WELCOME! THE FOLLOWING IS AN INTRODUCTION TO SERVICES WITH SUZANNE ROBISON, LICENSED PSYCHOLOGIST, PROFESSIONAL COUNSELOR, CERTIFIED CO-OCCURRING DISORDER PROFESSIONAL AND CERTIFIED INTERVENTION PROFESSIONAL

It is my goal to provide the highest level of competence, expertise, and services to my clients in the areas of individual psychotherapy, diagnostic evaluation, psychological testing, psychosocial skills training groups, & corporate consultations. This page describes some of the practice procedures which may affect you. These procedures comprise a significant part of my treatment contract with you unless we mutually agree on specific exceptions.

Office Hours: I am available by phone (610) 247-6782, or email therapy@suzannerobison.com throughout the week. I try to return all phone calls within a 24-48 hour period. When sending a confidential voice or email, please indicate if your call is urgent and needs immediate attention.
Emergencies: Clients should be aware that I may not always be available to respond to emergency calls, emails or text messages. ***In the event of a true mental health emergency, please dial 911 or proceed to the nearest Emergency Room.***
Grievances: If you have any dissatisfied in any way, please address your grievance directly to me, so that I may have the opportunity to resolve the issue(s).
Cancellations: If the need arises for you to cancel an appointment, I request that you provide me with 24 hours notice. If you do not cancel within this time frame, you will be charged a fee of **$50** for the cancelled session. If the cancellation was caused from serious illness, emergency, or similar unavoidable circumstance, I will make every reasonable effort to waive this fee.
Payments: Payment is due at time of service. In cases where full payment presents an economic hardship, a sliding fee scale may be available upon request. When there is insurance reimbursement, I will submit a request for payment after each session. Please read your policy to be sure that you are fully aware of any limitations, co-pays or deductibles of the benefits provided.
Health insurance: This is a partnership between you, your insurance company, and your Psychologist, depending on the reimbursement agreement. It **is not** a contract between the Psychologist and the insurance company. Your company may base its allowance in a fixed fee or HMO schedule, which may or may not coincide with my usual fees. In some cases, there are contractual agreements between myself and your insurance company concerning fees. **You are responsible for being aware of the coverage your insurance provides, as you are responsible for any fees not covered due to your failure to follow the procedures of your health plan.**
Returned checks: There will be a processing fee of $30 assessed for each returned check to cover the charges I incur.
Correspondence: Necessary, routine telephone calls or letters to you or on your behalf are part of practice and free of charge. **Lengthy documentation that is your request, or lengthy calls for clinical matters may be billed at an hourly rate of $75 which is not covered by your insurance company. This would be agreed upon before charging you.**

I thank you for the trust you have placed in me by choosing me for the psychological services you are seeking. I endeavor to maintain this trust and do everything I can to make your experience beneficial.

Please sign below to indicate that you have read the information and agree to be in compliance with the above stated policies.

Sincerely,

Suzanne Robison, Psy.D., LPC, CCDP, CIP

_____ _____
Client Signature Date

_____ _____
Parent Signature (If Under 18) Date

Suzanne Robison, Psy.D., LPC, CCDP, CIP ACCT ID#_____

Client Record

Administrative

Client: _____SS #: _____DOB: __/__/___

Sex: M__ F__ Spouse/Guardian/Parent : _____DOB: __/__/__

Address: _____City/St/Zip: _____

Phone: Home: (___)_____ Alt.: (____)_____)

Employer / School:_____

Emergency Contact:_____Emergency phone#:_____

FINANCIAL INFORMATION (must be completed):

Party responsible for payment: _____

Health Insurance Company: _____

Name of Policy Holder:_____SS # of guarantor_____

Identification #_____Group #_____Guarantor DOB___/___/___

2nd Insurance Company: _____Policy #_____

Authorization to Obtain / Release Information from Primary Care Physician

Please check on (must be completed)

[ ] I authorize [ ] I **DO NOT** authorize [ ] No PCP

Suzanne Robison, Psy.D., CCDP, LPC, CIP to release the reason for seeking treatment, treatment plan, diagnosis pertaining to my treatment during the period beginning _____ and ending 1(one) year after, thereafter. This information is needed for the purpose of coordinating treatment. These records are to be released to my primary care physician. I have been informed that I have the right to revoke consent at any time by oral and written request, except to the extent that action has been taken in reliance on the authorization. I have been informed of my rights, subject to chapter 7100.111.3 of the Pennsylvania Mental Health Procedures Act and/ or subject to Pennsylvania Drug and Alcohol Abuse Control Act, to inspect the material to be released. This form has been fully explained and I certify that I understand its contents and have been offered a copy.

