Adult Intake Form

Adult Client Information

Name_____ Date of Birth_____/_____/_____ Age_____
First MI Last Mo Day Year Years

Mailing Address_____
Street Address City State ZIP

Phones: Cell (_____)_____-_____ W (_____)_____-_____ H (_____)_____-_____

Email Address _____

Occupation_____ Employer_____

Internist_____ Phone (_____) _____-_____

Psychiatrist _____ Phone (_____) _____-_____

Referred By?_____ May I thank this person?_____

Marital Status: Married_____ Separated_____ Divorced_____ Other_____

Spouse Information

Name_____ Date of Birth_____/_____/_____ Age_____
First MI Last Mo Day Year Years

Mailing Address_____
Street Address City State ZIP

Phones: Cell (_____)_____-_____ W (_____)_____-_____ H (_____)_____-_____

Email Address _____

Occupation_____ Employer_____

Please list all other individuals who live in your household.

Name Relationship Age Grade or highest earned

_____

_____

_____

_____

Doctor-Patient Informed Consent Agreement

Pamela G. Luttig, PhD,

Licensed Psychologist

Welcome

I warmly welcome you to my psychological practice. Consistent with ethical practice, this document provides useful information about psychological services and my business policies. Please let me know if you have any questions prior to signing this agreement.

Initial Sessions & Appointments

Our initial sessions will involve an assessment of your or your child/adolescent's issues and needs. In the case of children, I typically meet with parent(s) first, meet with the child about three times, and then follow up with a parent session to discuss my impressions and recommendations. Adolescents may be seen prior to a parent intake due to their greater need for independence in the therapeutic relationship. If we all agree to proceed with treatment, we will schedule a 45-minute standing weekly appointment. Please note that I do not provide therapy on less than a once weekly basis. Please try to avoid conflicts once we settle on an appointment time, as rescheduling can be difficult.

Fees, Billing, and Payments

Sessions are charged by the amount of professional time spent at the rate of $260 for 45 minute face-to-face or telepsychology sessions. Prorated charges are made for additional time spent on telephone calls, coordination with other professionals, requested written documents, etc. Clients have the option to pay by check or credit card, and will receive an invoice at the end of each month. Please keep in mind that you will be charged in full for any scheduled appointment unless you provide at least 24 hours advance notice for the need to cancel. I do not participate in insurance panels but will provide you with an invoice that includes the information your insurance company needs to reimburse you for any covered charges.

How to Contact Me

If you need to reach me outside of appointments for scheduling or other matters, you can email me at drpamluttig@gmail.com or leave a voicemail at (301) 365-8105. If you or your child/adolescent has an emergency and you cannot reach me, please contact your physician's office, call 911, or go to an emergency room.

Confidentiality & Limits to Confidentiality

The law protects the privacy of communications between psychologists and their clients. In most situations I can release information only with a signed written authorization from you. If

you are involved in a court proceeding, I will release information only with your written consent and/or a court order. Exceptions to confidentiality include mandated reporting for child or vulnerable adult abuse or neglect, if a client reveals suicidal intention, or if a client reports the intention of physically harming a specific victim. Other exceptions may include government requirements for health oversight, professional consultation, and if there is a complaint or a lawsuit against a psychologist.

Confidentiality for Minors

Entrusting a therapist with confidential information about your child/adolescent's thoughts and feelings can be uncomfortable for many parents. It is important to understand, however, that children and adolescents, just like adults, require confidentiality to feel free to discuss sensitive and/or personal information. For example, young clients may not want to tell parents about problems because they worry that parents will become overly worried, stressed, or disappointed. Like adults, if children/adolescents do not believe that their privacy will be protected, therapy will be of limited value because they may not reveal or work on important problems. For these reasons, and consistent with professional practice, confidentiality for minors will be maintained (with the limits discussed in the previous section.)

While I will maintain confidentiality for minor clients, there are many times in which, especially younger children, are open to a team approach including parent(s). This can be extremely valuable as parent(s) can reinforce learned skills and make helpful changes at home. While respecting their choice, I will often urge the child/adolescent client to ask parents for help either on their own or with my assistance. Fortunately, many parents will find that after initiating psychotherapy, their child/adolescent also begins to express themselves more openly at home. Please note that parents do not hold confidentiality, and that I may reveal information that parents give me if I think it will be useful in directing the therapy. If you do not want me to reveal specific things that you tell me, please state that to me clearly so that I can respect your wishes.

By signing this document, you are acknowledging that you understand and agree with the need for your minor child's confidentiality and that, notwithstanding current laws and regulations, you waive the right to full disclosure of your minor child's Protected Health Information, and instead agree to abide by my clinical judgment as to what information is disclosed. You are further agreeing that neither you nor your legal representative(s) will request the release of your minor child's information via telephone, deposition, testimony, or clinical records, regarding custody or other legal manners.

