Deborah Cosmetis, Psy.D., Psychologist Inc.

Clinical Psychologist PSY24117
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Consent for Treatment and Notice of Business Policies

Process of psychotherapy

Psychotherapy is a collaborative process and your active participation is essential to your progress. Unlike other medical appointments, it calls for a very active effort on your part, which includes expressing yourself honestly, being open to feedback, questioning ideas that you do not understand, and implementing new strategies discussed in therapy. It is my responsibility to listen carefully to you, share my observations and insights related to your experiences, provide education on current perspectives from psychology research and practice, and connect you with additional resources that may be helpful (such as books, support groups, etc.).

Psychotherapy often leads to improved relationships, solutions to specific problems, and significant reductions in symptoms and feelings of distress. However, it can also have risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, and frustration. This is normal, especially in the beginning, as you begin to take a look at the areas in your life where you want to grow; however, it is transitory.

Our first few sessions will involve an evaluation of your needs. I will offer you my initial impressions of how our work together might be helpful, and/or if I believe you would be best helped by a different provider (e.g. with a specific specialty). You should also evaluate this information along with your own impressions of whether you feel comfortable working with me. Therapy involves a significant investment of time, money, and energy, so you should think carefully about making this commitment. If you have questions or concerns about our work together, we can discuss them whenever they arise.

Sessions

Psychotherapy typically consists of one session per week, but other arrangements might indicated, such as two times per week or once every two weeks. Since your appointment is a reservation of time specifically for you, a minimum of 24 hours notice is required for re-scheduling or cancelling an appointment; otherwise you will be responsible for paying a the missed session/late cancellation fee of ($70). Exceptions may be granted for emergency situations. Insurance companies do not cover fees for missed sessions; therefore you will be responsible for paying this fee.

Professional Fees and Payment for Services

My hourly fee is $140 for individual sessions and $160 for couple therapy sessions. Payment is expected at the time of service. Personal check may be made out to Deborah Cosmetis, Psy.D., and cash and credit cards are also accepted. Based upon your needs, I may be able to negotiate a temporary reduced fee or billing agreement (e.g. due to loss of job or financial hardship).

Insurance Reimbursement

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. If I am contracted with your insurance plan, I will bill the insurance company directly and you will only be responsible for paying your co-pay.

If I am not contracted with your insurance plan, I can also provide services as an Out of Network Provider and will provide you with a "super bill" at the end of each month, which you may submit to your insurance company for reimbursement. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. It is your responsibility to understand your insurance coverage.

Clients who wish to use their insurance should remember that submitting a mental health invoice for reimbursement carries a certain amount of risk, as not all conditions or problems are reimbursed by insurance companies. In such cases that a claim is denied, you are responsible for the full invoice amount.

Most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes, I have to provide additional clinical information, such as treatment plans or summaries. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. I will provide your insurance company with only the information required in order to meet their administrative needs. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

Termination

Termination is inevitable and part of the therapeutic process. It should not be done casually and is a valuable part of our work together. I reserve the right to terminate therapy at my discretion. While this is uncommon, reasons for termination include, but are not limited to, failure to comply with treatment recommendations, conflicts of interest, untimely payment of fees, client's needs being outside the scope of competence or practice, or the client not making adequate progress in therapy.

You also have the right to terminate therapy at your discretion. If you decide at any time that our work together is not satisfactory, I would be happy to help you determine another course of action, e.g., stopping treatment altogether or continuing with another mental health professional. If either party decides to terminate therapy, I recommend that we meet for at least one session to review our work together, progress on your goals, any further work to be done, and your options. This process is intended to facilitate a positive termination experience and give both parties the opportunity to honor and reflect on the therapeutic relationship and your progress to date.

Scheduling appointments is your responsibility. You are considered an "Active" client when we are meeting regularly. If you have not scheduled a next appointment for three months, I will consider this as a sign that you have decided not to return and I will close your file.

Chance Encounters

You may encounter someone you know in the waiting room - please respect their privacy by not sharing with others your knowledge of their therapy participation. It is possible that we may cross paths out in the community. If I see you in a public place, I will acknowledge you only if you initiate the interaction, so as to maintain your confidentiality. I will never acknowledge working with you therapeutically to anyone without your written permission.

Contacting Me

I am often not immediately available by telephone, as I will not answer the phone when I am with a client. While I typically work Monday – Friday, my hours often vary. I monitor my voicemail during my working hours and will make every effort to return your call as soon as possible, and typically within 24-48 hours, with the exception of weekends, holidays, and after hours.

