**CLIENT INFORMATION**

Full Name:

1)\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

# 2) \_

SS#:\_ \_ \_ \_ \_ \_ \_ \_ Birth Date Age

SS#: Birth Date: Age

Address:\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ City:\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ State: Zip: \_

Home phone: \_ Work phone: ( l) (2) \_ Cell phone: (1) (2) \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ ls it okay to leave y ou a message? Yes No

I prefer messages le ft on the following number: (Please Circle) Email: 1 ) \_

Home Work Cell

(2) \_

Employer:1) \_ (2) \_

**GENERAL INFORM AT I ON**

Marital Status : \_ Single Married Other

Employment Status:

Employed Full-time

Part-T i me \_ Not employed Student

Print Your Name ( I ): \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Signature (l ):\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Date:\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Print Your Name (2):\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Signature (2):\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Date:\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Referred By:\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**How did you learn about this service:** \_ Physician Friend Web site \_ Insurance Company

# \_ Employee Assistance Program Other : \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**PRIMARY CARE PHYSICIAN CONSENT TO USE** & **DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

I authorize Amanda Marlen, PLPC, supervised by Tammy Tellez, MA, LPC , to contact my Primary Care Physician (PCP) regarding my medical conditions as well as information pertaining to my psychological and emotional functioning. This information will be useful in treatment planning. I authorize the release of the information verbally or in writing.

Primary Care Physician: Telephone: \_

1 have the following health problems:

I take the following medications:

□ I do not permit \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ supervised by to contact my Primary Care Physician.

D I do permit supervised by to contact my Primary Care Physician.

D I do not have a Primary Care Physician.

Cli ent Signature Date

**PSYCHIATRIST CONSENT TO USE** & **DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

I am currently under the care of a psychiatrist. I authorize Amanda Marlen, PLPC, supervise d by Tammy Tellez, MA, LPC, to contact my psychiatrist regarding my mental health care, services, and treatment planning. I authorize contact to be verbal or

written.

Psychiatrist Name : \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Tele phone: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

I take the following medic at ions: \_

D I do not permit Amanda Marlen, PLPC, supervised by Tammy Tellez , MA , LPC, to contact my Psychiatrist.

D I do permit Amanda Marlen, PLPC, supervised by Tammy Tellez, MA , LPC to contact my Psychiatrist

D I do not have a Psychiatrist.

Have you ever seen another therapist , counselor or mental health professional?

YES NO

If s o, who

Reason for changing therapist?

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

I give permission for the following people to receive and give information regarding my mental health:

Name & relationship Name & relations hip Name & relationship

Client Signature Date

Amanda Marlen, PLPC, supervised by Tammy Tellez, MA , LPC

737 Dunn Rd.

Hazelwood, MO 63042 (314) 731-2433

CLIENT INFORMATION & CONSENT

Therapist, Amanda Marlen, is an PLPC engaged in providing mental health services to clients directly supervised by Tammy Tellez, MA, LPC, and is not affiliated with any other clinician in this office.

MENTAL HEALTH SERVICES: BENEFITS & RISKS

While it may not be easy to seek help from a mental health professional, I hope that this experience will assist you in understanding your situation or problem and moving toward a resolution of this issue. A therapist has professional training and knowledge of human development and behavior and will make observations about your situation and will assist you in finding options for resolution of your issue(s). The therapist may utilize various therapeutic approaches in order to assist you in resolving your problem(s). You should be aware that entering into psychotherapy is a risk. Psychotherapy sessions can be painful at times. Often times, you may learn new information about yourself that you may not like. Often personal growth cannot occur until you are able to confront your issues and experience the associated feelings. These feelings may include pain, sadness, anger or shame. The success of our work depends on quality effort of both therapist and client and the realization that you are ultimately in control of and responsible for the changes that

result from psychotherapy. Specifically, one risk of psychotherapy is encountering (positive or negative) reactions from significant others to your new lifestyle choices / changes.

