Tamara Wade LCSW
Licensed Clinical Social Worker
800 Pollard Road
Suite B201
Los Gatos, CA. 95032
408.666.3512
twadelcsw@sbcglobal.net
twadetherapy.com

INTRODUCTION

Thank you for calling the office of Tamara Wade LCSW. I appreciate your interest in my services. This letter tells you about getting started with my evaluation and therapeutic services.

The more information I have before your visit, the better I can plan for your evaluation and treatment plan. The first step in this process is the completion of the enclosed application and questionnaires. Please return these forms to me at the above address as soon as possible so we may begin our arrangements. If your appointment is soon, you can bring these forms with you. If you decide to bring the forms with you, please arrive 15 minutes prior to your set appointment time.

Reports: It is important for me to have reports from other agencies you may have contacted regarding your concerns. All information and procedures related to services are confidential. Medical information from your physician and a complete psychiatric evaluation if you are taking medication, or planning on taking medication, from your psychiatrist will be needed. Please sign the enclosed "Authorization for Release of Information" form. You may make additional copies of this form as needed.

If you should have any questions regarding reports needed, please do not hesitate to phone me at (408) 666.3512.

Thank You and I look forward to working with you,

Tamara Wade LCSW

OFFICE POLICIES AND GENERAL INFORMATION AGREEMENT FOR THERAPY SERVICES

Confidentiality:
All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (parent/guardian) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the notice of privacy practices that you received with this form.

When disclosure is required by law:
Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; and where a patient presents a danger to self, to others, to property, or is gravely disabled.

When disclosure may be required:
Although confidential, if a child reports intent to harm themselves or someone else, or reports grave disability, I consider that to be important enough to act upon to ensure safety, which at the least includes alerting the parent/guardian. I consider significant drug or alcohol use as self-harm and may disclose this information to a minor's parents. Disclosure may be required pursuant to a legal proceeding. If you place your child's mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Ms. Wade. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Ms. Wade will use clinical judgment when revealing such information. Ms. Wade will not release records to any outside party unless so authorized to do so by all adult family members who were part of the treatment.

Emergencies:
If there is an emergency during our work together, where Ms. Wade becomes concerned about your child's personal safety, the possibility of your child injuring someone else, or about your child receiving proper psychiatric care, Ms. Wade will do whatever she can within the limits of the law to prevent your child from injuring him or herself or others and to ensure that your child receive the proper medical care. For this purpose, she may also contact the police, hospital, or the person whose name you have provided on the biographical sheet.

Health Insurance and Confidentiality of Records:
Disclosure of confidential information may be required by your health insurance carrier in order to process the claims. Only the minimum necessary information will be communicated to the carrier. Unless authorized by you explicitly, the psychotherapy notes will not be disclosed to your insurance carrier. Ms. Wade has no control or knowledge over what insurance companies do with the information you submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems

from the fact that mental health information is entered into insurance companies' computers and soon will also be reported to the Congress-approved National Medical Data Bank.

Litigation Limitation:
Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, **divorce and custody disputes**, injuries, lawsuits, etc.), neither parent/guardian nor your attorney, nor anyone else acting on your behalf will call on Ms. Wade to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Consultation:
Ms. Wade consults regularly with other professionals regarding her patients; however, the patient's name or other identifying information is never mentioned. The patient's identity remains completely anonymous, and confidentiality is fully maintained.

Telephone and emergency procedures:
If you need to contact Ms. Wade between sessions, please leave a message on her voicemail (408) 666.3512 and your call will be returned as soon as possible, typically within 24 hours. Ms. Wade checks her messages a few times a day. Ms. Wade checks her messages less frequently on weekends and holidays. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, you can call Ms. Wade at (408) 666.3512, the Police (911) or 24-hour Suicide and Crisis Service at (855) 278-4204.

Media Use Agreement:
There is an agreement that needs to be made between client and Ms. Wade regarding text messaging and email messaging. These tools are vital and necessary in order to enable and facilitate timely communication between you and Ms. Wade. However there are some limitations with these forms of communication. They are as follows: (1) When available I will respond to text and email messages during my normal business hours between 8:00 am to 7:00 pm Monday-Thursday and 8:00 am to 5:00 pm Friday. (2) It is **NOT** recommended that you text or email message Ms. Wade if you are in a crisis. Please use the Suicide and Crisis Service at (855) 278-4204, dial 911 or go to your local emergency room. (3) Information appropriate to send in this form of communication is limited treatment information or for scheduling purposes only. It is **NOT** recommended that you send any identifying client information, i.e. only use client initials and a brief summary of information needing to be imparted. If these communications become lengthy, it will be recommended that you schedule an in office session with Ms. Wade.

