement activities; training programs; accreditation, certification, licensing or credentialing activities.
4. **Required or Permitted by Law**: I may use or disclose PHI when I am required or permitted to do so by law. For example: I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law. We may contact you-about reminders regarding an appointment, and we may send you information about treatment alternatives or other health related services, as well as about research participation options. You have the right to object to such disclosures.

B. Uses and Disclosures Requiring Your Written Authorization.

1. **Psychotherapy Notes**: Notes recorded by your clinician documenting the contents' of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.
2. **Marketing Communications**: We will not use your health information for marketing communications without your written authorization.

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3. **Other Uses and Disclosures**: Uses and disclosures other than those described in Section LA above will only be made with your written authorization. For example, you will need to sign an authorization form before we can send PH I to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at anytime.

II. YOUR INDIVIDUAL RIGHTS

A. **Right to Inspect and copy**: You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the, records. ALL requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor; please note that certain portions of the minor's medical record will not be accessible to you, consistent with State law

B. **Right to Alternative Communications**. You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at an alternative locations.

C. **Right to Request Restrictions**. You-have-the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing. I am not required to agree to any such restriction you may request.

D. **Right to Accounting of Disclosures**. Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. **Right to Request Amendment**: You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should-be amended. We may deny your request under certain circumstances.

F. **Right to Obtain Notice**. You have the right to obtain a paper copy of this Notice by submitting a request at any time.

G. **Questions and Complaints**. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may contact me at (410) 236- 1470. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the Director.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on August 1, 2011

B. Changes to this Notice. I may change the terms of this Notice at any time. If I change this Notice, I *may* make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the waiting area of my office. You may also obtain' any revised notice by contacting me and requesting a copy.

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PROFESSIONAL DISCLOSURE STATEMENT

Licensed Graduate Professional Counselor License Number: LC4083 (www.mbp.state.md.us/bopc)

National Board of Certified Counselor's License Number: 240153
(www.nbcc.org/nccregistry)

Employer Identification Number: 27-0408913

National Provider Identifier Number: 1972730596

Master's in Science Graduate of Loyola College in Maryland's Pastoral Counseling program: May, 2009. (Now known as Loyola University)

Bachelor's in Science Graduate (Cum Laude) of Towson State University's Clinical Concentration program: May, 2007. (Now known as Towson University)

Anxiety Disorders Specialist practicing at the Anxiety & Stress Disorders Institute (ASDI) of Maryland since 1997 as a coach for clients requiring *in vivo* Cognitive Behavioral Therapy. **Currently** in practice at ASDI and here in Westminster as an **LCPC** offering clinical psychotherapy services to clients from a pastoral perspective. My clinical perspective, while primarily from a CBT orientation, is influenced by the training and theoretical standpoint offered at Loyola, which is eclectic in nature and seeks to respect clients of all religious/spiritual orientations.

Clinical Fee Structure:
Sliding scale fees are offered to clients on an as-needed basis.
Usual fees:
$95 per 50 minute session for adults, **$105** per 50 minute session for children under age 18

If clients are seen out of the office for in vivo exposure therapy, charges will be applied for travel time, pro-rated on the length of time required. Please note that time spent travelling to and from appointments is time I could be spending with paying clients in the office.

This information is required by the Board of Professional Counselors and Therapists, which regulates all licensed and certified counselors and therapists.

Maryland Board of Professional Counselors and Therapists
4201 Patterson Avenue
Baltimore, MD 21215
(410) 764-4732

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I received a
(Please print)

copy of the Notice of Privacy Practices and the Professional Disclosure Statement for Stephnie Thomas, LCPC.

Signature of client: _____ **Date:** ___/___/___

Signature of personal representative: _____ **Date**: ___/___/___
(when applicable)

If this acknowledgment is signed by a personal representative on .behalf of the client, complete the. following:

Personal Representative's Name: _____

Relationship to Client: _____

For Office Use Only

. .

I attempted to obtain written acknowledgement of receipt of the Notice of Privacy Practices and the Professional Disclosure Statement, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining· acknowledgement
- ☐ Other (Please Specify) _____

This Form will be retained in your Medical Record

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General Information

Although we prefer to proceed with the therapeutic relationship informally, the following information has been proven helpful in avoiding future misunderstandings.

1. Therapy sessions are usually 45-50 minutes long and must stop on time in consideration of the next person, even if you arrive late.

2. ***Cancellation Policy:*** Since appointments constitute reserved times set aside specifically for each person, family, or couple, Stephnie Thomas asks that clients respect the value of that time. If you do not show up for your appointment, she cannot see other clients at that time, unlike other kinds of doctors/professionals. **Therefore you will be expected to pay for your appointment even if you do not come; unless you cancel at least 24 hours prior to your scheduled time**. However, there will not be a charge for a missed appointment if there is a genuine emergency, or if your time can be filled by another client at the last minute, or if she can find another time to meet with you before the end of that work week.

3. ***Payment in full is expected at the time of service***. You are responsible for clarifying your insurance benefits and whether authorization is necessary. Statements will be provided for you to submit to your insurer; your therapist will complete other forms that may be required. Bills outstanding 60 days may incur late fees or be referred for collection.

4. If you choose to use your insurance benefits to pay for a portion of your treatment, Stephnie may be required to submit clinical information about you and your treatment to your insurer or managed care company. These companies may send some information, such as diagnostic codes, to insurance industry data banks which could have implications for your future insurance purchases. If Stephnie is required to submit otherwise confidential information about you, she can no longer promise that such information will remain confidential once it leaves her office.

5. Stephnie will assist you in meeting your insurer's authorization requirements. However, authorization and reimbursement by your insurer may end before your need for treatment ends.

6. All information pertaining to your treatment will remain confidential unless you sign a release to a specific person or organization. The only exceptions to this are: (a) releases contractually required by insurers and managed care companies to establish what they define as "medical necessity" and to secure reimbursement; (b) your therapist assesses you to be of imminent danger to yourself or others, requiring action in the interest of safety; (c) by court order; (d) if you are a plaintiff in a lawsuit in which your emotional health is an issue; (e) information discussed in professional supervision; or, (f) as otherwise provided under Maryland law. (This last exception may include possible danger to a child or other vulnerable person, or your disclosure of a history of sexual abuse by an identifiable person.)

7. Messages should be left on Stephnie's personal telephone line: (410) 236-1470. In the case of an extreme emergency, if you are unable to contact her, you are encouraged to go to your nearest emergency room.

8. **Telephone calls over 10 minutes may be charged a prorated session fee**.

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9. When Stephnie is out of town, professional coverage will be provided for emergencies. However, your local hospital emergency room is the best place to go in a real emergency.

I understand and agree to abide by these policies. I give permission to release otherwise confidential information to my insurer or managed care company for the purpose of reimbursement. I understand that I am responsible for all fees incurred during treatment. I will ask my therapist about any remaining questions I may have, (e.g., fees, what to expect from therapy, etc.). I have received a copy of this agreement.

Signature: _____ Date ___/____/_____
(parent or guardian)

Signature: _____ Date ___/____/_____
(parent or guardian)

Signature: _____ Date ___/____/_____
(child)

Witness Signature: _____ Date ___/___/_____