# Tezlyn "Sam" Clark, M.Ed, LPC, LLC

Licensed Professional Counselor

## NEW CLIENT INFORMATION

Your Name: _____ Phone:_____

Physical Address: _____ City/Zip:_____

Mailing Address: _____ City/Zip:_____

Date of Birth: _____ Social Security #:_____

Home Phone: _____ Cell Phone:_____ Message Phone_____

How would you like reminder alerts (i.e. a call or text the day before to remind you of the appt. Please put an X beside the option you would like) :

_____ call to my home phone _____ call to my cell phone _____ by email

_____ as a text message to my cell phone (if so, my cell phone carrier is _____)

_____ I don't want reminder alerts, I will remember my appt and understand there is a cancellation fee if I do not cancel my appt with a 24 hr notice.

e-mail:_____

Employer: _____

Work Phone: _____ Occupation:_____

Work Address: _____

Is it all right to contact you at work: Yes: _____ No:_____

Significant Other or Nearest Relative: _____

Address: _____ Phone :_____

How were you referred: _____

**NAME OF INSURED PERSON:** _____

Insured's Address (if different from above): _____

City/Zip: _____ Date of Birth: _____

Home Phone: _____ Work Phone:_____

Employer: _____Occupation:_____

Work Address: _____

**NAME OF INSURANCE COMPANY: _____**

**PLAN NAME: _____ (*if Blue Cross please specify if it's Basic Option)***

**Telephone: _____**

**Address: _____ City/Zip: _____**

**Name of Insured Person: _____ ID number:_____**

**Social Security Number: _____ Group Number:_____**

**Has your insurance coverage reached a maximum for this service w/another provider _____**

**Would you like to be placed on our mailing list for announcements of workshops and groups?**

**Yes: _____ No: _____**

# Release of Information Consent Form

I,_____ authorize Tezlyn "Sam" Clark, M.Ed, LPC, at 2550 Denali Street, Suite 1606, Anchorage, Alaska 99503 to _____ (send) _____ (receive) the following _____ (to) _____ (from) the following agencies or people:

| Name | Address | City | State | Zip | Phone |
|---|---|---|---|---|---|
| Name | Address | City | State | Zip | Phone |
| Name | Address | City | State | Zip | Phone |

( ) Academic Testing Results
( ) Behavior Programs
( ) Case Notes
( ) Intelligence Testing Results
( ) Medical Reports
( ) Personality Profiles
( ) Progress Reports
( ) Psychological Reports
( ) Psychological Testing Results
( ) Service Plans
( ) Summary Reports
( ) Vocational Testing Results
( ) **Entire Record**
( ) Other (specify)_____
_____
_____

The above information will be used for the following purposes:

( ) Planning Appropriate Treatment or Program
( ) Continuing Appropriate Treatment or Program
( ) Determining Eligibility for Benefits or Program
( ) Case Review
( ) Updating Files
( ) Other (specify)_____
_____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed to whom it will be given, its purpose, and who will receive the information.

Signature of Client:_____ Date:_____

Signature of Parent/Guardian:_____ Date:_____

Signature of Witness:_____ Date:_____
(If client is unable to sign)

Signature of Person Informing Client of Rights:_____
Date:_____

Mail to:_____
Fax to:_____

# PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

In the event in which I or my staff must telephone you for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say my name or the nature of the call, but rather the mental health professional's first name or first and last name only.

If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that is it a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

## I wish to be contacted in the following manner (check all that apply):

- □ Home Telephone_____
  - □ OK to leave message w/detailed information
  - □ Leave message w/name and call-back number only
- □ Work Telephone_____
  - □ OK to leave message w/detailed information
  - □ Leave message w/name and call-back number only
- □ Cell phone _____
  - □ OK to leave message w/ detailed information
  - □ Leave message w/name and call-back number only
- □ email_____
  - □ OK to correspond via this email address
  - □ OK for billing dept. to use this email
- □ Written Communication
  - □ OK to mail to my home
  - □ OK to mail to work/office

**My signature below acknowledges the fact that I have read the material and am informed about the above Alaska mental health laws, and the practices of this office. I understand the meaning and ramifications of the law, and know that I am free to ask questions at any time for clarification.**

_____ _____

Patient Signature Date

_____ _____

Printed Name Birthdate

# Notice of Policies and Practices to Protect the Privacy of Your Health Information

This notice is required by the federal government under the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides privacy and protections and patient right with regard to the use and disclosure of Protected Health Information (PHI) used for the purpose of treatment, payment, and other health care operations. This notice describes how your information may be used and disclosed and how you can access this information. I am required to obtain your signature indicating that you have received this notice. Please note that this required notice details only minimum protections. I have opted to increase protection of your information as described in the last section of this document.

