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/hippaa/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 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 consultation is billable according to my hourly rate (e.g. 15 minutes= $50). Any of my time dedicated to legal matters are billed at the $300/hr rate. Non-payment of fees may result in termination of professional services and initiation of collection activity ($25 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. 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, in order 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

__Master Card

__ Discover

__ American Express

Account #: _____

Expiration Date: _____

CW2/CID _____

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. #_____ Group/Plan # _____

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

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

_____

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: Referred by: E-mail:

Name: spouse's:

Address:

Home Phone: Work Phone: Cell:

Birthday: S.S.N.#: 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,and 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/druging _____
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.
(9 months or more for adults, 3 months or more for children)

- ☐ Trouble concentrating
- ☐ Nervousness
- ☐ Excessive worrying
- ☐ Thought and speech mixed up
- ☐ Anxiety
- ☐ Uneasy in crowds
- ☐ Mind going blank
- ☐ Impulse to repeat absurd behaviors
- ☐ Feeling panicky
- ☐ Scared for no reason
- ☐ Fearful
- ☐ Avoiding places because they are frightening

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- ☐ Awakening at night or earlier that usual
- ☐ Unable to have a good time
- ☐ Recent weight loss
- ☐ Having no interest in things
- ☐ Tired most of the time
- ☐ Depression
- ☐ Crying more often than usual
- ☐ Feelings of hopelessness
- ☐ Feeling worthless

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- ☐ Feeling others are to blame
- ☐ Feeling most people cannot be trusted
- ☐ Others not giving proper credit for your work
- ☐ Others taking advantage if you let them
- ☐ Having ideas or beliefs that others do not share
- ☐ Being watched or talked about

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- ☐ Feeling weak in parts of you body
- ☐ Fast heartbeat
- ☐ Trouble with vision or hearing
- ☐ Headaches
- ☐ Dizziness or faintness
- ☐ Poor appetite
- ☐ Change of sensation in parts of your body
- ☐ Tremors
- ☐ Feeling a lump in your throat
- ☐ Nausea or upset stomach
- ☐ Trouble getting your breath
- ☐ Hot or cold spells

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

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

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- ☐ Financial problems
- ☐ Unable to find/ keep a job
- ☐ Using drugs
- ☐ Difficulty reading
- ☐ Difficulty in school
- ☐ Legal problems
- ☐ Having an unwanted habit
- ☐ Unhappy with present occupation
- ☐ Using alcohol
- ☐ (Create your own:)

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- ☐ Getting along with others
- ☐ Home conditions bad
- ☐ Socializing
- ☐ Feeling inferior to others
- ☐ Making decisions
- ☐ Communicating
- ☐ worried about sex matters
- ☐ having been abused
- ☐ feelings being easily hurt

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