OWN YOUR
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CREDIT CARD CONSENT

I _____ authorize Heather Michelle Tydings, LCSW-C to keep my credit card information on file and to use this information to charge and pay for psychotherapy sessions. I understand that I will be notified by invoice of the amount and nature of each charge.

Heather Michelle Tydings, LCSW-C will not use your credit card information for anything other than payment for the services listed above. Heather Michelle Tydings, LCSW-C will not release the Credit Card information to anyone aside from the service providers allowing for the transaction to be completed. Your information will be kept in a secure location.

Type of Credit Card: Visa | Mastercard | Discover | American Express | Debit/Check Card

Credit Card Number

Expiration Date

Security Code (Last 3 Digits on back of card)

Pin Number (for check and debit cards only)

Address

Signature

Printed Name

Date

Clinicians Signature

Date

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OWN YOUR EVOLUTION

NOTICE OF PRIVACY PRACTICES

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

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NOTICE OF PRIVACY PRACTICES

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

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Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

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NOTICE OF PRIVACY PRACTICES

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing.

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

Right to an Accounting of Disclosures You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Request Confidential Communication You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

Breach Notification If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice You have the right to a copy of this notice.

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NOTICE OF PRIVACY PRACTICES

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257.

NOTICE OF PRIVACY PRACTICES

Receipt and Acknowledgment of Notice

Patient/ClientName:

Birthdate:

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Own Your Evolution, LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Heather Tydings-Goldfarb of Own Your Evolution, LLC.

Signature of Patient/Client

Date

Signature or Parent/Guardian/Personal Representative

Date

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

Patient/Client Refuses to Acknowledge Receipt:

Signature of Staff Member Date

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CONFIDENTIALITY AGREEMENT

Information exchanged within our sessions is confidential and will be protected. Information will be shared outside of our sessions only with your written consent or in the event that a court of law demands it. However, the following are instances where I would be obligated by law to break our confidentiality agreement without your permission:

- If it is assessed during your participation in coaching sessions that abuse or neglect of children or elders is occurring;
- If you threaten to kill or harm another individual and I am convinced that you will act on this threat, or that you may lose control of your actions;
- If at any time during the course of our sessions, I determine that you are a danger to yourself, I will inform you of that opinion and make every effort to keep you from endangering your life. In some cases this may include, but not be limited to, notifying the police, emergency personnel, any medical personnel listed above and/or family members.

Client Signature

Date

SHARED AGREEMENTS

Payment is due at the time of service. I accept credit card, cash or PayPal. There is a link on my website www.ownyourevolution.com or go to PayPal directly (using email ownyourevolution@gmail.com.)

- 50 minute sessions are billed at $175.00.
- A bill will be provided and client is responsible for seeking reimbursement through their insurance company.
- A full session fee will be charged for any missed or cancelled appointments with less than 24 hours notice. Inclement weather and true emergency's are exceptions.
- Lateness on the part of the client does not alter the session fee or ending time of the session. Lateness on the part of the therapist will always be made up.
- Fees may change in the future and clients will be notified 30 days in advance.

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INSURANCE

As a Licensed Clinical Social Worker, my professional services qualify for patient reimbursement under most insurance plans and are considered to be within the usual and customary range set by most insurance companies.

Although the choice to use your insurance for reimbursement of therapy is yours, please consider the following before making this decision:

- Insurance companies are designed to reimburse for the treatment of illness. Therefore, a psychiatric diagnosis is usually required before any reimbursement.
- Managed care companies control many facets of your therapy, including the medical necessity of care, the type of therapy they will cover, and the duration and pace of therapy.
- All insurance companies require some personal information in order to facilitate processing your claim. Once this information is transmitted to an insurance company, there is no way of to ensure that it will remain private and confidential.

Because I value confidentiality and believe that your therapy should be guided by you and not your insurance company, I do not participate in any managed care plans.

Please sign below to indicate that you have read and agree to the above, and will honor these shared agreements and agree to pay your fees for service.

Client Signature

Date

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INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

First and Last Name

Date

Name of Parent/Guardian (if under 18 years - first, last, middle initial)

Birth Date

Age

Gender

Date

Street Address

City

State

Zip Code

County

Home Phone

Cell/Other Phone

Email

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INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

May I email you? Yes ☐ No ☐

**Please note: email correspondence is not considered to be a confidential medium of communication.*

Referred by (if any) _____

Emergency contact and relationship to you _____

Marital Status: Never Married | Domestic Partnership | Married | Separated | Divorced | Widowed

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

☐ Yes, Please list: _____

Have you ever been prescribed psychiatric medication?

☐ Yes, Please list and provide dates: _____

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GENERAL AND MENTAL HEALTH INFO

1. Are you currently experiencing overwhelming sadness, grief, or depression? Yes ☐ No ☐

If yes, for approximately how long? _____

2. Are you currently experiencing anxiety, panic attacks, or have any phobias? _____

If yes, when did you begin experiencing this? _____

3. Do you drink alcohol more than once a week? Yes ☐ No ☐

4. Do you engage recreational drug use? If so, how often do you use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

7. What significant life changes or stressful events have you experienced recently?

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FAMILY MENTAL HEALTH HISTORY

Do you have a family history of mental health and/or substance abuse? If yes, please indicate the family member's relationship to you in the space provided.

ADDITIONAL INFORMATION

1. Are you currently employed? ☐ Yes ☐ No

If yes, what is your current employment situation?

2. Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

Feel free to describe your faith or belief:

3. What would you like to accomplish out of your time in therapy?

Client Signature _____ Date _____

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