Ruth Samad, R.N., Ph.D.

Office Address: 9888 Carroll Centre Rd., Suite 118, San Diego, CA 92126
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New Client Information
please print clearly

Last Name_____First Name_____

Responsible person (If different from client) _____

Address_____

City_____ State _____ Zip _____

Telephone # home_____cell _____

Client Date of Birth _____SS # _____

Insurance Company_____

Member ID#_____Group #_____

Name of Insured (if dif)_____

Date of Birth of Insured (If dif)_____SS# (If dif)_____

Employer _____ Work phone_____

In an emergency, please notify (include phone number and relationship to patient):

_____
(I give consent for Dr. Samad to notify this individual in an emergency.)

Signed _____ Date_____

Please describe how you heard of me:_____

May I thank your referral source? _____ yes_____ no

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Informed Consent to Treatment
Psychotherapy Information Disclosure Statement

Therapy is a relationship that works, in part, because of clearly defined rights and responsibilities held by each party in this contractual relationship. The framework helps create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well being. There are also important limitations to those rights of which you should be aware. As a therapist, I have corresponding responsibilities to you.

Confidentiality
With the exception of certain specific circumstances described below, you have the absolute right to the confidentiality of your therapy. I cannot, and will not, tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you choose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you.

If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are in theory available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, may be printed out and kept in your treatment record.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

a) If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

b) If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.

c) If I believe that you are in imminent danger of suicide, I may legally break confidentiality and call the police or the county crisis team. I would explore all options available to you together with you before I took this step. If you remained unwilling to take steps to guarantee your own safety, I am obliged to call a crisis team.

d) This is not a legal exception to your confidentiality, however, it is a policy you should be aware of if you are in couples therapy with me. If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those

individual sessions may be considered part of the conjoint therapy and can, and probably will be discussed in our joint sessions. Do not tell me anything you wish kept secret from your partner. I will remind you of this policy before beginning such individual sessions.

Record Keeping
I keep very brief patient records, noting only that you have been here, what interventions happened in session, and the topics we discussed. Under the Health Care Information Act of 1992, you have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else.

Diagnosis
If you are having me seek reimbursement from an insurance company, I will be required to give you a diagnosis. Diagnoses are technical language that describes the nature of your problems and something about whether they are short-term or long-term issues. I will be glad to discuss your diagnosis with you.

Other Rights
You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I've decided to choose a particular treatment option, and to look at alternatives you feel might be more effective. You may ask me about my education, training, and experience working with particular issues or in specific treatment modalities. You are free to terminate therapy at any time.

My Approach to Therapy
My approach to therapy is psychodynamic and cognitive behavioral in orientation. I use a variety of techniques in therapy which may include dialogue, interpretation, and cognitive reframing, among others. If I propose a specific technique that may have special risks attached, I will inform you of that, and discuss with you the risks and benefits of what I am suggesting. I may suggest that you consult with a physical health care provider regarding corollary medical treatment that could help you. You have the right to refuse anything I suggest.

Risks Involved
Therapy also has potential emotional risks. Approaching feelings or thoughts that you have tried to disassociate from may be painful and sometimes temporarily disrupt relationships. Learning new strategies and releasing the old can be frightening and energy consuming. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful.

Termination
Ideally, ending of therapy occurs as a result of our discussion and mutual agreement that the goals are completed. While you certainly have the right to end therapy at any time, it is often very useful to discuss it with me so I can understand your reasons. The following are reasons for my ending your treatment 1) If I am not, in my judgment, able to help you because of the kind of problem you have or because my training and skills are in my judgment not appropriate. I will inform you of this fact and refer you to another therapist who may meet your needs. 2) If you do violence to, threaten, verbally or physically, or harass myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately from

treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

Patient Appointment, Payment, & Emergency Information

Appointments
Regular appointments are an important part of successful therapy. When we schedule an appointment, you are making an agreement to use and pay for this professional time reserved exclusively for you. A fee for telephone and or email consultation will be charged for time we spend together beyond five minutes. You will be charged a full fee for missed appointments or appointments cancelled with less than 24 hours notice. Insurance companies will not reimburse for your missed appointment and you will be charged directly.

Payment
The Initial Session fee is $230. After that, my fee is $200.00 per 45 minute session and $230 per 60 minute session. Payment is expected on the day we meet. I accept checks or cash, not credit cards. You will be charged a $25.00 fee for any returned check. If you are using your insurance, you are responsible for getting an authorization number, If required, finding out how many sessions you have, and the amount of your deductible (If any) and your copay. Your copay will be collected at the beginning of each session.

Emergency Information
If you are having a crisis call 911 or go to the nearest hospital emergency room. If you need immediate phone assistance, call the San Diego Crisis Line (1-800-479-3339). If you are able to wait up to 24 hours for a return call from me, please leave me a detailed voice message, including a telephone number and the best times to return your call. When I am on vacation, you will be given the name and phone number of the psychologist taking calls in my place.

Client Consent to Psychotherapy
I have read this statement, had sufficient time to understand it or have my questions answered. I understand my rights and responsibilities as a patient, and my therapist's responsibilities to me. Further, I agree to be financially responsible for all professional services rendered.

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Signature of Patient/ Responsible Party Date

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Notice of Privacy Practices

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. I have prepared this explanation of how I am required by HIPAA to maintain the privacy of your health information and how I may use and disclose your health information. I may use and disclose your medical records for each of the following purposes only: 1) Treatment - which means providing, coordinating, or managing health care and related services by one or more health care provider (an example is a therapy session); and 2) Payment - which means obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review (an example is sending a bill for your visit to your insurance company for payment).

Healthcare operations include the business aspects of running a practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer services. I may also create and distribute de-identified health information by removing all references to individually identifiable information. I may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer: The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. I am, however, not required to agree to a requested restriction. If I do agree to a restriction, I must abide by it unless you agree in writing to remove it. The right to reasonable requests to receive confidential communications of protected health information from me may include: the right to inspect and copy your protected health information; the right to amend your protected health information; the right to receive an accounting of disclosures of protected health information; the right to obtain a paper copy of this notice from us upon request.

I am required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. I will post and you may request a written copy of the Notice of Privacy Practices from this office. You have recourse if you feel that our privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. I will not retaliate against you for filing a complaint. Please contact me for more information.

For more information about HIPAA or to file a complaint contact:

The U.S. Dept. of Health & Human Services, Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201

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Signature of Patient/ Responsible Party Date