OFFICE POLICIES AND PROCEDURES for the Psychology Practice of Dr. Zeiders:

1. I will make payments or co pays on days of service. I accept that failure to pay on day of service results in a $5.00 surcharge.
2. If insurance companies refuse to pay claims, I will pay the therapist's fee.
3. If I cancel/miss a session for any reason under 48 hour lead time, I will be charged and I will pay a missed session fee of $65. This includes missing sessions in case of emergencies. I will not ask to be an exception. I realize this is a practice business necessity and not a punitive fee. Signature:____
4. I accept that phone conversations with my therapists that last over 5 minutes will be charged at a $1.00 a minute after the 5th minute.
5. I accept that high levels of rage, self injurious behavior, violence, violation of policies, loss of rapport, failure to pay, and lack of treatment progress can result in termination at the therapist's discretion.
6. If treatment is terminated, I understand that my therapist will offer to provide me with names and numbers of other mental health providers, but I am not obligated to use their services.
7. I understand that if I have an emergency while not in session, I have the option of calling 911, or going to an emergency room, and I acknowledge that it is in my interests to avail myself of these options if I am in a state of crisis.
8. I affirm that I will familiarize myself with the booklet or poster entitled Notice of Privacy Practices, writing if I feel that my privacy rights have been violated, and that I can further complain to the Secretary of the Department Of Health and Human Services. At any time, I can ask my therapist for the complaint form. There will be no retaliation whatsoever and corrective measures will be taken immediately.
9. I consent to allowing my therapist to disclose information about me to insurance companies, billing services, secretaries, and entitles involved in operations. I understand that information disclosed will be the minimum necessary amount of information to accomplish reasonable and customary business. I understand that my therapist has made arrangements with business associates to ensure satisfactory assurance that all information is appropriately safeguarded.
10. I understand that any other disclosure of information about me, like progress notes and therapy notes, letters, phone consultations, reports to other parties, etc. will only be made with my expressed notes, letters, phone consultations, reports to other parties, etc. will only be made with my expressed approval on a formal Authorization Form. I know that I can withdrawal such an authorization at any time.
11. I understand that my therapist makes reasonable efforts to store my records in a secure manner, whether in paper files or electronically stored.
12. I understand that my therapist makes reasonable efforts to keep all communication about me, secure whether written, faxed, or electronically submitted.
13. I understand that my therapist makes reasonable efforts to ensure that secretaries, billing services, and people related to operations will keep Information related to my treatment secure. If I request Dr. Zeiders to generate a document for me I will pay a minimum of $65 or more.
14. I understand that, unless otherwise specified, appointments will begin at or near the hour and end ten minutes of the next hour.
15. If for any reason my insurance carrier refuses to pay my therapist's customary fee, I will be responsible for the balance and will pay the fee within one month of being billed.
16. I agree that I will pay fees for the production of documents for which I ask and will be charged by the hour.
17. I enter into treatment freely and without coercion and realize that there are different viewpoints on therapy and that no therapy offers a guarantee of success. I know that I can leave treatment at any time.

18. I agree to pay Dr. Zeiders $1500 dollars if he is a fact witness or an expert witness for me during a deposition or court appearance testifying regarding my work with him. I acknowledge that I must provide this fee regardless of whether he is called to the stand or not.

Special Section on Cancellations

Dr. Zeiders' practice charges $65.00 for all sessions missed under 48 hours. Sessions that are canceled due to scheduling conflicts or emergencies or illness will be charged. Thank you for promptly paying all missed treatment fees following the missed session. Thank you for not asking to be an exception to this policy. Upon reading this, you agree to the following statement*: I have read these policies and I will pay for any session canceled or missed for any reason under 48 hours. I will pay the allowable amount for treatment not covered by or rejected by my insurance company within an 8 week period following treatment delivery. I will not ask to be an exception to these policies.*

Notice of Privacy Practices

Our practice is dedicated to maintaining the privacy of your personal health information. We are required by law to this. These laws are complicated and thorough. This form contains a short version of our privacy practices. The longer version is permanently available to you in the waiting room. By signing this you acknowledge that you have or will read it.