If you feel that you cannot wait for a return call or if it is an emergency, you should call the San Diego Access and Crisis Line (1-800-724-7240) or go to the nearest emergency room. If you are in a medical emergency, call 911.

I am available by email to discuss practical matters, such as scheduling concerns or providing referrals or resources. Please do not use email to communicate personal/clinical information, as email is not HIPAA compliant and privacy cannot be guaranteed. Email should never be used in emergency situations.

PROFESSIONAL RECORDS AND CONFIDENTIALITY

The laws of California and the standards of my profession require that I keep treatment records. The information in your medical record is utilized in a number of ways. I use it to plan your treatment and keep a record of the significant issues that we address in treatment. Your insurance company may require information in your medical record for payment by the insurance company or health plan. By signing this Consent, you authorize me to provide information to your insurance company as needed for payment for services.

In general, the law protects the privacy of all communications between a patient and a psychologist. Thus, I can only release information about our work to others with your written permission. In order to release any information (i.e. another medical professional or therapist), I will ask that you sign an *Authorization to Release Information* form.

Exceptions to your Confidentiality

In accordance with the law, there are some situations in which it is legally necessary to break confidentiality and report information that is obtained through our work together. These include:

1. Any serious **threat of harm against yourself,** in which there is reason to believe that you have the intention, plan, and ability to do so.
2. Any serious **threat of harm against another person,** in which there is reason to believe that you have the intention, plan, and ability to do so.
3. Any instances of **child, elder, or dependent adult abuse or neglect.**
4. Other circumstances, such as: grave disability, disclosure to insurance companies, worker's compensation claims, managed care and collection agencies, and your involvement in certain litigation processes in which records may be requested by the court. If records are requested, you will be notified, privilege will be claimed on your behalf, and only mandated information will be disclosed.

If I believe that you pose a serious risk to someone else, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for you. If you threaten serious intent to harm to yourself, I may be obligated to seek hospitalization for you

and/or contact your emergency contact. This information must be reported and does not require your permission. I am not required by law to inform you should reporting be necessary, however, my preference during these circumstances is to include you in the decision process. If I have to report any of the above situations, I will support you through these difficult times.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential.

Mediation and Arbitration

All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of therapist and client. Both parties to this contract, by entering into it, are giving up their right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the psychologist and the psychologist's partners, associates, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including claims for loss of consortium, emotional distress or punitive damages.

A demand for arbitration must be communicated in writing to all parties. Each party shall pay their pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request.

Your signature below indicates that you have reviewed the information contained in this Consent for Treatment & Notice of Business Policies document, and that you agree to abide by its terms during our professional relationship.

I understand that no specific promises have been made to me about the results of treatment. I have read and discussed the points addressed in the Consent for Treatment and have had all of my questions fully answered. I hereby agree to enter into therapy with Deborah Cosmetis, Psy.D., and to participate in the therapeutic process to the best of my ability, as shown by my signature here.

Signature: _____ Date: _____

Printed name: _____

I acknowledge having read and received a copy of the Notice of Privacy Practices.

Client Signature:_____ Date:_____

Printed name: _____

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California HIPAA Notice of Privacy Practices

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. This notice conforms to the Federal Health Insurance Portability and Accountability Act (HIPAA) effective April 14, 2003. It also conforms to the Health Care Privacy Laws of California.

I. Disclosures for Treatment, Payment, and Health Care Operations: I may use or disclose your protected health information (PHI), for certain treatment, payment, and health care purposes without your authorization. In certain circumstances, I can only do so when the person or business requesting your PHI gives me a written request that includes certain promises regarding protecting the confidentiality of your PHI.
To help clarify these terms, here are some definitions:

- **"PHI"** refers to information in your health record that could identify you.
- **"Treatment"** is when I provide or another healthcare provider diagnoses or treats you. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist, regarding your treatment.
- **"Payment"** is when I obtain reimbursement for your healthcare. Examples are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- **"Health Care Operations"** is when I disclose your PHI to your health care service plan (for example your health insurer), or to your other health care providers contracting with your plan, for administering the plan, such as case management and care coordination.
    - **"Use"** applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
    - **"Disclosure"** applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.
    - **"Authorization"** means written permission for specific uses or disclosures.

II. Uses and Disclosures Requiring Authorization: I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In instances when I am asked for information for purposes outside of treatment and payment operations, I will obtain an authorization from you before releasing this information. I will also 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 session. These notes are given a greater degree of protection than PHI. You may revoke or modify all such authorizations (of PHI or psychotherapy notes) at any time; however, the revocation or modification is not effective until I receive it in writing.

