Stephen J. Harris, Ph.D.

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FOR OFFICE USE ONLY

Patient Acct #_____ Start Date_____ DX_____ #Visits_____ Ded_____ Copay_____

Hello! And welcome to my practice. Attached is a confidential questionnaire and payment information I will appreciate you filling out. The questionnaire will help me understand who you are as a unique individual and what you are seeking from therapy. We will go over this information when we meet. Please complete all pages. This paperwork will take about 20 minutes to complete.

Today's Date:____/____/____

Patient Information

Last Name_____ First Name_____ MI____ Date of Birth_____

Gender: *M / F* ***Status:*** *Single Married/Other* ***SSN_____ Employment:*** *Full-time/Part-time/Full-time student*

Address_____ City, State, Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Fax_____ Email_____ **Ok to leave message at: Home Cell Work**

Employment Information

Employer Name_____ Phone_____Address_____

Primary Insurance

Insurance Name _____

Insurance Address_____ Ins Phone_____

Primary Insured ID_____ Insured Name_____Relationship to Patient_____

Group No_____ Plan Name_____Deductible_____ CoPay_____
Name or Type of Plan: PPO EPO HMO EAP Other:_____

Secondary Insurance

Insurance Name _____

Insurance Address_____ Ins Phone_____

Primary Insured ID_____ Insured Name_____Relationship to Patient_____

Group No_____ Plan Name_____Deductible_____ CoPay_____

Emergency Contact

Name_____Address_____

Home Phone_____ Cell Phone_____ Relationship to Patient_____

Guarantor (Responsible Party) if different from patient

Name_____Address_____

Home Phone_____ Cell Phone_____ Relationship to Patient_____

Ethnicity (optional): White Black Hispanic Oriental Asian Other:_____

Please share with me how you first find out about my services: Insurance Friend (Name?_____)
Yellow Pages (Under "Psychology" Under "Marriage") Ad (Name of publication) _____
Internet Search engine: _____ Other _____

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Payment Information (Please Read Carefully)

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A. Fee Schedule
$350 for 90-minute Initial Assessment and Evaluation
$175 per 45-minute session for Individual, Couple or Family Sessions
$115 per 30-minute session

B. Payment for Services
Payment is due at the time services are rendered and may be paid by check, cash or credit card. For insurance coverage, please read the information on the following page.

Please check how you wish to pay for services:

Check (make out to "Stephen J. Harris, Ph.D.") Cash Credit Card (MC/Visa) --- Exp Date _____/_____

C. Keeping Appointments
Each therapy session is about 45 minutes. The last few minutes are generally reserved to review the session and schedule any further appointments.
Sessions cancelled less then 24 hours or failure to show for appointments are charged a $75.00 fee.

_____Please initial here if you are willing to make and keep this agreement.

D. Confidentiality
You have a right of confidentiality that is covered by law. This means that the material you share with a therapist may not be revealed to anyone unless you give your written permission. There are, however, particular conditions in which a therapist is obligated by law to break confidence and report certain incidents to the authorities. These are: 1) Subpoena by a judge in a court of law, 2) If you have abused or molested a child or elder adult or if you reveal that such incidents have occurred by others, 3) If you indicate that you intend to harm or kill yourself or someone else.

I have read and understood the above information.

Signature: _____ Date: _____

E. Insurance Reimbursements (Please read carefully)
Check here if no insurance or not using insurance

In regards to insurance companies I am not a provider for; I appreciate payment directly from you as we go along. For insurance companies that I am a provider for, I will ask you to pay all applicable co-payments and deductibles at the time of the session. I will gladly bill your insurance company for you so that you may be reimbursed directly by them. Claims are filed immediately after each session and, generally, any reimbursement to you is made within 2-3 weeks. Or, if you choose, I will give you an itemized statement at the end of each month or a billing slip each session so that you can request reimbursement yourself. If you would like me to bill your insurance company for you, please

fill in the information below completely and accurately. Some insurance plans require an authorization and are very limited in mental health benefits so it would serve you well to become familiar with your plan. The items with an asterisk (*) are required for accurate billing.

Please indicate below which insurance reimbursement plan you wish to observe.

