Paperwork for new clients of Dr. Laura Lokker

Welcome. Please take a few moments to read these pages about my practice, policies, and privacy of health information, as well as fill out some demographic information. I will answer any questions you may have once we meet in person.

Thanks,

Laura J. Lokker, Psy.D.

Laura J. Lokker, Psy.D. | (202) 817-2818
1350 Connecticut Avenue, NW, Suite 402, Washington, DC 20036
DC License # PSY1000805 | National Provider Identifier # 1922349760

CLIENT INFORMATION SHEET

All questions are optional - please complete as much or as little as you like.

Name: _____DOB: _____ Age: _____
Address: _____
Place of birth: _____ Hometown: _____
Preferred Phone: _____ Cell / Home / Work. OK to leave msg? Y N
Secondary Phone: _____ Cell / Home / Work. OK to leave msg? Y N
Email address: _____
Social Security Number: _____
Emergency Contact (name, phone, relation): _____
Who referred you?: _____

Reason for seeking treatment:

_____
_____
_____

Issues of Concern: Please check all of the following items that are of concern for you.

_ Abortion issues
_ Abuse – emotional, physical
_ Academic issues
_ Aggression/violent behavior
_ Alcohol use
_ Anger, arguing
_ Anxiety, nervousness
_ Body image
_ Career concerns, choices
_ Childhood issues (yours)
_ Children/parenting concerns
_ Compulsive behaviors
_ Computer excessiveness
_ Concentration
_ Decision making, indecision
_ Depression, sadness, crying
_ Divorce, separation
_ Drug use
_ Eating problems
_ Emptiness
_ Family relationships
_ Fearing failure
_ Fears, phobias
_ Financial problems
_ Gambling
_ Grief issues
_ Guilt
_ Hallucinations
_ Harassment
_ Health, medical concerns
_ Identity issues
_ Impulsivity
_ Independence from parents
_ Intercultural issues
_ Irresponsibility
_ Learning disability
_ Legal problems
_ Loneliness, no friends
_ Memory problems
_ Mood swings
_ Motivation
_ Overly responsible to others
_ Overly sensitive to rejection
_ Panic attack
_ Peer relationship concerns
_ Perfectionism
_ Pregnancy
_ Prejudice/bias concerns
_ Procrastination/time mngt.
_ Racial/ethnic concerns
_ Relationship concerns
_ Relationship violence
_ Religious/spiritual concerns
_ Repeated troubling thoughts
_ Romantic relationship
_ Self-injury, mutilation
_ Self-neglect, poor self-care
_ Sexual assault
_ Sexual concerns
_ Sexual harassment
_ Sexual orientation/identity
_ Sexually transm.disease
_ Shame
_ Shyness, oversensitive
_ Sleep problems
_ Smoking, tobacco use
_ Stress
_ Suicidal thoughts
_ Tiredness, fatigue
_ Violent thoughts
_ Withdrawal, isolating
_ Worthless feeling
_ Other

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CLIENT INFORMATION SHEET *continued*

FAMILY: Please list any family history of mental health or substance abuse problems:

_____
_____
_____
_____
_____

EDUCATION AND EMPLOYMENT: Please list current and recent significant **employment** (position, company, & time frame), and **education** (school, degree).

_____
_____
_____
_____
_____
_____

HEALTH: Please list Significant Medical History (chronic conditions, accidents, major illnesses, surgeries):

_____
_____

Current psychiatrist: _____ Current psychiatric medication: _____
Past psychiatric medication: _____
Other current medication: _____

PREVIOUS PSYCHOLOGICAL TREATMENT (please list all past psychological treatment, including any hospitalizations; including reasons, location, and time frame):

_____
_____
_____
_____
_____

CURRENT OR RECENT SUBSTANCE USE:

_____
_____
_____
_____
_____

SUICIDALITY (check all that apply): ____current thoughts; ____ history of thoughts; ____history of attempts; ____ history of self-injury (e.g., cutting); ____not applicable

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Treatment Information and Agreement

Welcome to my practice. I am providing you the following information to answer common questions about the policies and procedures of my practice. If you have any questions or concerns about any of this information, please do not hesitate to discuss them with me.

Appointments:

Our first few sessions will involve an evaluation of your treatment needs and therapy goals. During this time I will share my initial impressions of what our work would entail if you choose to continue with therapy. The evaluation period is also a time for us to consider whether I am the best person to provide the services you need and for you to consider if you feel comfortable working with me. Each session lasts for 50 minutes.

Insurance:

Please note that I am not part of any insurance panels and am therefore considered an "out of network provider". If you wish to be reimbursed by your insurance carrier, please contact your insurance provider to determine (1) the type and amount of mental health coverage available to you; (2) the coverage for out of network providers; (3) if there is an annual deductible you must meet; (4) and if a note from your physician is required indicating your need for therapy. If your insurance does provide coverage, you must submit the claims yourself. I am glad to fill out any necessary forms and provide any assistance I can in helping you receive the benefits to which you are entitled. Please note that if your insurance claim is denied or not paid by your insurance, you are responsible for the full amount of charges.

Fees:

My fee is $180 per session and payment is due at the time of service. I accept checks, cash and credit card, and I will provide you with a statement at the end of each month. If this billing arrangement is not feasible, please discuss this with me to work out an agreeable arrangement. If your bill is two months overdue, I reserve the right to discontinue therapy until the balance is paid in full.