GOALS, PURPOSES, AND TECHNIQUES OF THERAPY

Psychotherapy may be one way to effectively treat your problem. There may be alternative ways to treat your problem. lt is important for you to discuss any concerns you have regarding the therapist's treatment recommendations. The therapist encourages you to provide input into setting your goals for therapy and the therapeutic techniques used for treatment. As therapy progresses, these goals and techniques may change.

RELATIONSHIP

Your relationship with your therapist is a professional relations hip. In order to preserve this relationship, the therapist cannot have any other type of relationship with you. Any personal or business relationships with you will undermine the effectiveness of the therapeutic relationship and therefore is strictly prohibited. Your therapist is committed to your mental health, but is not in the position to become socially or personally involved with you. Plea s e note that the therapist cannot accept any gifts, or barter/trade services.

SESSIONS

Individual Therapy sessions are 50 minutes in length. The number of sessions needed depends on various factors and can be discussed during your session. Some insurance companies may provide a li m ite d number of sessions under your designated plan. If your insurance company requires authorization for mental health services, it is your responsibility to obtain this authorization prior to our initial appointment. Requests for additional sessions from your insurance company will be requested by the therapist.

APPOINTMENTS & CANCELLATIONS

To schedule an appointment, please call (636) 358-6459. If you think that you will be unable to attend a scheduled appointment, please provide me with 24 hours’ notice. If you miss an appointment, it is your responsibility to contact the therapist to reschedule. **If you do not show up for an appointment, and do not call to cancel your appointment within 24 hours of the missed appointment. all**

**future scheduled appointments will be canceled.** The therapist does not provide reminder calls about your upcoming appointment. An appointment card will be provided to you for your convenience.

**CONHDENTIALITY:** All sessions with your therapist are confidential. No information will be released without your written consent. However, there are some exceptions including, but not limited to the follow in g:

I. Missouri State Law demands that all providers report any suspected physical or sexual abuse to the appropriate Child or Elderly Hotline Services, which is then reported to the appropriate agency for investigation.

1. Missouri State Law and Professional Ethics require all providers to report if a client is homicidal or suicidal. This is reported in order to help the client rather than harm the client. Therapist also has a duty to warn any person who is a potential target for harm by a client. Therapist will notify targeted person and law enforcement of any such threats.
2. If a Federal or State Court requests the release of records, the provider has to comply, with certain exceptions.
3. Most insurance companies require that a provider keep a patient's " Primary Care Physician" informed of his /her mental health treatment. By signing the consent, you agree to allow me to keep your physician informed at my discretion.
4. A fee dispute between the therapist and client.
5. A negligence suit brought by the client against the therapist or a complaint filed with a licensing board, or other state or federal regulatory authority.

For further information, please review the Notice of Privacy Practices handout provided to you by the therapist. If you have additional questions, please address them with the therapist. By signing this information and consent form, you are giving consent to the understated therapist to share confidential information with all persons mandated by law and with the managed care company and/or insurance carrier responsible for providing your mental health services and payment for those services. You are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN

I designate the following people to be contacted if I am in danger:

NAME RELATIONSHIP TELEPHONE NUMBER

FEES & PAYMENTS

The initial therapy session is$15.00. All payments and co-payments MUST be paid at the time of service. For your convenience, I accept cash, checks, MasterCard, Discover, and Visa. Returned checks will have a$25 fee. If there are questions or concerns about the therapy fee, please discuss this matter with me.

FINANCIAL POLICY

Adult patients are responsible for payment of their own accounts. MINOR PATIENTS

The adult accompanying a minor and the parents/guardians of the minor are responsible for payment of the minor's account.

DOCUMENTATION

I do not provide written documentation, summaries or completion of forms requested by you or other agencies (i.e. Social Security Administration, short-term disability companies, etc.). However, if any formal request for this service is requested, a fee of$50.00 per document will be charged. The fee will be collected from the client prior to the completion of the document.

