Confidential General Information

Date: _____

PATIENT INFORMATION

Full Legal Name: _____
(Last) (First) (MI)

Address: _____

City, State, Zip: _____

Preferred Daytime Phone: ( ) _____ Date of Birth: _____

Social Security: _____ M _____ F _____

Employer: _____ School: _____
(Parent's Employer if client is a minor)

Work Phone: ( ) _____ ext _____ Cell Phone: ( ) _____

Marital Status: Single _____ Married: _____ Other _____

Spouse/Parent Name: _____ Date of Birth: _____

Parent Name: _____ Daytime Phone #: ( ) _____

Parent Name: _____ Daytime Phone#: ( ) _____

Email: _____

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party: _____

Address: _____

City, State, Zip: _____

Daytime Phone: ( ) _____ Cell Phone: ( ) _____

Date of Birth: _____ Social Security: _____

M _____ F _____

Confidential General Information

ADDITIONAL INFORMATION

In Case Of Emergency Contact:

Name: _____ Phone: ( ) _____

Who may we thank for referring you: _____

Previous outpatient phychological/psychiatric counseling with: _____

Date of last visit: _____ Number of mental health visits used this year

Psychiatric Hospitalization: Yes _____ No _____ Dates: _____

Physical Illness/Disabilities:

General Physician:

INSURANCE INFORMATION:

Insurance Company: _____ Policy Number: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscribers Sex: M _____ F _____ Subscriber's Relationship to Patient: _____

Insurance Company: _____ Policy Number: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscribers Sex: M_____ F _____ Subscriber's Relationship to Patient: _____

If subscriber's address is different from patient please fill out below:

Address: _____

City, State, Zip: _____

Daytime Phone: ( ) _____

I authorize the release of any medical information necessary to process claims and request payment of medical benefits to the provider.

Signature of Patient/Legal Guardian: _____ Date: _____

CONTACT INFORMATION FOR REMINDER CALLS

We do provide a reminder for your appointments. Please indicate below how you wish to be contacted.

_____ Text Cell Number _____

_____ Email Email Address _____

_____ Phone Call Phone Number _____

_____ Do not contact me for reminder calls

_____ _____

(Print Name) (Date)

Terri Needels, Ph.D.
615 Piikoi St. * Suite 1603 * Honolulu, Hawaii 96814 (808) 596-8778 * Fax: (808) 596-8558

CONDITIONS OF TREATMENT

1. RECORD KEEPING:

Brief notes are kept, primarily to help organize treatment direction. Information given in the sessions will not be divulged to anyone without your written consent. All medical records are treated with the utmost concern for privacy and are kept in compliance with HIPAA regulations.

2. MISSED SESSIONS:

Appointment times are reserved for you, therefore must be cancelled 24 hours in advance. If not, clients will be billed for the therapy time reserved. Insurance does not cover missed appointments. Exceptions will be limited to bona fide emergencies.

3. FEES:

Sessions (individual, marital or family) are billed at the rate of $ ~~198.95~~ 190.00, including tax, per 50 minutes.

Most health insurance plans partially cover the cost of service. (I.E. most insurance companies cover 80% - 90% of the fee)

The therapist does not render services on the assumption that fees will be paid by the insurance company. THE CLIENT REMAINS SOLEY RESPONSIBLE FOR PAYMENT OF HIS/HER ENTIRE BILL, AND IT IS THE CLIENT'S RESPONSIBILITY TO DEAL WITH HIS/HER INSURANCE CARRIER IF THE CHARGES ARE DISALLOWED. THE CLIENT ALSO REMAINS RESPONSIBLE TO NOTIFY THIS OFFICE OF REQUIREMENTS, CHARGES, AND LIMITATIONS OF HIS/HER INSURANCE. (I.E. Preauthorization, primary physician referral, etc.)

4. PAYMENT PROCEDURE:

Co-payments/payments are due at each session. Please handle all payments promptly.

I have read, understood, and agree to the conditions described above.

Signature of Client _____ Date _____

Signature of Payment Guarantor _____ Date _____

615 Piikoi Street, Suite 1603
Honolulu, HI 96814
Phone: (808) 596-8778
Fax: (808) 596-8558

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY #
PATIENT ADDRESS	CITY	ZIP CODE

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I understand that:

1. This authorization may include disclosure of information related to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except by psychotherapy notes, and CONFIDENTAL HIVE RELATED INFORMATION only if I place my initials on the appropriate line in item 9(A). In the event the health information described below includes any these types of information, and I initial the line of the box in item 9(A), I specifically authorize release of such information to the person(s) indicated in item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.
3. I have the right to revoke this authorization at any time by writing to the health care provided listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient if I have agreed to participate in a court ordered evaluation with the recipient, and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOE S NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THA THE INDIVIDAUL OR AGENCY SPECIFICED IN ITEM 9(B).

