Stefanie Rosen, Psy.D, MFT

2277 Townsgate Road, Suite 210
Westlake Village, CA 91361

I welcome you to therapy, and I appreciate the opportunity to work with you. I provide adolescent and adult therapy to individuals, families and groups. Therapy involves a collaborative relationship between the therapist and client to modify troublesome thoughts, feelings or behaviors through the development of self-awareness, interpersonal understanding, and problem solving to enhance one's ability to cope, alleviate distress, or achieve life goals. This process assumes that feelings, thoughts, and behaviors are the product of life experiences and choices, and it takes place in an atmosphere of trust and acceptance. I will assist you to identify treatment goals to resolve conflicts, find solutions, and enhance acceptance of self and others.

Payment and Billing

Full payment is expected at the time of the appointment unless otherwise arranged. If needed, I will provide you statements containing all the information necessary for you to submit a claim to your insurance company.

Cancellations and Missed Appointments

Please notify me as soon as possible if you need to cancel your appointment, at least 48 hours prior to the appointment. Missed/late canceled appointments cannot be billed to insurance companies. Therefore, clients are responsible for the full fee for appointments canceled less than 48 hours in advance, some emergencies excepted.

Confidentiality

Communications between therapist and client are private and released only by written permission. However, therapists are legally obligated to report certain suspected or actual dangers. Please review the attached statement "Notice of Psychotherapists' Policies and Practices to Protect the Privacy of Your Health Information" for additional details.

Ending Treatment

Regular attendance will produce the maximum benefits, but you are free to discontinue treatment at any time. Please discuss with me any concerns you may have about your treatment and/or your progress. I strongly encourage you to notify me at least two weeks in advance of ending therapy so that we can discuss progress, goals, and plans for any future services.

Emergencies and Availability

I usually check my messages regularly between 9:00 a.m. and 6:00 p.m. Monday through Friday, and I return calls as soon as possible, usually within one business day. If you have not heard back from me, please leave another message, as technology sometimes fails. In case of emergency, call 911 or go to your local emergency room.

Policy Agreement

I/we have read the above policies, and I/we understand and agree to them fully.

Client/Parent name (printed) _____

Client/Parent Signature(s) _____ Date_____

Witness _____ Date _____

Stefanie Rosen, Psy.D, MFT
2277 Townsgate Road, Suite 200
Westlake Village, CA 91361

Notice of Psychotherapists' Policies and Practices to Protect the Privacy of Your Health Information

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

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 operations* 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 and Payment Operations"*
  -*Treatment* is when I provide or another healthcare provider diagnoses or treats you. An example of treatment would be when I consult with another healthcare provider, such as your family physician or another psychotherapist, regarding your treatment.
  -*Payment* is when I obtain reimbursement for your healthcare. Examples of payment 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 practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my practice, 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 those 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. 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.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** Whenever I, in my professional capacity, have knowledge of or observe a child I know or reasonably suspect, has been the victim of child abuse or neglect, I must immediately report such to a police department or sheriff's department, county probation department, or county welfare department. Also, if I have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, I may report such to the above agencies.
- **Adult and Domestic 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 experiences these or if I reasonably suspect such, I must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency.

I do not have to report such an incident if:

- 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:
- I am not aware of any independent evidence that corroborates the statement that the abuse has occurred.
- 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**
- in the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

(_____) Initials

Health Oversight: If a complaint is filed against me with the appropriate licensing board, the board has the authority to subpoena confidential mental health information from me relevant to that complaint.

- **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 subpeona 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 bring a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.
- **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.
- **Worker's 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 worker's compensation.

IV. Patient's Rights and Psychotherapist's Duties

Patients Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided 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.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures while you are still in active evaluation or treatment with me, I will notify you in person of the revision, and provide you with the revised notice in person at my office.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me to attempt to resolve the problem. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on 4/1/03.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If you are still in active evaluation or treatment with me after revision of this notice, I will notify you in person of the revision, and provide you with the revised notice in person at my office.

I acknowledge receipt of this document.

Name_____ Date_____ Signature_____

Witness_____ Date_____

Stefanie Rosen, Psy.D, MFT

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Financial Agreement

I, _____ agree to pay $ ____ per session. This fee will increase by $10 each year on July 1. I understand that I will be charged for time spent outside my scheduled appointment time for the completion of letters, reports or email/phone consultation if I request such services. I understand that I am fully responsible for the fee and that my treatment provider will cooperate with me to provide my insurance company (if applicable) information required for reimbursement. Missed/late canceled appointments cannot be billed to insurance companies. Therefore, clients are responsible for the full fee ($_____) for appointments canceled less than 48 hours in advance, emergencies excepted.

Client/Parent name(s) (printed) _____

Client/Parent Signature(s) _____ Date_____

Witness _____ Date _____

Consent to Treatment

I give my permission and consent to Stefanie Rosen, Psy.D, MFT to provide psychotherapeutic treatment or counseling to me and/or _____, who is/are my spouse/child/other. I know of no reason I/he/she/we should not undertake this therapy, and I/he/she/we agree fully and voluntarily to participate. While I expect benefits from this treatment, I fully understand that particular benefits or outcomes cannot be guaranteed.

Client/Parent name(s) (printed) _____

Client/Parent Signature(s) _____ Date_____

Witness _____ Date _____

Notice of Privacy Practices

I have read and I fully understand the *Notice of Privacy Practices* I received from Stefanie Rosen, Psy.D, MFT.

Client/Parent name(s) (printed) _____

Client/ Parent Signature(s) _____ Date _____

Witness _____ Date _____