Debby Moffett, Ph.D., Psy.D.
518 East Main St., Santa Maria, CA 93454
805-346-1999 phone 805-346-1998 fax

INTAKE FORM FOR PSYCHOTHERAPEUTIC SERVICES

Identifying Information

Name: _____ Sex: _____Birth date: _____ Age: _____

Social Security #: _____Driver License #: _____

Home telephone: ( ) _____ - _____ Is it okay to call you there? Yes / No Leave messages? Yes / No

Preferred contact number: ( ) _____ - _____Other contact umber(s):_____

Residence address (including zip code): Is it okay if we send mail there? Yes / No

_____

Address and Street City State Zip Code

If not okay to send mail to above address, what is your mailing address (including zip code)?_____

_____

e-mail address: _____ Is it okay if we send mail there? Yes / No

Occupation: _____Work telephone: ( ) _____ - _____

Is it okay to call you there? Yes / No Leave messages? Yes / No

How did you hear of Dr Debby Moffett, Ph.D., Psy.D.? _____

May we thank him/her for referring you? (Please **initial** your response) Yes _____ No _____

Please provide the name of someone that we may contact in the event of an emergency concerning you.

_____ _____ _____

Name Relationship Telephone

Physical History

Date of your last physical examination: _____

Do you have any serious medical conditions? Yes / No

If yes, what? _____

Have you ever had a serious head injury? Yes / No

Have you ever had a stroke, aneurysm, or other neurological insult? Yes / No

What medications do you take regularly? _____

Who is your current primary care physician? _____

Social History

Birth place: _____ Number of siblings: _____

Highest grade or degree completed in school: _____ How did you do in school? _____

Have you ever been diagnosed with or suspected of having a learning difficulty or other developmental difficulty? Yes / No

If yes, what? _____

Number of times you have been in a committed partnership: _____

Current marital / partnership status: _____ If in a committed relationship, for how long? _____

Number of children you have: _____ Children's ages: _____

CONTINUED ON PAGE 2

 Client Name: _____ **Date:** _____/_____/_____

Mental Health History

Have you ever suffered from a mental health concern before now? Yes / No

If yes, what type of problem?_____

Have you ever sought treatment from a mental health care professional before now? Yes / No

If yes, from whom? _____

When and for what? _____

Do you consider the treatment successful? Yes / No

Are you **currently** receiving treatment from another mental health care professional? Yes / No

Have you ever been harmed (e.g., sexually abused) by a mental health care provider? Yes / No

Have you ever filed a complaint or lawsuit against a mental health care provider? Yes / No

Have you ever taken medication for a mental health concern (e.g., depression, anxiety, etc.)? Yes / No

If so, when? _____

If so, what medication(s) and dosage? _____

Alcohol and Drug Use

Have you ever used alcohol or any other non-prescription drug? Yes / No

If yes, do you currently use alcohol or other non-prescription drugs? Yes / No

How often do you use alcohol or other non-prescription drugs? _____

When you use alcohol or other drugs, how much do you consume?_____

Has your alcohol or drug use ever resulted in any problems? Yes / No

Do you use tobacco? Yes / No If yes how many packs a day _____

Caffeine use _____ (none) _____ (infrequently) _____ (Moderately) _____ (Frequently)

Sexual Abuse History

Were you ever sexually abused / assaulted? Yes / No

If so, when? _____

By whom? _____

Did you receive any treatment to help you deal with the experience? Yes / No

Violence and Suicide Risk

Have you ever been in a physical fight with anyone? Yes / No If yes, have you been in a physical fight since the age of 25? Yes / No

If yes, have you ever used a weapon (e.g., firearm, knife, baseball bat, broken bottle, etc.) in a fight? Yes / No

If yes, have you ever injured another person in a physical fight? Yes / No

Have you ever seriously considered suicide? Yes / No

If yes, are you seriously considering suicide now? Yes / No

If yes, have you ever attempted suicide? Yes / No

If yes, how many times? _____

If yes, by what means? _____

Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? Yes / No

If so by whom? _____

Do you feel safe in your current relationship? Yes No

Is there a partner from a previous relationship who is making you feel unsafe now? Yes No

Have you ever been forced to engage in sexual acts against your will or under threat or coercion? Yes No

