Rebecca "Becky" Fogarty, M.A.
Licensed Marriage and Family Therapist, MFC# 46636
Licensed Professional Clinical Counselor, LPC# 1561
353 Park Marina Circle, Redding, CA 96001
Phone: (530) 605-5405 Fax: (530) 245-9222
Email: beckyfogartylmft@gmail.com

Disclosure Statement for Therapy

PSYCHOLOGIAL SERVICES

Psychotherapy includes risks and benefits and requires an investment of your time and energy in order to make the process of therapy successful. Occasionally, a person may go through periods of therapy, which may result in emotional discomfort, changes in relationships, or temporary worsening of symptoms. This should subside as work progresses. Psychotherapy has been shown to be beneficial and effective. It can help reduce distress, increase your ability to handle difficult life circumstances, enhance your relationships, and improve your all around emotional, mental, and spiritual well being, just to name a few. Please note that you have the right to request changes in treatment, refuse treatment, or terminate services at any time. On the other side, I am ethically bound to suggest suspension of treatment if progress is not being made, or if the financial agreement is not being met. If either of these situations arises you will be given appropriate referrals that you can choose to explore.

Initially when we meet, I will be evaluating your needs (or the needs of your child, if he or she is to be my primary client). Based on this evaluation, I will provide you with my initial impressions, which may include a diagnosis and treatment recommendations. Generally, sessions are scheduled for once a week; however we may decide to meet more or less frequently.

ARRIVAL AT THE OFFICE

I will usually be in session when you arrive at the office. Please have a seat in the waiting room. If you have a child with you please do the best you can to keep the child quiet as there are several therapy sessions going on in the building.

CONFIDENTIALTIY

I abide by the legal and ethical principles that govern privilege and confidentiality. In general, all communication between a therapist and client are confidential. I cannot release information about you or your child without your permission. However, there are important exceptions to confidentiality. Should such occasions arise, I will make an effort to discuss my actions with you beforehand.

- I am legally required to act to prevent you from physically harming yourself or others when there is "clear and imminent danger" of that happening.
- I am legally required to report suspected abuse of a child, elderly person, and dependent adult.
- I may have to release your records if ordered to do so by the court.
- Non-custodial parents may be able to gain access to their minor children's treatment records.
- In the event of an account becoming delinquent, it may be necessary for me to turn the account over to a collections service.

APPOINTMENTS

I will make every effort to make appointments that are mutually convenient Monday through Wednesday. End of the week and weekend appointments may be available on an emergency basis to handle unexpected crises, but are charged at a higher rate (see fees below). YOU ARE RESPONSIBLE FOR AND WILL BE CHARGED $110 FOR APPOINTMENTS THAT ARE NOT CANCELLED 24 HOURS IN ADVANCE, unless I am able to fill your vacated time or you reschedule for another AVAILABLE time during the week and attend that appointment. Be advised…I really will hold you responsible for cancellation without proper notice. Please note insurance companies and Victim Witness will not reimburse for "no shows" or late cancels.

PAYMENT

Payment is expected by cash, check, or credit card at the beginning of each session. If your check is ready when you arrive there will be a minimum of time spent getting your receipt, leaving more time for your session. I do this at the beginning of the session so you can leave therapy focused on your work and not the finances. You will be given a receipt that you can turn into your insurance company for possible reimbursement, if I am not billing your insurance.

FEES

Therapy is $110.00 per 50-minute session. The charge for the initial visit is $135.00. Payment is expected at the time of the session so that money does not become an issue in the therapeutic relationship. Payments made at any other date require advanced arrangements. Please make checks payable to Becky Fogarty, MA, LMFT. Sessions longer than 50 minutes will be prorated accordingly. If a report is necessary preparation will be prorated at $110.00 per 50 minutes. After hours emergency appointments will be taken on an immediate pay basis only and will be charged at the rate of $155.00 per 50 minute session. Testimony requires a subpoena and advanced payment of fees. If I am required to appear as a witness in court, the party responsible for my participation agrees to reimburse me at the rate of $125.00 per hour, with a 4 hour minimum charge, including but not limited to time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs. A $20.00 returned check fee will be applied to your balance if a check is retuned for any reason. Any additional charges incurred as a result of the retuned check will be your responsibility. Fees are subject to change with prior notice of at least 30 days.

