Betty Warden, LCSW
Resolutions Creative Conflict Management, Inc.
2052 NE 4th Street Bend, OR 97701
541-390-1181 541-383-2004
Fax: 541-383-2013

Today's Date: _____ *DX: _____Info sent _____*
(Office use only)

Client Name: _____ Pronoun(s): _____

Partner/Spouse Name (if being seen as a couple): _____

Parent Name (if Client is a minor) _____

Home Street Address: _____ Apt: _____

Mailing Address if different:_____**EMAIL:**_____

City: _____ **State**: _____ **ZIP**: _____

Phone: (Home) _____ (Cell) _____(Work)_____ **Okay to Call @ Work?**

Phone calls and mailingsto your homewill be discreet, but please indicate any restrictions:

_____

Client Date of Birth: _____ Age: ____

Partner/Spouse Date of Birth: _____ Age: ____

Emergency Contact Name:_____ Phone: _____ Cell Phone:_____

How did you learn about me or who gaveyou my name to call? _____

Insurance Information

Please provide the following insurance information.

Are you covered by a Health Plan?

Client Employer _____

Insurance Provider: _____ Phone #:_____

Name of Insured: _____Group #:_____ ID #: _____

Partner/Spouse's Current Employer: _____

CLIENTS RIGHTS AND RESPONSIBILITIES

You have the right to:

- Impartial access to treatment
- Considerate, respectful care
- Personal and information privacy
- Know the identity and professional status of your Counselor
- Informed participation in decisions involving your care
- Know reason for any transfer, referral of care
- Obtain access to your record including information about diagnosis, treatment, and prognosis
- Request and receive an itemized bill

Assessment and Treatment Planning:
To provide you with the best care possible, it is important that I have a clear understanding about what brings you to treatment. To assist me in this process, I may ask you to complete some forms, and I will ask you detailed questions about your past and current functioning, including information about past mental health problems, previous treatment and alcohol and drug use.

We will develop a treatment plan together (written or verbal), outlining specific goals to address the concerns you have. The plan will outline what we will work on and how we will approach it. I will also share with you my assessment of your concerns and we will evaluate together on an ongoing basis whether this treatment is helpful to you.

Risks to Treatment:
It is important for you to know there are risks involved in treatment. For example, some people experience an increase in stress, particularly during the early stages of treatment. Some problems also seem to get worse before they get better (in children this is called an extinction burst). In some cases (with a couple or a family) discussing long-standing, unresolved problems can seem to aggravate rather than help with the problem. These are natural occurrences, but you should be aware of them. Other risks may occur as well, depending on your unique situation.

Treatment Alternatives:
Not all clients are well-suited to my treatment approach, nor am I able to treat all problems confronting my clients. If at anytime you have doubts about the appropriateness or effectiveness of your treatment (or your child/adolescent's), please discuss these doubts with me as soon as possible.

Rights to Privacy and Exceptions to Privacy:
The work we do here is confidential. Occasionally information from other persons or professionals is useful in the treatment work. If that is acceptable, I will ask for your permission in writing and ask you to complete a "*Release of Information*" form. Similarly, I will not seek or receive information from others who know you without first receiving your permission. If there is specific information you believe would be helpful for me to know about, particularly the previous mental health treatment, please bring this to my attention as soon as possible. It is very important for you to know that some things, by law, cannot be kept private. Here are the exceptions to your right to privacy:

1. If I am subpoenaed to testify in court, I may have to give information about you without your permission. If I am subpoenaed I will make an effort to contact you. If you oppose release of information, a court may nevertheless require compliance with the subpoena.
2. If I learn or suspect that harm has been done to a child or elderly person, I will make a report to the authorities.
3. If I learn of a client's specific intent to bring harm to him, herself, or to another person, or to commit an act of violence, it is my responsibility to protect you and others. Under these circumstances I reserve the right to inform other family members, intended victims, or authorities as appropriate. If I learn of a client's intent to do harm to me, I also reserve the right to protect myself by informing the authorities.
4. A non-custodial parent who wants to learn about their child's treatment may have the right to review their child's treatment record and to discuss their child's care with me.

Privacy is also an important issue in children or when spouses are involved in treatment. When children and adolescents are referred for treatment, it is important to respect the need for some privacy. While in treatment, if a child or adolescent (ages 14-17) discusses an issue that I perceive as dangerous or clinically important to that child or adolescent, I will involve the parents or appropriate parties. Further, my approach strives to include parents (or appropriate others) when clinically appropriate with the consent of the child/adolescent. When both members of a couple are involved in treatment, it is important to balance the need for individual privacy with the need for open communication. If you know that your spouse or other family members will be involved in treatment, or may be in the future, please discuss these issues with me as soon as possible.