Debby Moffett, Ph.D., Psy.D. Clinical Psychologist # PSY 20088

518 East Main Street
Santa Maria, CA 93454
805 346-1999 office, 805 346-1998 fax

FINANCIAL POLICY FOR PSYCHOLOGICAL SERVICES

PAYMENT FOR SERVICE: Standard fees for Debby Moffett, Ph.D.,, Psy. D., are:

$200.00 for comprehensive psychiatric intake
$150.00 per 45 to 50-minute individual or family therapy session
$ 75.00 per 45 to 50-minute group therapy session ($112.50 per 80 to 90-minute group therapy session)
$150.00 per hour for general and educational psychological testing
$250.00 per hour for forensic psychotherapeutic services (e.g., evaluations for courts or legal proceedings, court testimony, travel time to and from the court, time required to be at the court for testimony)
$150.00 per hour for reports or letters other than for the court (e.g., employer, school, probation)

If the therapist is a contracted provider with your insurance company or health care coverage organization, the billing fees and procedures will coincide with the terms of the company plan or provider contract. Clients are responsible for the patient co-payment charges. Clients are expected to pay co-payments or fees for services in cash or check when services are rendered unless other arrangements are made. If I am not a contracted provider with your insurance company, we require the first visit to be paid for at the time of service. For subsequent visits, other financial arrangements can be made. Please notify us if a problem arises regarding your ability to make timely payment.

Telephone contacts to/for the client, as well as requested letters or reports written by the therapist, are billed at the standard hourly rate of the therapist ($25 minimum). Time tracking for telephone calls begins when the therapist makes contact and concludes when the call ends.

Requests for records will be handled with consideration of relevant and ethical legal guidelines. Charges for copying records or reports will vary depending on the size of the record, but will be a minimum of $15.

Clients are expected to pay for the portion of the cost for which they are responsible at the time the services are rendered. If an extraordinary situation arises that warrants an exception to this policy, the client, with the agreement of the therapist, may carry a balance and make reasonable monthly payments. A re-billing fee of $10 will be charged every month for which no payment is received. Failure to maintain the agreed monthly payments, as demonstrated by two or more consecutive partial or delinquent payments, will be viewed as non-payment of the bill.

NON-PAYMENT OF BILL: If you fail to pay your bill or make adequate alternative arrangements, actions will be taken to collect the unpaid balance. Such actions may include use of a collection agency, court litigation, a negative credit report, and/or filing a 1099-C with the IRS. Such actions will be pursued only as a last resort. If it becomes necessary to use any of the above-mentioned actions, your name, address, and telephone, along with the balance you owe, may be disclosed as necessary. No other information about your treatment will be revealed.

INSURANCE REIMBURSEMENT: Clients who carry insurance should remember that professional services are rendered and charged to the client, not the insurance company. Your insurance company may or may not reimburse for services at the same rate that your therapist charges. Nonetheless, you, not the insurance company, are responsible for any portion of the bill not paid by the insurance company unless we have a contract with your insurance company that prohibits us from billing you for certain charges. We are not responsible for negotiating with your insurance company for payment. You will be given a receipt of services if you desire so that you can request reimbursement from your insurance carrier. You should also be aware that submitting a claim to insurance or other third party payor for reimbursement may require disclosure of some aspects of your treatment (e.g., diagnosis, treatment plan, and/or treatment progress). A request for us to submit a claim to your insurance carrier or other third party payor is considered consent for us to release that relevant information. Only the information necessary to process your claim will be released unless additional consent is obtained.

CANCELLATION OF APPOINTMENT: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or cancellation of an appointment. **Twenty-five dollars will be changed for the first missed appointment or a cancellation notice of less than 24-hours. My full fee of $ 150.00 will be changed for subsequent missed appointments or late cancellations. These fees will be charged regardless of the reason for a late cancellation or missed appointment.**

_____ _____
Client's Name Printed Responsible Party Name Printed (if different than client)

I (I have read / I have had read to me) this financial policy. I have been provided with an opportunity to ask any questions needed for clarification, and with my signature affirm that I understand and agree to abide by this policy. **I accept financial responsibility for services rendered to the above-named client.**

_____ _____
Responsible Party Signature Date

Billing address:

