PATIENT INFORMATION FORM

TAYLOR LERNER, PSY.D.
1350 Connecticut Ave. NW, Suite 403
Washington, DC 20036
(202) 930-1350

Welcome. Please complete as much or as little of this form as you like.
The information you choose to share will remain confidential.

Name: _____ DOB: _____ Age: _____

Local Address: _____

Birthplace: _____ Hometown: _____ SSN: _____

Preferred Phone: _____ Cell Home Work OK to leave msg? Y N

Secondary Phone: _____ Cell Home Work OK to leave msg? Y N

Email Address: _____ OK to leave email? Y N

Emergency Contact (name, phone, relation): _____

Health Insurance: _____ Member ID#: _____

Do you have secondary health insurance? Y N Cultural/Ethnic Background: _____

How did you hear about me?: ___Psychologytoday.com ___Goodtherapy.org ___Online Search
___Referral: _____ ___Other: _____

REASON FOR SEEKING TREATMENT:

_____

_____

_____

_____

CURRENT ISSUES OF CONCERN: Please check all of the following items which are concerns at this time, and circle those which are most important:

___Abortion issues	___Divorce, separation	___Legal problems	___Self-injury, mutilation
___Abuse – emotional, physical verbal, sexual, neglect	___Drug use	___Loneliness, no friends	___Self-neglect, poor self-care
	___Eating problems	___Memory problems	___Sexual assault
___Academic issues	___Emptiness	___Mood swings	___Sexual concerns
___Advisor/faculty concern	___Family relationships	___Motivation	___Sexual harassment
___Aggression/violent behavior	___Fearing failure	___Overly responsible to others	___Sexual orientation/identity
___Alcohol use	___Fears, phobias	___Overly sensitive to rejection	___Sexually transmitted disease
___Anger, arguing	___Financial problems	___Panic attack	___Shame
___Anxiety, nervousness	___Gambling	___Perfectionism	___Shyness, oversensitive
___Body image	___Guilt	___Peer relationship concerns	___Smoking, tobacco use
___Career concerns, choices	___Harassment	___Pregnancy	___Sleep problems
___Childhood issues (yours)	___Health, medical concerns	___Prejudice/bias concerns	___Stress
___Children/parenting concerns	___Hallucinations	___Procrastination/time mngt.	___Suicidal thoughts
___Compulsive behaviors	___Identity issues	___Racial/ethnic concerns	___Tiredness, fatigue
___Computer excessiveness	___Impulsive, out of control	___Repeated troubling thoughts	___Violent thoughts
___Concentration	___Independence from parents	___Relationship concerns	___Withdrawal, isolating
___Decision making, indecision	___International student concern	___Relationship violence	___Worthless feeling
___Grief issues	___Irresponsibility	___Religious/spiritual concerns	___Other
___Depression, sadness, crying	___Learning disability	___Romantic relationship	

FAMILY: Please list all family members and any significant others (including names, relationship to you, age, location, occupation, and any mental illness):

_____

_____

_____

_____

_____

_____

EDUCATION AND EMPLOYMENT: Please list current and recent **significant employment** (position, company, location, and timeframe), and **education** (school, degree, location, and timeframe):

_____

_____

_____

_____

HEALTH: Please list significant medical history (chronic conditions, accidents, major illnesses, surgeries):

_____

_____

General health care provider (phone number, if available): _____
Current psychiatrist (phone number, if available): _____
Current psychiatric medication (include dosages): _____
Past psychiatric medication (include dosages): _____
Other current medication (include dosages): _____

PREVIOUS PSYCHOLOGICAL TREATMENT: Please list all past psychological treatment, including any hospitalizations (include reasons, location, and timeframe): _____

_____

_____

SUICIDALITY: Please check all that apply:

___Current suicidal thoughts ___History of suicidal thoughts ___History of suicide attempts
___Never had suicidal thoughts ___Current self-injury ___Historical self-injury

Signature _____ Date _____

PATIENT-PSYCHOTHERAPIST AGREEMENT FORM

TAYLOR LERNER, PSY.D.
1350 Connecticut Ave. NW, Suite 403
Washington, DC 20036
(202) 930-1350

Welcome to my practice. I appreciate your trust and the opportunity to assist you. I am providing you with the following information to answer many questions common to someone beginning psychotherapy, as well as to outline the policies and procedures of my practice. If you have any questions or concerns, please do not hesitate to discuss them with me. Signing this document represents an agreement between us.

Psychotherapy

I see patients for weekly or bi-weekly 45-minute psychotherapy sessions. I invite you to ask me about my training and therapeutic perspective, and you are free to voice any concerns or questions you have about therapy. It is my intention to be curious and supportive, and you are encouraged to share your thoughts and feelings openly and without fear of rejection. Because I only accept patients whom I believe I can help using my professional knowledge and training, I will enter our work with optimism and enthusiasm.