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(A) Specific information to be released:

_____ Medical records from (insert date)_____ to (insert date)_____

_____Entire medical record, including patient histories, office notes, test results, consults, and records Sent to you by other health care providers. Include: (indicate by initialing)

_____ALCOHOL/DRUG TREATMENT _____ MENTAL HEALTH INFORMATION _____ HIV-RELATED INFORMATION

9(B) AUTHORIZATION TO DISCUSS HEALTH INFORMATION

By initialing here_____ I authorize _____

To discuss my health information with_____

10. Reason for release of information:
_____ Custody Evaluation
_____ Mental Health Treatment
_____ Review of Prior Treatment

11. Date or event on which this authorization will expire:_____
Date

IF NO DATE IS SPECIFIED IT WILL EXPIRE 1 YR AFTER FROM DATE OF SIGNATURE

12. If not the patient or a minor, printed name of person signing form:

_____

Relationship to patient:_____

_____ _____

Signature of patient or representative authorized by law Date

Terri Needels, Ph.D.
615 Piikoi St. • Suite 1603 • Honolulu, Hawaii 96814
(808) 596-8778 • Fax: (808) 596-8558

Terri Needels, Ph.D.

CHILD THERAPY AGREEMENT

This "Child Therapy Agreement" is for use in the complex situation which exists when the parents or guardians of a child or teen who is seeking my services, are divorcing, divorced, separating, or separated. Under those conditions, I ask you to agree to the following:

Consent to Treatment: In case where parents/guardians have joint legal custody, I will require written consent from both parents/guardians for me to work with their child/teen. Signing this letter of agreement will represent such consent. I will also require, prior to the first meeting, a copy of that portion of the divorce decree/court document describing the custody of the child/teen.

Confidentiality: To assist their child/teen in establishing a trusting and therapeutic relationship with me, parents/guardians are willing to waive their right to access their child's/teen's therapeutic information, including their statements made during therapy, except when the child's/teen's physical health and safety are in imminent jeopardy. Parents/guardians attest to this waiver by signing this agreement.

Forensic Matters: Parents/guardians understand that my role is to be their child's/teen's therapist. Unless ordered to do so by a court order signed by a judge, I will not provide information to a court or attorney, either orally or in writing, as this may compromise my therapeutic role. I may consider discussing information with a court-appointed professional who is functioning in the role of a custody evaluator or guardian-ad-litem, if that professional is obtaining information from a variety of sources. It is NOT part of my role as therapist to recommend any changes in custody or visitation.

Dual Role: If I am your child's/teen's therapist, I will NOT take on a second role, such as parent therapist, court evaluator, mediator, or expert witness for one parent.

Financial: The parent/guardian who brings/accompanies the child/teen to their session with me, or, if not in attendance, who scheduled that appointment, will be responsible for the co-payment or payment of my fee, whichever is appropriate for that visit.

Your signature below indicates that you understand and agree to the conditions specified in this agreement.

_____	_____	_____
Signature	Child / Children	Date
_____	_____	_____
Signature	Child / Children	Date

TERRI L. NEEDELS, PhD
Hawaiifamilytherapy@yahoo.com
615 Piikoi St, Suite 1603
Honolulu, HI 96814
Ph: (808) 596-8778 Fax: (808) 596-8558

AUTHORIZATION FOR EVALUATION/TREATMENT OF MINOR

PATIENT NAME _____ **DATE OF BIRTH** _____

1. CONSENT TO PSYCHOLOGICAL CARE
I give permission to Terri Needels, Ph.D. to provide clinical, educational, diagnostic testing and/or therapeutic services for my minor child, as deemed appropriate by her professional judgment. I am aware that the practice of psychology is not exact science and I acknowledge that no guarantees have been made to me as to the results of evaluation or treatment. I am also aware that I should ask Dr. Needels any questions that I might have about my minor child's diagnosis, treatment, risks or complications, alternative forms of treatment and/or anticipated results of treatment.

