ANGIE LEWIS, M.S.

Client Information Questionnaire

Please complete each line of the questionnaire in order for us to provide you with the best possible care that we have to offer. If any question is unclear to you, do not hesitate to ask for clarification and assistance.

Date: ______________________

Name: ____________________________________ SS#: _________________________

Address: ____

City: ____________________________________ State & Zip: ______________________

Mailing Address if different from above: ____

Email Address: (optional) ____

Phone: (Home) ___________________ Phone: (Work) ____________________________

Phone: (Cell) _____________________

Date of Birth: _____________________ Marital Status: ____________________________

Employer: ____

Occupation: ____

Person to contact in case of an emergency: ______________________________________

Relationship to client: ____

Home Phone: ________________________ Work Phone #: _________________________

Cell #: ______________________________

Family Physician: _____________________________ Phone #: ______________________

Who referred you to this office: ____

Briefly describe your reason for seeking counseling: ______________________________

____

____

Have major changes of any kind occurred in your family in the last few years? (Moves, changes in family relationships, marital status/situation or income):

____

____

____

List any major health problems for which you are currently receiving treatment:

____

____

____

List any medications you are now taking: ____

____

COUNSELING POLICIES & GENERAL INFORMATION
AGREEMENT FOR PSYCHOTHERAPY SERVICES
ANGIE LEWIS, M.S.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions **are confidential** and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law (See HIPAA Attachment).

EMERGENCIES: If there is an emergency during our work together, or in the future after termination where Angie Lewis, M.S., becomes concerned about your personal safety, the possibility of you injuring yourself or others and to ensure that you receive the proper medical care, she may contact the person whose name you have provided on the biographical sheet.

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.) neither you (client's), nor your attorney's, nor anyone else acting on your behalf will call on Angie Lewis, M.S., to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

If your attorney, or anyone else acting on your behalf, chooses not to abide by this agreement, the fee for court testimony, or at any other proceeding, will be based on $250 per hour with a minimum fee of $1000.00. Insurance companies typically do not reimburse for this service and it is considered an out of pocket expense. If disclosure of your psychotherapy records is requested, a release of information form must be properly completed at least fourteen days in advance.

CONSULTATION: Angie Lewis, M.S. consults regularly with other professionals regarding her clients; however, client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

YOUR RIGHT TO REVIEW RECORDS: Both law and the standards of my profession require that I keep appropriate treatment records. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Angie Lewis, M.S. assesses that releasing such information might be harmful in any way. In such a case, Angie Lewis, M.S. will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, upon your request, Angie Lewis, M.S. will release information to any agency/person you specify, unless Angie Lewis, M.S. assesses that releasing such information might be harmful in any way.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact Angie Lewis, M.S. between sessions, please leave a message on the answering service (251)928.2983 and your call will be returned as soon as

possible. Angie Lewis, M.S. checks her messages a few times a day. If an emergency situation arises, please

indicate it clearly in your message. If you need to talk to someone right away, you may call the police (911), or go to the local hospital's emergency room.

PAYMENTS:

The Counseling Ministry at First Baptist is offered to members at a reduced rate of $50.00 per session on a sliding scale, according to your ability to pay. Checks are made payable to First Baptist and is expected at the time of the session.

MEDIATION AND ARBITRATION: All disputes arising out of or in relation to this agreement to provide therapy services shall first be referred to mediation, before, and as precondition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Angie Lewis, M.S. and you, the client. The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Baldwin County, Alabama in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding, the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Angie Lewis, M.S. can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum as and for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

THE PROCESS OF THERAPY/EVALUATION: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward those benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, or behavior. Angie Lewis, M.S. will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts, can result in you experiencing considerable discomfort, or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, etc. Angie Lewis, M.S. may challenge some of your assumptions or perceptions or propose different ways of looking at or thinking about, or handling situations which can cause you to feel challenged, upset, angry, or disappointed. Attempting to resolve issues that brought you to therapy in the first place may result in changes that were not originally intended. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often, it will be slow and even frustrating. There is no guarantee that therapy will yield positive or intended results. During the course of therapy, Angie Lewis, M.S. is likely to draw on various psychological approaches according, in part, to the problem that is being treated and her assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, and family systems approaches to treatment within a Christian framework.

Initial __________

DISCUSSION OF THE TREATMENT PLAN: Within a reasonable period of time after the initiation of treatment, Angie Lewis, M.S. will discuss with you her working understanding of the problem, treatment plan, therapeutic objectives, and her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, Angie Lewis, M.S. expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that Angie Lewis, M.S. does not provide, she has an ethical obligation to assist you in obtaining those treatments.

TERMINATION: As set forth above, after the first couple of meetings, Angie Lewis, M.S. will assess if she can be of benefit to you. Angie Lewis, M.S. does not accept clients, who, in her opinion, she cannot help. In such a case, she will give you a number of referrals that may be of help to you. If you request it, and authorize it in writing, Angie Lewis, M.S. will talk to the therapist of your choice in order to help with the transition. If at any time, you would like another professional's opinion or wish to consult with another therapist, Angie Lewis, M.S. will assist you in finding someone qualified, and if she has your written consent, she will provide her/him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, Angie Lewis, M.S. will provide you with names of other qualified professionals whose services you might prefer.

DUAL RELATIONSHIPS: Therapy never involves sexual or business relationships or any other dual relationship that impairs Angie Lewis, M.S. objectivity, clinical judgment, therapeutic effectiveness, or can be exploitive in nature.