_____
Street address City State Zip Code

Phone (_____) _____ - _____

Debby Moffett, Ph.D., Psy.D Clinical Psychologist PSY 20088
518 East Main Street
Santa Maria, CA 93454
805 346-1999 office 805 346-1998 fax

Authorization to Bill Insurance / Third Party Payor

Client: _____ **Client's date of birth:** _____/_____/_____

Primary Insurance or Payor: _____

Name of Insured: _____ Relationship of insured to client: _____

Insured's Policy or ID #: _____ Group #: _____

Insured's date of birth (if different than client's): _____/_____/_____ Insured's phone #: (_____) _____ - _____

Insured's address (if different than client's):

_____
street city state zip

Insured's employer: _____Employer Phone #__(_____)_____-_____

Employer address: _____

Secondary Insurance or Payor: _____

Name of Insured: _____ Relationship of insured to client: _____

Insured's Policy or ID #: _____ Group #: _____

Insured's date of birth (if different than client's): _____/_____/_____ Insured's phone #: (_____) _____ - _____

Insured's address _____
(if different than client's) street city state zip

Insured's employer: _____Employer Phone #__(_____)_____-_____

Employer address: _____

Authorization and Assignment

I authorize Debby Moffett, Ph.D., Psy.D., to furnish all information that any insurance company or third party payor may request and need in connection with my illness or injury. I also authorize the insurance company or third party payor to make payable to Debby Moffett, Ph.D., Psy.D., any medical benefits that may be due to me under this policy as a result of my illness or injury.

If applicable, I authorize Debby Moffett, Ph.D., Psy.D., to release to the Social Security Administration or its intermediaries or carriers, or to the billing agent of this group, any information needed for this or a related Medicare or Medi-Cal claim.

I permit a copy of this authorization to be used in place of the original, and request payment of medical benefits to the party who accepts assignment.

It is understood that Debby Moffett, Ph.D., Psy.D., does not accept responsibility for collection of my insurance / health care benefits or negotiating the settlement of a disputed claim. I am responsible for payment of all charges regardless of anticipated coverage.

_____ _____
Responsible party Date

Debby Moffett, Ph.D., Psy.D Clinical Psychologist PSY 20088
An independently owned and operated psychological practice
518 East Main Street
Santa Maria, CA 93454

INFORMED CONSENT FOR TREATMENT / EVALUATION BY DEBBY MOFFETT, PS.D., PSY.D.

Following is information that might be relevant to your decision to receive psychotherapeutic treatment / evaluation.

INDEPENDENT PRACTITIONERS: The therapists at this facility are composed of professionals who share certain expenses and administrative functions, but their practices are independently owned and operated by each therapist. Your records are maintained separate from the records of the other therapists. Except for an emergency situation described below involving the long-term incapacitation of your therapist, no other therapist will have access to your records without your specific, written permission.

GENERAL INFORMATION: There might be alternative treatment approaches available for your condition. You are free to discuss those options with your therapist at any time. You may also seek consultation with another professional about possible treatment options.

Psychotherapy, while intended to heal, carries some risks. For example, at times while receiving treatment a client might experience a temporary worsening of symptoms due to focus on emotionally painful material. If you become concerned that your symptoms are worsening or that your treatment might be causing some negative side effect, please address your concerns with your therapist.

Many people find psychotherapy beneficial for a variety of problems. However, because many factors can influence treatment outcome, we are not able to guarantee that you will achieve all of your desired goals with treatment. If you have questions about the potential benefits of treatment for your situation, please discuss those questions with your therapist. If during the course of treatment you become concerned that you are not benefiting from treatment, please discuss your concerns with your therapist.

You are free to discontinue treatment at any time. Please be aware that premature termination from therapy might result in failure to achieve desired treatment goals. You are encouraged to discuss the option of termination and its foreseeable implications given the specifics of your situation with your therapist should you wish to consider it.

LIMITS TO CONFIDENTIALITY: Information you provide during treatment or evaluation is confidential and may not be disclosed without your permission except under specific circumstances, as permitted or required by law.

Disclosure is required by law under the following circumstances:

- where there is reasonable suspicion of child abuse and/or elder/dependent adult abuse
- if you or a creditable third party (e.g., family member, close friend, coworker, etc.) communicate to the therapist that you seriously plan to harm another person physically
- if you are suspected of terrorist involvement and a government agency is investigating you, I have to release your records without acknowledging to you that your records have been seized.