_____ _____

Signature of Client Date Signature of Witness Date

Or Guardian of Client if Under 18 years of age

Primary Care Physician Name:_____

Address:_____City/St/Zip:_____

Telephone #:_____ Fax #:_____

ACCT: _____

Suzanne Robison, Psy.D., LPC, CCDP, CIP

Informed Consent for Treatment

I have chosen to receive treatment services under a benefit plan managed by my insurance company, or paid for by myself. My choice has been voluntary and I understand that I may terminate therapy at anytime.

I know my treatment is provided by Suzanne Robison, Licensed Psychologist, Licensed Professional Counselor, Certified Co-Occurring Disorder Professional, & Certified Intervention Professional.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my Psychologist, I will work with my Psychologist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that require that my Psychologist reports all cases of abuse and neglect of minors or vulnerable adults.

I understand that state and local laws require that my Psychologist reports all cases in which there exists an imminent danger to self or others.

I understand that there may be other circumstances in which the law requires my Psychologist to disclose confidential information.

I understand that I may be contacted by my insurance company, or its managed care component, (I) to ensure continuity and quality of my treatment and/or (II) after the completion of treatment, to assess the outcome of treatment.

I have read and had explained to me the basic rights of individuals, who seek such services.
These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I understand that my Psychologist and my insurance company and/or their managed care company may exchange any and all information pertaining to my therapy, to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

Please note: If you are divorced or separated and are the parent of a child under the age of 14 seeking treatment for your child and you share legal custody with the other parent; both parents must sign the consent form for the child to receive psychotherapy.

My Signature Below Indicates that I have read, understand, and been offered a copy of this consent.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent if under 14 Date

Psychotherapy is not easily described in general statements. It varies depending on the personality of both the Psychologist and you, the Client; and the particular problems which you, the Client brings. There are a number of different approaches, which can be utilized to address the problems you hope to address. It is not like visiting a medical doctor, in that psychotherapy or psychological counseling, requires a very active effort on your part. In order to be most successful, you will have to work on things talked about both during sessions and at home.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration, loneliness and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. Psychotherapy has also been shown to have benefits for people who undertake it. Therapy often leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. But there are no guarantees about what will happen.

The first few sessions will involve an evaluation of your needs. At the end of the evaluation you will be offered some initial impressions of what the work will include and the initial treatment plan to follow, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with our practice. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the Psychologist you select. If you have questions about our procedures, they should be discussed whenever they arise. If your doubts persist, we would be happy to help you secure an appropriate consultation with another mental health provider.

Account Number: _____

Suzanne Robison, Psy.D., LPC, CCDP, CIP
Members' Rights and Responsibilities Statement

Statement of Members' Rights

- Members have the right to be treated with dignity and respect.
- Members have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability or source of payment.
- Members have the right to have their treatment and other member information kept private. Only by law, may records be released without member permission.
- Members have the right to easily access care in a timely fashion.
- Members have the right to know all about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Members have the right to share in developing their plan of care.
- Members have the right to information in a language they can understand.
- Members have the right to have a clear explanation of their treatment options and condition.
- Members have the right to information about Magellan, it's practitioners, services and role in treatment process.
- Members have the right to get information about clinical guidelines used in providing and managing their care.
- Members have the right to information about the providers work history and training.
- Members have the right to know about advocacy and community groups and prevention services.
- Members have the right to provide input on insurance policies and services.
- Members have the right to freely file a complaint, grievance or appeal and to learn how to do so.
- Members have the right to know about the laws that relate to their rights and responsibilities.
- Members have the right to know of their rights and responsibilities in the treatment process.

