

ROSARIO ORTIGAO, M.A., L.M.H.C.

Notice of Privacy Rights and Practices

Under the 1996 Health Insurance Portability and Accountability Act (HIPAA) , you have specific Privacy Rights, as a client. The purpose of this form is to notify you of them:

1. The right to inspect your own health information and obtain a copy (excluding psychotherapy notes).
2. The right to request an amendment to health information (excluding psychotherapy notes).
3. The right to receive an accounting of disclosures for purposes other than treatment, payment, and healthcare operations.
4. The right to request that uses and disclosures of health information be restricted.
5. The right to file a privacy complaint with your provider and/or the secretary of HHS (Department of Health and Human Services). You must do it in writing and you may either give it to me at your next appointment or send it by mail. To file a complaint with the Secretary of HHS, you may do it via the internet at <http://cms.hhs.gov/hipaa/hipaa2/default.asp> or you may mail it to HIPAA Complaint 7500 Security Blvd, C5-24-04 Baltimore, MD 219244. The information needed to file a complaint is your contact information (name, address and phone), the name of the Covered Entity you are filing the complaint about, their tax identification #, Medicare identification #, if applicable, their address and phone number.

As your provider, I am legally required, under Federal Law and HIPAA, to protect your health data and to release only the minimum necessary information for the purposes of treatment, payment or healthcare operations, unless otherwise specifically authorized by you.

Confidentiality- No one will reveal information concerning your counseling to anyone outside of this office except as follows: (1) You consent in writing, (2) if life or safety is seriously threatened (including abuse of children/elderly/disabled), (3) disclosure is required by law (such as a judge requesting the records), (4) you file a benefit claim and the claim payer or your insurance requires information, (5) the files are audited by Quality Assurance bodies, (6) or the IRS, (7) I choose to disclose anonymous information pertaining to your case for the purpose of clinical and professional consultation, personal publication and/or educational illustration, (8) If, through the use of a fax or cell phone, your information, inadvertently, falls in the hands of someone other than the one intended, (9) Other people who may have limited access to your file and or may learn of your name associated with our counseling relation may include but not be limited to: anyone working for me, the Bank, (when check depositing), collections, bankruptcy court, this Building cleaning crew/landlords/its representatives, porter, personnel related to building emergencies, such as fire.

Fees- professional services are due when rendered. Your signature below will indicate that you accept full responsibility for payment of any balance incurred for services; that you further understand that without two-(or three, if a 2-hr-appointment) full-business-days-notice of

intention to cancel that you will be charged for the full professional fee. E.g.: a Monday appointment needs to be canceled early on Thursday or late Wednesday, the week prior. If you have health insurance plans, at no charge to you and, as a courtesy, I will bill them and collect from you your co-pay and/or deductible (in cash or check), if applicable. It is *your responsibility* to keep up with your insurance and specific benefits and inform me of your plan and of any changes.

Phone or email is billable according to my hourly rate (e.g. 15 minutes= \$50). Any of my time dedicated to legal matters is billed at the \$375/hr rate. Non-payment of fees may result in termination of professional services and initiation of collection activity (\$40 additional fee).

Parents/legal guardians: your signature below is your acknowledgment that if your child is 18 years old or older, but brought here through you, that you are ultimately responsible for the bills. Furthermore, the Law requires *both parents'* signature in the treatment of minors; your signature below is not only your permission of my treatment of the minor child but also your acknowledgement that you have full legal authority to consent it, without obtaining approval of another person. Email and text messages need to be secure, i.e., through encrypted methods. Any out-of-the office contacts are not covered by insurance; my rate is \$50 per email exchange (unless it's a long email and then my hourly rate applies).