INSURANCE AND BILLING

If billing is arranged under special circumstances, payment will be expected within 10 days of receipt of the statement. A $10.00 re-billing charge will be added monthly to any account with an overdue balance (older than 20 days). If arrangements have been made to bill a third party, such as your insurance company, sessions will be charged at the rate of $120.00 per session. It is important for you to know that YOU ARE RESPONSIBLE FOR COMPLETE PAYMENT should these programs deny your claim or only pay a partial amount, for any reason. MY CONTRACT IS WITH YOU, THE CLIENT, NOT WITH YOUR INSURANCE COMPANY. Insurance companies are in a rapid and unpredictable state of flux. I cannot be responsible for how your company will handle your claim. As such, it is important for you to find out exactly what mental health services your insurance policy covers.

Please be aware that most insurance companies require that you authorize me to provide them with information about you or your child's treatment. Typically, this includes demographic information, diagnosis, and treatment plan. If your insurance requires preauthorization for any treatment, it is your responsibility to obtain such preauthorization. If you choose to bill your own insurance, please let me know and I will be sure to give you a receipt and a Superbill to

send to your insurance company. You are still required to pay the full fee at the time of service. Please know that you always have the right to pay for services yourself and without involvement of your insurance company.

I use a biller to generate insurance billing forms and statements. This person will have access to limited information regarding you, personally, and only what is necessary for billing and insurance reimbursement purposes. That person is also fully aware and is compelled to abide by privacy and confidentiality practices as it relates to the field of psychotherapy.

TELEPHONE CALLS

There is no charge for brief telephone calls to set or change appointments. Please feel free to leave me a message on my confidential voicemail. I check my voicemail regularly during the week and will return your call by the next business day. Extensive information calls and/or crisis calls will be charged at the emergency session rate of $155.00 per 50 minutes. If you are unable to reach me and it is an emergency that requires immediate attention, call 911, your family physician, Helpline (530) 225-5252, or go to the nearest emergency room.

If you have any questions or concerns regarding these guidelines, let's talk about them. Therapy is an excellent place to practice communication skills.

Sincerely,

Rebecca "Becky" Fogarty, M.A.
Licensed Marriage and Family Therapist, MFC 46636
Licensed Professional Clinical Counselor, LPC 1561
CA License # MFC 46636

Please sign below to indicate the following:

- I have read and understand this agreement and agree to the provision of services as described.
- I authorize the release of the necessary information to my insurance company of the purposes of healthcare credentialing, utilization review, quality assurance review, and payment of fees.

_____

Client's name (Please print clearly)

_____

Parent or Legal Guardian, if applicable (Please print clearly)

_____ _____

Client/Parent or Legal Guardian Signature Date

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Client Intake Form

CLIENT INFORMATION

Client's Name:_____Today's Date:_____

Gender: M_____F_____Ethnicity:_____Date of Birth:_____Age:_____

Social Security Number:_____Marital Status:_____

Physical Address:_____
Street City State Zip

Mailing Address (if different):_____
Street City State Zip

Telephone:(___)_____(___)_____(___)_____
Home Work Cell

May I leave a message at: Home: Yes___No___ Work: Yes___No___ Cell: Yes___No___

Employer:_____Work Phone:(___)_____

Significant Other's Name:_____Date of Birth:_____

Their Employer:_____Work Phone:(___)_____

Who referred you:_____

RESPONSIBLE PARTY/GUARDIAN INFORMATION

Responsible Party/Guardian (if different from above):_____

Relationship to client:_____Date of Birth:_____

Social Security Number:_____

Employer:_____Work Phone:(___)_____

INSURANCE INFORMATION

Primary Insurance:_____

Name of Policy Holder:_____Date of Birth:_____

Relationship to client:_____Subscriber ID#:_____

Group #:_____Customer Service Phone:(___)_____

Employer to Subscriber:_____

Secondary Insurance:_____

Name of Policy Holder:_____Date of Birth:_____

Relationship to client:_____Subscriber ID#:_____

Group #:_____Customer Service Phone:(___)_____

Employer to Subscriber:_____

Victim Witness Case: Yes___No___

Claim Number (required):_____

Do you have primary insurance?: Yes___No___ If yes, you must provide the above insurance information.

Name of Victim:_____Relationship to Victim:_____

Name of Advocate at Victim Witness:_____

Insurance Certification and Assignment: I hereby certify that the information given to me in applying for payment under the title XIX of the Social Security Act, by insurers, or by any other third party is correct. I assign payment to the provider rendering medial services to the client. I understand that I am responsible for payment of any health insurance deductible(s), co-insurance, or any other charges incurred which are not paid by any insurance of third party payers.

Release of Information: I hereby authorize my psychotherapist, physical, hospital, pharmacy, insurance company, employer or organization responsible for payment of this claim or to any physical or health service provider who will render care to the client after discharge.

