

**Dr. Renee Alpert Ph.D.**

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

Phone(Home) \_\_\_\_\_ Cell \_\_\_\_\_ (Work) \_\_\_\_\_

Age \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Single \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Married \_\_\_\_\_ Spouse: \_\_\_\_\_

Children ( names and ages) \_\_\_\_\_

Insurance \_\_\_\_\_ Group # \_\_\_\_\_

Social Security Number \_\_\_\_\_ Drivers License # \_\_\_\_\_

Emergency Contact/Phone \_\_\_\_\_

**Responsible Party Information if different from above:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone  
(Home) \_\_\_\_\_ Cell \_\_\_\_\_ (Work) \_\_\_\_\_

Social Security Number of Insured \_\_\_\_\_

Employer \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Primary Care Physician, Address and Phone \_\_\_\_\_

Medicines \_\_\_\_\_

Medical Problems \_\_\_\_\_

Allergies \_\_\_\_\_

History and Current Use of Alcohol, Drugs, Cigarettes, Caffeine:

Counseling History (Dates ( in or outpatient), with Whom): \_\_\_\_\_

## **Office Policies & Agreement for Psychotherapy Services**

**Renee Alpert Ph.D.**

Welcome to my office. I am committed to making our professional relationship bring you positive results and leave you satisfied with your therapy. Below is some information that will be important for you to understand before we get started with our work together.

A standard “one hour” session runs for 45 minutes: “Half-Hour” sessions are for 25 minutes. If your insurance covers my services, you will be responsible for the co-payments and any deductible. If your insurance does not pay what was expected, based on telephone verification of benefits or insurance benefit booklet information, you will be responsible for full payment of the agreed amount. It is your responsibility to notify me of changes in your health care coverage and you assume financial liability for charges not covered due to a change in eligibility of coverage.

The agree amount for full sessions is \_\_\_\_\_, including insurance coverage and any co-payment. Since scheduling an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or canceling an appointment. Please note you may leave a voice message \_\_\_\_\_ notifying me of any changes – even on weekends. The full fee \_\_\_\_\_ will be charged for “no-shows” or \_\_\_\_\_ for cancellations made less than 24 hours in advance. Please understand that the reason for your cancellation or “no-show”, unless a true emergency, will not effect my policy about payment for lost time.

Finally, it is important for you to be aware of the confines of confidentiality. By law, you hold the privilege of confidentiality and I will not release any information to anyone without your written permission. However, there are some statutory exceptions to the confidentiality right. Some of the circumstances where disclosure is required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled. If I come to believe that you are threatening serious harm to another person, I am required to try and protect the other person or persons. In that case, I may have to tell the intended victim, the police, or perhaps seek your hospitalization. Similarly, if you threaten or act in a way that is very likely to harm yourself, I may have to seek hospitalization for you, or call your family member or others who can help protect you. If I believe or suspect that a child, elderly person or a disabled person is being abused or neglected, I must file a report with the appropriate state agency who will investigate the matter. In these situations, I would only reveal the least amount of information necessary.

Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you (workers compensation, physical injury, sexual harassment, custody, etc.), the defendant may have the right to obtain your psychotherapy records and/or my testimony. In couple or family therapy, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgement when revealing such information and I will not release records to any outside party unless I am authorized to do so by all adult family members who were part of the treatment.

Disclosure of information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Only the minimum necessary information will be communicated to the carrier. Usually this includes just a diagnosis, my fee and when we met. However for managed care clients, treatment summaries and plans may be required for further authorization of care.

If you have any questions concerning these matters, please talk to me. I have read the above information and agree to abide by these guidelines.

Signed \_\_\_\_\_ Date

Renee Alpert, Ph.D. \_\_\_\_\_ Date

# **NOTICE OF PRIVACY PRACTICES**

**I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW THIS INFORMATION IS ACCESSED.**

**II. Dr. Renee Alpert (RA) AND ITS LEGAL NETWORK OF PROVIDERS HAVE A LEGAL DUTY TO SAFEGUARD PROTECTED HEALTH INFORMATION (PHI).**

RA is legally required to protect the privacy of PHI, which includes information received that can be used to identify patients, their past, present, or future health or condition, the provision of health care, or the payment of this health care. A "use" of PHI occurs when information is shared, examined, utilized, applied, or analyzed within the organization. PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of the organization. With some exceptions, no more PHI than is necessary to accomplish the purpose for which the use or disclosure is made may be used. RA is legally required to follow the privacy practices described in this Notice.

