RICHARD W. FOSS, PH.D.
CALIFORNIA PSYCHOLOGIST LIC. # 20396
150 E. MEDA AVENUE, SUITE 110, GLENDORA, CA 91741-2607
TEL: (626) 335-6677 FAX: (626) 335-6670

Informed Consent for Treatment

This document contains some essential information about my services. Please read each item carefully and print your initials to signify your understanding and agreement.

About your treatment…

x_____ 1. Your appointment will last **50-60 minutes,** unless we make other arrangements.

x_____ 2. My standard fee is **$140.00/hour.** I accept cash, credit cards, and some insurance. Unless you are using insurance, full payment is expected at time of treatment.

x_____ 3. To **cancel or reschedule** an appointment, please call by noon on the day before your appointment, or you will be charged $75.00. Insurance will not pay for this.

x_____ 4. **Phone/Email Contact:** To contact me between appointments, text or voicemail me at (626) 335-6677 or email me at drrichardfoss@drrichardfoss.com. I reply within a day on weekdays. I may charge for phone conversations over 10 minutes.

x_____ 5. I am a psychologist in independent practice and do not belong to a partnership, joint venture, or corporation. I am not affiliated with any other practitioner.

Your rights…

x_____ 6. **Your care is private and confidential (See "Notice of Privacy Practices")**

a. When you sign this form, I may use information about you only for treatment, payment, and health care operations. Other uses need your special permission.

b. You have rights regarding your privacy and confidentiality, including:

- You can ask me to call you only at certain times or places.
- You can see and copy your treatment record and ask to add to it.
- If you feel your privacy has been violated, you can file a complaint with the Board of Psychology, 1625 N Market Blvd, N-215, Sacramento CA 95834.

c. I may be forced to disclose information about you without your consent if:

- You tell me you plan to harm yourself, another person, or the public.
- Court or law enforcement officials require me to release your information.

x_____ 7. **Your treatment is voluntary.** You are free to end treatment at any time.

Consent for Treatment

I, the undersigned, have read and fully understand this Consent. I agree to abide by all of its conditions. I understand that I am responsible for all balances unpaid by my insurance.

☑ I received Dr. Foss' "Notice of Privacy Practices." ☑ I received a copy of this form.

x_____ Client Signature

x_____ Today's Date

_____ Therapist Signature

_____ Today's Date

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Adult Client Information Form

Contact Information

Client _____ Birthdate (M/D/Y) _____ ☐ Male ☐ Female

Address _____ City _____ Zip _____

Home Phone _____ Cellphone _____ Work Phone _____

May I say who I am if I phone you at home? ☐ Yes ☐ No

May I say who I am if I phone you at work? ☐ Yes ☐ No

Email Address _____

Significant Other Status: ☐ Single ☐ Living Together ☐ Married ☐ Divorced ☐ Widowed

Who lives with you? _____

Your Profession _____ Employer _____

Emergency Contact _____ Emergency Phone _____

Insurance Information

Insurance Company _____ Insurance ID# _____

Subscriber _____ Subscriber's Birthdate _____

Group# _____ Policy# _____ ☐ HMO ☐ PPO ☐ EAP

Medical Information

Primary Care MD _____ MD Phone _____

Current medical conditions _____

_____

Medications (with dose) _____

_____

Your Concerns Today

☐ Relationship ☐ Marital ☐ Family ☐ Substance Abuse/Addiction

☐ Emotional ☐ Spiritual ☐ Parenting ☐ Other _____

Previous counseling? ☐ Yes ☐ No Therapist _____

Effective January 10, 2018

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Notice of Privacy Practices to Protect Your Health Information

I. What I Mean by Your Health Information

I collect information about you and your physical and mental health each time you visit me. U.S. law calls this Protected Health Information (PHI) and requires me to protect it. Your PHI may include your symptoms, diagnosis, progress notes, billing records, or other information.

I may use your PHI to plan treatment, communicate with your doctor, and arrange payments from your insurance company. Although your treatment record is my property, you have a right to read it and your PHI belongs to you. (In rare situations, I might not allow you to read part of your treatment record. I can explain more about that if you ask me.)

