Hanna Kuyper, M.A.

Registered Associate Marriage and Family Therapist (AMFT 109748)
Supervised by DaLene Forester, LMFT, LPCC (LMFT 33095, LPCC 629)
Park Marina Center for Wellbeing, 353 Park Marina Circle, Redding, CA 96001
Phone: (530) 710-4037 | Email: hannakuyper@gmail.com

Patients Name: _____ Date of Birth: ___/___/____
Responsible Party/Guardian (if different from above): _____
Date of Birth (of resp. party): ___/___/____ Relationship to patient: _____

Patient Information: Sex (M/F) ____ Married ____ Single ____
Telephone: (_____) _____ Can this # be called: (Y / N) _____
Physical Address: _____
Mailing Address (if different): _____
Employer: _____ Work Phone: (____) _____
Spouse's Name: _____ Spouces Date of Birth: ___/___/____

Insurance Information: Primary Insurance: _____
Name of Policy Holder: _____ Date of Birth: ___/___/____
Relationship to patient: _____ Subscriber ID #_____
Group #: _____ Customer Service Phone: (____) _____
Employer of Subscriber: _____

Secondary Insurance Information: Secondary Insurance: _____
Name of Policy Holder: _____ Date of Birth: ___/___/____
Relationship to patient: _____ Subscriber ID #_____
Group #: _____ Customer Service Phone: (____) _____
Employer of Subscriber: _____

Is this a Victim Witness Case? (Y/N)_____ Claim Number (required) _____
Do you have private insurance? (Y/N) _____ If so, you must provide the above insurance information.
Name of Victim: _____ Relationship to Victim: _____
Name of Advocate at Victim Witness: _____

Credit Card *Information:* *Name on card:* _____
Card Number: _____ *Security Code:* ___ ___ ___ *Expiration Date:* ___/____

Insurance Certification and Assignment: I hereby certify that the information given by 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 medical service to the patient. 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 or third party payers.

I understand 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.

Patient/Guardian Signature: _____Date: _____

Occupation: _____ Religious Preference: _____

Physician: _____ Date of last visit to Physician: _____

Medication(s) you are currently taking and dosage(s): _____

_____

_____

_____

Others living in the home:

_____Age: _____

_____Age: _____

_____Age: _____

_____Age: _____

_____Age: _____

_____Age: _____

What is your primary reason for being here: _____

_____

_____

How long has this been a concern? _____

_____

What have you tried so far? _____

_____

_____

Please check all of the following that apply

__ Headaches
__ Dizziness
__ Stomach problems
__ Weight change
__ Tremors or Tics
__ Trouble concentrating
__ Blurred vision
__ Always tired
__ Change in appetite
__ Feeling lonely
__ Previous suicide attempts
__ Nightmares
__ Unusual thoughts
__ Ready to explode
__ Panicky feelings
__ Feel like crying
__ Financial problems
__ Drug or alcohol use
__ Trouble sleeping
__ Family conflict
__ Feeling sad
__ Self inflicted wounding
__ Always worried
__ Difficulty making friends
__ Difficulty keeping friends
__ Sexual problems
__ Fear of things I shouldn't
__ Feeling worthless
__ Unable to make decisions
__ Strong dislike of criticism
__ Thoughts of suicide
__ Unable to get interested

Who can I thank for referring you? _____

Did an attorney or court officer recommend that you seek counseling? _____

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

_____

_____

_____

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STATEMENT OF DISCLOSURES FOR THERAPY

ARRIVAL AT THE OFFICE: I will usually be in a session when you arrive at the office. Please have a seat in the waiting room, I will be with you soon. Please do the best you can to respect the quiet atmosphere of the office, as several therapy sessions will be happening in the building.

CONFIDENTIALITY: All information shared in our therapy sessions will be kept confidential except when referred for non-confidential therapy (an example would be if you were referred for mediation or evaluation by an attorney) or in the event of such mandated reports as suspected child abuse, danger to self or others, elder abuse and other issues mandated by law.

