Carol Ray, Psy.D, L.C.S.W
Doctor of Psychology & Licensed Clinical Social Worker
License #21901

Intake Form

Client Name:_____

Guardian/Parent:_____

Address:_____

City, Zip Code:_____

Cell Phone:_____

E-mail Address:_____

Do you want me to use discretion when calling, e-mailing or texting you? No___ Yes___

(if Yes, please be specific) _____

Emergency Contact:_____

Phone Number:_____

Referred By:_____

Reason for seeking treatment:_____

_____

_____

Goal(s) for therapy:_____

_____

_____

2774 Jefferson Street, Carlsbad CA
(760) 845-4161

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Information and Policies

Please carefully review and sign this form as confirmation that you understand and agree to the terms of this therapeutic relationship. Feel free to ask for clarification on any of the items.

Confidentiality: All communication between client and therapist shall remain confidential unless you request specific information be discussed with outside parties (for example, family members, other health professionals, school staff, etc.). In such cases, written authorization to release the information will be requested from you. I am mandated by law to break this confidentiality in the following circumstances:

- If I am ordered by the court to testify or release records.
- If you are a victim or perpetrator of child abuse.
- If you are a victim or perpetrator of elder or dependent adult abuse.
- If you threaten harm to yourself, someone else, or the property of others.

Fees: My fee is $190 for a 50 minute session and will be collected at the beginning of the appointment. I recommend preparing your payment prior to your arrival so that your time is maximized. Telephone consultations with you or other persons designated by you will be billed at my hourly rate with a $20 minimum (brief phone calls regarding scheduling are excluded). Preparing reports will be billed at my hourly rate plus an administrative fee of $100. I do not accept insurance, but will provide you a bill to submit to your insurance company for reimbursement. Please let me know if you would like me to provide you with a statement at the end of each month for you to send to your insurance company.

In the instance that an unpaid balance accrues, it will be turned over to a collection agency. You will be responsible for the original bill, service charges, collection fees, and any legal costs that are incurred. There will be a $25 charge for returned checks.

Cancellations: 24 hours notice is required if you need to cancel a session. My full fee will be billed if you miss a session or fail to reschedule 24 hours prior to the scheduled appointment.

I/we have read and understand this information and agree to these policies.

Client Name (print)	Client Signature	Date
Parent/Guardian Name (print)	Parent/Guardian Signature	Date

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INFORMED CONSENT ADDENDUM FOR ONLINE THERAPY

This form is designed to allow you to give informed consent for the use of video technology for online therapy. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

This is to be used in conjunction with, but does not replace, the Informed Consent document that is required of all clients prior to starting therapy services.

Online therapy or teletherapy is defined as the use of technology to have a therapy session. We will use thera-LINK, a HIPAA compliant platform that uses video and audio technology through a webcam on your device and my device to connect us securely.

Thera-LINK uses encrypted data streams (AES-256) for our video sessions. Any data that is stored outside of our video session on the thera-LINK platform (such as documents, messages, or progress notes) is encrypted and meets or exceeds all HIPAA and HITECH guidelines.

The benefits of teletherapy include the convenience of location, time, wait times, and accessibility which allows for better continuity of care. In addition, teletherapy allows for greater accessibility to services for clients with limited mobility or with lack of transportation. Teletherapy can also allow for couples or families to meet when in different locations.

With all technology, there are also some limitations. Technology may occasionally fail before or during our session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video, the therapist will either use the in-session video chat to trouble shoot or will call you back to complete the session.

If, for any reason, we are unable to connect and you are in an immediate crisis or a potentially life-threatening situation, get immediate emergency assistance by calling 911.

I agree to take full responsibility for the security of any communications or treatment on my own computer and in my physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

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I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

I understand that I am not allowed to do any recording, screenshots, etc. of any kind, of any session, and are grounds for termination of the client-therapist relationship.

Consent to Treatment

I, voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize Dr. Carol Ray to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Dr. Carol Ray at any time. I understand Dr. Carol Ray will determine on an on-going basis whether the condition being assessed and/or treated is appropriate for online therapy.

By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____
Patient/Client Signature

_____
Parent, Guardian or Legal Representative Signature
(if minor or needed otherwise)

_____
Date

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Credit Card Authorization Form

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request.