Benefits & Limitations of Psychological Services

I tailor my treatment to the needs of each client using an integration of many therapeutic approaches. There are no guarantees for success, but psychotherapy has been shown to have many benefits such as easing emotional distress and solving specific problems. At times, clients can experience discomfort when discussing painful issues or experiences. Treatment will be most successful when you follow additional referral recommendations, and when you work on goals between sessions.

Professional Records & Patients' Rights

The laws and standards of my profession require that I keep Protected Health Information in a Clinical Record. For adult clients, you may examine your Clinical Record if you request it in writing, or you may have the right to a summary and/or to have your record sent to another mental health provider. If I feel there could be harm done by releasing your record, you still have a right to review it with me. Your rights under the United States Health Insurance Portability and Accountability Act (HIPAA) are further described in the copy of the HIPAA Maryland Notice (attached).

Signed Consent

Your signature below indicates that you have read the information in this document and agree to abide by its terms. If further serves as acknowledgement that you have received the HIPAA Maryland Notice (attached).

_____

Name of Patient/Client

_____ _____ _____

Signature of Patient/Client (or legal guardian) Date Relationship (e.g. self or parent)

_____ _____ _____

Signature of Patient/Client (or legal guardian) Date Relationship (e.g. self or parent)

Release of Information Authorization Form

Pamela G. Luttig, PhD

Licensed Psychologist

This form, when completed and signed by you, authorizes Pamela G. Luttig, PhD to secure and/or release protected information from your (or your minor child's) clinical record to and from the person(s) you designate below.

I, _____(your name), authorize Pamela G. Luttig, PhD and/or or her staff to secure and release information related to the treatment of myself and/or my minor child_____(child's name), including any treatment and/or evaluation information and test results to the following:

1._____ _____
Pediatrician or Internist Name Phone Number

2._____
Psychiatrist Name Phone Number

3._____
Other Phone Number

I am authorizing Pamela G. Luttig, PhD to secure and/or release this information at my request. I understand that I have the right to revoke this authorization, in writing, at any time by sending such notification to Pamela G. Luttig, PhD's office address. However, this revocation will not be effective to the extent that Dr. Luttig has acted in reliance on this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by HIPAA Privacy Rules.

_____ _____
Signature of Patient (or legal guardian) Date

_____ _____
Signature of Patient (or legal guardian) Date

Maryland Notice Form

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.

I. Uses and disclosures for treatment, payment, and health care operations.
Pamela G. Luttig, PhD (henceforth I) may use or disclose your protected health information (PHI) for treatment, payment, and health care operation 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.
  -Payment is when I obtain reimbursement for your healthcare.
  -Health Care Operations are activities that relate to the performance and operation of my practice.
- Use applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
  Disclosure applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.
- Disclosure applies to activities outside of my 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 treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain authorization before releasing your Psychotherapy Notes. Psychotherapy Notes are notes I may have made about the conversation during a private, group, joint, or family counseling session, which have been kept separate from the rest of your medical record. These notes give 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 obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

III. Uses and disclosures with authorization.
I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child abuse--If I have reason to believe that a child has been subjected to abuse or neglect, I must report this belief to the appropriate authorities.
- Adult and Domestic Abuse--I may disclose protected health information regarding you if I reasonably believe that you are a victim of abuse, neglect, self-neglect or exploitation.
- Health oversight activities--If I receive a subpoena from the Maryland Board of Examiners of Psychologists because they are investigating my practice, I must disclose any PHI requested by the Board.
- Judicial and administrative proceedings--If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- Serious threat to health or safety-- If you communicate to me a specific threat of imminent harm against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures that I consider necessary to protect you from harm.

IV. Patient's rights and psychologist's duties.

Patient 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 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. On your request, I will send your 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 practice's 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 this decision reviewed. You have the right to inspect or obtain a copy (or both) of Psychotherapy Notes unless I believe the disclosure of the record will be injurious to your health. On your request, I will discuss with you the details of the request and denial process for both PHI and Psychotherapy Notes.
- 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. On 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. On 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.

Psychologist's duties:

- I am required by law to maintain the privacy of PHI and to provide you with notice of the 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 the policies and procedures, I will post a revised copy in a prominent place in the waiting room.

V. Questions and complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision made about access to your records, you may complain by contacting me as listed at the bottom of this notice. You may also send a written complaint to the Secretary of the US Department of Health and Human Services.

VI: Effective date, restrictions, and changes to privacy policy

This notice will go into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make a new notice provision effective for all PHI that I maintain. I will provide you with a revised notice by posting a revised copy in a prominent place in the waiting room.

VII. Updated policies as a January 2013

- Patients who pay out of pocket in full have a right to restrict disclosure of patient information to insurance companies.
- You have a right to be notified of a breach of PHI records.
- You must sign authorization for use and disclosure of 1) psychotherapy notes (if kept separately), 2) use of PHI for marketing purposes, and 3) use that constitutes a sale of PHI.

Privacy Officer: Pamela G. Luttig, PhD
Address: 8222 Lilly Stone Drive, Bethesda, MD, 20817
Phone: (301) 365-8105
Email: DrPamLuttig@gmail.com