PLEASE NOTE: The office of Ms. Wade **does not** provide a 24-hour crisis service.

Payments and insurance reimbursement:
I have agreed to a set fee of $ 190.00 (individual. Please see services section for additional fees) . Payment in full at the time of service is required. I will provide you with a statement at the end of the month to submit to your insurance carrier for reimbursement upon request. Some insurance companies will not cover outpatient psychotherapy as these services are considered to be out of network. Therefore, it is your responsibility to contact your insurance company prior to

our initial appointment to inquire about reimbursement. Your estimated fees and a payment schedule were discussed during our initial phone interview. There will be a $25 fee for all returned checks. Standard fees may be raised on an annual basis. You will be notified in writing at least one-month prior to any changes in fees if they occur. At this time, a new contract will be signed.

Telephone conversations, site visits, report writing and reading, consultation with other professionals on your or your child's behalf, release of information, reading records, longer sessions, travel time, and so forth, will be charged at the same rate, unless indicated and agreed otherwise. Please notify Ms. Wade if any problem arises during the course of therapy regarding your ability to make timely payments.

The office of Ms. Wade will provide me with written notice regarding all unpaid fees and allow a reasonable amount of time for payment of those fees. If a mutually agreed upon arrangement cannot be made, and if payment is not received, a collection agency will be notified.

The process of therapy/evaluation:
In situations involving separation or divorce, authorization for consent for treatment and authorization for the release/exchange of information must be signed by both parents. Ms. Wade will make reasonable efforts to involve both parents in the treatment of the minor patient.

Participation in therapy can result in a number of benefits to your and/or your child, including resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Ms. Wade will ask for your feedback and views on you and/or your child's progress in therapy.

During the evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your child experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, and so forth, or experiencing anxiety, depression, insomnia, and so forth. Ms. Wade may challenge some of your and/or your child's assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause your child to feel upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you and/or your child into therapy in the first place may result in changes that were not originally intended. Therapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships etc. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. There is no guarantee that therapy will yield positive or intended results.

Discussion of treatment plan:
Within a reasonable period of time after the initiation of treatment, Ms. Wade will discuss with you her working understanding of your and/or your child's problem, treatment plan, therapeutic objectives, and view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your child's therapy, their possible risks, Ms. Wade's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your child's

condition and their risks and benefits. If you could benefit from any treatment that Ms. Wade does not provide, she has an ethical obligation to assist you in obtaining those treatments.

Medications:
Medications need to be prescribed by a psychiatrist or physician. A referral to a psychiatrist for an evaluation can be made if needed.

Termination:
Ms. Wade accepts patients into treatment in an effort to determine whether he or she can benefit from the services available. If, in the opinion of Ms. Wade, your child is not able to benefit, or Ms. Wade is not effective in helping your child reach their therapeutic goals, Ms. Wade is obliged to discuss it with you and, if appropriate, withdrawal will be recommended and other plans discussed. Parents/guardians have the right to terminate therapy at any time. If you choose to do so, Ms. Wade will offer to provide you with names of other qualified professionals whose services your child may benefit from.

Cancellation:
If you are unable to keep an appointment, please be sure to cancel at least **24-hours in advance**, or you will be charged my usual fee for that session. I can more easily fill time slots for everyone who would like appointments if I know of cancellations ahead of time. It is your responsibility to keep track of the appointments you have made. Most insurance companies do not reimburse for missed sessions.

I have read the above agreement and office policies and general information carefully. I understand them and agree to comply with them:

Signature (client/parent/guardian) Date

Signature (client/parent/guardian) Date
Date **10/7/19**

CLIENT DATA FORM

Patient's Name (last, first, middle)	Date of Birth	Primary contact number (client or guardian)
Complete Home Address		
Email (both parents if appropriate)	Cell Phone	Spouse/Other parent (or significant other)
Referred by (name)	Referred by (phone)	Relationship
Physician Name/Psychiatrist Name	(phone)	

Call in Emergency:

_____
_____
_____

(Name, address, phone #, and relationship to child. Please include all legal guardians to the minor)

(Others in Household)

Name	Relationship	Telephone	Age and Occupation
		(H): (C):	
		(H): (C):	
		(H): (C):	
		(H): (C):	
		(H): (C):	

Patient's Name: _____

Your Name: _____

1. Please describe in your own words the concerns or problems you wish to discuss in therapy:

2. How long has the problem(s) existed?

3. What ways have you tried in the past to handle this problem? Have you sought other help, and if so, with whom (therapist, psychiatrist, other)? Mental health diagnosis and or/medications?