I will pay you for services as we go; I would like you to bill my insurance company for the cost of our sessions with any reimbursements going to me.
(Please fill out insurance information below]

I will pay you for services as we go; I would like you to give me a statement at the end of the month or at the time of the session so that I can bill my insurance company myself for reimbursements [you will be given a simple statement that is accepted by most insurance companies] (Go to questionnaire).

I will pay you my deductible and co-payment as I go since you are a provider for my insurance company; I would like you to bill my insurance for me.

Name of Primary Care Physician (PCP):_____

Phone # of PCP:_____

□ Check here if you want me to contact your PCP and please sign below:

_____ _____
Signature Date

CONFIDENTIAL INFORMATION (Please check the answers that best fit for you and fill in the appropriate blanks)

1. PRESENTING PROBLEM
a. The main problem I am seeking help for is
_____

_____

(Please circle the answer closest to what you believe)
b. I would rate the severity of this problem as: Mild; Moderate; Severe; Disabling

c. I have had this problem for: Several days; Several wks; Several mos; Past year; Past 2 yrs; Over 2 yrs

d. During the past year, the best this problem has been was: Not a problem; Mild; Moderate; Severe; Disabling

e. This problem effects: my Work; Personal relationships; Marriage; Health; School; work; Family relationships

2. SUBSTANCE USE

a. In regard to using alcohol: I drink occasionally; I drink regularly; I drink daily; I do not drink at all
b. When I drink, the number of drinks I usually have is _____.
c. What I like about drinking is_____
d. I consider my drinking to be: A definite problem; A growing problem; A potential problem; Not a problem
e. In regard to illegal drug use: I do not use any illegal drugs; I have experimented on an occasional basis in the past; I used for a short period of time but no longer use; I used for a long period of time but no longer use; I have used drugs in the past and continue to use
f. The drugs I currently use are Crystal Meth; Speed; Pot; Cocaine/Crack; LSD; Heroin; PCP; Sedatives; Inhalants; Other
g. I use drugs: Daily; 3 to 6 times a week; 1 to 2 times a week; 1 to 3 times a month
h. What I like about using drugs is:_____
i. I consider my drug use to be: A definite problem; A growing problem; A potential problem; Not a problem

3. PERSONAL SAFETY
a. As far as any suicidal thoughts are concerned:

- I have no thoughts of suicide
- The thought has crossed my mind but I would never do it.
- The thought has crossed my mind, and I have thought of ways of doing it but I would not do it.
- I have had some serious thoughts of suicide and I am afraid I could follow through with them.

b. As far as any thoughts of harming anyone:

- I have not had any recent thoughts of harming anyone
- I have had recent thoughts of harming someone but I would not act on them
- I have had some recent thoughts of harming someone and I am afraid I could carry them out

4. MY MARRIAGE/PRIMARY RELATIONSHIP: I am not married and not in a relationship
a. I have been married/in this relationship for ____ years

b. I have known my partner for ____ years

c. My commitment to this marriage/relationship is: 100%; Questionable; I am having serious thoughts about leaving

d. My major dissatisfactions in my marriage/relationship are: Our sexual relationship; Our communication; Our finances; Our parenting; My in-laws; Our mutual interests; Our mutual goals; Other _____

e. Major feelings I have with my partner are: Anger; Resentment; Regret; Sadness; Fear; Betrayal; Abandonment; Guilt; Rejection; Unimportance; Hurt; Jealousy; Disappointment; Abuse; Distance; Warm; Loving; Respect; Other _____

5. MY WORK: I am not working
a. My current work is _____. I have been at my present job for _____ years.

b. In regard to my work I am: Pleased; Mostly satisfied; Mixed; Mostly Dissatisfied; Unhappy

c. My major dissatisfactions with my work are: The job itself; My career; My coworkers; My boss; My income; Other_____