Disclosure may be permitted when there is reasonable suspicion that a client presents a danger of violence to himself/ herself, or to the person or property of another, and that disclosure of confidential information might prevent the threatened danger.

A court may require disclosure of confidential information in a legal proceeding where your condition or treatment is a relevant concern.

Finally, requests for treatment authorizations and submission of a bill to an insurance company or other third party payor for reimbursement often involves disclosure of information about your condition, symptoms, treatment, or progress. Sometimes an insurance company will require copies of session notes to authorize continuing treatment or process a claim for services rendered. If you request that we bill your insurance company or other third party payor, that request will constitute consent to release the information necessary to obtain treatment authorization and or to process the claim. We will release only the information or materials that are appropriate and necessary.

_____**Please initial here and continue on the next page**

INFORMED CONSENT FOR TREATMENT / EVALUATION BY DEBBY MOFFETT, PH.D, PSY.D.

(CONTINUED FROM PAGE ONE)

CONFIDENTIALITY IN GROUP/FAMILY/COUPLES TREATMENT: Confidentiality is important to the therapeutic process because it provides the basis for trust and honesty. If you participate in a therapy modality that includes other clients, you are responsible for maintaining the confidentiality of what others disclose during the course of treatment. They have that same responsibility to you. Persons who violate the confidentiality in group therapy may be asked to discontinue the group treatment and may receive a recommendation for another treatment modality.

SECRETS POLICY: Therapists believe that some secrets, when held from a family, spouse, partner, and/or specific others, can be destructive to the relationships of the individuals involved, including the holder of the secret. When working with families, couples, or other groups, the therapist reserves the right, when asked to maintain a secret, to work toward disclosure when disclosure has been determined by the therapist to be in the best interests of the parties involved.

CONSULTATION WITH OTHER PROFESSIONALS: At times your therapist may deem it appropriate to consult briefly with another professional about your case. Brief consultations are ethically appropriate to ensure that you are being provided the best possible treatment. If your therapist believes it is appropriate to consult with someone else regarding your case, she will not use your name or any unique identifying information unless you give permission to do so. If extensive consultation that would involve disclosure of your name or other unique identifying information is required, your therapist will seek your written consent to do that.

EMERGENCY CONTACT: Our office uses a 24-hour answering machine. A pager contact number for your therapist is specified in the outgoing message for your therapist‘s voice mail. In the event of a clinical emergency, you may page your therapist at the number indicated or call 211 to be connected to the crisis line. Occasionally other obligations might prevent your therapist from returning your call immediately. If your emergency is life-threatening, please call 911 immediately.

In the event of the unexpected death or long-term / permanent incapacitation of your therapist, you will be contacted by another clinician to arrange continued care. Shannon Larrabee, MFT, will contact Dr. Moffett’s clients. In the event that Ms. Larrabee is also incapacitated, Erin Bunnell, MA, MFT will contact Dr. Moffett’s clients.

RECORD KEEPING AND ACCESS TO RECORDS: While your case is active, our records our maintained in paper format and stored in a locked file cabinet. Upon closure of the case, the records may be electronically archived. As a client, you have the right to request access to your records. Ethical standards require that we consider the impact that your viewing of the records might have on you before deciding how to respond to such a request. In some cases the records or a summary may be released directly to you. In other cases, we might opt to release the records or a summary only to another licensed psychotherapist or physician.

FAILURE TO HONOR FINANCIAL AGREEMENT: Our financial policy is explained in detail on a separate form. You should be aware, however, that failure to honor your financial obligations with us may result in disclosure of your name and amount of money owed to a collection agency or credit-reporting agency.

CONSENT: I (I have read / I had read to me) this Informed Consent for Treatment/Evaluation. I have been provided with an opportunity to ask any questions needed for clarification, received answers to all such questions, and with my signature affirm that I understand it and agree to treatment without implied guarantee as to therapy results or outcome.

I authorize and request that Debby Moffett, Ph.D., Psy.D., her agents, and/or employees, carry out psychotherapeutic evaluations, treatments, and/or diagnostic procedures which during the course of my care as a client are advisable. I understand that the purpose of such procedures will be explained to me and will be subject to my agreement.

