

*Julie Fennimore, Psy.D.*

*Licensed Psychologist (# PSY 18518)*

**CLIENT INFORMATION FORM**

**Demographics**

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ #OF YEARS MARRIED: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ SPOUSE'S OCCUPATION: \_\_\_\_\_

CHILDREN/STEP/GRAND (names/ages) : \_\_\_\_\_

SIBLINGS (names/ages): \_\_\_\_\_

PARENTS/STEP-PARENT(s) (Names/Ages or year of death): \_\_\_\_\_

**Medical Information**

Are you currently under a doctor's care for any medical condition? \_\_\_\_\_ If so, please explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

When did you last have a full medical exam? \_\_\_\_\_

What medications do you currently take? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL CARE** (Specify: major problems, accidents, hospitalizations): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**WHAT IS YOUR PAST/PRESENT DRUG/ALCOHOL USE/ABUSE** (any addiction, AA/NA/etc.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Medical information (continued)**

**PLEASE LIST ANY FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, VIOLENCE, SUICIDE (Specify**

**family member/illness):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Psychological Information**

**Why are you seeking treatment now?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Are you currently or have you in the past been in treatment with a counselor, therapist or psychiatrist?** \_\_\_\_\_

**If so, please specify names/dates of treatment:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Who may I notify in case of emergency?** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Work phone number:** \_\_\_\_\_ **Home phone number:** \_\_\_\_\_

**Who referred you to me?** \_\_\_\_\_

**You have been given a 2-page therapy information statement (TIS-R/TIS-11/02) describing the confidentiality of therapy sessions, limits to confidentiality, fees and payment arrangements, and other details about your therapy. Please feel free to ask questions or discuss any aspect of the therapy process with me at any time.**

***I HAVE READ AND RECEIVED A COPY OF THE THERAPY INFORMATION STATEMENT:***

**NAME (printed):** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE (if needed):** \_\_\_\_\_

*(Use the space on the back of this form if you need to give further information)*

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### **INFORMATION ABOUT YOUR THERAPY**

Psychotherapy is different for each individual. You and I must collaboratively determine the length and depth your course of therapy will take. Sometimes a client will see a therapist for a particular concern only to discover that unanticipated topics or issues shift the focus. Significant life changes do not typically occur in a straight positive line. It is possible to "feel worse" before "feeling better." Plateaus and setbacks occur.

Psychotherapy is not an exact science and clear predictions about improvement cannot be made. The "success" a client experiences depends upon many factors within the client, the therapist, and the relationship that develops between them. Psychotherapy requires your very active involvement, honesty, and openness to change your thoughts, feelings, or behavior. Not every client and therapist is a good match, nor is every type of therapy appropriate for every person or problem. Therefore, it is very important that you let me know how you are experiencing our work together. I am always interested in hearing your feedback and answering questions you may have about your therapy.

If you could benefit from any treatments that I do not provide, I have an ethical obligation to assist you in obtaining those treatments. I consult regularly with other professionals regarding my clients; however, your name or other identifying information are never mentioned. At the end of the first or second session, I will assess whether I think I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In such a case, I will provide you with a number of referrals who you may contact. Additionally, if at any time during your treatment you wish to consult with another professional, I will assist you in finding someone qualified. You have the right to terminate therapy at any time. I will provide you with referrals if requested. However, I ask that before terminating, you speak honestly to me about your concerns or issues about continuing treatment.

### **CONFIDENTIALITY**

The fact that we are meeting, as well as the content of our meetings, is confidential. I will not talk about you (in any identifying way) with another person unless I have your written permission to do so, with the following exceptions:

1. If you disclose that you are going to cause physical injury to another person, I am mandated by law to warn the person and to notify the police.
2. If I hear from you about a situation in which I reasonably suspect that a child, an elderly person or a dependent adult is being physically abused, sexually abused, or neglected, I am required to report this information to the appropriate agency.

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3. If you are gravely disabled, or because of your mental state, I believe you may harm yourself, others, or the property of others, I have the right to break confidentiality in order to consult with others in the process of trying to maintain your safety.

4. If you want to receive insurance reimbursement or payment from a third party, I may need to submit a formal diagnosis, appointment dates, and session summaries to the carrier. Once submitted I have no control or knowledge over what others do with the information.

5. Disclosure may also be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain my psychotherapy records and/or testimony.

6. In couple or family therapy or when different family members are seen individually, confidentiality does not apply between the couple or among family members. I will use my clinical judgment when revealing such information.

### **SESSIONS, PAYMENT AND BILLING**

Sessions are 50 minutes in length. If you need to cancel an appointment time, please do so 48 hours in advance or you may be billed for the session. You should know that most insurance companies do not reimburse for missed sessions. Your fee will be set before our first meeting. Payment is expected at each session (unless other arrangements are made), and should be in the form of cash or a check. Please have your check (made payable to Julie Fennimore, Psy.D.) made out prior to our session so that our full time can be used for treatment rather than check writing.

Please notify me if during the course of therapy a problem arises regarding your ability to make timely payments. I raise my fees periodically; however, I will discuss any increase with you well in advance. If you are utilizing your insurance for reimbursement, please note that my professional services are rendered and charged to you and not to the insurance carrier. I will provide you with a monthly accounting of your payments for reimbursement.

### **TELEPHONE AND EMERGENCY PROCEDURES**

If you need to speak with me between sessions, leave a message for me at (707) 479-0330. I pick up my messages throughout the day from 9 a.m. to 8 p.m., and will return your call between those hours. If more than brief contact is needed, we can schedule an additional appointment or do a half-session (25 min.) over the phone. If you are in a crisis situation and cannot wait for a return call from me, call the Sonoma County 24-hour Crisis Line at (707) 576-8181 or the police (911) for immediate help.

*Julie Fennimore, Psy.D.*

*Licensed Psychologist (# PSY 18518)*

*633 Cherry Street Santa Rosa, CA 95404 (707) 479-0330*

### **HIPAA 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 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 data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide 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, apply, 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 the general waiting room. You may also request a copy of this Notice from me, or you can view a copy of it in the general waiting room.

**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 the 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, and other licensed health care providers who provide you with health care services or 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 others to make sure that I am in compliance with applicable laws.

**3. To obtain payment 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 isn't 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 your 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 or authorization 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 disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations,** such as the Privacy Rule that requires 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 California Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.
8. **If disclosure is mandated by the California 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 need 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 interests 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.** Examples: 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 I offer.
16. **If an arbitrator or arbitration panel compels disclosure,** 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 prior 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 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.**

**1. Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care 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 my 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 how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel 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 agree to your request, I will put those 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 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.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom 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 cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional

request.

**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 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It 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 changes 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 Julie Fennimore, Psy.D. at 707-479-0330; 633 Cherry Street, Santa Rosa, CA 95404.

#### **VII. EFFECTIVE DATE OF THIS NOTICE**

This notice went into effect on April 14, 2003.

*Julie Fennimore, Psy.D.*                      *Licensed Psychologist (# PSY 18518)*  
*633 Cherry Street   Santa Rosa, CA 95404   (707) 479-0330*

**Receipt of HIPAA Notice of Privacy Practices**

**I acknowledge receipt of the HIPAA Notice of Privacy Practices, dated effective 4/13/03.**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_