I understand that all the charges incurred are my responsibility, regardless of insurance coverage or third party agency. For collection I agree to pay all reasonable court costs and collection fees. I understand that all judgments in a court of law may bear interest at the legal rate.

Client/Guardian/Responsible party:

Signature:_____
Date:_____

Personal and Medical History (Child)

Please answer the following questions as thoroughly and accurately as possible.

Your primary reason for being here:_____

_____

_____

How long has this been a concern?:_____

_____

What have you tried so far?:_____

_____

Please indicate (based on the rating scale below) any of the concerns you may have regarding your child. Use a **P** for past concerns or problems.

Never	**Rarely**	**Sometimes**	**Often**	**Always**
1	**2**	**3**	**4**	**5**

___Headaches	___Nightmares	___Undue worrying
___Stomach problems	___Unusual thoughts	___Difficulty making decisions
___School problems	___Exposes privates	___Difficulty keeping friends
___Hoards objects	___Irritable mood	___Violation of others' boundaries
___Tremors or Tics	___Always moving about	___Negative self-statements
___Trouble concentrating	___Clingy	___Feeling worthless
___Tantrums	___Drug or alcohol use	___Restlessness
___Poor concentration	___Trouble sleeping	___Slow development/disabilities
___Change in appetite	___Family conflict	___Thoughts of suicide
___Feeling lonely	___Feeling sad	___Unable to get interested
___Previous suicide attempts	___Self-inflicted wounding	___Feeling hopeless
___Outbursts of anger	___Social withdrawal	___Cries easily
___Physical aggression	___Racing thoughts	___Tiredness/fatigue
___Low self-esteem	___Poor impulse control	___Wets pants (day or night)
___Fears	___Purging/vomiting	___Sexual abuse victim
___Emotionally reactive	___Oddities	___Witness of domestic violence
___Depressed	___ Defiance	___Physical abuse victim

Is there any other information you think I may need to know?:_____

_____

_____

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Parental Consent for Treatment of Minor

If the child client is under 18 years of age, we require written permission to treat the child in counseling sessions and / or treatment groups.

If you are the parent of the child client and are divorced or legally separated, and you and you ex-spouse share legal custody of the child, we are **legally required** to obtain **BOTH** parents' permission to treat the child. Please indicate below your legal / custody status. Your signature asserts your consent for treatment of the client and /or contacting the other parent (if applicable).

If you are not the parent, but are the legal guardian, your signature asserts your consent for treatment of the client.

_____ I have sole legal custody of the child. _____ Signed legal documents provided
The last standing order is dated: _____
_____ I have joint legal custody of the child _____ Both parents signed the consent
_____ I am the foster parent. _____ is the legal guardian.
_____ Foster parent placement documentation provided.
_____ I am the County Social Worker / Probation Officer and have legal guardianship of the child.
_____ Legal documentation authorizing consent for treatment is attached.

The other child's parent is:

Name: _____ _____ Other parent deceased

Address: _____ _____ Never Married/No papers

_____ _____ Married

Home Phone: _____ _____ Other:_____

Cell/Work Phone: _____

I / We consent to allowing the above named child to receive treatment with Rebecca "Becky" Fogarty, M.A., LMFT, LPCC, and give consent for Rebecca "Becky" Fogarty, M.A., LMFT, LPCC to contact both the child's parents (as applicable).

_____
Parent / Guardian / County Social Worker / Probation Officer Name(s) [PLEASE PRINT]

_____ _____
Signature Date

_____ _____
Signature Date

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Please read and sign the following:

Financial Responsibility:

I understand that I am financially responsible for all sessions that I sign up for. I am responsible for these sessions at the time of service.

24 Hour Cancellation Policy:

I understand that I must provide 24 hours notice of cancellation prior to a session in order to not be charged for that session. I understand that my insurance will not pay for missed sessions and therefore I will be responsible for that payment of $110 at the start of the next session.

_____

Client/Guardian/Responsible Party Signature

_____

Date

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Notice of Privacy Practices, HIPAA

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

Privacy is a very important concern for all those who come to my office. This Notice of Privacy Practices describes how I protect your personal health information (PHI), tells how I may use and disclose your clinical information, and explains certain rights you have regarding this information. I am providing you with this notice in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and will comply with the terms as stated.