## 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 general consent to treatment. 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 related services. An example of treatment would be when I consult with another health care provider, such as your family physician or another mental health practitioner. *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 your coverage. *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality improvement activities and business-related matters such as audits and administrative services.
- *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 your PHI for purposes outside of treatment, payment, or health care operations only with your authorization. An "authorization" is specific written permission. When I am asked for information for purposes outside of treatment, payment or heath care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing you Psychotherapy Notes if they are maintained separately. "Psychotherapy Notes" are notes I may have made about our conversation during a private, group, joint, or family counseling session, which may or may not be kept separate from the rest of your record.

You may revoke, in writing, all such authorizations at any time. You may not revoke an authorization to the extent that (1) I have already relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer their right to contest a claim for payment.

## III. Uses and Disclosures with Neither Consent nor Authorization

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

- Child Abuse – It I, in the performance of my occupational duties, reasonably suspect that a child has suffered harm as a result of child abuse or neglect, I must immediately report the harm to the appropriate authority.
- *Adult and Domestic Abuse* – If I, in the performance of my occupational duties, have reasonable cause to believe that a vulnerable adult suffers from abandonment, exploitation, abuse, neglect or self-neglect, then I must report that belief to the appropriate authority.
- *Health Oversight Activities* – I may disclose the PHI to the appropriate board of the Alaska Division of Occupational Licensing or Department of Community and Economic Development in proceeding conducted by the board or the department where the disclosure of confidential communications is necessary to defend against charges before the board or department.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will 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 will inform you in advance if this is the case.

- Serious Threat to Health or Safety – I may disclose PHI where you communicate an immediate threat of serious physical harm to an identifiable victim. If you present an imminent risk of serious harm to yourself, I may disclose information necessary to protect you.

### IV. Patient' Right and Practitioner'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 Review 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, if you do not want a family member to know that you are seeing me.)
- *Right to Inspect and Copy* – You have the right to inspect and/or obtain a copy of PHI in my records for as long as they are retained with limited exceptions. On your request, I will discuss the request process with you. There may be a fee for copying your records.
- *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 the amendment process with you.
- *Right to an Accounting* – You have the right to receive an accounting of disclosures of PHI that were made without your authorization (those in Section II of this notice). On your request, I will discuss the accounting process with you. There may be a fee for time required to compile this information.
- *Right to a Paper Copy* – You have the right to obtain a paper cop of this notice from me upon request.

Practitioner'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 change, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide or make the revisions available to you. If you are a current patient, I will provide you with a revised version in person or by mail. If you are a former client, not currently receiving service from me, you may request a current version by contacting my office.

### V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your record, or have other concerns bout your privacy rights, pleases discuss these with me. If you are dissatisfied with the outcome of that discussion, you may 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.

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

Please note that this notice is a *minimum standard* dictated by state and federal laws. The same laws allow me to further limit the uses or disclosures that I will make without your consent. I have chosen to further protect your confidentiality by requiring specific authorization for any disclosure in section I of this notice unless you choose to provide general consent for those purposes. This does not affect the uses and disclosures in section III of this notice that don not require your consent.

**I have read, understand, and agree with the above stated Notice of Policies and Practices**

_____ _____

**Signature of Client** **Date**

_____

**Printed name of Client**

**Tezlyn "Sam" Clark, M.Ed, LPC.** **2550 Denali Street Suite 1606, Anchorage, AK 99503**
Licensed Professional Counselor Tel: 907-278-9355

# FACT SHEET FOR CLIENTS

CONFIDENTIALITY: Your confidentiality is protected by law. I may be authorized to discuss information about you only if you sign a release of information, and this can be revoked by you at any time. Please note the following exceptions to confidentiality:

- The law requires that I notify civil or mental health authorities if I judge that a client has made a clear threat of violence to an identifiable victim.

- If I believe a client is in clear danger of suicide or unable to take care of him/herself, I may notify family members and/or the proper authorities to arrange hospitalization.

- I am obligated by law to report suspected physical or sexual abuse or severe neglect of children, the elderly or the handicapped.

- In cases of criminal liability or child custody disputes my records may be subpoenaed by a legitimate court of law

- Insurance companies and other third party payers require that I give them information which they request regarding clients – for example, type of service, date and time, diagnosis, treatment plan, progress reports, descriptions of impairment, case notes, and summaries. Some companies require very little; others require extensive detail. If you are concerned, please ask me about the practices of your particular company, or call them directly.