Your signature below is proof that you fully understand this form and accept it as the terms of your participation in this counseling. The above remains in effect until revoked by you in writing; should there be any changes to these forms, provided you are still actively involved in therapy, you will be notified and given new ones to sign, as well as a copy. You also assign the following person as your ***emergency contact***, and hold Rosario Ortigao harmless, should the need arise and notification of the person below have to occur:

_____ Phone # _____

Generalized Consent

I hereby give my consent for Rosario Ortigao and her business associates to use and disclose my protected health information (PHI) to a third party for the purpose of carrying out "treatment," "payment" and "health care operations." I understand that, otherwise, for my psychotherapy notes to be released to any party, I have to sign an "Authorization for release of information" form. I also understand that I have the right to request restrictions on how and to whom my protected health information may be released. I fully understand what I have just read and acknowledge that I have received a copy today. _____ (Initials)

Patient Signature

Witness

Parent or Legal Guardian Signature

Date

ROSARIO ORTIGAO, M.A., L.M.H.C.

PRE- AUTHORIZED HEALTH CARE FORM

I authorize the practice of Rosario Ortigao, L.M.H.C., to keep my signature on file and charge my credit card account for:

- Charges for attended appointments (co-pays or full fees rendered services fees)
- Charges for missed appointments (no-shows or late cancelations, i.e., those not cancelled within two full business days)
- Balance of charges not paid by insurance or me within 90 days

I understand that I may revoke this agreement at any time by providing a request in writing.

Client Name: _____

Cardholder's name: _____

Cardholder's Address: _____

City: _____ State: _____ Zip: _____

Visa Account #: _____

Master Card Expiration Date: _____

Discover CW2/CID _____

American Express Signature: _____

VERIFICATION OF BENEFITS

Date and time of appointment _____ When 1st called for appt. _____

Patient Name _____ Parent _____

Date of Birth _____ Address _____

Phone () _____ Reason for coming in _____

Desired Outcome _____

EAP and/or Insurance Name _____ Ins. Agent Name, date & Time: _____

Phone _____ Authorization # _____

Authorization Effective/ End date _____ How many visits? _____

Person Insured _____ Insured Employer _____

Policy/ I.D. # _____ & SS# _____ Group/Plan # _____

Insured's date of birth _____ Insured's address _____

Mental Health Claims Address (sometimes different than regular claims address) _____

Who/How were you referred to our office _____

BENEFIT INFORMATION

Deduct in Network _____ Deduct out of Network _____

Co-pay in Network _____ Co-pay out of Network _____

Yearly Max. in Network _____ Yearly Max. out of Network _____

Lifetime Max. Outpatient _____ Lifetime Max. Inpatient _____

Out of pocket Expense _____ Effective Date _____

Pre-existent Conditions (esp. related to problem) _____

ROSARIO C. ORTIGAO, M.A.
LICENSED MENTAL HEALTH COUNSELOR
NATIONAL CERTIFIED COUNSELOR

CLIENT INFORMATION

Date: Preferred pronouns:

Name: Email:

Address:

Cel #: Spouse's Name & cel #:

Birthday: Ok to leave msgs?:

Marital status: How long? # of marriages:

Occupation: Spouse's:

Children's names and ages:

Anyone else living with you?

Religious background:

Previous counseling (Provider, date, duration):

Why seen?/Helpful?/Why?

Do you have any health problems (incl. allergies):

Any medication? (name/dosage/frequency/since when?)

Last Dr.'s visit: Dr.'s name:

Why seen?

Any past hospitalizations (date and reasons):

Have you ever felt guilty about your drinking/drugging _____

Have you ever felt annoyed by people criticizing it? _____

Have you ever thought you should cut it back? _____

Have you ever had a morning eye opener to relieve a hangover _____

Please check the box if you are
PRESENTLY experiencing any of the symptoms below.
Please add a star (*) next to those that have been going on a long time.
(6 months or more for adults, 3 months or more for children)

- | | | |
|--|---|---|
| <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Feeling panicky |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Uneasy in crowds | <input type="checkbox"/> Scared for no reason |
| <input type="checkbox"/> Excessive worrying | <input type="checkbox"/> Mind going blank | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Thought and speech mixed up | <input type="checkbox"/> Impulse to repeat absurd behaviors | <input type="checkbox"/> Avoiding places because they are frightening |