Statement of Members' Responsibilities

- Members have the responsibility to treat those giving them care with dignity and respect.
- Members have the responsibility to give provider information they need. This is so they can deliver the best possible care.
- Members have the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in that care.
- Members have the responsibility to follow their treatment plans for their care. The plan of care is to be agreed upon by the member and provider.
- Members have the responsibility to follow the agreed upon medication plan.
- Members have the responsibility to tell their provider about medication changes, including medications given to them by others.
- Members have the responsibility to keep their appointments. Members should call their providers as soon as possible if they need to cancel visits.
- Members have the responsibility to let their provider know when the treatment plan no longer works for them.
- Members have the responsibility to let their provider know about problems with paying fees.
- Members have the responsibility to not take actions that could harm others.
- Members have the responsibility to report abuse.
- Members have the responsibility to report fraud.
- Members have the responsibility to openly report concerns about the quality of care.

_____

Client Signature (if 14 or above)

_____

Parent Signature (if under 18)

Date _____ **MHP Initials**_____

HIPAA Privacy Notice: PENNSYLVANIA NOTICE FORM

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

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY SUZANNE ROBISON, PSY.D., LPC, CCDP AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Suzanne Robison, Psy.D., LPC, CCDP may *use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent.* To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
    - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
    - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within our group practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of our practice group, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Suzanne Robison, Psy.D., LPC, CCDP may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes made about conversations during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance

coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If I have reasonable cause, on the basis of our professional judgment, to suspect abuse of children with whom I come into contact in my professional capacity, I are required by law to report this to the Pennsylvania Department of Public Welfare.

Adult and Domestic Abuse: If I have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), I may report such to the local agency which provides protective services.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made about the professional services provided you or the records thereof, such information is privileged under state law, and I will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and I determine that you are likely to carry out the threat, I must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

Worker's Compensation: If you file a worker's compensation claim, I will be required to file periodic reports with your employer which shall include, where pertinent, history, diagnosis, treatment, and prognosis.

IV. Patient's Rights and Psychologist Duties

Patient's Rights:

Right to Request Restrictions — You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

Right to Inspect and Copy — You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend — You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting — You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy — You have the right to obtain a paper copy of the notice upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will provide you with a revised notice by mail, and, if a current client, within the time of our next meeting.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, I invite you to discuss this with me.

If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to me for review.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on May 1, 2013. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in person, or via mail or e-mail.

My signature below confirms that I have had the opportunity to read the Pennsylvania Notice Form concerning my privacy rights, and that I have been offered a copy.

_____ _____

Client Signature **Date**

_____ _____

(AND Guardian if Client is under 14 yrs of age) **Date**

Suzanne Robison, Psy.D., LPC, CCDP, CIP

To better help me assess your psychological and emotional needs, please circle to what degree any of the following symptoms apply to you at this time. You may be asked to complete this form several times during the course of your treatment to monitor your progress.

Name:_____ Date_____ Acct#_____

Please circle the appropriate number: 1 = not at all; 2 = a little; 3 = often; 4 = a lot 5 = usually.

1. Depressed mood, sad, or tearful, most of the day	**1**	**2**	**3**	**4**	**5**
2. Significant decrease in interest or pleasurable activities	**1**	**2**	**3**	**4**	**5**
3. Significant weight loss/weight gain within the past 12 months (circle one)	**1**	**2**	**3**	**4**	**5**
4. Decrease or increase of appetite (circle one)	**1**	**2**	**3**	**4**	**5**
5. Feeling either overly agitated or slowed down movements (circle one)	**1**	**2**	**3**	**4**	**5**
6. Low energy or a feeling of fatigue	**1**	**2**	**3**	**4**	**5**
7. Feelings of worthlessness or excessive guilt	**1**	**2**	**3**	**4**	**5**
8. Difficulty concentrating	**1**	**2**	**3**	**4**	**5**
9. Recurrent thoughts of death	**1**	**2**	**3**	**4**	**5**
10. Excessive worry or anxiety	**1**	**2**	**3**	**4**	**5**
11. More irritable than usual	**1**	**2**	**3**	**4**	**5**
12. Restlessness	**1**	**2**	**3**	**4**	**5**
13. Muscle tension	**1**	**2**	**3**	**4**	**5**
14. Sleeping too much or too little (circle one)	**1**	**2**	**3**	**4**	**5**
15. Self destructive or risky behaviors (ex. Substance abuse, self injury, reckless driving)	**1**	**2**	**3**	**4**	**5**
16. Other: (Specify)	**1**	**2**	**3**	**4**	**5**