- If your account is delinquent for 90 days or more and payment arrangements have not been agreed upon, a collection agency may be used (in which case, a 30% delinquency fee will be added to the balance). If the matter progresses and small claims court is needed, legal costs will be included in the claim. If this happens, your name will be released for bill collections processing, but no specific content of your therapy will be disclosed. As with any unpaid debt, it may later be reported to credit agencies and your credit report may state the amount owed, time frame, and my name. Since payment usually occurs at each session, this is very rare. Please do not let this happen, I would much rather talk these issues out and find some other solutions to overdue accounts.

- There will be a $25 charge for all checks returned for Non Sufficient Funds.

- The ethics of my profession require that I sometimes seek supervision of my work in order to provide the best possible treatment for you. Since I am an experienced therapist, this is only occasionally necessary. While I may discuss treatment issues, your identity is kept confidential in the course of this supervision.

- In couple and family therapy, the information in your file legally belongs to all parties. In legal proceedings for custody, confidentiality may be waived. In all other cases (except when I am subpoenaed by a court of law) both partners must give permission for any information to be released about the couple or family therapy.

- If you are in group therapy, separate files are kept for individuals within the group.

## CONTACTING ME

Due to the nature of my work, there are times I am not readily available by telephone, for example, when I am in session with clients. The best way to reach me during working hours is to call and leave a message at (907) 278-9355. This is a confidential voicemail, where you can leave a detailed message if needed. I will make every effort to return your call that same business day, excluding evenings, weekends, and holidays. If I plan to be gone for any length of time, I will notify you prior, as well as indicating the date of my return on my voicemail.

If I am not available and you are in crisis, you can contact the 24 hour crisis line at (907) 563-3200. It is a very good service, staffed by competent professional therapists. Hospital emergency rooms are also prepared to handle psychiatric emergencies, or you can call 911.

Although email is a convenient form of communication, the information transmitted is not entirely secure; thus I do not recommend you contact me by email. The best mode of communication is by phone.

## FEE FOR SERVICES

The initial intake appointment is $245 and lasts approximately 90 minutes. My hourly fee for a standard therapy session is $120 and lasts 50 minutes. For your convenience, I am happy to bill insurance companies, but it is your responsibility to work out all the details**, including calling to check eligibility, number of visits allowed per year, amount allowed per visit, if authorization is required in advance, and if your deductible has been met?**). Your co-pay is due at the time of the appointment. Reduced fee services are offered on a limited basis. This fee is determined by the previous year's income tax return, taking into account the household's gross income, number of dependents, and type of services requested. Some insurance companies have predetermined fees higher or lower than my standard rate. Alternative arrangements should be made directly with me.

The fee for brief reports, letters, or copies of records is $25. If the requested material takes more than 15 minutes, my hourly fee will be charged. Some insurance companies require me to bill them directly; otherwise, a receipt will be issued for you to process with your insurance carrier. I am able to bill primary insurance as a courtesy if you need that for financial reasons. Clients under a managed care program should discuss payment with me, as each contract has its own requirements. If your managed care benefits end, you may have mental health coverage for a limited number of sessions at a higher rate.

My hourly rate of $120 / hr applies for depositions and / or court testimony. Please be advised I am not trained in forensic evaluation or testimony and therefore prefer not to testify in court. If you think you might be involved in litigation of any kind, please let me know in advance.

## MEETINGS / CANCELLATION POLICY

Therapy sessions are by appointment only and the length of time is scheduled for 50 minutes. Because your appointment time is reserved only for you, it is necessary to charge 25% of your scheduled cost for appointments that are not canceled 24 hours in advance. For example, if you appt was for a standard therapy session at $120, you would be charged $30 for a missed or late-cancelled appointment. This is not to be mean or to punish, but simply because this could be a time slot where another person could have been getting help. I'm sure you can understand. I can usually fill appointments if I have sufficient notice. **PLEASE REMEMBER,** insurance companies do not provide reimbursement for unused sessions, these are your responsibility to pay.

## PRE-SESSION RESPONSIBILITY

It is not necessary to "prepare" for a session, although you may wish to do so. I suggest that you do not use mood-altering substances for at least 24 hours before our session, as this affects how you think and feel, and may impede your therapeutic progress. This includes, but not limited to, alcohol and marijuana. If you think that you may have problems with alcohol or drugs, I encourage you to let me know as soon as possible so treatment can proceed in your best interest.

**My signature below acknowledges the fact that I have read the material and am informed about the above Alaska mental health laws, and the practices of this office. I understand the meaning and ramifications of the law, and know that I am free to ask questions at any time for clarification.**

Client Signature:_____Date:_____

Therapist Signature:_____Date:_____