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Cancellations:

If you need to cancel an appointment, please notify me at least 24 hours in advance. Because the appointment time is reserved for you, appointments that are not cancelled 24 hours in advance will be charged full fee. If you are using insurance to cover all or part of your treatment, please note that most insurance plans do not pay for missed sessions, so you would be responsible for the total charge for the missed session.

Telephone and Emergency Policy

If you need to reach me between regularly scheduled appointment times, you can call me at (202) 817-2818. The voicemail at this number is confidential. I check these messages regularly and will return your call at the earliest possible opportunity. If you are unable to reach me and feel that you cannot wait for me to return your call, please contact your family physician or go to the nearest emergency room. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary.

Confidentiality:

Strict confidentiality is assured except for the following situations:

1. You may authorize me to release records or other information to individuals of your choosing. This may be done only with your expressed written consent.
2. In the event of a clear imminent danger to yourself or another person, I would break your confidentiality in order to ensure safety, taking whatever steps deemed appropriate to prevent harm, including notifying the police and/or the intended victim (where applicable).
3. In the event of suspected child/elderly abuse or neglect, I am by law required to disclose the relevant information and breach confidentiality.
4. In certain legal proceedings, confidential information may be disclosed due court order.

Freedom to Withdraw:

You have the right to end therapy at any time. If you wish, I will provide you with referrals to other qualified providers.

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Physician Contact:

Because physical and psychological symptoms often interact, I encourage you to seek medical consultation if warranted. In addition, medication may sometimes be helpful for psychological problems. When appropriate, I will arrange a referral for a medication evaluation.

Patient Rights

Health Insurance Portability and Accountability Act (HIPAA) provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. The attached form entitled "Notice of Policies and Practices to Protect the Privacy of Your Health Information" lists these rights.

Acknowledgement

I have read the above listed policies and understand and agree to their consent. I also received a copy of the HIPAA Notice of Privacy Practice and have been informed that I may direct any questions about this Privacy Policy to Laura J. Lokker, Psy.D.

Patient Signature:_____ Date:_____

Patient Name (printed): _____

Parent or Guardian Signature (for patients under the age of 18):

Signature:_____ Date:_____

Parent/Guardian Name (printed): _____

Notice of Policies and Practices to Protect the Privacy of Your Health Information:
HIPAA (The Health Insurance Portability and Accountability Act)

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

I may *use* or *disclose* your *Protected Health Information* (PHI) for *Treatment*, *Payment*, and *Health Care Operations* purposes with your *written authorization*. 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 a psychologist.
    - *Payment* refers to reimbursement for your health care. Examples of payment are when PHI is disclosed 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 or operation of the practice. Examples are quality assessment and improvement activities, business-related matters (such as audits) and administrative services, case management and care coordination.
- "*Use*" applies only to activities within the office, such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of the office, such as releasing, transferring or providing access to information about you to other parties.
- "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of those outlined above, I will obtain authorization from you before releasing that information. I will also need to obtain authorization before releasing your *Psychotherapy Notes*. These are notes I have made about our conversation during a private, group, joint or family counseling session, which I have kept separate from the rest of your 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 insurance coverage, the law provides the insurer with the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

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

- *Child Abuse* – If I know or have reasonable cause to suspect that a child known to me in my professional capacity has been or is in immediate danger of being mentally or physically abused or neglected, I must immediately report such knowledge or suspicion to the appropriate authority.
- *Adult and Domestic Abuse* – If I believe that an adult is in need of protective services because of abuse or neglect by another person, I must immediately report this belief to the appropriate authorities.
- *Health Oversight Activities* – If the D.C. Board of Psychology is investigating me or my practice, I may be required to disclose PHI to the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about the professional services I have provided you and/or the records thereof, such information is privileged under D.C. law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court offered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If I believe disclosure of PHI is necessary to protect you or another individual from a substantial risk of imminent and serious physical injury, I may disclose the PHI to the appropriate individuals.
- *Worker's Compensation* – If I am treating you for Worker's Compensation purposes, I must provide periodic progress reports, treatment records and bills (upon request) to you, the D.C. Office of Hearings and Adjudication, your employer, or your insurer (or their representatives).

IV. Patient's Rights and Provider's Duties

Patient's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Information 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 in treatment with me. Upon your request, I will send bills to another address).
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my 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 the decision reviewed. You may be denied access to Psychotherapy Notes if I believe that a limitation of access is necessary to protect you from a substantial risk of imminent psychological impairment or to protect you or another individual from a substantial risk of imminent and serious physical injury. I shall notify you or your representative if I do not grant complete access. Upon 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. Upon 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. Upon 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 from me upon request, even if you have agreed to receive the notice electronically.

Provider'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 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 intend to revise my policies and procedures, I must describe in the notice to patients how I will provide patients with a revised notice of privacy policies and procedures (e.g. by mail, e-mail).

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, you may contact me (Laura Lokker, Psy.D., at 202-817-2818). 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: 1350 Connecticut Avenue, NW, Suite 402, Washington D.C. 20036. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. Please note: 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 went into effect on August 1, 2004. 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 by mail or in person.