However, RA reserves the right to change the terms of this Notice and privacy policies at any time. Any changes will apply to PHI on file. Before any important changes to policies are made, this Notice will be changed and posted. A request for a copy of this Notice from RA may be made or viewed in the RA office or website.

## **III. USE AND DISCLOSURE OF PHI.**

RA may disclose your PHI for many different reasons. For some of these uses of disclosures, prior authorization is required; for others, it is not. Below are the different categories of uses and disclosures along with examples:

### **A. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations That Do Not Require Prior Written Consent.**

PHI can be used without consent for the following reasons:

1. For treatment. PHI may be disclosed to physicians, psychiatrists, psychologists, and other licensed health care providers who provide health care services or are involved in patient care. For example, if you're being treated by a psychiatrist, RA can disclose PHI to that psychiatrist in order to coordinate your care.
2. To obtain payment for treatment. RA can use and disclose PHI to bill and collect payment for the treatment and services provided. For example, RA might send PHI to your insurance company or health plan to get paid for the health care services provided to you. RA may also provide PHI to third parties, such as billing companies, claims processing companies, and others that process health care claims.
3. For health care operations. RA can disclose PHI in the normal course of business operation. For example, RA might use PHI to evaluate the quality of health care services that are received or to evaluate the performance of the health care professionals who provided such services. RA may also provide PHI to accountants, attorneys, consultants, and others to insure that RA is in compliance with applicable laws.
4. Other disclosures. RA may also disclose PHI to others without consent in certain situations. For example, consent isn't required if to provide emergency treatment, as long as consent is obtained after treatment is rendered, or if the patient is unable to communicate (for example, unconscious or in severe pain) and would consent to such treatment if able to do so.

### **B. Certain Uses and Disclosures Do Not Require Consent. PHI can be used without consent for the following reasons:**

1. When required by federal, state or local law; judicial or administrative proceedings; or law enforcement.
2. For public health activities.
3. For health oversight activities.
4. For research purposes.
5. To avoid harm.
6. For specific government functions.
7. For workers' compensation purposes.
8. Appointment reminders and health related benefits or services.

### **C. Certain Uses and Disclosures Require The Patient Have the Opportunity to Object.**

1. Disclosures to family, friends, or others.

**D. Other Uses and Disclosures Require Prior Written Authorization.** In any other situation not described in sections III A, B, and C above, written authorization is required before using or disclosing PHI. If an authorization is signed to disclose PHI, it can be later revoked.

#### **IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**

**A. The Right to Request Limits on Uses and Disclosures of PHI.** You have the right to ask that limits be placed on disclosure of PHI.

**B. The Right to Choose How PHI Is Sent to You:** You have the right to ask that information be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). RA must agree to such requests so long as the information can easily be provided in the format requested.

**C. The Right to See and Receive Copies of PHI.** In most cases, you have the right to look at or obtain copies of PHI in writing, with reasons for the denial and appeal procedure. Requested copies of PHI, will cost \$.25 per page. Instead of providing the PHI requested, RA may provide a summary of or explanation of the PHI, as long as you agree to that and to the cost in advance.

**D. The Right to Get a List of the Disclosures.** Patients have a right to be provided a list of instances in which PHI has been disclosed. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. An accounting of disclosures will receive a response within 60 days of receiving your request. The list will include disclosures made in the last six years unless a shorter time is requested. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. More than one request in the same year will result in a reasonable cost-based fee for each additional request.

**E. The Right to Correct or Update PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request correction of the existing information or addition of the missing information. You must provide the request and your reason for the request in writing. RA will respond within 60 days of receiving your request to correct or update your PHI. Requests may be denied in writing if the PHI is (i) correct and complete, (ii) not created by RA, (iii) not allowed to be disclosed, or (iv) not part of RA records. Written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and RA's denial be attached to all future disclosures of PHI. Approved requests will result in changes to PHI.

**F. The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

#### **V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES**

If you think that privacy rights have been violated, or you disagree with a decision, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington D.C. 20201. No retaliatory action against you will be taken if you file a complaint.

#### **VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE**

If you have any questions about this notice or any complaints about privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Dr. Renee Alpert 1500 Adams Ave STE 305 Costa Mesa, CA 92626

#### **VII. EFFECTIVE DATE OF THIS NOTICE**

This notice went into effect on April 14, 2003.

I acknowledge receipt of this notice.

Patient Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_