We will use information about your health which we get from you and others to provide you with treatment, to arrange payment of our services, and to engage in business operations. After you read this Notice of Privacy Practices, please sign the Consent Form to let us use and share your information. If you do not sign the Notice of Privacy Procedures and Consent Form we cannot treat you.

If we or you want to discuss your information for any purpose, like interacting with a school or lawyer, etc., we will discuss it together and disclose information only after you have signed an Authorization Form.

Of course we will keep your health information private, but there are some times when the law requires us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these, but they don't happen often. They are described in the longer version of the Notice of Privacy Practices.

Your rights regarding your health information:
You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule or cancel and appointment. We will try our best to do as you ask.

You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law.

You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records, but we may charge you.

If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes to your health information. You have to make this request in writing and tell us the reasons you want to make these changes.

You have a right to a copy of this notice.

You have a right to complain if you believe that your privacy rights have been violated. You should let your therapist know in writing, and you can also complain to the Secretary of the Department of Health and Human Services.

Ask us if you have a question about how your information will be used.

Consent Form:

When we examine, diagnose, treat or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you.

We need to use this information to engage in customary, discrete treatment and business matters.

We my need to share the minimum necessary information with others to provide treatment to you.

We may share information with others to arrange payment for your treatment, to discretely consult with knowledgeable professionals, and to engage in other normal professional operations.

By signing this form you are agreeing to let us use your information and send it to others for such purposes.

The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information.

If you do not sign this consent form, agreeing to the above, and to what is in our Notice of Privacy Practices, we cannot treat you.

If you are concerned about some of your information, you have the right to ask us not to use or share parts of it for treatment, payment, or administrative purposes. You will have to tell us in writing.

After you have signed this consent, you have the right to revoke it in writing, and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information prior to that time and cannot change that.

I understand and fully accept the policies from pages one and two that apply to me.

______________________________ __________

Signature of Client or Representative Date

INTAKE INFORMATION

(Please complete all questions on this form)

Date: ____________________

Name: ____

Address:____

____

Phone (Home):_________________________Phone (Work):_________________________

Date of Birth: __________________________ Social Security#:_______________________

Guardianship (for children and adults when applicable):____________________________

Marital Status (check one)

( ) Never Married ( ) Divorced

( ) Married ( ) Separated

( ) Widowed ( ) Cohabiting

Race (optional)

( ) White ( ) Native American

( ) African-American ( ) Asian

( ) Hispanic ( ) Other

Gender: ( ) Male ( ) Female

Age: ________

Family Members:

Name Age Sex Relationship

____
____
____
____

Employer: ____________________________ Occupation: ______________________________

School (for children, and adults when applicable):____

Referral Source: ____

Emergency Information:

Name of Emergency Contact: ________________________________ Phone: ________________

Relationship to Patient: ____

Presenting Problem (include onset, duration, and intensity):

____
____
____
____
____
____
____

Precipitating Event (why treatment now?):

____
____
____
____
____
____
____
____

Previous Medical History:

Allergies (adverse reactions to medications/food/etc.):____

Physician's Name and Tel Number: ____

Date of Last Physical Exam: ____

Findings from Exam: ____

Psychiatrist's Name and Tel Number: ____

Dr. Zeiders has my ongoing permission to contact my Physicians to ensure continuity of care: Y/N

Any relevant medical conditions (diabetes, hypertension, head traumas, cardiac problems, asthma or other breathing problems, cancer, etc.):____

Current medications (include prescribed dosages, dates of initial prescription and refills, and name of doctor prescribing medication):
____
____
____
____

Hospitalization/Surgeries (include dates, complications, adverse reactions to anesthesia, outcomes, etc.):
____
____
____
____

Past Psychiatric History (Mental Health and Chemical Dependency):

