Carol Ray, Psy.D, L.C.S.W
Doctor of Psychology & Licensed Clinical Social Worker
License #21901

Intake Form

Client Name:_____

Guardian/Parent:_____

Address:_____

City, Zip Code:_____

Cell Phone:_____

E-mail Address:_____

Do you want me to use discretion when calling, e-mailing or texting you? No_____ Yes_____

(if Yes, please be specific) _____

Emergency Contact:_____

Phone Number: _____

Referred By:_____

Reason for seeking treatment:_____

_____

_____

Goal(s) for therapy:_____

_____

_____

100 E. San Marcos Blvd. #423, San Marcos, CA
(760) 845-4161

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Information and Policies

Please carefully review and sign this form as confirmation that you understand and agree to the terms of this therapeutic relationship. Feel free to ask for clarification on any of the items.

Confidentiality: All communication between client and therapist shall remain confidential unless you request specific information be discussed with outside parties (for example, family members, other health professionals, school staff, etc.). In such cases, written authorization to release the information will be requested from you. I am mandated by law to break this confidentiality in the following circumstances:

- If I am ordered by the court to testify or release records.
- If you are a victim or perpetrator of child abuse.
- If you are a victim or perpetrator of elder or dependent adult abuse.
- If you threaten harm to yourself, someone else, or the property of others.

Fees: My fee is $220 for a 50 minute session and will be collected at the beginning of the appointment. I recommend preparing your payment prior to your arrival so that your time is maximized. Telephone consultations with you or other persons designated by you will be billed at my hourly rate with a $20 minimum (brief phone calls regarding scheduling are excluded). Preparing reports will be billed at my hourly rate plus an administrative fee of $100. I do not accept insurance, but will provide you a bill to submit to your insurance company for reimbursement. Please let me know if you would like me to provide you with a statement at the end of each month for you to send to your insurance company.

In the instance that an unpaid balance accrues, it will be turned over to a collection agency. You will be responsible for the original bill, service charges, collection fees, and any legal costs that are incurred. There will be a $25 charge for returned checks.

Cancellations: 24 hours notice is required if you need to cancel a session. My full fee will be billed if you miss a session or fail to reschedule 24 hours prior to the scheduled appointment.

I/we have read and understand this information and agree to these policies.

_____	_____	_____
Client's Signature	Client's name (print)	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian name (print)	Date

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Teletherapy Consent Form

Definition of Services: I hereby consent to engage in teletherapy with my therapist. Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to teletherapy:

Client's Rights, Risks, and Responsibilities:

1. I, the client, must be physically located in California at the time of services. (This is a legal requirement for psychologists and marriage and family therapists practicing in this state under a CA license.)

2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment with my therapist.

4. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

5. There is a risk that services could be disrupted or distorted by unforeseen technical problems.

6. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area.

7. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse.

8. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychological treatment provider to do the same on their end.

_____	_____	_____
Client's Signature	Client's name (print)	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian name (print)	Date

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Credit Card Authorization Form

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request.

In case of late cancellations and/no shows for scheduled sessions or if a check is returned unpaid, you will be charged the session fee. An additional $25 is assessed for returned checks.

I, _____, am authorizing Carol Ray, Psy.D, LCSW to use my credit card information to charge my credit card in the event that I do not notify her of my inability to attend a scheduled therapy appointment, do not cancel my appointment at least 24 hours in advance, a check is returned for any reason or there is an outstanding balance after 30 days.

Card Number:_____ Exp. Date:_____

Verification/Security Code:_____ Zip Code:_____

By signing below I am authorizing Dr. Carol Ray to charge for scheduled appointments or outstanding balances after 30 days.

Signature:_____ Date:_____

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Good Faith Estimate

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider listed, nor does it include any services rendered to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

The fee for a 50-minute psychotherapy visit (in-person or via telehealth) is $220. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs.

You have a right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges). You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

_____	_____	_____
Client's Signature	Client's name (print)	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian name (print)	Date

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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. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

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 of 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.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (if applicable). You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at (insert website address, if applicable).

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. Uses 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 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 care. 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 the 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 the 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 that 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 that 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 a 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 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 to 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 uses 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 consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that 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 a 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 response to a search warrant.
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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 Vl below. You also may 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: (760) 845-4161

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 to 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 (760) 845-4161.

I acknowledge receipt of the Notice of Privacy Practices of Carol Ray, Psy.D, LCSW.

Signature:_____ Date:_____