As with any treatment, there are both benefits and risks associated with psychotherapy. The benefits of therapy have been repeatedly and scientifically demonstrated for most people in most situations. Possible benefits include a reduction in symptoms, obtaining solutions to specific problems, increased self-understanding and acceptance, the attainment of more meaningful relationships, and deeper life satisfaction.

Since therapy often involves discussing unpleasant aspects of your life, you may experience an increase in uncomfortable feelings, including sadness, anger, fear, guilt, or anxiety. As you begin the healing process and face difficult thoughts and feelings, you may experience an exacerbation of symptoms, the questioning of beliefs and values, the recollection of unpleasant life events, and possible changes in lifestyle, relationships, or employment. Of note, these feelings may be natural, normal, and important parts of your therapy. During our work together, I hope to discuss any of your reactions or adverse side effects to your therapy.

Our work will end once you are satisfied with your progress. You may also decide to terminate therapy for other reasons, but I encourage that we meet for at least one additional session to discuss ending our work together. In addition, Ethical Standards dictate that I should terminate therapy when I do not feel it is helpful, and if I do so, I will be sure to provide you with appropriate referrals.

Appointments and Office Hours

My services are scheduled by appointment only and are for 45 minutes. Our first few sessions will involve an evaluation of your treatment needs; approximately 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need to meet your treatment goals. Once psychotherapy has begun, I will usuallly schedule one 45-minute session per week at a time we agree upon, although some sessions may be more frequent. Due to the nature of psychotherapeutic work, I must adhere firmly to time guidelines. As such, if you are late for a scheduled session, it will end at its regularly scheduled time. If I am late for a session, I will either make up the lost time or adjust the fee accordingly.

Cancellation Policy

I require **48 hours notice to cancel a session**. This is because the time we agree on is considered yours and thus the time cannot be offered to anyone else. If you are unable to cancel within 48 hours of a scheduled session, I will have to charge the full fee for the session. Please note that insurance companies typically do not reimburse for canceled sessions, leaving you responsible for the entire fee.

Telephone and Emergency Policy

If you need to reach me between regularly scheduled appointment times, you can call me at (202) 930-1350. The voice mail at this number is confidential. I check these messages regularly and will return your call at the earliest possible opportunity.

- If you are calling because of an **emergency**, please leave a message for me; however, if you cannot wait for a return call, contact your nearest emergency room or call 911.
- I do not charge for telephone contact shorter than 10 minutes. I will charge you for the percentage of time used, based on your hourly fee, for conversations longer than 10 minutes.

Billing and Fees

I charge an hourly rate for each 45 minute session. **I require payment at the time of service.** Upon your request, I will provide you with a bill detailing the service provided and the total amount paid. (Please note that returned checks are subject to a $25.00 fee). If this billing arrangement is not feasible, I ask that you discuss this with me to work out an agreeable arrangement. If the bill is two months overdue, I reserve the right to discontinue therapy until you pay the full amount. If you cannot, I will refer you to an inexpensive alternate source of help, if necessary. Additionally, I require that a credit card remain on file for the purpose of missed or late-canceled appointments or overdue balances. I will do my best to notify you before charging your card and will always supply you with a receipt for all charges incurred. If your bill remains overdue with no agreed upon payment plan, I reserve the right to refer your balance owed to a collections agency. Finally, my fee increases by $5 per session annually, beginning January 1st of each calendar year.

Insurance Reimbursement

Please note that I am not part of any insurance panels and am therefore considered an "out of network provider." If you plan to use out-of-network mental health coverage, I will fill out any necessary froms required of me and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled. Additionally, at the end of each month, I will provide you with a statement of all services rendered for you to submit to your insurance company for reimbursement. However, you (and not your insurance provider) are ultimately responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

Georgetown Student Health Insurance

I work with Georgetown Student Health Insurance (GUSHI) and seek reimbursement from them directly. If you are a Georgetown University student and plan to use your GUSHI health insurance for psychotherapy, I request permission to disclose protected patient information to your health insurance for the purpose of reimbursement, including your name, date of birth, and diagnostic code. If you do not wish to use your student health insurance or if GUSHI denies any portion of your coverage, you are ultimately responsible for full payment of my fees.

Professional Records

The laws and standards of my profession require that I keep Protected Health Information about you in your clinical record, which you have access to (upon a written request). However, since they can be confusing, I request that I am present with you to explain them if you want to read them, and you will be required to pay for this time.

Patient Rights

HIPAA (Health Insurance Portability and Accountability Act) provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. The attached form entitled "Notice of Policies and Practices to Protect the Privacy of Your Health Information" lists these rights.