LEGAL PROCEEDINGS

The therapist does not attend court proceedings. If you believe any situation you are involved in will require the therapist being involved in legal matters, a referral to other therapists will be provided to you. If the therapist is subpoenaed on your behalf or if for testimony on behalf of another party which involves you, a fee of$200/hour will be charged for the therapist's time, preparation and expense spent in responding to a subpoena. This fee also applies to travel time and time spent in court. This fee will be charged from when the therapist leaves her residence, the duration of court proceedings and until the time the therapist returns to her residence. You will be required to pay the estimated fee prior to the court date. Any amount collected in excess of the actual time spent will be refunded to you.

TELEPHONE CONCERNS AND AFTER HOURS CONTACT

I can be reached via phone at (636) 358-6459.

My clients are assumed to be self-responsible and autonomous and not in need of day-to-day supervision. Therefore, I cannot assume responsibility for day-to-day functioning as can an institution (hospital, mental health agency). ln order for me to provide the best care for my clients, if you believe you are in a life threatening crisis, please call 911, call your psychiatrist, go to the nearest emergency room, and call Life Crisis 314-647-4357 or Behavior Health Response (BHR) at 314-469-6644. Please leave a message at my number (636)-358-6459. If you need to cancel an appointment on a day prior to your scheduled appointment.

THERAPIST'S INCAPACITY OR DEATH

In the event Amanda Marlen, supervised by Tammy Tellez, MA, LPC, is unable to continue facilitating therapy sessions with me, due to his/her illness, death or other emergency situation, it will be necessary for another mental health professional to take possession of my file and records and access to my contact and treatment information. I give permission to allow Amanda Marlen, supervised by Tammy Tellez, MA, LPC, to take possession of my file and records. I am aware that I may have a copy of portions of the file or request that my entire file be transferred to a mental health professional of my choosing.

4

ELECTRONIC MESSAGING POLICY

It is understood that any written communication via the PLPCet, including e-mail, or via texting may be susceptible to unauthorized interception, In the event that you do not wish any communication via e-mail or other means, please notify us in writing.

\_ I do NOT want to communicate by any form of electronic messaging

\_ I give you permission to communicate with me by electronic messaging. I understand this form of communication may be susceptible to unauthorized interception.

CONSENT TO TREATMENT

I voluntarily agree to receive menta l health services which include assessment, care, treatment or services through the understated the rapist.

I agree to participate in the planning of my ca re, treatment or services and I acknowledge that I may discontinue care, treatment or services at any time.

1 have thoroughly read and understand this Client Information and Consent Form. I agree to all the terms and information contained in this document. I have been given opportunity to ask questions and seek clarification of this document. l acknowledge that I have been given the choice to receive a copy of this signed Client Information & Consent Form

] ) \_

Client Signature Date

2)\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Client Signature Date

Responsible Party if other than client Date

Amanda Marlen, PLPC Date

Tammy Tellez, MA , LPC Date

Client received a copy

Client declined a copy

Notice of Privacy Practices

Amanda Marlen, PLPC, supervised by Tammy Tellez, **MA,** LPC

(Effective April 1 5, 2003; amended August I. 201 3)

*This notice is developed in compliance with the Health*

*Insurance Portability and Accountability Act of I 996 (45CRF)*

**If you are a client of Amanda Marlen, PLPC , supervised by Tammy Tellez, MA, LPC, this notice describes how your health information may be used and disclosed and how you can get access to this in formation. Please review this notice carefully.**

1. *Understanding Your Health Record/ Information*

As a client of Amanda Marlen. PLPC. supervised by Tammy Tellez. MA, LPC . a record is kept of your visit. This record contains your reason for seeking services. symptoms, diagnosis ,and a plan of treatment for future services. Although this record is the property of Walter·s Walk. the information with in the record belongs to you. Th is information is considered your --Protected Health Information•· (PH I) and is afforded certain protections under the law.

*H ITECH Amendments:* Amanda Marlen, i ntern supervised by Tammy Tellez. MA ,LPC, has included HIT ECH Act provision to its No tice as follows: H IT ECH Notification Requirements. Under HITECH, Amanda Marlen, PLPC, supervised by Tammy Tellez, MA, LPC. is required to notify clients whose PHI has been breached. Notification must occur by fir s t-class mail within sixty (60) days of the event. A breach means the acquisition, access, use or disclosure of PHI in a manner not permitted under the Privacy Rule which compromises the security or privacy of such information. This Notice mu s t: ( I ) contain a brief description of what happened , including the date of the breach and the date of discovery :

(2) the steps the individual should take to protect themselves from potential harm resulting from the breach; and (3) a brief description of what Amanda Marlen, PLPC, supervised by Tammy Tellez, MA, LP C, is doing to investigate the breach, mitigate losses, and to protect against further breaches.

