DAVID E.DICKMAN, MSW, LICSW

Clinical Social Worker

19009 33rd Ave W, Ste 320 - Lynwood, WA 98036

(253)508-0108 - dedickman@msn.com

PATIENT INFORMATION FORM

Patient Name:________________________ Date of Birth:________________________

Address:________________________ Marital Status:________________________

____

________________________ Email Address:________________________

Insurance ID Number:________________________ Insurance Group Number:________________

Primary Care Physician:________________________ PCP Phone Number:________________

Insurance companies would like me to contact your physician, informing them of your participation in counseling.

Would you like me to do this? YES________ NO__________ Initials authorizing contact:______

Employer:________________________ Work Phone:________________________

Home Phone:________________________ Cell Phone:________________________

Insured's Name (if different):________________________ Insured's Date of Birth:________________

Insured's Address (if different):____

____

Emergency Contact:________________________ Emergency Phone Number:______________

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I understand that my insurance company will be billed for services received, and I hereby authorize the release of medical or other information necessary to process the claims. I hereby assign to my service provider all payment for services rendered for myself or my dependents. I understand that I am not responsible for any amount not covered by insurance that is not specifically disallowed under insurance benefits.

Patient or Authorized Person's Agreement:________________________ Date:______________

I hereby acknowledge receiving a copy of the "Telehealth Informed Consent" (page 2 of this document) "Notice of Privacy Practices" (pages 3-5 of this document) and "WA State Disclosure Statement" (p 6, 7, 8)

Signed: ____ Date: ____________________

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TELEHEALTH INFORMED CONSENT

I _________________________________ [name of patient] hereby consent to engaging in telemedicine with David E. Dickman, MSW, LICSW as part of my psychotherapy.

Patient's Preferred Email address for notifications: ____

Patient's Preferred Phone# for Text Invitation & Reminder: _______________________________________

Technology: I understand that I will need to have a broadband Internet connection or a smart phone with a good cellular connection

Financial Obligations: Fees associated with telemedicine appointments are identical to in person appointments. I agree to have my credit/debit card information on file with David E.Dickman, MSW, LICSW.

Clients using insurance: I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pocket costs may be. I authorize insurance benefits to be paid directly to David E.Dickman, MSW, LICSW and that David E.Dickman, MSW, LICSW may release any information to my insurance provider required for processing my claims. (Client Initial: ___________)

Self-Pay clients: I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telemedicine appointments in accordance with the current David E.Dickman, MSW, LICSW cancellation policy (24 hours notice required). (Client Initial: _________)

I understand that using the Telemedicine platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations.

Scheduling: I understand that scheduling is conducted exactly as before, and is based on my provider's normal business hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.

Video/Audio Recording: As a general practice David E.Dickman, MSW, LICSW DOES NOT record Telemedicine sessions.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is confidential according to the laws of the State of Washington. David E.Dickman, MSW, LICSW's Telemedicine platform is HIPAA compliant to protect my privacy and confidentiality. This is further explained in the Mental Health Informed Consent, which I have signed.

I also understand that in case of technology failure, I may contact David E.Dickman, MSW, LICSW via phone to coordinate alternative methods of treatment.

I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my counselor/therapist, that the transmission of my session could be disrupted or distorted by technical failures. In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services.

I have read and understand the information provided above. I have discussed it with my counselor/therapist, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this platform.

Client Signature ____Date _________

Client Guardian's Signature ____ Date _________

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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. State and Federal law protects the confidentiality of this information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Your rights regarding your PHI

You have the following rights regarding PHI that I maintain about you:

Right of Access to Inspect and Copy. You have the right, which may be restricted only in certain limited circumstances, to inspect and copy PHI that may be used to make decisions about your care. I may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. The original record will not change, but the amendment will be added.

Right to an Accounting of Disclosures. You have the right to request a copy of the required accounting of disclosures that I make of your PHI.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. I will accommodate reasonable requests and will not ask why you are making the request.

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

Right of Complaint. You have the right to file a complaint in writing with me or the Secretary of Health and Human Services if you believe that I have violated your privacy rights. I will not retaliate against you for filing a complaint.