Confidentiality and Privacy of Information

I will make every effort to safeguard the privacy of information concerning our work together. It is a violation of the District of Columbia Mental Health Information Act of 1978, as well as the Ethical Principles of the American Psychological Association, to disclose any information regarding the treatment of patients. There are several additional, specific exceptions to the rule of confidentiality. These are listed below:

- You may authorize me to release records or other information to individuals of your choosing. I may only do this with your expressed written consent.
- Under ethical and legal requirements, I may be required to break confidentiality in the event of a clear and imminent danger to yourself or another person.
- In the event that you disclose information that provides evidence of current abuse or neglect of minor children or a vulnerable adult, the law may require that I make a report to the appropriate state agency.
- In certain legal proceedings, confidential information may be disclosed by court order. This is a rare occurrence and would not happen without your knowledge.

Minors and Parents

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. The effectiveness of psychotherapy depends on the patient's sense of trust and safety in the therapeutic relationship so that the patient is willing to honestly address problems. While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is usually my policy to request an agreement from any patient between 15-18 and his/her parents allowing me to share general information about the progress of treatment and their child's attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Acknowledgement

Your signature below indicates that you have read this agreement and agree to its terms, and also serves as an acknowledgement that you have received the HIPAA notice form "Notice of Policies and Practices to Protect the Privacy of Your Health Information."

Name of Patient: _____

Signature of Patient: _____ Date: _____

If minor, Guardian's Signature: _____ Date: _____

Signature of Therapist _____ Date: _____

Taylor Lerner, Psy.D.

Notice of Policies and Practices to Protect the Privacy of Your Health Information:
HIPAA (The Health Insurance Portability and Accountability Act)

THIS NOTICE DESCRIBES HOW MENTAL HEALTH 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 Operation

I may use or disclose your Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations purposes with your written authorization. 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 a psychologist.
  - *Payment* refers to reimbursement for your health care. Examples of payment are when PHI is disclosed 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 or operation of the practice. Examples are quality assessment and improvement activities, business-related matters (such as audits) and administrative services, case management and care coordination.
- *"Use"* applies only to activities within the office, such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of the office, such as releasing, transferring or providing access to information about you to other parties.
- *"Authorization"* is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other 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. In those instances when I am asked for information for purposes outside of those outlined above, I will obtain authorization from you before releasing that information. I will also need to obtain authorization before releasing your Psychotherapy Notes. These 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 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 insurance coverage, as the law provides the insurer with the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

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

- *Child Abuse* – If I know or have reasonable cause to suspect that a child known to me in my professional capacity has been or is in immediate danger of being mentally or physically abused or neglected, I must immediately report such knowledge or suspicion to the appropriate authority.
- *Adult and Domestic Abuse* – If I believe that an adult is in need of protective services because of abuse or neglect by another person, I must immediately report this belief to the appropriate authorities.
- *Health Oversight Activities* – If the D.C. Board of Psychology is investigating me or my practice, I may be required to disclose PHI to the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about the professional services I have provided you and/or the records thereof, such information is privileged under D.C. law, and I will not release information without the written authorization by 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. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If I believe disclosure of PHI is necessary to protect you or another individual from a substantial risk of imminent and serious physical injury, I may disclose the PHI to the appropriate individuals.
- *Worker's Compensation* – If I am treating you for Worker's Compensation purposes, I must provide periodic progress reports, treatment records and bills (upon request) to you, the D.C. Office of Hearings and Adjudication, your employer, or your insurer (or their representatives).

IV. Patient's Rights and Provider'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 Information 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 in treatment with me. Upon your request, I will send 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 the decision reviewed. You may be denied access to Psychotherapy Notes if I believe that a limitation of access is necessary to protect you from a substantial risk of imminent psychological impairment or to protect you or another individual from a substantial risk of imminent and serious physical injury. I shall notify you or your representative if I do not grant complete access. Upon 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. Upon 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. Upon 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, even if you have agreed to receive the notice electronically.

Provider'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 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 intend to revise my policies and procedures, I must describe in a notice to patients how I will provide patients with a revised notice of privacy policies and procedures (e.g. by mail, email).

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 me (Taylor Lerner, Psy.D. at (202) 930-1350). If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me at: 1350 Connecticut Ave., Suite 309, Washington, DC 20036. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. Please note: 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 went into effect on August 1, 2004. 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. I will provide you with a revised notice by mail or in person.

CREDIT CARD INFORMATION FORM

TAYLOR LERNER, PSY.D.
1350 Connecticut Ave. NW, Suite 403
Washington, DC 20036
(202) 930-1350

I require that a credit card remain on file for the purpose of missed or late-canceled appointments or overdue balances. I will do my best to notify you before charging your card and will always supply you with a receipt for all charges incurred.

Name on Card: _____

Card Number: _____

Expiration Date: _____

CVV Code: _____

Billing Zip Code: _____