Cash Clients

HIT ECH provides, that is a client pays in full for their services out of pocket, they can demand that the information regarding the service not be disclosed to the client' s health plan since no claim is being made to the health plan.

Access to E-Health Records

HIT ECH expands this right, givi ng individuals the right to access their own e-health record in electronic format, and to direct Amanda Marlen. PLPC, supervised by Tammy Tellez, MA, LPC, to send thee-health record directly to a third party. Amanda Marlen, supervised by Tammy Tellez, MA, LPC, may only charge for labor costs under these new rules. Amanda Marlen, PLPC, supervised by Andrew

Jovanovic , MA, LPC , currently does not participate in E-Health Records, when this becomes an option, all clients will be notified.

*Ill. How I May Use and Disclose Your Protected Health Information*

Amanda Marlen, PLPC, supervised by Tammy Tellez, MA, LPC, will not dis close your health information without your authorization. except as described in this notice.

Other

Walter's Walk: Amanda Marlen, PLPC, supervised by Tammy Tellez, MA, LPC, may also provide your contact information (name, address and phone number) to Walter' s Walk, which handles fundraising efforts. However, you may opt out from these efforts. To opt out, please notify Amanda Marlen, PLPC, supervised by Tammy Tellez, MA, LP C.

*Treatment:* Amanda Marlen, PLPC, supervised by Tammy Tellez, MA, LPC, will use your health information to provide treatment. For example, information obtained will be recorded in your record and used to determine the course of treatment/services. Amanda Marlen, PLPC, supervised by Tammy Tellez, MA, LPC, may consult with other health care professionals to coordinate treatment/services. This will only be done to ensure the course of treatment/services is appropriate to your situation.

*Health Care Operations:* Your health information may be reviewed by regulatory and accrediting organizations to ensure compliance with their requirements.

*When Required by Law:* Amanda Marlen, PLPC, supervised by Tammy Tellez, MA, LPC, may dis close your health in formation when a la w requires that the therapist report information about suspected abuse, neglect, domestic violence. relating to suspected criminal activity, or in response to a court order.

*Duty to Warn:* Amanda Marlen, PLPC, supervise d by Tammy Tellez, MA, LPC, may disclose protected health information when a client communicates to him/her a serious threat of suicide or physical violence against himself/herself or a reasonably identifiable victim(s). In such an

instance, Amanda Marlen, PLPC, supervised by Tammy Tellez, MA, LPC, will notify either the threatened person(s) and/o r law enforcement.

*Notification:* In an emergency, Amanda Marlen, PLPC, supervised by Tammy Tellez, MA , LPC , ma y use or disclose health information to notify or assist in notifying a family member, personal representative or another person responsible for your care, of your lo cation and general condition.

*Workers Compensation:* Amanda Marlen PLPC, supervise d by Tammy Tellez, MA, LPC , may disclose health information to the extent authorized by and to the extent necessary to comply with laws re lati ng to worker' s compensation or other similar programs established by the law.

*Public Health:* As required by federal and state law, Amanda Marlen, PLPC, supervised by Tammy Tellez, MA. LPC may disclose your health information to pub li c health or leg al authorities charged with preventing or controlling disease, injury or disability.

*Correctional Institution:* Should you be an inmate of a correctional institution, Amanda Marlen. PLPC, supervised by Tammy Tellez. MA. LPC. may disclose to the institution health information necessary for your health and the health and safety of others.

*Charges Against:* Amanda Marlen, PLPC, supervised by Tammy Tellez. MA, LPC. may dis close your health information to defend himself/ herself against any legal action you may take against him/her.