Hospitalizatious:____
____
____
____

Prior Outpatient Therapy

Previous practitioners and dates of treatment: ____
____

Previous treatment interventions: ____
____

Response to treatment interventions including medications: ____________________________
____
____

Results of recent laboratory tests and consultation reports:
____
____
____

Family Mental Health or Chemical Dependency History:
____
____
____

Psychosocial Information:

Marital History: ____

Legal History: ____

Military History: ____

Spiritual Beliefs: ____

Major Depressive Disorder

Criteria:

At least 5 of the following symptoms have been present during the same 2 week period

At least 1 of the symptoms is 1) depressed mood or 2) loss of interest/pleasure

Depressed mood most of the day, nearly every day, ( ) Yes ( ) No

As indicated either by subjective account or observation of others.

Markedly diminished interest or pleasure in all, or almost all, ( ) Yes ( ) No

Activities most of the day, nearly every day

Significant weight loss or weight gain when not dieting ( ) Yes ( ) No

(more than 5% of body weight in one month) or decrease/Increase

In appetite nearly every day

Insomnia or hypersomnia nearly every day ( ) Yes ( ) No

Psychomotor agitation or retardation nearly every day ( ) Yes ( ) No

Fatigue or loss of energy nearly every day ( ) Yes ( ) No

Feelings of worthlessness or excessive or inappropriate guilt ( ) Yes ( ) No

nearly every day (not merely self-reproach or guilt about being sick)

Diminished ability to think or concentrate, or indecisiveness, ( ) Yes ( ) No

nearly every day

Recurrent thoughts of death (not just fear of dying), recurrent ( ) Yes) No

Suicidal ideation without a specific plan, or a suicide attempt

Or a specific plan for committing suicide

Client's Signature: ______________________________________ Date: _____________

TO BE COMPLETED BY PSYCHOLOGIST:

RISK FACTORS
Risks related to Demographics LMH
Risks related to Current Stressors LMH
Risks related to Mental Status LMH
Risks related to Dangerousness LMH
Risks related Functionality LMH
Risks related Support System LMH
Risks related Substance Use LMH
Risks related Medical Condition LMH
Risks related Treatment History LMH

Referral to **PREVENTIVE SERVICES** for all patients (as appropriate):
_____Relapse prevention
_____Stress management
_____Wellness programs
_____Lifestyle changes
_____Referrals to community resources
_____Legal Aid
_____Financial aid
_____Pastoral care
_____Medical/Psychiatric Assessment
_____Others :(describe)

Mental Status (circle appropriate items):
Appearance: Appropriate Inappropriate DisheveledUnclean Bizarre

Affect: Appropriate Inappropriate (describe):________________________________

(sad, anger, anxious, superficial, restricted, labile, flat)

Orientation: Oriented Disoriented (to person, place, time, date, day, situation)

Mood: Normal Other_______________ (euthymic, depressed, irritable, angry)

Thought Content: Appropriate Inappropriate

Thought Process: Logical Tangential Illogical

Speech: Normal Slurred Slow Pressured Loud
Motor: Normal Excessive Slow Other: _____________
Intellect: Above Average Below
Insight: Present Partially Present Absent
Judgment: Normal Impaired
Impulse Control: Normal Impaired
Memory: Normal Impaired Immediate Recent Remote
Concentration: Normal Impaired
Attention: Normal Impaired
Behavior: Appropriate Inappropriate (anxious, agitated, guarded, drowsy, hostile, hyperactive, psychomotor, retardation)
Thought Disorder: No Problem Delusions Grandiosity Paranoia

Tangential Ideas of reference Flight of ideas Obsessions
Perseveration Confusion Thought blocking Loose associations

Diagnostic Impression:

Axis I:
Axis II:
Axis III:
Axis IV: _____ Mild _____Moderate _____ Severe
Name of Stressors: _____ Family _____School _____Work _____Other (describe)
Axis V:
Current GAF: _____
Highest GAF: _____
Initial Transition/Discharge Plan: ______________________________________Client's Physicians contacted on this date with permission: Y/N

Clinician Signature: ____ Date: _________________________________