III. Uses and Disclosures with Neither Consent nor Authorization: I may use or disclose PHI without your consent or authorization in the following circumstances:

1. **Child Abuse:** Whenever I, in my professional capacity, have knowledge of or reasonably suspect that a child has been the victim of child abuse or neglect, I must immediately report such to Children Protection Services. Also, if I have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional wellbeing is endangered in any other way, I may report such to CPS.
2. **Elder or Dependent Adult Abuse:** If I, in my professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these or if I reasonably suspect such, I must report the known or suspected abuse immediately to Adult Protective Services (APS) or the local law enforcement agency.
   I do not have to report such an incident if: i. I have been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect; ii. I am not aware of any independent evidence that corroborates the statement that

the abuse has occurred; iii. the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court ordered conservatorship because of a mental illness or dementia; and iv. in the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

3. **Health Oversight:** If a complaint is filed against me with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.
4. **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services that I have provided you, I must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; or 3) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides me with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified me that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court--ordered. I will inform you in advance if this is the case.
5. **Serious Threat to Health or Safety:** If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.
6. **Workers' Compensation:** If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of your initial examination, and at subsequent intervals as may be required by the administrative director of the Worker's Compensation Commission in order to determine your eligibility for WC.

IV. Patient's Rights and Psychologist's Duties: 1. Patient's Rights:

1. **Right to Inspect and Copy:** You are entitled to receive a copy of your medical record unless I believe that receiving that information would be emotionally damaging. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records or receive a copy of your records, I require written notice to that effect, and I would expect to discuss your request with you in person. If I deny you access to your records, you can request to speak with an independent colleague of mine about your request. Your request for independent review of your request should also be made in writing. If you are provided with a copy of your medical record information, I may charge a fee for any costs associated with that request.
2. **Right to Amend:** If you believe that the information I have about you is incorrect or incomplete, you may ask me to amend that information. It is my practice to accept this sort of request in writing, and that any information you may wish to add to your record also be provided to me in written form.
3. **Right to an Accounting of Disclosures:** You have the right to request an "Accounting Of Disclosures." This is a list of the disclosures I have made of medical record information. That information is listed on the Authorization To Release Information, and will be provided to you at your written request.
4. **Right to Request Restrictions:** You have the right to privacy, and to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. As noted above, I will not release your confidential information without your written permission. Any restrictions to your Authorization To Release Information should be specified on the Authorization.
5. **Right to Request Confidential Communications:** You have the right to request that I communicate with you only in certain ways. For example, you can ask that I not leave a telephone message for you, or that I only contact you at work or by mail.
6. **Complaints Regarding Privacy Rights:** If you believe your privacy rights have been violated, you may file a written complaint with me, or with an independent colleague of mine, or with the U.S. Department of Health and Human Services, 50 United Nations Plaza, Room 322, San Francisco, CA, 94102.

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CLIENT INTAKE FORM

Patient Name_____ Sex _____ Age_____ DOB ____/____/____

Address_____

City_____ State _____ Zip _____

Phone _____ Email _____

Emergency Contact _____

Relationship to Patient _____

Phone #(s)_____

INSURANCE INFORMATION:

Insurance Company_____
Name on Insurance Card _____
Member # or Subscriber ID on Card _____
Insured's Relationship to Patient: Self ___ Spouse ___ Child ___ Other ___
Effective Date of Insurance _____

SOCIOCULTURAL BACKGROUND:

Racial/Ethnic Background: _____

Religious/spiritual preference: _____

Sexuality (i.e. LGBQIA, hetero, poly, etc)**: _____**

Gender Identity: _____

ACADEMIC/ WORK BACKGROUND:

Place of employment: _____
Position: _____
Hours worked per week: _____ Years with employer: _____
Are you satisfied with your job? Yes No Not Sure
Education: _____

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FAMILY BACKGROUND:

Please list the members of your family (i.e Brittany, sister, grade school teacher, 32):

Family Member Name	**Relationship**	**Occupation**	**Age**

Who currently lives with you? _____

FAMILY MENTAL HEALTH HISTORY:

Have any of your blood relatives ever had any of the following?

	List Family Member
Alcohol/Substance Abuse	_____
Anxiety	_____
Depression	_____
Bipolar	_____
Psychiatric Hospitalization	_____
Schizophrenia	_____
Suicide Attempts	_____

SUPPORT SYSTEM:

Please indicate your current relationship status:

Single In a Committed Relationship Living with Partner Married Separated Divorced Widowed

Other:_____

If you are in a romantic relationship, how long have you been in this relationship? _____

Are you satisfied with your current romantic relationship? Yes No Not Sure

How would you rate the quality of your friendships?