4. How do you hope I can be of help?

AUTHORIZATION TO RELEASE INFORMATION

I, (parent/guardian/client) _____, hereby authorize Tamara Wade LCSW. (hereinafter "Provider") to exchange mental health treatment information and records obtained in the course of therapy of (patient)_____, including, but not limited to, this therapist's diagnosis of patient, to:

_____

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at **800 Pollard Rd. Ste. B 201, Los Gatos, CA 95032** to be effective.

This disclosure of information and records authorized by parent/guardian is required for the following purpose: _____

The specific uses and limitations of the types of medical information to be discussed are as follows:

_____

_____

This authorization shall remain valid until: _____

Signature: _____Date: _____
(*parent/guardian/client)

Signature: _____Date: _____
(*parent/guardian/client)

*Please have both parents and/or guardians sign this form, if the client is a minor. If the parents or guardians are separated or divorced, both signatures are required.

HIPAA 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. It is my legal duty to safeguard your protected health information (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this notice about my privacy procedures. This notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this notice. Please note that I reserve the right to change the terms of this notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this notice and post a new copy of it in my office. You may also request a copy of this notice from me, or you can view a copy of it in my office.

III. How I will use and disclose your PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent

I may 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. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI in order to coordinate your care.

2. **For health care operations:** I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control—I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. **To obtain payment for treatment:** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. **Other disclosures:** Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent

I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel, and/or in an administrative proceeding.

2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**

3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**

4. **If disclosure is compelled by the patient or the patient's representative pursuant to California health and safety codes or to corresponding federal statutes of regulations,** such as the privacy rule that requires this notice.

5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).

6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**

7. **If disclosure is mandated by the California Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.

8. **If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.

9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/ imminent threat of physical violence by you against a reasonably identifiable victim or victims.**

10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.

11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

12. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the president of the United States or assisting with intelligence operations.

13. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.

14. **For Workers' Compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.

15. **Appointment reminders and health-related benefits or services.** Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options or other health care services or benefits I offer.

16. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

17. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of HHS to investigate or assess my compliance with HIPAA regulations.

18. **If disclosure is otherwise specifically required by law.**

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object

I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization

In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. The rights you have regarding your PHI

A. The Right to See and Get Copies of Your PHI.

In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

If you ask for copies of your PHI, I will charge you not more than $0.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI

You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You

It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via e-mail instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

D. The Right to Get a List of the Disclosures I Have Made

You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, that is, those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, disclosures to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for 6 years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous 6 years (the first 6-year period being 2003–2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than 1 request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI

If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by E-mail

You have the right to get this notice by e-mail. You also have the right to request a paper copy of it.

V. How to complain about my privacy practices

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also 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 or by calling (202) 619-0257. If you file a complaint about my privacy practices, I will take no retaliatory action against you**.**

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 DHHS, please contact me at: 800 Pollard Rd. Ste. B 201, Los Gatos, CA 95032.

VII. Effective date of this notice

This notice is in effect as of April 14, 2003.

ADDENDUM: Please note that Tamara Wade LCSW provides privacy protection beyond these Federal requirements as outlined by the California Board of Behavioral Sciences. However, your notification of the above is required by Federal law.

Notice of Policy Practices
Receipt and Acknowledgement of Notice

I hereby acknowledge that I have been given an opportunity to read a copy of this Notice of Privacy Practices.

Patient Name: _____ Date: _____ Signature: _____
(if patient is adult)

Patient Name: _____ Date: _____ Signature: _____
(if patient is adult)

Patient Name (if minor): _____ Date: _____

Signature of parent/guardian: _____
(if patient is minor)

Patient Name: _____ Date: _____

Signature of parent/guardian: _____
(if patient is minor)

*Please note: If you are signing this as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

SECURITY NUMBER (CRV): _____

EXPIRATION DATE: _____

NAME ON CREDIT CARD: _____

BILLING ADDRESS: _____

PHONE NUMBER: _____