6. MY FAMILY OF ORIGIN
a. My father is Alive; I live with him Alive; lives nearby Alive; lives far away Died when I was ____ years old

b. In general, I would describe my father as: Argumentative; Physically abusive; Sexually abusive; Critical; Absent; Emotionally distant; Supportive and nurturing; Caring; Other_____

c. Major feelings I have with my father are: Anger; Resentment; Regret; Sadness; Fear; Betrayal; Abandonment; Guilt; Rejection; Unimportance; Hurt; Jealousy; Disappointment; Abuse; Distance; Warm; Loving; Respect; Other _____

d. My mother is Alive; I live with her Alive; lives nearby Alive; lives far away Died when I was ____ years old

e. In general, I would describe my mother as: Argumentative; Physically abusive; Sexually abusive; Critical; Absent; Emotionally distant; Supportive and nurturing; Caring; Other_____

f. Major feelings I have with my mother are: Anger; Resentment; Regret; Sadness; Fear; Betrayal; Abandonment; Guilt; Rejection; Unimportance; Hurt; Jealousy; Disappointment; Abuse; Distance; Warm; Loving; Respect; Other _____

7. PREVIOUS THERAPY
a. I have: Never seen a therapist before; Been in therapy with (#)_____different counselors, the last time was _____

b. The last time I saw a therapist my experience was: Positive, Neutral, received limited benefit, Negative

c. I was in therapy for: A problem similar to the one I have now; A different problem: (Please describe)_____

d. I have been hospitalized for psychiatric or substance abuse problems: Never, Yes, (#)_____times. Year(s) that I was hospitalized: _____

e. Medications I am now taking are _____ by Dr. _____; Not taking any medications

8. HEALTH
a. In the past I have received major medical treatment for_____. Have not had major medical problems

b. Currently I am being treated for _____. Nothing in particular

c. Physical symptoms I am having but not being treated for are_____. Do not have any physical symptoms

d. The number of cigarettes I smoke per day are_____. Do not smoke; The number of caffeine drinks I have each day are _____

e. In the past year I have exercised: Regularly; Occasionally; Rarely; Never

f. I consider myself to be: In excellent health; In good health; In fair health; In poor health

g. I consider my diet to be: Very healthy; Questionably healthy; Not very healthy; Often changing

9. SOCIAL
a. In regard to my social network I have: Virtually no close friends; One close friend; A few friends; Many friends

b. I mostly make contact with my friends: Rarely; Spontaneously; On special occasions; At parties; At organized activities; To discuss personal problems; To make small talk; Other:_____

c. In general, my friends Influence me positively; Influence me negatively; Don't have a big influence on me

d. What I most like to do for fun or recreation is:
_____

10. FOR PARENTS I do not have any children
a. The number of children I have is _____. Their ages and gender are:
_____

b. In regard to parenting, my partner and I: Are pretty agreeable; Seem to disagree; I am a single parent

c. My general approach to parenting is: to Punish misbehavior; Reward good behavior; Teach good behavior; Try to listen; Give responsibility; Be a model; Involve myself; Other
_____

d. Major feelings I have with my children are: Anger; Guilt; Regret; Disappointment; Distance; Warm; Loving

11. SELF ASSESSMENT
a. My problems would seem to clear up: If others would change; If I would change; If I understood myself better; If I could express myself better; If I could let go of the past; If I could get rid of certain emotions; If I could make a decision; If I could change my thinking; If I had some direct answers

12. GOALS FOR THERAPY
a. Three results I am looking for in therapy are:
_____

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(To be completed by Dr. Harris)
anx: 300.01-pan w/o ag 300.21-panic w ag 300.3-ocd 309.89-ptsd 300.02-gen anx 300.00-nos
cd: 303.90-alc dep 305.00-alc ab 304.40-amph dep 305.70-amphab 296.21-mj dep sing 296.31-mj dep rec: 300.4-dys 311-nos 296.6x-b/p mixed 296.4x-b/p manic 296.5x-b/p dep conduct group: 312.2 312.0-c/sol agg 313.81-opp def adhd: 314.01-combined 314.00-inattentive 314.01-impulsive adj: 309.0-dep 309.24-anx 309.28-mixed 309.9- nos impulse: 312.34-int exp 312.32-klep 312.31-gam
other: _____._____-_____

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

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

With your consent, my practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of use of your health information for treatment purposes:

I obtain treatment information about you and record it in your case record. During the course of your treatment, I determine a need to consult with another specialist in the area. I will share the information with such specialist for input.

