Susan Ko, PhD

CLINICAL PSYCHOLOGY

NEW CLIENT FORM: LYRA HEALTH

Please complete this form and bring it with you to your first appointment.

Name of client

Birthdate Age Gender Ethnicity

Name of Parent(s)/Guardian(s) (if client is under the age of 18)

Street Address

City State Zip Code

Phone Alternate Phone

Is it ok to leave a message on your phone or alternate phone?

If you are a LYRA HEALTH CLIENT & you are not the primary insured, please provide:

Name of LYRA HEALTH Insured _____LYRA HEALTH Insured DOB_____

Occupation/Employer

School Grade

Relationship Status

□ Married □ Separated □ Single □ Divorced □ Living with a partner □ Other

□ Children (ages & names)

Emergency Contact Name Relationship

Address Phone

GOALS FOR THERAPY

MEDICAL INFORMATION

Current Medications	Dosage	Allergies

Major Medical Events / History (e.g., hospitalizations, major surgery)

Family Medical & Mental Health History (e.g., diagnoses, hospitalizations, major surgery)

Physician (primary care/pediatrician) Phone Permission to contact?
☐ Yes ☐ No

Psychiatrist Phone Permission to contact?
☐ Yes ☐ No

Previous Therapist Phone Permission to contact?
☐ Yes ☐ No

Date of Last Physical Exam

TREATMENT CONTRACT

Treatment Methods

I understand that the practitioner may use a range of interventions and techniques in the treatment, including (but not limited to) cognitive restructuring, stress management, skills development, behavioral management, stabilization, supportive counseling, play therapy, education, and referrals to other practitioners. I understand that participating in psychotherapy can have benefits and risks. Since therapy often involves discussing challenges, I may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. I understand that there are no guarantees regarding what I will experience.

Limits of Confidentiality

I understand that my health information is protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. I have received a Notice of Privacy Practices (continue to the end of this document).

I understand that conversations with the practitioner will usually be confidential. I further understand that a mental health professional, by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the practitioner has a legal responsibility to protect anyone that the patient may threaten with violence, harmful or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. I understand that the mental health professional will make reasonable efforts to resolve these situations before breaking confidentiality.

I also understand that information about my attendance to sessions and monthly outcome measures to document treatment progress will be shared with LYRA HEALTH, the company that is being billed for my sessions.

Office Policies

Payments are to be made at the end of each session, unless other arrangements are agreed upon.

I understand that although regular attendance will produce the maximum benefits, attendance is voluntary, there are alternatives to psychotherapy, and I am free to discontinue treatment at any time. I agree to notify the practitioner at least **48 business hours in advance** if I will be unable to attend any session. I understand that if I fail to make such notification, I will be charged for the full cost of the session. I accept responsibility for these charges and agree to pay them.

I understand that LYRA HEALTH is responsible for the cost of the psychological services to me. I understand that LYRA HEALTH'S failure to pay these bills may result in collection procedures (including court proceedings) being taken by the practitioner or collection agency contracted by the practitioner to collect these bills. I also understand that LYRA HEALTH will be responsible for any additional charges incurred with a collection agency or the filing of a court action including late fees, attorney and filing costs.

My signature below indicates that I have read and agreed to the terms and policies described in this treatment contract.

Name of Client *Name of Parent/Guardian (if client is under 18)*

Signature of Client or Parent/Guardian (if client is under age 18) *Date*

HIPAA Notice of Privacy Practices

Notice of Psychologist's 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 AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Use and Disclosure of PHI

Protected Health Information (PHI) may not be used or disclosed in violation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CRF parts 160 and 164) (hereinafter, the "Privacy Rule") or in violation of state law.

I am permitted but not mandated, under the Privacy Rule to use and disclose PHI without patient consent or authorization in limited circumstances. However, state or federal law may supercede, limit, or prohibit these uses and disclosures.

Under the privacy Rule, these permitted uses and disclosures include those made:

- To the patient
- For treatment, payment, or health care operations purposes, or
- As authorized by the patient

Additional permitted uses and disclosures include those related to or made pursuant to:

- Reporting on victims of domestic violence or abuse, as required by law
- Court orders
- Workers' compensation laws
- Serious threats to health or safety
- Government oversight (including disclosures to a public health authority, coroner or medical examiner, military or veterans' affairs agencies, an agency for national security purposes, law enforcement)
- Health research
- Marketing or fundraising

I do not use or disclose PHI in ways that would be in violation of the Privacy Rule or state law. I use and disclose PHI as permitted by the Privacy Rule and in accordance with state or other law. In using or disclosing PHI, I meet the Privacy Rule's "minimum necessary requirement," as appropriate.