Client Name Printed	Date	Client Signature
Parent/Guardian Name Printed	Date	Parent/Guardian Signature
Parent/Guardian Name Printed	Date	Parent/Guardian Signature

Debby, Moffett, Ph.D., Psy.D.
518 East Main St., Santa Maria, CA 93454
805-346-1999 office 805-346-1998 fax

AUTHORIZATION TO RELEASE / EXCHANGE CONFIDENTIAL INFORMATION

To provide you with the best care, I may need to communicate with your other health care providers. If you consent to Dr. Debby Moffett contacting other health professionals, please provide the relevant information in the spaces provided and sign where indicated. **If you prefer not to provide that consent, please initial the line on the next page indicating that you decline to provide consent and sign on the line below where indicated.**

Client's Name: _____

DOB: _____ or ID#: _____

I authorize Debby Moffett, Ph.D., Psy.D., to release / exchange confidential information concerning my medical, psychological, substance abuse evaluations and/or treatment for the purposes of planning and/or coordinating my care with other health care providers. This information may be released to or exchanged with:

Primary Care Physician: _____

Address/Telephone: _____

Psychiatrist: _____

Address/Telephone: _____

Concurrent/Previous Therapist: _____

Address/Telephone: _____

Other Health Care Provider: _____

Address/Telephone: _____

(Continued on next page)

(Continued from previous page)

I understand there are statutes and regulations protecting the confidentiality of medical/psychological/substance abuse evaluation and treatment records. I understand that the information I am consenting to have released consists of such protected information. The need for this information has been explained to me, and I voluntarily give my consent for release. This consent is valid until this request is fulfilled, but not to exceed one year. Date consent will end _____. I further understand that upon written request, I may revoke this consent at any time except to the extent that action based on this consent has already been taken.

_____ **I decline to authorize release of my confidential information to my other heath care providers.**

_____

Signature of Client **Date**

_____

Signature of Parent, Guardian, or Authorized Representative of Client (specify) **Date**

Debby Moffett, Ph.D., Psy.D.
Licensed Clinical Psychologist
518 East Main Street
(805) 346-1999 office (805) 346-1998 fax

There are times when a client is in a crisis situation and needs to be seen right away. If a scheduled appointment is cancelled 24 hours or more in advance, I can accommodate the needs of these clients. Thus, in order to better serve all of my clients, I will be strictly adhering to my missed appointment policy stated in my financial statement. Please allow yourself a moment to thoroughly read the missed appointment policy. If you have any questions please ask me now, as I will be upholding the following:

MISSED APPOINTMENT POLICY

A minimum of a **24-hour advance notice** is required in order to cancel an appointment without fees being accumulated. Any appointment not cancelled at least 24 hours in advance will be considered a missed appointment/late cancellation and all fees will be applicable.

Fees that will be imposed for missed appointments are as follows:

First missed appointment will be assessed at $25.00

Second and subsequent missed appointments will be charged at my full fee of $ 150.00 per missed appointment

If more than 3 sessions are missed it will be at my discretion whether discharging you is an appropriate action.

When a missed appointment fee is charged, it will be due at the next session unless other financial arrangements are made with me.

Please remember to keep appointments to prevent incurring any additional fees.

Thank you for your cooperation

_____ _____

Client Signature Date

Debby Moffett, Ph.D., Psy.D. **Client Copy**
Licensed Clinical Psychologist
518 East Main Street
Santa Maria, CA 93454
(805) 346-1999 office (805) 346-1998 fax

There are times when a client is in a crisis situation and needs to be seen right away. If a scheduled appointment is cancelled 24 hours or more in advance, I can accommodate the needs of these clients. Thus, in order to better serve all of my clients, I will be strictly adhering to my missed appointment policy stated in my financial statement. Please allow yourself a moment to thoroughly read the missed appointment policy. If you have any questions please ask me now, as I will be upholding the following:

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Thank you for your cooperation

_____ _____
Client Signature Date

Please Keep For Your Records

Debby Moffett, Ph.D., Psy.D.
518 E. Main Street
Santa Maria, CA 93454
Phone: (805) 346-1999
Name of Contact: Debby Moffett, Ph.D., Psy.D.

HIPAA Notice of Privacy Procedures and Policies

THROUGHOUT THIS DOCUMENT, THE PRONOUNS "I", "ME", AND "MY" REFER TO YOUR THERAPIST AND/OR HIS/HER AGENTS.

