Dr. Laurie Patlin Suttenberg, DSW, LCSW, DCSW
2200 NW Corporate Blvd. Suite 303
Boca Raton, FL 33431
609.413.5964

INTAKE FORM

Date: _____

Name: _____
(Last) (First)

Name of parent or guardian (if under 18 years)

_____
(Last) (First)

Address: _____ City/State/Zip_____

Email: _____ May I email you? Yes____ no__

Home Phone: _____ May I leave message here? Yes____ no__

Cell Phone: _____ May I leave message here? Yes____ no__

Birth Date: _____ Age: _____Gender: _____

Single: _____Married: _____ Separated: ____Divorced: _____ Widowed: _____

Referred by: _____

Please describe the challenges or symptoms for which you are seeking services:
_____
_____

What issue/specific concern is the most important to address in therapy?
_____
_____

What significant life changes or stressful events have you experienced recently?
_____
_____

What goals would you like to work toward in therapy?
_____
_____

What other information might you like me to know about why you are seeking therapy?
_____
_____

Dr. Laurie Patlin Suttenberg, LCSW, DCSW

INFORMED CONSENT FOR TREATMENT

My choice to engage in treatment is voluntary, and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative process and effort between my therapist and me, I will work with my therapist in a collaborative manner to resolve my challenges for which I am seeking support.

I understand that during the course of my treatment I may discuss matters that are emotionally challenging, which might be a necessary part of the process.

I understand that records and information collected about me will be held or released in accordance with state and federal laws regarding confidentiality. I am aware and recognize that written, telephone, or personal inquiries about me will not be acknowledged by my therapist without my written consent. I must sign an authorization before any information is disclosed to anyone.

I understand that confidentiality cannot be maintained when:
1. A child or vulnerable adult is being neglected, exploited or physically or sexually abused.
2. Client is in danger of hurting self or others.
3. Court ordered or for a subpoena unopposed by client.

I understand I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken.

Social Media Policy:
I understand that social media is used to deliver services in this practice. Social media includes online communications to seek and share information, provide professional services, and send and receive information. Examples include emails and texting. I understand that social media may not protect my privacy and is considered public communication. The use of social media to provide services is only done with my approval.

Search Engines: Search engines are not used to seek information about me. A rare exception would be during a crisis when my therapist has reason to suspect that I may be in danger to myself or others and my therapist has exhausted other resources. Should this ever occur, this will be documented in my clinical record and discussed with me at my next session.

Texting: I understand that my therapist does not respond to mobile phone text messages (SMS).

Emails: I understand that my therapist does accept and respond to emails. I am aware that email communication may not be secure nor confidential. I understand that if an emergency occurs, I may email after following the emergency protocol listed below. I understand that emails received from me and sent to me by my therapist become a part of my clinical record.

Location-Based Services: There are privacy concerns related to location- based services on a mobile phone. I understand that if I have GPS tracking or a location-based device on my mobile phone, it may compromise my privacy and provide a clue that I am a therapy patient due to my regular check-ins.

Emergencies:
In the event of any emergencies, such as harm to self or others, clients are directed to the nearest emergency room and/or call 911 for help.

I understand that I am responsible for all fees related to my treatment. I agree to pay $_____ at each session that I attend with Dr. Suttenberg.

I have read and understand the above. My signature below indicates that I give my full and informed consent to receive services.

_____ _____

Client/Legal Guardian Signature Printed Name Date

Dr. Laurie Patlin Suttenberg, LCSW, DCSW

CANCELLATION POLICY AND AUTHORIZATION FOR CREDIT CARD USE

Your session time is reserved for you. Should you need to cancel, please give Dr. Suttenberg at least 24 hours notice; she is rarely able to fill a cancelled session unless she has at least 24 hours in advance. If you are unable to provide at least 24 hours notice when you cancel, your credit card on file will be charged the full fee for your session.

_____ _____

Client/Legal Guardian Signature Date

_____

Printed Name

Please provide the following credit card information, which will be charged **only** in the event that a 24-hour notice is not provided.

Name on card: _____

Credit card type: _____ Visa _____ MasterCard ____ Discover _____ AmEx

Credit card number: _____

Expiration date: _____

Card security number: _____

I authorize Dr. Laurie Patlin Suttenberg to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

_____ _____

Cardholder Signature Date

_____

Printed Name

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HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA)
CLIENT RIGHTS & THERAPIST DUTIES

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a client and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-client privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a client files a complaint or lawsuit against me,I may disclose relevant information regarding that client in order to defend myself.
4. If a client files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the client's employer, the insurance carrier or an authorized qualified rehabilitation provider.

I may disclose the minimum necessary health information to my business associates that perform functions on my behalf or provide me with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed using or disclosing any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a client's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the appropriate state authorities. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the appropriate state authorities. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the client, to other individuals, or to society, I am required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the client.

CLIENT RIGHTS AND THERAPIST DUTIES
Use and Disclosure of Protected Health Information:

For Treatment - I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of my practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.

For Payment - I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
For Operations - I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Client's Rights:

Right to Confidentiality - You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
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.
Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
Right to Amend - If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
Right to a copy of this notice - If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
Right to an Accounting -You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
Right to choose someone to act for you - If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
Right to Choose - You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
Right to Terminate -You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
Right to Release Information with Written Consent - With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my 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 in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me; the Florida Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling; the State of New Jersey Department of Health; or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Dr. Laurie Patlin Suttenberg Date

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AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Dr. Laurie Patlin Suttenberg to other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize Dr. Laurie Patlin Suttenberg to: release to_____, obtain from _____,

_____

(name of agency/individual)

the following information pertaining to myself:

_____ Treatment summary
_____ Diagnosis
_____ Psychiatric evaluation/medication history
_____ Other (specify) _____
_____ History/intake
_____ Psychological test results
_____ Dates of treatment attendance

for the purpose of:
_____ Evaluation/assessment and/or coordinating treatment efforts

_____ Other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event:_____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Dr. Laurie Patlin Suttenberg Date