- | | | |
|---|---|---|
| <input type="checkbox"/> Awakening at night or earlier than usual | <input type="checkbox"/> Having no interest in things | <input type="checkbox"/> Crying more often than usual |
| <input type="checkbox"/> Unable to have a good time | <input type="checkbox"/> Tired most of the time | <input type="checkbox"/> Feelings of hopelessness |
| <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> Depression | <input type="checkbox"/> Feeling worthless |

- | | | |
|--|--|---|
| <input type="checkbox"/> Feeling others are to blame | <input type="checkbox"/> Others not giving proper credit for your work | <input type="checkbox"/> Having ideas or beliefs that others do not share |
| <input type="checkbox"/> Feeling most people cannot be trusted | <input type="checkbox"/> Others taking advantage if you let them | <input type="checkbox"/> Being watched or talked about |

- | | | |
|--|--|--|
| <input type="checkbox"/> Feeling weak in parts of you body | <input type="checkbox"/> Dizziness or faintness | <input type="checkbox"/> Feeling a lump in your throat |
| <input type="checkbox"/> Fast heartbeat | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Nausea or upset stomach |
| <input type="checkbox"/> Trouble with vision or hearing | <input type="checkbox"/> Change of sensation in parts of your body | <input type="checkbox"/> Trouble getting your breath |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tremors | <input type="checkbox"/> Hot or cold spells |

- | | | |
|--|--|--|
| <input type="checkbox"/> Bothered by unusual odors | <input type="checkbox"/> Hearing voices that others do not hear | <input type="checkbox"/> Feeling something is wrong with your mind |
| <input type="checkbox"/> Feeling things are unusual | <input type="checkbox"/> Having strange and peculiar experiences | <input type="checkbox"/> Seeing things that other do not see |
| <input type="checkbox"/> Never feeling close to another person | <input type="checkbox"/> Traveling somewhere without knowing how you got there | |
| <input type="checkbox"/> Having thoughts that are not your own | | |

- | | | |
|--|--|--|
| <input type="checkbox"/> Urges to smash things | <input type="checkbox"/> Urges to harm someone | <input type="checkbox"/> Being "on top of the world" for no reason |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Easily irritated | <input type="checkbox"/> "losing it" |
| <input type="checkbox"/> Temper outbursts | <input type="checkbox"/> Controlling your impulse | <input type="checkbox"/> Being a hothead |
| <input type="checkbox"/> Feelings of "wanting to end it all" | <input type="checkbox"/> Having made a suicide attempt | <input type="checkbox"/> Wanting to hurt yourself |

- | | | |
|---|---|--|
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Difficulty in school | <input type="checkbox"/> Unhappy with present occupation |
| <input type="checkbox"/> Unable to find/ keep a job | <input type="checkbox"/> Legal problems | <input type="checkbox"/> Using alcohol |
| <input type="checkbox"/> Using drugs | <input type="checkbox"/> Having an unwanted habit | <input type="checkbox"/> (Create your own:) |
| <input type="checkbox"/> Difficulty reading | | |

- | | | |
|---|--|---|
| <input type="checkbox"/> Getting along with others | <input type="checkbox"/> Communicating | <input type="checkbox"/> having been abused |
| <input type="checkbox"/> Home conditions bad | <input type="checkbox"/> worried about sex matters | <input type="checkbox"/> feelings being easily hurt |
| <input type="checkbox"/> Socializing | | |
| <input type="checkbox"/> Feeling inferior to others | | |
| <input type="checkbox"/> Making decisions | | |

ROSARIO ORTIGAO, M.A.

Name _____

Date of Birth _____

Today's Date _____ Session's Beg/End Time _____

Outcome Rating Scale

Looking back over the last week or two, including today, help me understand how you have been feeling, by rating how well you have been doing in the following areas of your life. Marks to the left represent low levels (zero: the worst) and marks to the right indicate high levels (10: the best).

Socially

(Work, school, friendships)

0-----10

Interpersonally

(Family, close relationships)

0-----10

Individually

(Personal well-being)

0-----10

Overall

(General sense of well being)

0-----10