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

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

A. I am required by legal statue to protect the privacy of your health information. This "personal health information" is defined as that health information that can be used to identify you, has been created by my office, or has been received from another office or entity. It applies to past, present, and future health or condition, your treatment, payment for services, and other health practices, which will be explained to you.

B. My office is legally required to apply/follow the practices described in this **NOTICE.**

C. My office has the right to change the privacy practices as described in this **NOTICE** at any time, as permitted by law. The changes will apply to your health information held by my office. You will receive an updated copy of the **NOTICE** and it will be posted in my office. You can request a copy of this **NOTICE** at any time by notifying the **CONTACT OFFICER** at the address and telephone listed at top of this page.

III. HOW I MAY USE AND DISCLOSE YOU PHI

- The **USE** of your PHI applies to sharing utilization, examination, or analysis of the information within this treatment facility.
- The **DISCLSOURE** of your PHI takes place when information is released or transferred out of this office to another party or entity.

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

1. **For Treatment.** Your PHI can be used within my practice to provide you with mental health treatment including discussing or sharing your PHI with trainees and interns. My office can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.
2. **To Obtain Payment for Treatment.** Use and disclosure of your PHI is permitted in order to bill and collect payment for the treatment and services provided to you by my office. These disclosures are limited in scope and serve to provide insurance companies or other third party payors with only the necessary information needed to process payment for your treatment. For example, I might send your PHI to your insurance company or health plan to be paid for the health care services that I have provided to you that might include, but not limited to, your name, social security number, diagnosis, treatment plan, fee charged, insurance number, dates

of service and other essential information to process your claim. I also may provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims.

3. **For Health Care Operations.** My office can use and disclose your PHI to operate the practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provide such services to you. I also may provide your PHI to accountants, attorneys, consultants, or others to further health care operations.
4. **For Research Purposes.** My office can release limited confidential health information for research purposes.
5. **Patient Emergency.** My office may disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent is not 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 Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. My office can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, and local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.
2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I also may have to use or disclose your PHI in response to a subpoena.
3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant
4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.
5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization
6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health and safety of others. However, any such disclosures will be made only to someone who might be able to prevent the threatened harm from occurring.
7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.
8. To remind you about appointments.
9. A limited data set of your PHI can be released for research purposes without your consent. If fully identifiable health information is needed for research purposes, an authorization for release of information must be signed before information is released.

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

In any other situation not described in section III, your written authorization before using or disclosing any of your PHI is required. 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 have not taken any action in relation to such authorization) of your PHI. I also will need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation during a private, group, joint, or family counseling sessions, which I have kept separate from the rest of your health

record. These notes are given a greater degree of protection than PHI and written authorization will be obtained before psychotherapy notes are released.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Restrictions on Uses and Disclosures. You have the right to request restrictions or limitations on uses or disclosures of your PHI to carry out treatment, payment, or health care operations. Please submit such requests to my office in writing, I will consider your requests, but I am not legally required to accept them. If your requests are accepted, I will put them in writing and my office will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. The Right to Choose How I Send PHI to You. You have the right to request that I send confidential information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and when appropriate, you provide me with information as to how payment (if required) for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communication on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI.

1. In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I do not have your PHI but I know who does, I will tell you who does, and I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, the reasons for the denial and explain your right to have the denial reviewed.
2. If you request copies of your PHI, I will charge you not more than $ .50 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.
3. Minors have the right to access their records when:
   a. The minor may legally obtain treatment without parental consent
   b. The parents sign a confidentiality waiver
   c. The minor can provide the consent for treatment
   d. Parents can access the minor's records when such access is permitted or required by law.

D. **The Right to Receive a List of the Disclosures Made By My Office.** You generally have the right to receive an Accounting of Disclosures of PHI for which you have provided neither consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

E. **The Right to Amend 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 your reason for the request in writing. Upon request, I will discuss with you the details of the amendment process.

F. **The Right to Receive a Paper Copy of This Notice.** You have the right to receive a paper copy of my notice even if you have agreed to receive it via e-mail.

V. HOW TO COMPLAIN ABOUT PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a compliant with the person listed in Section VI below. You also may send a written compliant to the Secretary of the Department of Health and Human Services at 200 Independence Avenue.S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my office's privacy practices.