How I use and disclose your personal health information

I protect your personal health information from inappropriate use and disclosure. Your information is obtained in the course of providing services to you and is related to your medical records, psychotherapy visits, and payment information. It is likely to include your history, reasons you came for psychotherapy, diagnoses, progress notes I make (but not psychotherapy notes I may choose to make (recording dreams, fantasies, theme, etc. for my own use), records I get from others who worked or work with you or evaluate you, and billing and insurance information. I will not disclose any personal health information without your written authorization, unless such disclosure is permitted or required by law.

The law permits me to disclose your health information without a signed authorization from you when I am using it to provide you with your mental health care. For example, I use your clinical information to plan your care, to decide how well your psychotherapy is working, when I talk with other professionals who are also treating you, for teaching and training other psychotherapy professionals, and for mental health research.

How your protected health information can be used and shared

When your information is read by me, in the law that is called "use." If the information is shared with or sent to others outside this office, in the law that is called "disclosure." Except in some special circumstances, when I use your PHI here or disclose it to others, I share only the minimum necessary for those other people to do their jobs. The law gives you rights to know about your PHI, how it is used and to have say in how it is disclosed (shared), and so I will tell you more about what I do with your information.

Uses and disclosures of PHI in health care with your consent

After you have read this Notice you will be asked to sign a separate consent form to allow me to use and share your personal health information. In almost all cases, I intend to use your personal health information here, or to share your personal health information with other people or organizations to provide treatment to you, to arrange for payment for our services, or some other business functions called health care operations. Generally, I may use or disclose your PHI for three purposes: treatment, obtaining payment, and what are called health care operations.

Treatment and care management

I need information about you to provide care to you. You agree to let me collect the information and to use it and share it to care for you properly. Therefore you must sign the Consent form before I begin to treat you, because if you do not agree and consent I cannot treat you. Health information about you may be used or disclosed to assist treatment by health care providers. This would include treatment provided to you by me, and coordinating your care with other providers such as physicians, hospitals, or nursing homes. For example, I may refer you to other health-care or medical professionals or consultants for services I cannot provide. When I do this I need to tell them some things about you and your conditions. I will get back their findings and opinions, and those will go into your records here. If you receive treatment in the future from other professionals, I can also share your health information with them.

Payment
I may use your information to bill you, your insurance, or others so I can be paid for the treatments I provide to you. I may contact your insurance company to check on exactly what your insurance covers. I may have to tell them about your diagnoses, what treatments you have received, and the changes I expect in your conditions. I will need to tell them about when we met, your progress, and other similar things.

Health Care Operations
Health information may be used and disclosed to carry out health care operations, which includes using your health information to see where I can make improvements in the care and services I provide. I may be required to supply some information to some government health agencies so they can study disorders and treatment and make plans for services that are needed. If I do, your name and personal information will be removed from what I send. Information may be disclosed to a law enforcement agency to respond to a subpoena, to help identify or locate a suspect or missing person, or to provide information about a victim of a crime. Information may also be shared for certain types of public health efforts involving communicable diseases. In addition, information may be disclosed to the appropriate governmental authorities to avoid a serious threat to your health and safety or that of another person or the public, or when there is reason to suspect neglect, abuse or domestic violence. Information will also be shared about a deceased person when necessary with coroners, medical examiners, funeral directors or with organizations involved with organ, eye or tissue donations.

To individuals involved in your care. Your health information may be disclosed to a family member, other relative or close personal friend assisting you in receiving or obtaining payment for health care services. I will disclose your health information to these individuals only if you tell me to do this or if I can reasonably infer that you do not object. I may also disclose your health information to disaster relief organizations such as the Red Cross to assist your family members or friends in locating you or learning about your general condition in the event of a disaster.

Appointments, information or services. I may contact you to provide appointment reminders or information about treatment alternatives or other health-related services that may be of interest to you. I may also use or disclose your health information for judicial or administrative proceedings, for specialized government functions, for workers' compensation or similar purposes. If you want me to call or write to you only at your home or your work or prefer some other way to reach you, I can usually arrange that. Just tell me.

Business associates. There are some tasks I may hire other businesses to do for me. Examples include a copy service used to make copies of your health records, and a bookkeeper. These business associates need to receive some of your health information to do their jobs properly. To protect your privacy, they agree in their contract with me to safeguard your information.

Obtaining Your Authorization for Other Uses and Disclosures
I will not use or disclose your health information for any purpose not specified in this Notice of Privacy Practices unless I obtain your express written authorization to do so. If you give us your authorization, you may revoke it at any time in writing, in which case we will no longer use or disclose your health information for the purpose you authorized, except to the extent we have relied on your authorization in providing benefits. I may refuse to enroll or continue to provide benefits to you if you decide not to sign an authorization form.

Your Rights Regarding Your Health Information Right to inspect and copy. You have the right to inspect or request a copy of personal health information about you that I maintain and that I may use in making decisions about your care. Your request should describe the information you want to review. In limited circumstances, you may not be able to review or copy certain information. These include psychotherapy notes, or information collected in anticipation of a claim or legal proceeding. If I determine that reviewing your records may cause substantial and identifiable harm to you or others or would have a detrimental effect on your treatment, on our professional relationship, or on your relationship with parents, guardians, spouses, or children, I may deny access to your records. A patient over the age of twelve may be notified of any request by a qualified person to review his or her record, and if the patient objects to the disclosure, I may deny the request for access. I may charge you a reasonable fee for copying.

Right to Request Amendments. You have the right to request changes to any health information I maintain about you if you state a reason why this information is incorrect or incomplete. I may not agree to make the changes you request. If I do not believe the changes you requested are appropriate, I will notify you in writing how you can have your objection to my decision included in my records.

Right to an Accounting of Disclosures. You have the right to receive a list of disclosures of your health information that have been made by me. The list will not include disclosures made for certain types of purposes, such as disclosures for treatment, payment or health care operations or disclosures you authorized in writing. Your request should specify the time period for which you want this list, which can be no longer than six years and may not include dates prior to April 14, 2003. The first time you ask for a list of disclosures in any 12-month period, I will provide it for free. If you request additional lists during a 12-month period, I may charge you a fee to cover our costs in providing the additional lists.

Right to Request Restrictions. You have the right to request restrictions on the ways in which I use and disclose your health information for treatment, payment and health care operations, or disclose this information to disaster relief organizations or individuals who are involved in your care. I may not agree to the restrictions you request.

Right to Request Confidential Communications. You have the right to ask me to send health information to you in a different way or at a different location if you believe that you may be endangered by my ordinary form of communication. You must state in your request that you believe you will be endangered by my ordinary form of communication but you do not have to explain why you believe this is the case. You may ask me to send health information to you in a different way or at a different location. Your request should also specify where and/or how I should contact you. We will accommodate all reasonable requests.

Right to Paper Copy of Notice. You have the right to receive a paper copy of this Notice of Privacy Practices at any time. You may receive a paper copy even if you have previously requested to receive this Notice electronically.

Uses and disclosures where you have an opportunity to object

If I want to use your information for any purpose besides those described above, I need your permission on an **authorization form**. If you do authorize me to use or disclose your health information, you can cancel that permission, in writing, at any time. After that time I will not use or disclose your information for the purposes that we agreed to. Of course, I cannot take back any information that I had already disclosed with your permission or that I had used in my office. Occasionally, with your permission and if we determine this to be helpful to your care, I can share some information about you with your family or close others. I will only share information with those involved in your care and anyone else you choose such as close friends or clergy. I will ask you about whom you want me to tell what information about your condition or treatment. You can tell me what you want, and I will honor your wishes, as long as it is not against the law.

If it is an emergency, so that we cannot ask if you disagree, I can share information if I believe that this is what you would want and if I believe it will help you if I do share it. If I do share information in an emergency, I will tell you as soon as I can. If you don't approve I will stop, as long as it is not against the law.

If you have questions or problems

If you need more information or have questions about the privacy practices described above, please contact me at (530) 605-5405. Written requests should be addressed to: Becky Fogarty, M.A., LMFT at 353 Park Marina Circle, Redding, CA 96001. If you believe that your privacy rights have been violated, you may file a complaint with me or with the Secretary of Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C., 20201. You will not be penalized for filing a complaint. I will not take any action against you or change my treatment of you in any way.

Effective Date

This Notice of Privacy Practices is effective as of April 14, 2003.

Acknowledgement of Receipt of **Notice of Privacy Practices, HIPAA**

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given you. The Notice of Privacy Practices provides information about how I may use and disclose your protected health information (PHI). I encourage you to read it in full.

The Notice of Privacy Practices is subject to change. If this notice changes, you may obtain a copy of the revised notice from me by contacting me at 530-605-5405.

If you have any questions about the Notice of Privacy Practices, please let me know.

I acknowledge receipt of the Notice of Privacy Practices from
Rebecca "Becky" Fogarty, M.A., LMFT, LPCC:

Signature: _____
(Patient / Parent / Conservator / Guardian)

Date: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain the client's acknowledgement of the receipt of the Notice of Privacy Practices, including [describe attempts] _____ _____. However, because of [explain] _____ _____ I was unable to obtain the client's acknowledgement.

Signature of Provider: _____ Date: _____