Legal Proceedings/Court Involvement:
It is my policy to **NOT** testify at any judicial procedures on behalf of clients who are engaged in adversarial issues. This includes legal proceedings involving marital, custody, and/or visitation. My goal is to support our clients through the achievement of therapeutic gains.

In the event that you require my testimony or involvement in non-adversarial aspect of legal and court proceedings, I will do so only with your consent. I will need to bill for time spent talking with your lawyer, drive time, wait time, and actual court time. If I am asked to provide anything in writing I will also need to bill accordingly. I will be unable to disclose any information pertaining to other family members or parties involved in treatment without their specific consent to disclose this information. A letter describing all fees will be sent to the client and/or attorney should testimony be required. *Please carefully review my Practice Policies (attached) for further discussion of my involvement with legal proceedings of any kind.*

Financial Insurance:
If you have insurance, I will be happy to complete the work necessary to bill your insurance; however, due to the changes in mental health service delivery requirements, it may not be known whether your insurance will pay for each session until after the fact. Insurance benefits have become increasingly complex. Many payers will be post-auditing beginning January 1, 2013. If a claim is denied, you will be responsible for payment.

I authorize payment directly to Betty Warden, LCSW of all benefits otherwise payable to me or for my benefit by reason of insurance policies. I irrevocably assign such benefits to Betty Warden, LCSW in an amount not to exceed the charges for services referred provided. I authorize Betty Warden, LCSW to

release information to my insurance company, and if insurance is provided through an employment plan, to my employer, with respect to my (or my dependents) diagnosis or treatment. I request that payment of authorized benefits be made on my behalf. *Clients who owe money and fail to make arrangements with my office to pay may be referred to a collection agency and will then be solely responsible for all fees related to collection of the debt.*

Your Responsibility:
Part of your commitment to me is to be financially responsible for your sessions, since I am in business and expect fair payment for my services. This means that if your insurance fails to pay, for any reason, you will be responsible for your balance. Full payment or co-pay amounts are due at the time of service unless special arrangements have been made with my office.

EMERGENCIES:
Please Note: In the event of a mental health emergency, please dial **911** or go to the nearest **Emergency Room.** My phone voice message will inform you as to my office days/hours. **I do not** check this line unless it is during my office hours. **DO NOT LEAVE A MESSAGE OF MENTAL HEALTH EMERGENCY ON THIS LINE OUTSIDE MY OFFICE HOURS**. If you are having a mental health emergency during my office hours I may be in session and not able to get and/or respond to your message until later in the day. I am asking that your commitment to yourself and to me (if you engage in treatment with me) is that you keep yourself safe. Therefore, if you are not safe from imminent self-harm (even during office hours) please dial **911** or go to the nearest emergency room.

Appointments and Cancellations

PLEASE NOTE: Cancellation for scheduled appointments must be made with me at least 48 hours in advance. Failure to cancel 48 hours in advance or not showing for a scheduled appointment will result in being charged the entire session fee. There is no reimbursement from insurance for these charges. If late for an appointment by more than 15 minutes, the appointment may be rescheduled at my discretion.

_____ _____
Client Signature for a *Minor* **Date**
(Please sign here if you are the ***parent of a minor*** receiving treatment

_____ _____
Client Signature **Date**
(Please sign here if you are an ***adult*** client 14 years or older)

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Practice Policies & Procedures

Betty J. Warden, LCSW

I am a Licensed Clinical Social Worker in private practice. I have a Masters Degree in Social Work and have been a Licensed Clinical Social Worker in Oregon since 2005. I adhere to the National Association of Social Workers Code of Ethics. The following information answers some important and frequently asked questions concerning my practice. Please read this form carefully and sign it; let me know if you need more information about policies or treatment. I am happy to provide you a copy of this information should you request it.

Payment:

Fees for Services are $275.00 for the initial assessment session and $215.00 for all additional 53-minute sessions. Family sessions (53 minutes) are billed at $230.00. ***You are responsible for all costs of services. Clients who owe money and fail to make necessary arrangements with my office to pay may be referred to an outside collection agency and in doing so assume all costs related to collection of the account.***

Insurance:

It is your responsibility to contact your insurance company prior to your first session to clarify what your policy covers and request pre-authorization if it is needed. Most insurance companies will be billed directly by my office. If we bill the insurance company directly, ***you are responsible to pay all deductibles and co-pays at each session*** (unless another arrangement has been made). If we bill your insurance directly, be advised that billing information may be transmitted electronically to my billing agent. Due to the changes in mental health service delivery requirements, it may not be known whether your insurance will pay for each session until after the fact. Insurance benefits have become increasingly complex. Many payers will be post-auditing beginning January 1, 2013. If a claim is denied, you will be responsible for payment.

