Client Agreement Form

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New Patient Information Form

Name: ____

Date of Birth: _______________ Age: ____________ Marital Status: ___________

Mailing Address: ____
Street and number City State Zip code

Home Phone: ______________________ Okay to leave message: Yes No

Cell Phone: _______________________ Okay to leave message: Yes No

Email: __________________________ Okay to leave message: Yes No

Emergency Contact: ___________________________ Phone: _________________

Your Employer: ____

Insurance Information

Person responsible for bill: ____

Insurance #1

Name of Insurance Company: ____________________ ID # ____________________

Name of Insured Party: ________________________ Insured's DOB: ____________

Insured's place of work: ____

Insurance #2

Name of Insurance Company: ____________________ ID # ____________________

Name of Insured Party: ________________________ Insured's DOB: ____________

Insured's place of work: ____

I authorize Dr. Lisa Smith Klohn to contact my insurance company to ascertain insurance coverage and file claims for reimbursement. Only the information necessary to make this determination and the information necessary to facilitate reimbursement will be disclosed. I also authorize contact with my managed care company to provide information needed to aid in determining and applying benefits. I understand that I am ultimately responsible for payment of my account.

____ ______________________
Signature Date

General Information

Name of Family Physician: ____

Who referred you here? ____

Please list all previous therapists: ____

____

Please list all current medications: ____

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Please list any current medical problems or significant past problems: ____________________________

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Psychologist-Client Services Agreement

This Agreement contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act ((HIPAA) that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Insurance Information (PHI) used for the purpose of treatment, payment and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and the client and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. Psychotherapy can have benefits and risks. Since therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, etc. On the other hand, psychotherapy has been shown to have many benefits. Therapy often leads to better relationships and solutions to specific problems; however, there are no guarantees about what you will experience.

Therapy Sessions

Following our first session or two, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Sessions are 60 minutes long and are scheduled weekly or every other week, though other arrangements can be made. **Once an appointment time is scheduled, you will be expected to pay for the session, regardless of whether you attend, unless you provide 24 hour advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.**

Professional Fees

My fee is $150.00 per session. If you are using health insurance to cover part of the cost of treatment and I am an authorized provider for your insurance company, I will gladly accept the fee they establish, typically less than $120.00 per session. If you become involved in legal proceedings that require my participation, my charge is $175.00 an hour for preparation and attendance at any legal proceedings.

Contacting Me

My office phone number is 803-787-7889. Once established as a client, I make every attempt to return all routine phone calls within 24 hours. I also will provide you with a list of alternative numbers to reach me in case of an emergency. During the evenings and some weekends, you will be able to reach me at home at 803-788-8080. Please reserve the use of home phone calls for emergencies only. In the event that you cannot reach me and you have a psychiatric emergency, please call 911 or go to the nearest emergency room for assistance.

Limits on Confidentiality

The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form. There are other situations that require only that you provide written, advance consent. Your signature on this agreement provides consent for those activities as follows:

- I may occasionally find it helpful to consult other health professionals about your treatment. When doing so, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don't object, I won't tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning the services I provided you, such information is protected by the psychologist-client privilege law. I cannot provide any information without your written authorization or a court order. If you are involved in contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I am required to provide it to them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If I am treating a client who files a worker's compensation claim, I may, upon appropriate request, be required to provide otherwise confidential information to the client's employer, the insurer, or the Worker's Compensation Commission.

There are some situations in which I am legally obligated to take actions which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a client's treatment when doing so.

- If I receive information that gives me reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect, or by acts or omissions that would be abuse or neglect if committed by a parent or other caretaker, the law requires that I file a report with the count Department of Social Services. If I believe that a child has been or may be abused by any person, I must report that to the appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that a vulnerable adult has been or is likely to be abused, neglected, or exploited, the law requires that I file a report to the Adult Protective Services Program. Once such a report is file, I may be required to provide additional information.
- If I believe that a client presents a clear and substantial risk of imminent, serious harm to another. I may be required to take protective action, including notifying the potential victim, contacting the police and seeking hospitalization for the client.
- If a client threatens to harm himself/herself. I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.
- If a client reveals his or her intent to commit a crime. I may be required to take preventative action, such as calling the police.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations in which specific advice is required, formal legal advice may be needed.

Professional Records

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your clinical record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person you may examine and/or receive a copy of your clinical record if you request it in writing. Because these are profession records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I ask that you review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. I charge a copying feel of $2 per page. If I refuse your request for access to your records, you have a right of review which I will discuss with you upon your request.

Client Rights

HIPAA provides you with expanded rights with regard to your clinical record and disclosures of PHI. These rights include requesting that I amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the location to which PHI disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

SC provides the client the opportunity to file inquiries with its Board of Examiners in Psychology. Board offices can be reached at SC Board of Examiners in Psychology, PO Box 11329, Columbia, SC 29211-1329.

Please note that Klohn Psychology Service, PA and Lisa Smith Klohn, Ph.D. are separate business entities and share no joint liability.

Minors and Parents

Clients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's clinical records, unless I decide that such access is likely to injure the child, or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her 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.

Billing and Payment

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. If such legal action is necessary, its costs will be included in the claim.

Regarding insurance reimbursement, I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you, not your insurance company, are responsible for full payment of my fees. You should be aware that your contract with your health insurance company requires that I provide it with information relevant to the services I provide to you. I am required to provide a clinical diagnosis and sometimes other information as well. I make every effort to release only the minimum information necessary for the purpose requested. I will, of course, provide you with copies of any information released to an insurance company, at your request. **By signing this agreement, you agree that I may file for insurance reimbursement from your insurance carrier, and you agree that I may provide them with requested information. Your signature also indicates you have read the information in this document and agree to abide by its terms during our professional relationship. Your signature also serves as an acknowledgement that you have received the HIPAA Notice form.**

Social Medial Policy

It is my policy not to engage (communicate, "friend", etc.) with clients on social media, to include Facebook, Twitter, Instagram, Messenger, etc.

____ ____________________

Client Signature **Date**