2. AUTHORIZATION FOR REVIEW AND RELEASE OF INFORMATION
I understand that Dr. Needels may disclose my child's health information for the purposes of treatment, payment, quality assurance, outcomes assessment, competence or qualifications review of healthcare professional, accreditation, licensing or credentialing activities, health plan claims or health care record analysis, provider clinical performance evaluations, utilization management, required audits or qualified healthcare operations. **I understand further that my child's records may contain entries or information relating to sexually transmitted diseases, including human immunodeficiency virus (HIV) or psychological impairment, drug and alcohol abuse and other personal information and I specifically authorize the release of such information.**

3. FINANCIAL AGREEMENT AND PAYMENT PROVISIONS
I will be billed by Dr. Needels for her services. I understand that prior to receiving services I may choose to pay for services directly if I do not want my health insurance information for that service provided to the insurance company. I further understand and agree to be liable for the full payment of the cost of service rendered to my child and will make full payment within 30 days of the bill. I understand Dr. Needels may release information to my health care insurer and it's representatives. Should the charges not be paid and account is referred to an attorney for collection, reasonable attorney's fees and collection expenses will be added to the charges. **A flat fee of $50.00 will be assessed for all no shows or cancellations less than 24 hours, for each visit.**

4 ASSIGNMENT OF INSRUANCE BENEFITS
I authorize assignment of any mental health benefits I am due to Dr. Needels for application to my bill. I further authorize Dr. Needels to accept such insurance payments. I agree to remain responsible and liable for payments of all amounts due to Dr. Needels and not received by the insurance carrier(s). I understand that Dr. Needels is rendering me a courtesy in submitting claims on my behalf. In the event that the insurance carrier rejects claims OR pays for services but later rescinds payment, I understand that I am liable for full payment of services.

5. E-MAILS, CELL PHONES, COMPUTERS AND FAXES: It is important to be aware that computers, e-mails and cell phone communication can be accessed by unauthorized people which can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access as servers have unlimited and direct access to all emails that go through them. Additionally, Dr. Needels e-mails and data on her computers are not encrypted. It is always possible that faxes can be sent erroneously to the wrong address and computers, including laptops, may be stolen. Dr. Needels computers are equipped with firewall, virus protection and passwords, and she also backs up all confidential information from her computers on to CD's on a regular basis. Please notify Dr. Needels if you decide to avoid or limit, in any way, the use of e-mails, cell phones or faxes, or storage of confidential information on computers. If you communicate confidential or private information via e-mail, Dr. Needels will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and she will honor your desire to communicate on such matters via e-mail. Please do not use e-mail or faxes for emergencies. Due to computer network problems, e-mails may not be deliverable, and Dr. Needels may not check her emails or faxes daily.

My signature below will confirm I have read and agreed to the terms of this authorization for treatment for my child and that I acknowledge that I have received the HIPAA notice of policies and practices to protect the privacy of my child's health information.

THE UNDERSIGNED CERTIFIES THAT YOU UNDERSTAND THE FOREGOING AND ARE AUTHORIZED TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

_____
SIGNATURE OF PARENT, NEXT OF KIN, AUTHORIZED REPRESENTIVE OR OTHER RESPONSIBLE PARTY:

_____ _____
DATE OF SIGNATURE RELATIONSHIP TO PATIENT

COPY AS VALID AS ORIGINAL

Terri Needels, Ph.D.
615 Piikoi St. • Suite 1603 • Honolulu, Hawaii 96814
(808) 596-8778 • Fax: (808) 596-8558

Parent Counseling Agreement

The goal of parent counseling is to have the parents arrive at mutually agreed decisions regarding the best ways to parent their children. This requires an environment that would allow open and honest communication between parents. An important component of that environment is confidentiality regarding the discussions and the counseling process. As such, I agree that I will hold all discussions that occur in the counseling sessions as confidential. I further agree that neither my/our counseling records nor the parent counselor will be subpoenaed in any part of our divorce/paternity or custody case.

Any agreements that we jointly make as parents may be shared with the court and others. Whatever agreements we make as parents will be put in writing by either or both of us and will be signed by both of us to demonstrate the mutuality of the decision.

Father	Date	Mother	Date

Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reason to believe that child abuse or neglect has occurred or that there exists a substantial risk that child abuse or neglect may occur in the reasonably foreseeable future, I must immediately report the matter to the appropriate authority.
- *Adult and Domestic Abuse* – If I, in the performance of their professional or official duties, know or have reason to believe that a dependent adult has been abused and is threatened with imminent abuse, I must promptly report the matter to the appropriate authority.
- *Health Oversight Activities* – If the Hawaii Board of Psychology is investigating my competency, license or practice, I may be required to disclose protected health information regarding you.

Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the counseling or psychotherapy services provided to you and/or the records thereof, such information is privileged under Hawaii law, and I shall not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I shall inform you in advance if this is the case.

- *Serious Threat to Health or Safety* – I may disclose protected health information regarding you where there is clear and imminent danger to you or another individual or to society, and then only to appropriate professional workers or public authorities. If you are at risk, I may also contact family members or others who could assist in providing protection.

- *Worker's Compensation* – If you have filed a worker's compensation claim, I may be required to disclose PHI about any services I have provided to you that are relevant to the claimed injury.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a copy.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact your doctor. If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to your doctor at 615 Piikoi Street #1603 Honolulu, HI 96814.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Our office staff can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain.