`For New Patients of Abby Holland Ph.D.

This packet contains several important documents and forms to fill out and sign. Please fill out and sign all sections indicated in yellow.

Directions to my office: My address is **3468 B Mt. Diablo Blvd. Suite 200, Lafayette, CA. 94549. Please remember to bring the suite number for your first visit as I am not listed individually on the outside directory.** I am located in Lafayette, Ca. off the Central Lafayette Exit of Highway 24, in the Corporate Terrace office complex near the intersection of Mt. Diablo Blvd. and 1st street, directly across Mt. Diablo Blvd. from Boswells and McDonalds. There is parking on both sides of the building and four designated patient parking spots marked Suite B200, B201, B300 and A200.
My suite - Suite B200 is on the second floor. Restroom codes are indicated inside the waiting room on the sign with office names and the restrooms are located by the elevators on all three floors. When you arrive, please turn on the light in the waiting room that corresponds to my name (#2). My phone number is 925-962-9089. My email is abbyholland@sbcglobal.net and my website is abbyhollandphd.com.

I	**Client Information Form**
II	**Medical Information Form**
III	**Psychotherapy Services Agreement**
IV	**Signature form for Notice of Privacy Practices**
V	**Notice of Privacy Practices**

Thank you for completing the paperwork and I look forward to meeting with you.

Abby Holland, Ph.D.

Client Information

For the office of
Dr. Abby Holland

Patient Information

_____

Last Name First Name MI

_____ (___)_____ (_ __)_____

Number Street Name Apt # Home Phone Cell Phone

_____ (___)_____ _____@_____

City State Zip Work Phone Email Address

_____ _____

Referred By: Date of Birth

Parent Name/s (if applicable)

Parent Phone / email

Medical Information

Date of Last Physical Exam:_____/_____/_____/

Please indicate any chronic medical conditions (please be specific)

_____

Name of physician/pediatrician_____

Physician Phone Number _____

Are you being treated for these or any other medical conditions? [yes] [no]

If yes, by whom? _____

Are you currently taking any medication(s)? [yes] [no]
If you are taking any medications, please indicate dosage, frequency, and prescribing physician name and phone number:_____

_____

Is there a family history of any chronic physical or psychological illness? [yes] [no]

If yes, please specify here:_____

_____

Any physical conditions that may effect your ability to participate in psychotherapy? Please specify here:_____
_____

Thank You

Abby Holland, Ph.D.
Licensed Psychologist
3468 Mt. Diablo Blvd., Suite B200
Lafayette, Ca 94549

Psychotherapy Services Agreement

Outpatient Services Contract:
Welcome to my practice. This packet contains two documents. The first document (THE AGREEMENT) contains important information about my professional services and business policies. The second document (THE NOTICE) summarizes the Federal Health Insurance Portability and Accountability Act (HIPPA) and explains your rights with regard to the use and disclosure of your Protected Health Information (PHI). The law requires that I obtain your signature acknowledging that I have provided you with this information by the end of our first session. When you sign this document it will represent an agreement between us which you can revoke at any time unless I have taken action in reliance on it or your health insurer requires be to substantiate claims in process; or if you have not fulfilled your financial obligations to me.

It is the responsibility of the patient to pay for services at the time of the appointment. Paperwork will be provided monthly for the patient to submit to insurance if requested. Payments can be made by cash, check or credit card. Treatment may be suspended or terminated if there are more than one months outstanding unpaid sessions. There may be a 4% fee added for the use of credit cards.

Psychological Services:
Psychotherapy can be a difficult as well as rewarding process. Since therapy often involves exploring unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, or helplessness. On the other hand therapy can often lead to better relationships, solutions to specific problems, and a reduction in feelings of distress. Because we will work toward your goals together, it is important that you inform me of any problems or difficulties that may arise for you.

Fees:
My standard fee is $190 per 50 minute individual session and $205 per 50 minute couples or family session. In addition, time spent on your case including consultation with other health care professionals, report writing, and telephone calls to or from you will be billed at the above rate in 15 minute increments. Any legal related activity will be billed at the rate of $350.00 per 60 minutes, which is higher than my standard rate for therapeutic services. You will be expected to pay at each session unless we agree otherwise and I will provide you with a monthly invoice if you so request..

Insurance Reimbursement:
If you have a health insurance policy, it will often provide some coverage for your treatment. I will provide you with the necessary paperwork to help you receive the benefits to which you are entitled, however, you (not the insurance company) are responsible for full payment of my fees. It is very important that you clarify what mental health services your insurance policy covers. **It should be understood that insurance companies and managed care organizations often require information about your treatment. You should be aware of what confidentiality you may have waived when you enrolled with them.**

PLEASE NOTE FOR CANCELLATIONS: A **24 hour** advance notification of cancellation is required to avoid charges for a missed session.

Please note that insurance companies do not provide reimbursement for late cancellations or missed appointments.

Confidentiality:

The law protects the privacy of communications between a client and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by state law and/or the Health Insurance Portability and Accountability Act (HIPAA). However there are some situations where I am permitted or required to disclose information without your consent or authorization. These exceptions include the following:
Disclosures required by health insurers or to collect overdue fees.
If your records are subpoenaed I may be required by law in specific instances to provide them.
If a patient files a complaint or lawsuit against me, I may disclose relevant information in order to protect myself.
If a client poses a serious threat to himself/herself, I may enlist family members or others in an effort to protect a potentially suicidal client.
If child abuse is suspected, (may include both past and present), including the use of underage pornography.
If dependent elder abuse is suspected.
If a client threatens to physically harm an identifiable victim(s). In this situation I am required by case law to inform any potential victims and the appropriate authorities so that protective measures can be taken.
Every effort will be made to fulfill this reporting requirement in a manner that is in the best interest of all involved.

Availability:

Sessions are by appointment only. You can email me at any time at **abbyholland@sbcglobal.net** or find me through my website at **abbyhollandphd.com**

For phone contact, clients can leave a confidential voicemail message at **925-962-9089**. I check my messages throughout the day Monday through Thursday and once a day on Friday, Saturday and Sunday.

For situations that require immediate assistance, please notify me and then call the Contra Costa Crisis Line at 1-800-833-2900. If you have a life-threatening emergency, call 911.

Therapist Background Information:

My educational and professional background information is available upon request or on my website at abbyhollandphd.com

I have read, understand, and agree to all of the above information, and give my permission to **Abby Holland, Ph.D.** to provide psychotherapy services to:

Myself_____ My minor child _____
print name here print name here

Myself_____
print name here

Signature_____ Date_____

Signature_____ Date_____

If a personal representative of the client (non- parent) signs the authorization, a description of the representative's authority to act for the patient must be provided.

_____

FOR THE OFFICE OF
Abby Holland Ph.D.

Your Signature Below Acknowledges That You Have Received The HIPPA Notice Of Privacy Practices included on the following pages.

SIGNATURE _____

DATE _____

PRINT NAME_____

THANK YOU

Therapist Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES

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

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice, PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office. You can also request a copy of this Notice from me, or you can view a copy of it in my office, which is located at 3468 Mt. Diablo Blvd., B201, Lafayette, CA. 94549.

III. HOW MAY I USE AND DISCLOSE YOU PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

For treatment. I can disclose your PHI to physicians, psychiatrists, psychologists, and any other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist in order to coordinate your care.

To obtain payment for treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

For health care operations. I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and other to make sure I complying with applicable laws.

Other disclosures. I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get you consent after treatment is rendered, or if I try to get your consent and you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

Certain Uses and Disclosures Do Not Require Your Consent. I can use and disclose your PHI without your consent or authorization for the following reasons:

When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement. For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.

For public health activities. For example, I may have to report information about you to the county coroner.

For health oversight activities. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a healthcare provider or organization.

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

To avoid harm. In order to avoid a serious threat to my health or safety of another person, I may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

For specific government functions. I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.

For workers' compensation purposes. I may provide PHI in order to comply with workers' compensation laws.

Appointment reminders and health related benefits or services. I may use PHI to provide appointment reminders or give you information about treatment alternative, or other health care services or benefits I offer.

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

Disclosures to family, friends, or others. I may provide your PHI to a family member,

other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III, A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

Your have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. Your have the right to ask that I limit how I use and disclose you PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

B. The Right to Choose How I send PHI to You. You have the right to ask that I send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. **The Right to Get a List of the Disclosures I Have Made.** You have a right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. 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 charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

E. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving you request. I may deny your request in writing if the PHI is (i) correct and complete (ii) not created by me (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have tie right to request a paper copy of it.

V. HOW TO COMPLAIN ABOUT MY PROVACY PRACTICES. If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave. S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

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 complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Dept. of Health and Human Services, please contact me at **Abby Holland, Ph.D. 3468 Mount Diablo Blvd Ste B201, Lafayette, CA 94549**

VII. EFFECTIVE DATE OF THIS NOTICE.

10/16/2016.