My uses and disclosures of PHI for treatment, payment and health care operations

Treatment. Your PHI may be used and disclosed by me for the purposes of providing, coordinating, or managing your health care treatment and any related services. This may include coordination or management of your health care with a third party, consultation with other health care providers or referral to another provider for health care services.

Payment. I will not use your PHI to obtain payment for your health care services without your written 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.

Healthcare Operations. I may use or disclose, as needed, your PHI in order to support the business activities of my professional practice. Such disclosures could be to provide quality assurance (such as with managed care companies), financial services (if I chose to use a billing service) provided that I have a written contract requiring them to safeguard the privacy of your PHI. I may also contact you to inform you of treatment alternatives and/or health-related products or services that may be of interest to you.

Other uses and disclosures that do not require your authorization or opportunity to object

Required by Law. I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports and law enforcement reports. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Health Oversight. I may disclose PHI to a health oversight agency for activities authorized by law, such as professional licensure. Oversight agencies also include government agencies and organizations that provide financial assistance to me (such as third-party payors).

Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect of children or elders. However, the information I disclose is limited to only that information which is necessary to make the initial mandated report. I may disclose PHI regarding deceased patients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Research. I may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and an authorization or a waiver to the authorization requirement; (b) the researchers

establish protocols to ensure the privacy of your PHI; and (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations.
Threat to Health or Safety. I may disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety to the public or another person.

Criminal Activity on My Business Premises/Against Me and My Office Partners. I may disclose your PHI to law enforcement officials if you have committed a crime on my premises or against me or my office partners.

Compulsory Process. I will disclose your PHI if a court of competent jurisdiction issues an appropriate order. I will disclose your PHI if you and I have each been notified in writing at least 14 days in advance of a subpoena or other legal demand, and no protective order has been obtained, and I have satisfactory assurance that you have received notice of an opportunity to have limited or quashed the discovery demand.

Uses and disclosures of your PHI with your written authorization

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke this authorization in writing at any time, unless I have taken an action in reliance on the authorization of the use or disclosure you permitted, such as providing you with health care services for which I must submit subsequent claim(s) for payment.

This notice

This *Notice of Privacy Practices* describes how I may use and disclose your protected health information (PHI) in accordance with all applicable law. It also describes your rights regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this *Notice of Privacy Practices*. I reserve the right to change the terms of my *Notice of Privacy Practices* at any time. Any new *Notice of Privacy Practices* will be effective for all PHI that I maintain at that time. I will make available a revised *Notice of Privacy Practices* upon request, if the client is not currently active, or directly prior to a counseling session if they are active.

Contact information

I am my own Privacy Officer. So, if you have any questions about this *Notice of Privacy Practices*, please contact me. My contact information is listed on the top of the first page of this Notice.

Complaints

If you believe that I have violated your privacy rights, you may file a complaint in writing to me, as my own Privacy Officer, specified on the first page of this Notice. I will not retaliate against your for filing a complaint. You may also file a complaint with the U.S. Secretary of Health and Human Services.

The effective date of this Notice is April 14, 2003.

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WASHINGTON STATE LICENSE NUMBER: LW00004961

MY TREATMENT PHILOSOPHY:

I consider the counseling relationship to be a partnership in which one seeks an understanding of the problems that are affecting one's life, and learns of strategies that will help alleviate them. Sometimes problems are manifested in depression, anxiety, or other stress-related problems such as sleeplessness, tension and the inability to enjoy life, family and activities. Occasionally problems result in behaviors that CAN become addictive, such as alcohol and drugs, gambling, sexual acting our, spending or over-over-eating or working. Since this partnership is based upon trust and mutual respect, it is important for the client to meet a professional who can best address those problems, and has the experience to know how and when to help implement changes.

The therapy process can result in a number of benefits, including a better understanding of personal goals and values, improved interpersonal relationship, and the resolution of the specific concerns that led to the seeking of therapy. Working toward these benefits often requires significant effort, and can result in initial discomfort. Change will sometimes come easily and quickly, but often is slow and methodical, producing strong emotions of depression, fear, grief, etc., before the positive changes are realized.