APPOINTMENTS: I make every effort to make appointments that are mutually convenient within my standard office hours. Phone calls may be available for unexpected crises but are charged at a higher rate (see fees below).

CANCELLATION POLICY: I do have a 24-hour cancellation policy. APPOINTMENTS THAT ARE NOT CANCELED 24-HOURS IN ADVANCE WILL BE CHARGED for the amount of time reserved for your session, unless I am able to fill your vacated time. I will make every effort to fill your time slot. However, you are responsible for "no shows" and cancellations with less than 24-hours notice. Please know, I really will hold you responsible for cancellations. *Note, second party payers (insurance companies and Victim Witness) will not reimburse for "no shows."

PAYMENT: Payment is expected by cash, check, debit 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.

FEES: The charge for an initial evaluation is $125.00, therapy is $110.00 per 50-minute session. Payment is expected at the time of your session. Payments made at any other date require advanced arrangements. Sessions longer than 50 minutes will be prorated accordingly. If a report is necessary, preparation will be prorated at $150.00 per 50-minutes. After hour emergency appointments will be taken on an immediate pay basis at the rate of $150.00 per 50-minute session. Testimony requires a subpoena signed by a Judge and advanced payment of fees. Fees for testimony are $600.00 for each 4-hour half-day minimum. Travel outside Shasta County for testimony is charged at the hourly rate.

BILLING: I operate a fee for service, immediate pay business. Payments are expected at the time of your session so that money does not become an issue in the therapeutic relationship. Please make checks payable to DaLene Forester, PhD. If billing is arranged under special circumstances, payment will be expected within ten 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 or State Disability, sessions will be charged at the rate of $110.00 per session. Please note I am not on any provider lists or panels with insurance

companies. 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, NOT YOUR INSURANCE COMPANY. Insurance companies are in a rapid and unpredictable state of flux. I cannot be responsible for how your insurance company will handle your claim.

TELEPHONE CALLS: There is no charge for brief telephone calls to set or change appointments. Extensive information calls and/or crisis calls will be charged at the emergency session rate of $150.00 per 50-minutes.

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

Sincerely,
Hanna Kuyper, M.A.

I have read and understand the guidelines for confidentiality and payment given to me by Hanna Kuyper, M.A. and agree to them. I understand that I will be expected to pay for any session that I do not show up for or that I cancel without 24-hour notice.

Patient/Guardian Signature: _____Date: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

If you have any questions about this notice, please contact our office at 530-710-4037. Written requests should be addressed to: Hanna Kuyper, M.A., 353 Park Marina Circle, Redding, CA 96001.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). Please retain these pages (inclusive of this one) for your records.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE

You will be asked to provide a signed acknowledgment of receipt of this notice. It is our intention to advise you of the permissible uses and disclosures. The services will not be conditioned upon your signed acknowledgment.

NOTICE OF PRIVACY PRACTICES

This Notice describes the types of uses and disclosures regarding your Protected Health Information (hereafter referred to as "PHI"); it explains how, when and why we use and disclose PHI about you; it notifies you that we may use and disclose your PHI as described in this Notice.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who may provide "on-call coverage" for your health care provider.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION

We are required to protect the privacy of your health information that can identify you. This information is called "PHI." We understand that mental health and other health information about you is personal. We are committed to protecting PHI about you. We must protect PHI information that we created or received about your past, present, or future health condition; the services, care and treatment provided to you; or payment for your health care.

HOW MAY WE USE AND DISCLOSE PHI ABOUT YOU

For Treatment: We may use and disclose PHI about you to provide you with medical and mental health care and other related services. We may use and disclose PHI about you to provide, coordinate or manage your medical and mental health care and other related services.

– We may disclose PHI about you to doctors, nurses, technicians, or other personnel who are involved with the delivery of services provided to you.

– We may communicate with other medical, mental and other health care providers regarding your treatment, the coordination, and management of your health care with others.

– Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Health Care Operations: We may use and disclose your PHI in order to run the office and make sure that we provide quality care and reduce health care costs. Examples of the way we may use or disclose your PHI for "health care operations" include the following:

– To review and improve the quality, efficiency, treatment, services and cost of care provided to you and to evaluate the performance of staff providing services to you.

— To review and evaluate the skills, qualifications, and performance of health care providers taking care of you.

For Payment: We may use and disclose your PHI to others such as your insurance company and third party payers for purposes of receiving payment for the services rendered. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also share portions of your medical information with the following:

– Billing departments;
– Collection departments or agencies;
– Insurance companies, health plans and their agents which provide you coverage;
– Consumer reporting agencies (e.g., credit bureaus).

Appointment Reminders: We may use and disclose your PHI to contact you regarding the scheduling of an appointment, to remind you of an appointment, and to send written notification of a scheduled appointment for treatment.

Treatment Alternatives: We many use and disclose your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Benefits and Services: We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you. For example, if you are diagnosed with diabetes, we may tell you about nutritional and other counseling services that may be of interest to you.

To Avert Serious Threat To Health Or Safety: We may use and disclose your PHI consistent with applicable state and federal laws and standards of ethical conduct, if we in good faith believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or that of a person or the public; if the disclosure is made to a person or person(s) reasonably able to prevent or lessen the threat, including the target of the threat or is necessary for law enforcement authorities to identify or apprehend an individual. Additionally, we may use and disclose your PHI when the disclosure relates to victims of abuse, neglect or domestic violence.

Research: Under certain circumstances, we may use and disclose your PHI for research purposes, but only under specific criteria. You have the right to request information about these criteria and may obtain a copy of the policy by contacting the Privacy Officer in writing.

Worker's Compensation: We may release your PHI for worker's compensation or similar programs as authorized by state worker's compensations laws and programs.

Public Health Activities: We may use and disclose your PHI for public health reasons in order to prevent or control disease, injury or disability; report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: We may use and disclose your PHI to a state or federal health oversight agency which is authorized by law to oversee our operations. These activities include audits, investigations, inspections, and licensure. These activities are required by government programs to monitor the health care system, government programs and compliance with applicable laws, including civil rights law.

Judicial Administrative Proceedings, Lawsuits And Disputes: If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. Prior to this disclosure, we must make a good faith effort to inform you about the request or to obtain an order protecting the information requested and to follow applicable state laws.

As Required By Law: We will disclose your PHI when required to do so by federal, state or local law or other judicial or administrative proceeding.

Specialized Government Functions: If you are a member of the armed forces, we may disclose your PHI as required by military command authorities. We may use and disclose your PHI to authorized federal, foreign and other national security officials when the use and disclosure is for activities deemed necessary to assure the proper execution of the military mission or for other specialized government functions.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

EXAMPLES OF OTHER PERMISSIBLE OR REQUIRED DISCLOSURES OF HEALTH INFORMATION ABOUT YOU WITHOUT YOUR AUTHORIZATION:

Business Associates: Some activities are provided on our behalf through contracts with business associates. Examples of when we may use a business associate include coding and claims submission performed by a third party billing company, consulting and quality assurance activities provided by an outside consultant, billing and coding audits performed by an outside auditor, and other legal and consulting services provided in response to billing and reimbursement issues which may arise from time to time. When we enter into contracts to obtain these services, we may need to disclose your PHI to our business associate so that the associate may perform the job which we have requested. To protect your PHI, however, we require our business associate to appropriately safeguard your information.

Communication with family members: Health professionals, including those employed by or under contract may disclose to a family member, other relative, close personal friend or any other person you identify, health information relative to that person's involvement in your care or payment related to your care, unless you object to the disclosure.