Please have payments ready at the beginning of sessions.
There is a $25.00 charge for returned checks.

The 4th Street Clinic:

The 4th Street Clinic is the practice location to four (4) independently operating practitioners. The 4th Street Clinic exists as a name of the place from which these four (4) independently operating practitioners operate from, nothing else. Each practitioner is an individual entity, properly licensed and credentialed, and operating out of one space to most conveniently serve our clientele. All professional relationships are confidential between the client and his or her individual therapists and any questions or concerns should be addressed solely to the relative practitioner.

Managed Care and Employee Assistance Programs (EAP):

Some insurances use managed care systems. In order to access treatment, managed care companies may require written treatment plans to authorize additional sessions. Only information pertinent to the request for additional sessions is provided (please see the Confidentiality section listed below).

Some employers and/or insurance systems provide employee assistance programs. I am a participating provider on many EAPs and am happy to work within the parameters the EAP sets if I am a participating provider. It is your responsibility to know how this benefit works and if you wish to utilize it. Additionally, most EAPs do not reimburse for no-show appointments or late cancellations. **If you are utilizing an EAP benefit and no show for a scheduled appointment I will bill you for 100% of my normal session fee (see section below) and you will lose that allotted session.**

Cancellations/No-Shows/Lateness/Appointment Reminders:

When it is necessary to cancel an appointment, please give **48 hours** notice ***(a full 48-hour notice is required). Sessions not canceled with 48-hour notice will be billed at 100%) of the session fee and insurance WILL NOT reimburse this charge.*** Exceptions may be made for emergencies or illness. Snow, accidents, and severe illness are considered emergencies. If you are going to be 15 minutes or more late for a scheduled appointment, please call. If no call is received, the appointment will not be guaranteed and you will be charged the no show fee. Additionally, if you no-show for an appointment I **DO NOT** call you, it is your responsibility to contact me so we can discuss scheduling and payment for the missed appointment. I **DO NOT** provide reminder phone calls for appointments. It is your responsibility to arrive for our scheduled appointment time. I am happy to provide a card with your appointment date and time written.

Sessions:

Sessions are 53 minutes in length, as this is the allowable time as mandated by the insurance industry.

Emergencies:

In the event of an emergency, please contact 911 or go directly to the nearest emergency room or hospital.

Legal/Court Involvement/Disability Paperwork:

If you enter into treatment with me, you are agreeing **not** to involve me in legal/court proceedings or to attempt to obtain records of treatment for legal proceedings. This prevents misuse of your treatment for legal objectives. My goal is to support you in achieving therapy goals, not to address legal issues that require an adversarial approach.

If you are involved in or anticipate being involved in legal or court proceedings, please notify me as soon as possible. It is important for me to understand how, if at all, your legal involvement might affect our work together. It is important for you to recognize that treatment is not an appropriate way to obtain evaluative results. If you need formal psychological evaluation, I will be happy to assist you to find a provider who offers this service.

In the event you do require my testimony or involvement in any non-adversarial aspects of legal/court proceedings, I will do so only with your written consent. I will be unable to disclose information pertaining to other family member or parties involved in treatment without their written consent to disclose this information. If my testimony is required we will review together my fees before any involvement has begun.

Additionally, if I am subpoenaed to testify I will meet my legal obligation but hold you responsible for ensuring payment. Before such time that I testify under a subpoena I will provide a fee schedule to the subpoenaing attorney and I will hold you responsible for ensuring payment.

If you are requesting my assistance with Worker's Compensation paperwork, or any other disability related paperwork, including the preparation of, and sending records to your attorney or agent, I will do so only with your written consent and there will be a charge of $150.00 @ hour for such a service plus a charge for the copying of your record (if requested) and this fee must be paid in advance. In certain circumstances I will bill this charge to the requesting attorney or agent on your behalf and will hold you responsible for ensuring payment. These services are not reimbursable by medical insurances.

Confidentiality:

Information revealed during treatment is confidential and cannot be shared with anyone else without your written consent. However, you should be aware that there are some exceptions:

- According to State and Federal laws, if a disclosure is made regarding child or elder abuse or neglect, the therapist must report the abuse/neglect to the appropriate authorities. Also, if a client demonstrates imminent danger to her/himself or to another person, the therapist must act to avert that danger.
- In rare situations, clinical records and/or a therapist's testimony may be subpoenaed by a court.
- As part of my profession, I engage in supervision. In accordance with ethical standards, I make every effort to maintain confidentiality by withholding identifying information.
- In addition, managed care companies and employee assistance programs may require that written treatment plans be filed for review by their employees for authorization of services.

In all cases, steps are taken to protect privacy; that is, only information relevant to the situation is disclosed. Every effort will be made to inform you if an exception occurs.