The counseling relationship is only the beginning - the real work begins when the clients leaves the office and applies the knowledge, understanding and "tools" learned in therapy.

APPROACH TO TREATMENT:

I use a variety of counseling techniques, developed from my career in clinical social work. I provide individual therapy for clients 21 years of age and older. I work a great deal in the areas of chemical and other addictions, co-dependence and issues related to adult children from dysfunctional families. I also specialize in mental health areas such as anxiety and stress-related problems, depression and transitional problems, grief and bereavement, and have specialized training in the area of trauma and PTSD. I employ primarily reality and cognitive-behavioral therapy (CBT) in helping individuals work through their issues, as well as mindfulness, meditation, and relaxation for anxiety, stress and panic. I refer clients to homework which may include, reading, meetings or classes, CDs, writing, etc., and I employ specialized techniques such as Emotion Freedom Techniques (EFT) and Eye Movement Desensitization and Reprocessing (EMDR) specific to client needs. The first session is generally devoted to intake history so that I get a firm understanding of the presenting problems to help structure therapy to fit the client's needs.

EDUCATION AND EXPERIENCE:

I have a Master's Degree in Social Work (M.S.W.) from the University of Utah in 1973. Since that time I have been Executive Director of several chemical dependence program in both Wyoming and Oregon. I was also the Executive Director for the Washington State Chapter of the National Association of Social Workers for 8 years. I taught in the field of mental health and addictions at Seattle University for 8 years, and have presented workshops throughout the West Coast on a variety of human service issues. I have been in practice in this area since 1984.

FEE INFORMATION AND PAYMENT POLICIES:

Counseling sessions are generally 50-55 minutes in length, and the fee is $160.00. The initial interview is billed at a higher rate of $175.00. Collateral interview, report-writing and other support services are billed at the $130.00 rate. A fee is paid at the time of service unless otherwise arranged. Reasonable fees are charged for copying.

CANCELLATIONS/NO SHOWS:

The time that has been reserved for you cannot generally be filled if the cancellation is too late. I require that you cancel no later than 24 hours prior to the appointment time. Late cancellations and No Shows will be billed $100.00.

APPOINTMENT REMINDERS:

You will receive an appointment reminder text and phone message the day before your appointment.

CLIENT'S RIGHTS:

1. You have the right to know the content of your records at any time, and I have the responsibility to provide you with complete records OR a summary of their content.

2. I will release your records, upon request, to any person you designate but I require a signed "Release of Information" form that clearly identifies what information is to be released.

3. You have the right to a confidential relationship with me. I am bound by my professional ethics, the laws of the State of Washington, and the Federal HIPAA requirements (provided seperately) to protect client rights to confidential communication in regards to our participation in counseling. However, I am required by law to disclose certain legally defined information provided in the counseling session. This includes:

a. Active child abuse or neglect, including if an alleged perpetrator is still in contact with minors and there is a reasonable suspicion that they may still be abusing.

b. Active physical or sexual abuse of a dependent adult or elder.

c. Potentially suicidal behavior.

d. Serious threat of harm or death to another person. I am required to warn the intended victim and notify law enforcement.

e. If a Court of Law issues a subpoena.

4. You have the right to ask questions about any of the procedures used in the course of therapy.

5. You have the right to terminate therapy with me at any time without any financial or legal obligations other than those you have already incurred. I have the right to terminate therapy with you under the following conditions:

a. When I believe that therapy is no longer beneficial to you.

b. When I believe that another professional will better serve you.

c. When you have not paid for the last 2 sessions, unless we have made other arrangements.

d. When you have failed to show up for your last 2 sessions without 24 hour notice.

e. If I determine during the first 3 sessions that I cannot be of help, or your needs are outside of my scope of practice.

f. If you fail to cooperate with the agreed-upon treatment plan.

CONTRACTUAL OBLIGATIONS:

If you are using insurance I may be required to provide access to counseling information for the purpose of evaluating fulfillment of my contract with them, or to determine medical necessity.