CANCELLATION: Since scheduling of an appointment involves the reservation of time specifically for you, **a minimum of twenty-four hours notice is requested** for re-scheduling or canceling an appointment.

I have read the above Agreement and Office Policies and General Information carefully. I understand them and agree to comply with them.

____

Client Name (print) **Date**

____

Client Name (print) **Date**

____

Therapist **Date**

ANGIE LEWIS, M.S.
Licensed Professional Counselor
National Certified Counselor
306 South Greeno Road
Fairhope, Alabama 36532
251.928.2983

HIPPA 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 THE INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law, I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains information about your past, present, and future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide to you with this Notice about my privacy procedures. This notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, supply, utilize, examine, or analyze information within my practice. PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. However, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization, others, however, will not. Below, you will find different categories of my uses and disclosures with some examples.

A. **Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.** I may use and disclose your PHI without your consent for the following reasons:

(1) For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, or other licensed health care providers who provide you with health care services that are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

(2) **For health care operations**. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control – I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and to others to make sure that I am in compliance with applicable laws.

(3) **To obtain payments for treatment.** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

(4) **Other disclosures.** Examples: Your consent is not required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. **Certain Other Uses and Disclosures Do Not Require Your Consent.** I may use and/or disclose your PHI without your consent for the following reasons:

(1) **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel, and/or in an administrative proceeding.

(2) **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**

(3) **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**

(4) **If the patient compels disclosure or the patient's representative pursuant to corresponding federal statutes or regulations, such as the Privacy Rule that required this Notice.**

(5) **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.

(6) **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**

(7) **If disclosure is mandated by the Alabama Child Abuse and Neglect Reporting Law.** For example: If I have reasonable suspicion of child abuse or neglect.

(8) **If disclosure is mandated by the Alabama Elder/Dependent Adult Abuse Reporting Law.** For example: If I have a reasonable suspicion of elder abuse or dependent adult abuse.

(9) **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**

(10) **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may have to give the county coroner information about you.

(11) **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

(12) **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interest of national security, such as protecting the President of the United States or assisting with intelligence operations.

(13) **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.

(14) **For Workers' compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.

(15) **Appointment reminders and health related benefits or services.** For example: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits that I offer.

(16) **If an arbitrator or arbitration panel compels disclosure.** Example: When arbitration is lawfully requested by either party, pursuant to subpoena "duces tectum" (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

(17) **I am permitted to contact you, without your authorization, to provide appointment reminders or information about alternative or other health related benefits and services that may be of interest to you.**

(18) **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by the U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.

(19) **If disclosure is otherwise specifically required by law.**

C. **Certain Uses And Disclosures Require You To Have The Opportunity To Object. Disclosures to family, friends, and others.** I may provide your PHI to a family member, friend, or other individuals who you indicate is involved in your case or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. **Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization in writing to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. **The Right to See and Get Copies of Your PHI.** In general, you have the right to see your PHI that is in your possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you as to how you can get it. You will receive a response from me within thirty days of my receiving your written request. Under certain circumstances, I may feel that I must deny your request, but if I do, I will give you in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do not agree with your request, I will put these limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. **The Right to Choose How I send Your PHI to You.** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

D. **The Right to Get a List of the Disclosures That I Have Made.** You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent

directly to you, or to your family, neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

E. **The Right to Amend Your PHI.** If you believe that there is some error in your PHI, or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within sixty days of my receipt of your request. I may deny your request in writing if I find the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not a part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reason for the denial. I must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the change(s) have been made and I will advise all others who need to know about the change(s) to your PHI.

F. **The Right to Get This Notice by Email.** You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to 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. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

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 my office at 306 South Greeno Road, Fairhope, Alabama 36532, 251.928.2983.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003

I acknowledge receipt of this notice.

Patient Name (Print): ____

Date: ____

Signature: ____

Witness: ____

ANGIE LEWIS, M.S.
Licensed Professional Counselor
National Certified Counselor
306 S. Greeno Rd. Fairhope, AL 36532
251.928.2983

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, __________________________, DOB:_____________ SS#__________________________

hereby authorize and request _____________________________________ and release and/or receive confidential, psychological, psychiatric medical records and opinions resulting from my contact with them to ________________________ for the purpose of ______________________________

Specified Information:____

I understand that all matters relating to alcohol or drug abuse patient records are considered privileged and confidential and are treated as such by this agency. Information regarding such matters cannot be given without consent of the patient. This is in compliance with Section 2/31 of Public Law 93-282, 42 CFD Part 2. Information relating to alcohol and/or drug abuse is not required to be disclosed, except by specific consent permitted by the Regulations. Further, I understand that pursuant to state law, reports and other information pertaining to diagnostic treatment or care of sexually transmitted diseases are to be confidential and are not subject to public inspection or admission into evidence in any court, except proceedings brought under particular chapter relating to compelling examination testing, commitment or quarantine of a person of upon specific written consent of the person to whom information pertains. I understand that I specifically consent to the release of such medical records.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME. HOWEVER, IN ANY EVENT, IT WILL AUTOMATICALLY EXPIRE ONE (1) YEAR AFTER THE DATE BELOW OR SOONER IF I ELECT.

Signature:___________________________________ Date:____________________________

Witness:___________________________________ Date:_____________________________

PARENT OR GUARDIAN IF UNDER 19 YEARS OF AGE:

Signature:__________________________________ Date:_____________________________