II. Privacy and Laws About Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires me to keep your PHI private and offer you this Notice of Privacy Practices. I will obey the rules described in this Notice. If I revise it, I will post it in my office or you can obtain a copy from me.

III. How Your Protected Health Information Can Be Used and Shared

HIPAA gives you a right to know how your PHI will be used and disclosed. After you consent to treatment, HIPAA allows me to use and disclose your PHI to deliver treatment, obtain payment and perform health care operations. For any other purpose, I need your written authorization. When I disclose your PHI to others, they will receive the minimum necessary to do their jobs.

A. Uses and Disclosures of PHI That *Do Not Require* Your Authorization

1. **Treatment.** I will use information about you and your health condition to provide for your care. I may also use your PHI to conduct psychological testing. I may disclose your PHI to other professionals to seek advice regarding your care or refer you for services that I do not offer. Their advice, findings, and observations may become part of your record.
2. **Payment.** I may disclose information about you and your health condition to your health insurance company to find out if your treatment will be covered. I may also disclose your PHI when I bill your insurance for my work. If I hire a "business associate" for billing or other services, he or she may need to use your PHI to do their jobs. Your health insurance company and my business associate will contract with me to safeguard your PHI.
3. **Health Care Operations.** I may disclose your PHI to government agencies that collect health care data, but I will not include any information that might identify you.
4. **Other Uses and Disclosures That Do Not Require Your Authorization**

   a. ***Research.*** I may use your PHI in research, but must remove PHI that might identify you.

   b. ***Scheduling.*** I may contact you between sessions to schedule or cancel appointments.

   c. ***Family or friends.*** I may disclose your PHI to family or others involved in your care.

   d. ***Emergencies.*** I may disclose your PHI in an emergency when you cannot authorize it and I think that it is in your best interest or you would have agreed if you were able.

B. Uses and Disclosures That ***Require*** Your Authorization

To use your PHI for purposes other than those listed above, I would need your written authorization. You could cancel your authorization at any time with a written notice.

C. Exceptions to Privacy and Confidentiality

I am committed to protecting your privacy and confidentiality. Nevertheless, some federal, state, or local law may require me to disclose some of your PHI if:

1. I believe there is a **serious threat** to your safety or the safety of others.
2. I suspect that **abuse or neglect** of children, elders, or dependent adults has occurred.
3. Police officers investigating a crime present a **court order** seeking your record.
4. You are involved in a legal proceeding and I receive a **subpoena** or **discovery request**. (In this case, I must try to tell you about the request before I disclose your PHI.)
5. A **government audit** of my health care operations requires me to disclose your PHI.
6. A **worker's compensation program** requires information related to your claim.
7. If you are an armed forces member and **military authorities** require your information.
8. A federal agency investigating a **national security** issue seeks access to your record.

IV. Your Rights Concerning Your Health Information

A. Right to Limit Communication Between Sessions

If we need to communicate between sessions, you can ask me to contact you in a way that ensures your privacy. For example, you can ask me to call you at home, rather than at work, to schedule or cancel appointments.

B. Right to Limit Who Receives Your Health Information

1. You can ask me to limit what I disclose to family, medical professionals, or others involved in your care. I will honor your request unless the information is needed for your care.
2. You can restrict disclosures to your health insurance when you pay me in full by yourself.

C. Right to Inspect, Copy, and Amend

1. You have the right to examine your treatment record and obtain a copy of it. (In certain very limited circumstances, I may deny your request to inspect or copy your record.
2. You can make additions to your record if you believe it is incorrect or incomplete. You must submit these changes in writing and explain why you want to make them.

D. Right to Be Notified of Disclosures

1. If you ask in writing, I will report who received your PHI, when I sent it, and what I sent.
2. You have a right to be notified of an **unauthorized disclosure of your PHI** if your PHI was not encrypted to government standards and was probably readable by others.

F. Right to Submit a Complaint

1. If you believe your privacy has been violated, you may contact me or submit a written complaint to the **Board of Psychology**, 1625 N. Market Blvd, N-215, Sacramento, CA 95834 or to the **U.S. Department of Health and Human Services**, 200 Independence Ave, S.W., Washington, D.C. 20201.
2. If you submit such a complaint, I cannot and will not retaliate against you in any way.