Kelly Spagnuolo, MFT

Licensed Marriage and Family Therapist

CA License # 49760

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(310) 529-5510
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I acknowledge you for the courage it takes to seek support.
Please take a few moments to complete the following information:

1. Complete the **Client Information Form**.

2. Read and sign the **Informed Consent**, which includes my policies and an agreement of participation in therapy.

3. Sign that you have received the **Notice of Privacy Practices** (HIPPA) form, and keep the copy for your records.

Thanks and I look forward to working with you.

Kelly Spagnuolo, MFT

CLIENT INFORMATION FORM

This form requests information about your needs and informs you of my services and policies. Complete all questions to the best of your ability.

Name(s) _____
Birthdate(s) _____
Address _____
_____
Cell number _____
Home number _____
Work number _____
How do you prefer to be contacted? _____

Emergency Contact _____
Relationship _____Phone # _____

Relationship Status_____
Spouse/Partner_____
Children: Name, Age, Sex, Living at home (Y/N)
_____
_____
_____
_____
_____

Name of employer_____
Length of time _____ Position_____

Primary Care Physician _____Phone_____
Please list any current medical conditions or if there is a history of medical issues in your family:
_____
_____
_____
Please list any medications you are currently taking:
_____
_____
_____

Describe your typical alcohol consumption (what you drink and how often)

_____
_____
_____

Describe your usage of street drugs (include name of drugs and frequency)

_____
_____
_____

Have you ever received mental health treatment before? If so, please list dates, provider name, and the issue for which treatment was sought:

_____
_____
_____

Please describe your reason(s) for seeking treatment at this time. If there is a particular event that triggered your decision, please describe:

_____
_____
_____
_____
_____

What are your goals for therapy? What results would you like to accomplish?

_____
_____
_____

How did you hear about my services? Who referred you?

_____
_____

Is there any additional information you would like to share at this time that may be pertinent to your treatment?

_____
_____
_____

INFORMED CONSENT AND CONTRACT

Fees and Financial Responsibility

Our agreed upon fee for therapy is $150 per 50 minute session. Payment is expected at the beginning of each session. I am an out of network provider for insurance purposes. So I create a *Super Bill* for you at the end of each month. This details the number of sessions and fees you paid me, which you then submit to your insurance company. You are required to pay me in full and then receive reimbursement from your insurance company for a portion of the payment (amounts vary for each insurance company). Please contact your insurance company to see if they will accept a *Super Bill* for services provided by a Licensed Marriage and Family Therapist.

Cancellation Policy

A scheduled appointment means that time is reserved for you. If you are unable to attend a session, you must call to cancel 24 hour prior to your appointment. If you do not show for your appointment and fail to provide 24 hours' notice, you will be billed for the session at your normal rate.

Emergency Procedures

If you need to contact me, please leave a message on my office phone and I will make every effort to return your call within 24 hours with the exception of weekends and holidays. ***Please note that for phone calls that exceed 15 minutes, you will be charged based on my hourly rate.*** In the event of a medical emergency or emergency involving a threat to your safety or the safety of others, please call 911 or go to your nearest hospital. The following are some resources that are available in to assist individuals who are in crisis:

Crisis Hotline: 1-800-273-TALK
Little Company of Mary Hospital: (310) 540-7676
Domestic Violence: 1800-799-SAFE
Del Amo Hospital: (310) 530-1151
Youth Shelters: 800-442-HOPE
Redondo Beach Police: (310) 379-5411

Confidentiality

All information discussed in therapy sessions and telephone contacts are confidential unless:

1. You provide written permission to release information regarding your treatment.
2. You present a physical danger to yourself or to others.
3. Child abuse, elder abuse, or dependent adult abuse is suspected.
4. When information is ordered by a judge in a court order pursuant to a legal proceeding.

I am required by law to inform potential victims and legal authorities when I have determined that a client presents a serious danger of physical violence to another person. I am required by law to report instances of suspected child abuse (i.e. physical, sexual, emotional, neglect) both present or in the past to the Department of Children and Family Services. I am also required by law to report instances of suspected elder or dependent adult abuse (any person over the age of 65 or a person unable to care for him/herself and is a victim of physical abuse, financial abuse, neglect, or isolation). If you participate in couples or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in treatment provide written authorization to release such information. However, it is important for you to know that I utilize a “no-secrets” policy when conducting couples and family therapy. This means that if you participate in couples or family therapy, I may use information obtained in an individual session with me when working with other members of your family if I feel it is necessary. In order to provide you with the best care, I regularly consult with colleagues and participate in mandatory continuing education. At no time would your name or identifying data be revealed to others without prior written consent from you.

Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask me to address any questions or concerns you have about this information before you sign.

I understand and agree to all of the above information.

_____

Client Name(s)

_____

Client Signature(s) or Parent’s Date

NOTICE OF PRIVACY PRACTICES

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

II. I have a legal duty to safeguard your PHI, protected health information.
I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And I am legally required to follow the privacy practices described in this Notice.

III. How I may use and disclose your PHI.
I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.
A. Use and disclosures relating to treatment, payment, or health care operations do not require your prior written consent. I can use and disclose your PHI without your consent for the following reasons:
1. For treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can also disclose your PHI to physicians, psychiatrists, psychologists and other licensed health care providers who provide you with health care services or are involved in your case. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.
2. To obtain payment for treatment. I can use and disclose your PHI to bill and collect payment for treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies and others that process my health care claims.
3. For health care operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants or others to further my health care operations.

4. Patient incapacitation or emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think you would consent to such treatment if you were able to do so.

B. Certain other uses and disclosures also do not require your consent or authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.
2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.
3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in a response to a search warrant.
4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.
5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.
6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.
7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.
8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or give you information about treatment alternatives, other health care services or other health care benefits that I offer that may be of interest to you.

C. Certain uses and disclosures require you to have the opportunity to object.

1. Disclosures to family, friends or others. I may provide your PHI to a family member, friend or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other uses and disclosures require your prior written authorization. In any other situation not described in sections III A, B, and C above, I will need your written

authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. What rights you have regarding your PHI.

You have the following rights with respect to your PHI:

A. The right to request restrictions on My Uses and Disclosures. You have the right to request restrictions or limitations on my use or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your case or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. The right to choose how I send PHI to you. You have the right to request that I send confidential information to you at an alternate address (for example, sending information to your work address instead of your home address) or by alternate means (e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The right to inspect and receive a copy of your PHI. In most cases, you have the right to inspect and receive a copy of such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you in writing, my reasons for the denial and explain your right to have it reviewed. If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The right to receive a list of the disclosures I have made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003. I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I give you will include disclosures made in the last six years unless you request a shorter

time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you made more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. The right to amend your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete , (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that my denial be attached to all future disclosures of your PHI. If I approve of your request, I will make the changes to the PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The right to receive a paper copy of this notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via email.

V. How to complain about our privacy practices.

If you think that I may have violated your privacy rights or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. Person to contact for information about this notice or to complain about my privacy practices

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at:

Kelly Spagnuolo, MFT
205 Avenue I, Suite 27, Redondo Beach, CA 90277

VII. Effective date of this notice

This notice went into effect on April 14, 2003

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have given you. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full. My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at (310) 529-5510. If you have any questions about my *Notice of Privacy Practices*, please contact me at 205 Avenue I Ste 27, Redondo Beach, CA 90277

I acknowledge receipt of the *Notice of Privacy Practices of* Kelly Spagnuolo, Licensed Marriage and Family Therapist

_____

Name

_____

Signature (*client/parent/conservator/guardian)* Date