Use and Disclosure of PHI – Minimum Necessary Requirement

When using, disclosing or requesting PHI, I make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. I recognize that the requirement also applies to covered entities that request my patients' records and required that such entities meet the standard, as required by law.

The minimum necessary requirement does not apply to disclosures for treatment purposes or when I share information with a patient. The requirement does not apply for uses and disclosures when patient authorization is given. It does not apply for uses and disclosures as required by law or to uses and disclosures that are required for compliance with the Privacy Rule.

Use and Disclosure of PHI – Psychotherapy Notes Authorization

I abide by the Psychotherapy Notes authorization requirement of the Privacy Rule, unless otherwise required by law. In addition, authorization is not required in the following circumstances:

- For my use for treatment
- For use or disclosure in supervised training programs where trainees learn to practice counseling
- To defend myself in a legal action brought by the patient, who is the subject of the PHI
- For purposes of HHS in determining my compliance with the Privacy Rule
- By a health oversight agency for a lawful purpose related to oversight of my practice
- To a coroner or medical examiner
- In instances of permissible disclosure related to a serious or imminent threat to the health or safety of a person or the public

I recognize that a patient may revoke an authorization at any time in writing, except to the extent that I have, or another entity has, taken action in reliance on the authorization.

Patient Rights – Notice

As required under the Privacy Rule, and in accordance with state law, I provide notice to patients of the uses and disclosures that may be made regarding their PHI and my duties and patient rights with respect to notice. I make a good faith effort to obtain written acknowledgement that my patient receives this notice.

Patient Rights – Restrictions and Confidential Communications

The Privacy Rule permits patients *to request* restrictions on the use and disclosure of PHI for treatment, payment, and health care operations, or to family members. While I am not required to agree to such restrictions, I will attempt to accommodate a reasonable request. Once I have agreed to a restriction, I may not violate the restriction; however, restricted PHI may be provided to another health care provider in an emergency treatment situation.

A restriction is not effective to prevent uses and disclosures when a patient requests access to his or her records or requests an accounting of disclosures. A restriction is not effective for any uses and disclosures authorized by the patient, or for any required or permitted uses recognized by law.

The Privacy Rule also permits patients *to request* receiving communications from me through alternative means or at alternative locations. As required by the Privacy Rule, I will accommodate all reasonable requests.

Patient Rights – Access to and Amendment of Records

In accordance with state law, the Privacy Rule, and other federal law, patients have access to and may obtain a copy of the medical and billing records that I maintain. Patients are also permitted to amend their records in accordance with such law.

Patient Rights – Accounting of Disclosures

I provide my patients with an accounting of disclosures upon request, for disclosures made up to six years prior to the date of the request. While I may, I do not have to provide an accounting for disclosures made for treatment, payment, or health care operations purposes, or pursuant to patient authorization. I also do not have to provide an accounting of disclosures made for national security purposes, to correctional institutions or law enforcement officers, or that occurred prior to April 14, 2003.

Business Associates

I rely on certain persons or other entities, who or which are not my employees, to provide services on my behalf. These persons or entities may include accountants, lawyers, billing services, and collection agencies. Where these persons or entities perform services, which require the disclosure of individually identifiable health information, they are considered under the Privacy Rule to be my business associates.

I enter into a written agreement with each of my business associates to obtain satisfactory assurance that the business associate will safeguard the privacy of the PHI of my patients. I rely on my business associate to abide by the contract but will take reasonable steps to remedy any breaches of the agreement that I become aware of.

Administrative Requirement – Privacy Officer

I will be the privacy officer, who is responsible for the development and implementation of the policies and procedures to protect PHI, in accordance with the requirements of the Privacy Rule. As the contact person for my practice, the privacy officer receives complaints and fulfills obligations as set out in notice to patients.

Administrative Requirement – Training

As required by the Privacy Rule, I train all members of my staff, as necessary and appropriate to carry out their functions, on the policies and procedures to protect PHI. I have the discretion to determine the nature and method of training necessary to ensure that staff appropriately protect the privacy of my patients' records.

Administrative Requirement – Safeguards

To protect the privacy of the PHI of my patients, I have in place appropriate administrative, technical, and physical safeguards, in accordance with the Privacy Rule.

Psychologist'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 by mail.

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, you may contact me at 310.949.9221.

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me at 1554 S. Sepulveda Blvd, Suite 215; Los Angeles, CA 90025.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I will 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.

Acknowledgment
Your signature below indicates you have read and agreed to the terms and policies stated in the above Notice. This Notice will go into effect today.

Signature: _____ Date:_____