In case of late cancellations and/no shows for scheduled sessions, if a balance accrues due to an unpaid balance from the insurance company, or if a check is returned unpaid, you will be charged the session fee. An additional $25 is assessed for returned checks.

I, _____, am authorizing Carol Ray, Psy.D, LCSW to use my credit card information to charge my credit card in the event that I do not notify her of my inability to attend a scheduled therapy appointment, do not cancel my appointment at least 24 hours in advance, a check is returned for any reason or there is an outstanding balance after 30 days.

Type of Card: VISA ❒ MasterCard ❒ American Express ❒ Discover ❒

Card Number: _____

Verification/Security Code:_____ Exp. Date:____/____Zip Code:_____

By signing below I am authorizing Dr. Carol Ray to charge for scheduled appointments or outstanding balances after 30 days.

Signature:_____ Date:_____

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NOTICE OF PRIVACY PRACTICES

Required Notice Under Federal HIPAA Law

I. 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.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice. However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website. You can also request a copy of this Notice from me.

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples in each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons.

1. *For treatment***.** I can disclose your PHI to physicians, psychiatrists, psychologists, and to other licensed health care providers who provide you with health care services or are involved in your care. For example, if you are being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care.
2. ***To obtain payment for treatment.*** I can use and disclose your PHI to bill and collect payment. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
3. ***For health care operations.*** I can disclose your PHI to operate my practice. For example, I may provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.
4. ***Other disclosures.*** I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Uses and Disclosures Do Not Require Your Consent. I can use and disclose your PHI without your consent or authorization for the following reasons.

1. *When disclosure is required by federal, state or local laws; judicial or administrative proceeding; or; law enforcement.* For example, I may make a disclosure to applicable officials when a law requires me to report information to governmental agencies and law enforcement personnel about victims of abuse or neglect, or when ordered in a judicial or administrative proceeding. For example, if you are involved in a lawsuit or a claim for worker's compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order.
2. *For public health activities*. For example, I may have to report information about you to the county coroner
3. *For health oversight activities*. For example, I may have to report information to assist the government when it conducts an investigation or inspection of a health care provider or organization
4. *To avoid harm.* In order to avoid a serious threat to the health or safety of a person or the public, I may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
5. *For specific government functions.* I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
6. *For worker's compensation purposes.* I may provide PHI in order to comply with worker's compensation laws.
7. *Appointment reminders and health related benefits or services.* I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

C. Certain Uses and Disclosures require You to Have the Opportunity to Object

1. *Disclosures to family, friends, or others.* I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your healthcare, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization.

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In any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI to me.

1V. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by then except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

B. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, email instead of regular mail). I must agree to request so long as I can easily provide the PHI to you in the format you requested.

C. The Right to See and Get Copies of your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your request. In certain situations, I may deny your request. If I do, I will tell you in writing, my reasons for the denial and explain your rights to have my denial revised. If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI, I may provide you with a summary or explanation of the PHI as you as agree to that and to the cost in advance.

D. The Right to Get a List of Disclosures I have Made. You have a right to get a list of instances in which I have disclosed your PHI. 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 won't include uses and disclosures made for national security purposes, to corrections, or law enforcements, or disclosures made before April 15, 2003. I will respond within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom the PHI was disclosed, a description of the information disclosed, and the reason for disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

E. The Right to Correct or Update your 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 that I correct the existing information or add the missing information. You must provide the request and reason for request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me (iii) not allowed to be disclosed, or (iv) not part of my records. My 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 my denial be attached to all future disclosures of your PHI. If I approve your request I will make the changes to your PHI, tell you that I have done it, and tell others that need to know about the changes to your PHI.

F. The Right to Get this Notice by Email. You have the right to get a copy of this notice via e-mail. Even if you have agreed to receive a 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 I many have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave S.W., Washington DC 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAINT ABOUT MY PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the secretary of department of Health and Human Services, please contact me at (760) 845-4161.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices, HIPPA Compliant, which I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full. If you have any questions about my Notice of Privacy Practices, please contact me at (760) 845-4161.

I acknowledge receipt of the Notice of Privacy Practices, HIPPA Compliant, of Dr. Carol Ray.

Signature: _____ Date: _____

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