Unsatisfactory About Average Good Excellent

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MENTAL HEALTH HISTORY:

Have you received counseling here or elsewhere before? Yes No
If yes, where: _____ When: _____ Duration_____
What was the focus of previous counseling? _____

Have you seen a psychiatrist in the past? Yes No
If yes, Who: _____ When: _____

Are you currently seeing a psychiatrist? Yes No
If yes, Who: _____

What psychiatric medications do you take and for what reason (i.e. Zoloft – depression)**:**

_____
_____
_____

How often are you having suicidal thoughts presently? Frequently Sometimes Rarely Never
How often have you had suicidal thoughts in the past? Frequently Sometimes Rarely Never
Have you ever attempted suicide? Yes No
If so, when: _____

Have you ever been hospitalized for psychological reasons? Yes No
If so, when: _____

Have you ever intentionally inflicted any harm upon yourself? Yes No
If so, how and when: _____

Are you having thoughts of harming others presently? Frequently Sometimes Rarely Never
Have you had thoughts of harming others in the past? Frequently Sometimes Rarely Never
If so, when: _____

ALCOHOL AND DRUG USE:

Do you have a history of alcohol or drug abuse? Yes No
If yes, when, what, and how long? _____

How often do you drink alcohol presently?
Daily 3+ times per week 1-2 times per week 1-2 times/month Less than once/month Never

How much do you drink? (i.e. # beers/wine/shots per day) _____
How often do you have 4 or more drinks in one day? _____

How often do you use other drugs (i.e. marijuana, cocaine, ecstasy, meth, oxycotin, etc)?
Daily 3+ times per week 1-2 times per week 1-2 times/month Less than once/month Never

If so, which ones? _____

Do you feel you need to cut down or stop using alcohol and/other drugs? Yes No Maybe
Has a friend or family member expressed concern about your alcohol or drug use? Yes No

PHYSICAL HEALTH:

How would you describe your physical health at present?
Poor Satisfactory Good Excellent

Name of your primary care physician: _____
Please list any health concerns (e.g. chronic pain, hypertension, diabetes, etc.):
_____
_____
_____
_____

Please list all medications, the reason for which each is prescribed, name of prescribing physician:
Name of Medication Reason Prescribed Prescribing Physician
_____
_____
_____
_____

Are you having any problems with your sleep habits? Yes No
Are you having any difficulty with appetite or eating habits? Yes No
Have you had a significant weight change in the last 2 months? Yes No
Do you have any problems or worries about sexual functioning? Yes No
How many times per week do you exercise? _____ **For how long each time? _____**

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SYMPTOM CHECK LIST Please check off items of concern to you.

____ Depression/Sadness
____ Low self-esteem
____ Mood swings
____ Suicidal thoughts
____ Racing thoughts
____ Anxiety/Worrying/Fearfulness
____ Panic attacks
____ Stress
____ Irritability
____ Obsessive thinking
____ Anger
____ Compulsive behaviors
____ Lack of energy
____ Poor concentration
____ Poor memory
____ Chronic pain
____ Feeling easily startled
____ Nightmares
____ Upsetting memories
____ Sleep difficulties
____ Physical pain or discomfort
____ Health issues
____ Headaches
____ Digestive problems
____ Weight problems
____ Problems with eating habits, nutrition
____ Body image or appearance
____ Sexual concerns
____ Family concerns
____ Relationship Issues
____ Dating Issues
____ Grief/loss
____ Loneliness or isolation
____ Shyness
____ Trusting others
____ Identity issues (cultural, gender, etc.)
____ Career dissatisfaction
____ Problems in school
____ Spiritual/religious
____ Sexuality
____ Legal Issues
____ Drug use
____ Alcohol use
____ Cigarette/nicotine use
____ Addictive behavior (i.e. shopping, gambling, etc.)
____ Impulsiveness/lack of control
____ Dishonesty
____ Perfectionism
____ Guilt
____ Indecisiveness
____ Procrastination
____ Paranoid thinking
____ Hearing things others do not hear
____ Thoughts to hurt someone

In what ways have you attempted to cope with this/these problem(s)?

_____
_____
_____

How many counseling sessions do you anticipate needing?

1-6 7-12 12-20 20+

List your strengths and qualities you admire about yourself:

_____
_____
_____