Mutual Responsibility:

My responsibility is to provide you a safe, private space, dedicated time, and the best counseling services I can. Your responsibility is to attend appointments, try your best, and keep current with your payments.

Signature:

I have read, understand and agree to the policies outlined above.

I give Betty Warden, LCSW permission to send information electronically, including fax, email, and/or other electronic devices, to a person or agency for the purpose of billing insurance.

I give Betty Warden, LCSW permission to contact me via cell phone.

I understand my practitioner is Betty Warden, LCSW and that *The 4th Street Clinic* is the name of the building she practices from.

Client Signature: _____ Date: _____

Betty Warden, LCSW: _____ Date: _____

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HIPAA COMPLIANCE

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

Introduction:

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by me in any form are kept properly confidential. This act gives you certain rights and control regarding how your health information is used.

My Commitment To Your Privacy:

Your health record contains personal information about you and your health. Except in the specific instances mentioned below, I do not release identifying health information (called protected health information or PHI) about you without your specific written authorization.

How May I Use And Disclose Health Information About You:

1. **Treatment:** If I need to communicate with others about your treatment, I will obtain your written permission to do so. In most instances, the purpose of this communication is to enable me to provide or coordinate your treatment. This can include consultation with physicians, other clinicians, or consultants. There are some very circumscribed situation as explained in the "Required or Permitted by Law" section on page 2 of this form in which your written permission to communicate with specific others is not required.

2. **Payment:** I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment related activities include determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, or reviewing services provided to you to determine medical necessity. The type of information usually requested by insurance companies pertains to your diagnosis, symptoms, current functioning, treatment plan, response to treatment, and other information of this nature. I will, at your written request, discuss what information I am sharing with your insurer and allow you to review this information before I submit it. If you request that this information not be shared with your insurer, treatment may be arranged on a self-pay basis.

3. **Health Care Operations:** At times, I will have to contact you regarding your treatment, scheduling of appointments, bulling and other matters. It is your responsibility to inform me which methods you prefer to maintain your privacy. For example, if you do not want to be contacted at work please inform me of this fact. Or, if you do not want me to leave my name on a family voicemail, let me know about your concerns. I attempt to conduct these communication with respect for your privacy, cut you will need to inform me of special concerns you have regarding such matters.

Revocation of Authorization: You may revoke authorization you have given for release of your personal health information at any time provided it is done in writing. You may not revoke authorization to the extent that (1) I have already taken actions relying on your original authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

Required or Permitted by Law: Uses and disclosures of PHI from mental health records *not requiring* consent: Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of situations. I may disclose protected health information when I am required or permitted to do so by law. For example, if I believe that you present an imminent, serious risk of physical injury or death to yourself, I may make disclosures I consider necessary to protect you from harm. If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear and imminent risk of physical injury being inflicted against another individual, I may make disclosures I consider necessary to protect that individual from harm. Suspected child or elder abuse or neglect must be reported to the authorities. Other disclosures permitted or required by law include the following: disclosures for public health activities, health oversight activities and disclosures to judicial and law enforcement officials in response to a court order or other lawful process.

Your Rights Regarding Your PHI:

- **Right to Access and Inspect and Copy:** You may request access to your health information and billing records maintained by me in order to inspect and request copies of the records. Under limited circumstances, I may deny access to your records. Requests for access must b made in writing. I may charge a reasonable, cost-based fee for copies.
- **Right to Amend:** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to do so.
- **Right to an Accounting Disclosure:** You generally have the right to receive an accounting of the disclosures of your PHI by be after April 14, 2003.
- **Right to Request Restrictions:** You have the right to request, in writing, a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to a restriction of your request.
- **Right to Confidential Communication:** You have the right to reasonable requests to receive confidential communications of protected health information from me by alternative means or at alternative locations. For example, you may wish to receive phone calls from me at home rather than at work or you may prefer to have bills sent to a particular location.
- **Right to a Copy of this Notice**: You have the right to a copy of this notice.

This notice is effective as of April 14, 2003 and I am required to abide by the terms of the Notice of Privacy Practices currently in effect. I reserve the right to change the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. I will provide you with a written copy in the case of a revised document.

Questions and Complaints:

If you desire further information about your privacy rights or are concerned that I have violated your rights, please speak to me.

If you believe that I have violated your privacy protections or violated the terms of this notice, you have the right to file a written complaint with me as well as with the Secretary of the Department of Health and Human Services.

You will not be penalized for filing a complaint. To file a complaint with the Secretary, contact: **The US Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, SE, Washington, DC, 20201, phone 202-619-0257 or 1-877-696-6775**.

Your Signature:
Your signature below indicates you have read the information in this document, understand its terms, and agree to abide by its provisions.

_____	_____	_____
Client Signature	**Printed Name**	**Date**