Federal law allows for the release of your PHI to appropriate health oversight agencies, public health authorities or attorneys, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public. Any use or disclosure of your PHI that is not described in this notice will be made only with your written authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION:

Right to Inspect and Copy: You have the right to inspect and copy all or any part of your medical or health record, as provided by federal regulations. You may request and receive an electronic copy of your protected health information, or "PHI" if we maintain your PHI in an electronic health record. To inspect and copy your PHI, you must submit your request in writing to our Administrator at the address listed on the first page of this notice**.** The right of access to inspect and copy must be subject to and consistent with applicable laws as set forth in the Florida Statute. In addition to the Florida law requirements, the following exceptions apply: psychotherapy notes; information compiled in reasonable anticipation of or for use in a civil, criminal or administrative proceeding; or subject to the Clinical Laboratory Improvement Amendments of 1988. Instead of providing you with a full copy of your PHI, we may give you a summary or explanation of the PHI about you, if you agree in advance to the form and cost of the summary or explanation. If you request a copy of your PHI we may charge a reasonable, cost-based fee in accordance with state law for the costs associated with fulfilling your request. We may deny your request to inspect and copy your PHI in certain limited circumstances.

Right to Amend: You have the right to request that we amend your PHI, clinical or billing record about you if you feel that health information we have about you is incorrect or incomplete. You have the right to request an amendment for as long as we keep the information. Your request for amendment must be in writing and you must provide the basis for the requested amendment. If we accept your requested amendment, in whole or in part, we will respond in a timely manner and forward a copy of the amendments to the relevant person(s), if necessary. If we deny your request for an amendment, we will respond to you in writing, stating the basis of the denial of your request.

Right to an Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your PHI we have made, except for disclosures made for the purpose of treatment, payment, health care operations and certain other purposes if such disclosures were made through a paper record or other health record that is not electronic, as set forth in federal regulations. If you request an accounting of disclosures of your PHI, the accounting may include disclosures made for the purpose of treatment, payment and health care operations to the extent that disclosures are made through an electronic health record. To request an accounting of disclosures, you must submit your request in writing to our Administrator at the address listed on the first page of this notice. We will, to the extent possible, mail you a list of disclosures in paper form within 60 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; such date will not be later than a total of 90 days from the date you made the request.

Right to Request Restrictions: You have the right to request a restriction or limitation on the use and disclosure of your PHI. You also have the right to request a restriction or limitation on the disclosure of your PHI to someone who is involved in your care or the payment for your care, such as a family member or friend. We are not required to agree to your request for restrictions, except if you pay for a service entirely out-of-pocket. If you pay for a service entirely out-of-pocket, you may request that information regarding the service be withheld and not provided to a third party payer for purposes of payment or health care operations. We are obligated by law to abide by such restrictions. To request a restriction on the use and disclosure of your PHI, you must make your request in writing to our Administrator at the address listed on the first page of this notice. In your request, you must tell us what information you want to limit and to whom you want the limitations to apply. We will notify you of our decision regarding the requested restriction. If we do agree to your requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures as previously addressed in this Notice.

Right to Revoke Authorization: If you execute any authorization(s) for the use and disclosure of your PHI, you have the right to revoke such authorization(s), except to the extent that action has already been taken in reliance on such authorization.

Right To Receive Confidential PHI: It is our practice to contact clients at the home number and address provided to us by the client. This contact information is documented in the client records. You have the right to request that we contact you in a different manner. This request is conditioned upon two requirements 1) you must provide us with the alternative phone and address or other method of contact 2) when appropriate, information as to how the method of payment, if any, will be handled. We must accommodate reasonable requests if you clearly state that the disclosure of all or part of the information that you are requesting could endanger you.

Right To A Copy Of This Notice: You have the right to receive a paper copy of this Notice on the date you first receive service from us. In emergency situations, we will provide the Notice to you as soon as possible. We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with us 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. We will not take any action against you or change our treatment of you in any way.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* for the office of Hanna Kuyper, M.A. The *Notice of Privacy Practices* provides information about how your protected health information may be used. I encourage you to read the notice in full.

This *Notice of Privacy Practices* is subject to change. If there is a change in the notice, you will receive an updated copy.

If you have any questions about the *Notice of Privacy Practices*, please contact the office at 530-710-4037.

I acknowledge receipt of the Notice of Privacy Practices of Hanna Kuyper, M.A.

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____