*App ointments/Treatment:* Amanda Marlen, PLPC, supervised by Tammy Tellez, MA, LPC, may contact you about appointment reminders or treatment alternatives.

In all of the above stated circumstances, other than for treatment, Amanda Marlen, PLPC , supervised by Tammy Tellez , MA , LPC , will release only the minimum amount of information n necessary to accomplish the purpose of the use or disclosure.

Other:

In any other situation, Amanda Marlen, PLPC, supervised by Tammy Tellez, MA, LPC, will request your written authorization before using or disclosing any of your identifiable health information. For instance, most us es and disclosures of psyc hotherapy notes (if recorded by therapist) and most uses and dis closures for marketing purposes, including subsidized treatment communications, will require your authorization.

Additionally, most disclosure s of PH I that constitute the sale of PHI will require your authorization. If you choose to sign such an authorization to disclose information, you can revoke that authorization at any time to stop future/dis closures.

*IV Your Rights Regarding Your Health Information*

You have the following rights with respect to your protected health information:

I . You have the right to re quest in writing that your protected health information not be used or disclosed by Amanda Marlen PLPC. supervised by Tammy Tellez, MA, LPC, for treatment, payment or administrative purposes or by to persons involved in your care

except when specifically authorized by you. Amanda Marlen, PLPC, supervised by Tammy Tellez, MA, LPC ,will consider the request, but is not legally bound to agree to the restriction unless it pertains to dis closures to a client' s health plan concerning an item or service for which Amanda Marlen, supervised by Tammy Tellez , MA, LPC, has been paid out-of-pocket in full. To the extent that she does agree with any restriction, she will put the agreement in writing and abide by it except in emergency situations. She cannot agree to limit uses/dis closures that are required by law.

* 1. You have the right to request that Amanda Marlen, PLPC, supervised by Tammy Tellez, MA, LPC , contact or send you

information at an alternative address or by an alternative means. He/she will agree to your request as long as it is reasonably easy for him/her to do so.

* 1. You have the right, within the limits of Missouri statutes, to inspect and copy your protected health information. Any such requests must

be made in writing. Amanda Marlen, PLPC, supervised ed by Tammy Tellez , MA, LPC. will respond in writing to such a request t within 30 days. If you request copies , Amanda Marlen , PLPCs , supervised by Tammy Tellez , MA, LPC , may charge you a reasonable cost for copyi ng.

* 1. You have the right to submit a request to amend you r information if you believe that information in your record is incorrect or if important information is missing.
  2. You have the right to receive an accounting of certain disclosures of your protected health information.
  3. You have a right to receive this Notice in paper and/or in electronic format.
  4. *Amanda Marlen. PLPC. supervised by Tammy Tellez, MA. LPC Duties*

I . Amanda Marlen, PLPC, su pervi sed by Tammy Tellez, MA. LPC , is req uired by law to maintain the priva cy of protected health in formation an d to provide individua ls with notice of its legal duties and privacy practices with respect to protected health information.

1. Amanda Marlen, PLPC, supervised by Tammy Tellez, MA. LPC , is required to abide by the terms of this Notice currently in effect, and
2. Amanda Marlen. PLPC supervised by Andre w Jovanovic , MA , LPC, reserves the right to change the terms of this Notice and make

the new Notice provisions effective for all protected health information that he/she maintains. Should Amanda Marlen, PLPC.

supervised by Tammy Tellez , MA, LPC , make changes in its Notice, he/she will post the changed Notice in the office wa iting area. You may request a copy of the Notice at any time.

* 1. *Complaint Procedure*

If you are concerned that Amanda Marlen, PLPC supervised by Tammy Tellez, MA, LPC, has violated your privacy rights, please contact him/her. You have the right to file a complaint with him/her or with the Board of Walter's Walk and/or with the Secretary of the Federal Department of Health and Human Services. Under no circumstances will any action be taken against you for filing a complaint.

By signature , I confirm that J have received this Notice relative to the use of my protected health in formation .

Client or Guardian Signature

0 Client received a copy

D Client declined a copy

Date

Amanda Marlen Date

Tammy Tellez MA, LPC Date