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

If you have any questions about my notice or any complaints about the privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact Debby Moffett, Ph.D., Psy.D. at: (805) 346-1999.

VII. EFFECTIVE DATE OF MY NOTICE

This notice will go into effect September 1, 2003.

I will limit the uses or disclosures that I will make as follows:

It is customary among mental health professionals to limit use and disclosure of confidential information to those that the client has specifically consented, those required by law (e.g., reporting suspected child abuse, etc), and in litigation procedures against you or myself. My office will abide by that standard when it is prudent to so. There may be exceptions and in those cases where I reasonably believe that, it is in your best interest that I disclose information even without your specific consent. An example of such a situation might be if you needed emergency treatment and information I provided would help to ensure that you received appropriate care.

Debby Moffett, Ph.D., Psy.D.
518 E. Main Street
Santa Maria, CA 93454
(805) 346-1999
Name of Contact Officer: Debby Moffett, Ph.D., Psy.D.

ACKNOWLEGEMENT OF RECEPT OF NOTICE OF PRIVACY PRACTICES

You have the right to refuse to sign this document

I _____, have received a copy of the Notice of Privacy Practices.

Patient's Printed Name: _____

Signature _____

Date: _____

FOR OFFICE USE ONLY

My office attempted to obtain written acknowledgment of receipt of the NOTICE of Privacy Practices, however, we were unable to obtain it because:

_____ The patient refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented my office from obtaining the Acknowledgment

Other (see below)

_____

_____

_____

Client Name _____

INTAKE FORM FOR PSYCHOTHERAPEUTIC SERVICES

Place an X next to any problems you or your child have been experiencing or showing lately

	ADULT SYMPOTMS			CHILD or ADOLESCENT SYMPTOMS
	Aggressive/violent urges or behaviors			Academic problems
	Anger/hostility/irritability			Aggressive/violent urges or behaviors
	Anxiety/nervousness			Anger/hostility/irritability
	Body aches/feeling sick often			Body aches/feeling sick often
	Career concerns			Bullying/intimidating behaviors to others
	Childhood abuse issues			Cheating/lying/stealing
	Concentration Difficulties			Concentration difficulties
	Depression/sadness/crying			Cruelty to animals
	Drug abuse/dependence/usage			Defiant/disobedient behavior
	Eating problems			Depression/sadness/crying
	Fatigue/tiredness/low energy			Developmental delays
	Fears/phobias			Disruptive behavior
	Financial problems			Eating problems
	Grief/loss			Family changes (divorce, remarriage, etc.)
	Guilt/Worthlessness			Fatigue/tiredness/low energy
	Headaches			Fears/phobias
	Health concerns			Feelings of inferiority
	Hopelessness			Fire setting
	Hot or cold spells			Grief/loss
	Hypersensitivity/feelings easily being hurt			Guilt or worthlessness
	Impulsivity problems			Headaches
	Interpersonal problems			Hopelessness
	Judgment problems/risk taking			Hypersensitivity/feelings easily being hurt
	Legal problems			Impulsivity/hyperactivity problems
	Life transitions (birth, move, start school, divorce)			Interpersonal problems (siblings, peers)
	Marital problems			Judgment problems/risk taking
	Memory problems			Legal problems
	Menstrual problems/PMS/menopause			Life transitions (birth, move, start school, divorce)
	Miscarriage			Memory problems
	Mood swings			Mood swings
	Motivation problems or “laziness”			Motivation problems or “laziness”
	Obsessions/compulsions			Obsessions/compulsions
	Panic or anxiety attacks			Panic or anxiety attacks
	Parent-child problems/child management			Self-esteem problems
	Retirement adjustment			Self-injurious behavior
	Self-esteem problems			Sexual preoccupation
	Self-injurious behavior			Shyness
	Sexual preoccupation			Sleep problems
	Shyness			Smoking or other tobacco use
	Sleep problems			Social withdrawal/isolation
	Smoking or other tobacco use			Soiling bed or clothes
	Social withdrawal/isolation			Suicidal thoughts
	Stress			Targeted for teasing/bullying by others
	Suicidal thoughts			Temper tantrums
	Work problems			Wetting bed or clothes

_____

Signature of Client or Parent/Guardian Date