Example of use of your health information for payment purposes:

I submit a request for payment to your health insurance company. The insurance company requests information from me regarding psychological care given. I will provide information to them about you and the care given.

Example of use of your information for health care operations:

I obtain services from my insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credential, medical review, legal services, and insurance. I will share information about you with such insurers of other business associates as necessary to obtain these services.

Your Health Information Rights

The health record I maintain and billing records are the physical property of my practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of you protected health information ‘
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treamtne, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members of friends in the course of providing care;
- Request that communication of your health information as required to be maintained by law by delivering a written request to my office; and,
- Revoke authorizations that you made previously to use of disclose information except to the extent information or action has already been taken by delivering a written revocation to my office.

If you want to exercise any of the above rights, please contact my office, in person or in writing, during normal hours. I will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

My practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of my duties and privacy practices as to the information I collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if I cannot accommodate a requested restriction or request; and
- Accommodate you reasonable requests regarding methods to communicate health information with you.

I reserve the right to amend, change, or eliminate provisions in my privacy practices and access practices and to enact new provision regarding the protected health information I maintain. If my information practices change, I will amend my Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of my "Notice" or by visiting my office and picking up a copy.

To Request Information of File a Complaint

If you have question, would like addition information, or want to report a problem regarding the handling of your information, you may contact my office.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at my office. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address is: Federal Office Building, 50 United Nations Plaza- Room 322, San Francisco, CA 94102.

- I cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment form the practice.

- I cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.

Other Disclosures and Uses

Notification
Unless you object, I may use of disclose your protected health information to notify, or assist in notifying, a family member, personal representation, or other person responsible for you care, about you location, and about you general condition, or your death.

Communication with Family
Using my best judgment, I may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to hat person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)
I may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation
If you are seeking compensation through Workers Compensation, I may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, I may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse and Neglect
I may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, I may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Aw Enforcement
I may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or the extent an individual is in the custody of law enforcement.

Research
I may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief
I may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations
Consistent with applicable law, I may disclose your protected health information to organ procurement organization or other entities engaged in the procurement; banking; or transplantation of organs for the purpose of tissue donation and transplant.

For Specialized Government Function
I may disclose your protected health information for specialized government functions as authorized by law, such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
I may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If I maintain a website that provides information about my entity, this Notice will be on the website.

Acknowledgement of Receipt of "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information"

The federal government mandated that as of April 14, 2003 all health care patients are to receive from their clinicians a notice (hereafter referred to as "Notice") regarding the protection of their private health care information in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule (45 C.F.R. parts 160 and 164).

This acknowledgement documents that your mental health care provider has given you the "Notice" that is required. HIPAA covers what is called "protected health information" (PHI) that is used for treatment, payment, and health care operations. PHI is information in your health record that could identify you.

The Notice contains basic information about:

1. how your PHI may be used and disclosed for treatment, payment and health care operations (these terms are defined in the Notice)

2. which uses and disclosures require authorization from you and which don't

3. how you may revoke an authorization you have made

4. certain rights you have to restrict use and disclosure of PHI, to receive confidential communications by alternative means and at alternative locations, to inspect and copy your records, to amend your records, to have an accounting of disclosures

5. a list of my duties to protect the privacy of your PHI, my right to change the privacy policies and practices described in the Notice, and how I will inform you of changes

6. what you can do if you have any complaints about violations of your privacy rights, about decisions about access to your records I may make

7. any restrictions and limitations you or I wish to put on the use and disclosure of your PHI.

The Privacy Notice is a few pages in length. Generally, this Notice is given on a patient's first visit unless there is good reason to delay. A copy of the Notice is available in my waiting room and will be on my website if I create one. I will also give you a copy of this notice. This page documents that I have given you a copy of the Notice.
I acknowledge that Dr. Harris has given me a copy of the Privacy Notice (version dated 8/24/03) as required by the federal government's HIPAA legislation. I have been given the opportunity to ask any questions I may have regarding this Notice.

Date _____

_____ _____

Print Patient's Name Signature

_____ _____

Print name of Parent or Legal Guardian Signature

if patient is a minor