



Linda S. Stead, LCSW

Estate Building, 10 Crater Lake Ave. Medford, OR 97504
Ph: 541-772-5993 Fax: 541-646-7969

REGISTRATION INFORMATION

Patient Name _____ Today's Date _____
Phone No. _____ Cell Phone _____ Other _____ Msg OK? _____
Mailing Address _____ City _____ State _____ ZIP _____
Social Security Number _____ Age _____ Date of Birth _____
Occupation _____ Employer _____ Work Phone _____
Marital Status: S ___ M ___ Sep ___ Div ___ W ___ Education _____
Spouse/Significant Other _____ Date of Birth _____
Spouse/Significant Other Employer _____ Work Phone _____
Emergency contact person _____ Relationship _____ Phone _____

MEDICAL HISTORY

Severe Illnesses _____
Surgeries _____
Accidents _____ Allergies _____
Current Medications _____
Previous Mental Health Care _____
Personal Physician _____ How were you referred to this office _____
Reason for visit today _____

OFFICE POLICIES

Please initial to show that you have read and understand the Office Policy Information provided _____

ASSIGNMENT AND RELEASE

I assign directly to Heartline Mental Health Practitioners all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize Heartline Mental Health Practitioners to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions.

I understand that I am financially responsible for all charges whether or not paid by insurance. I certify that the above information is true and accurate to the best of my knowledge.

Signature of Insured

Date

FOR UPDATE USE ONLY:

I have reviewed the above information. To the best of my knowledge, the above information is current and updated with changes.

Signature of Insured

Date

CONSENT TO USE OR DISCLOSE CLINICAL INFORMATION

I authorize Linda Stead, LCSW to use and disclose the health and clinical information of

_____ for the purpose of **Treatment, Payment and Health Care Operations**.
(Name of client)

- ❖ **Treatment** (includes activities performed by a practitioner, facility, program, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any practitioner who covers my/our practice by telephone as the on-call practitioner).
- ❖ **Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for clinical necessity, justification of charges, precertification and preauthorization).
- ❖ **Health Care Operations** (includes the necessary administrative and business functions of our office).

You may review Linda Stead, LCSW **“Notice of Privacy Practices”** for additional information about the uses and disclosures of information describe in the CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our **Notice** by placing your initials here:_____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the **Notice** may change also. A summary of the **Notice** will be posted in the lobby of our office indicating the effective date of the **Notice** in the upper right hand corner. We will offer you a copy of the **Notice** on your first visit to us after the effective date of the then current **Notice**. We will also provide you with a copy of the **Notice** upon your request.

As more fully explained in the **Notice**, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. **We are not required to agree to your request.** If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other practitioner/providers who provide call coverage for our office are required to use and disclose your protected health information consistent with the **Notice**.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that [name of practitioner/provider/practitioner/provider group] has already used or disclosed the information in reliance on this CONSENT.

_____ (or)
(Date) (Signature of client)

(Date) (Signature of person authorized by law)



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ETHICAL STANDARDS AND PRACTICES

The following answers some important and frequently asked questions concerning this practice. Please read the following information carefully and let us know if there is any part you do not understand.

I Treatment Philosophy

Psychotherapy has both benefits and risks. It also requires an investment of your time and energy in order to make the process of therapy most successful. It will begin with an evaluation of your needs. Next, I will develop and discuss a treatment plan in accordance with your goals and aims. Occasionally individuals may go through periods in therapy which may result in emotional discomfort, changes in their relationships, or temporary worsening of their symptoms. This should subside as the work progresses. Remember, you always retain the right to request changes in treatment or to refuse treatment at any time.

II Health Insurance

If you are using a health insurance benefit as payment for these services, you need to be aware of what this means. Your health plan requires cooperation between client, provider and insurance company to provide services as efficiently as possible.

Health insurance companies usually limit mental health coverage to:

1. Services that are determined "medically necessary". Medically necessary may be defined as presentation of a covered DSM IV Axis I diagnosis (these are acute symptoms).
2. Conditions that are able to be treated by short-term, problem-focused, goal-oriented approaches whenever possible.

This may mean your insurance company may cover a limited number of office sessions to work on your problem as intensely as possible with the focus of eliminating acute symptoms. I am contracted with insurance companies to provide these services within these conditions.

Many insurance companies review cases for quality assurance and preauthorization purposes. Your case may be reviewed by a utilization review/ quality assurance group set up by the insurance company. I will maintain, to the best of our ability, your confidentiality in this process.

III Office Policies

Please see separate page containing my office policies in detail.

IV Confidentiality

I abide by the laws and ethical principles that govern privilege and confidentiality. I will not disclose any information about you or your treatment without your written consent by way of signed release. There are some exceptions to this standard:

- It is legally required of me that I act so as to prevent physical harm to yourself or to others when there is “clear and imminent” danger of that happening.
- I am legally required to report cases of ongoing child, elder and disabled abuse.
- I may have to release clinical information regarding you to insurance carriers as required for payment or review of your claim.
- I may have to release your records when ordered to do so by court subpoena. However, I will discuss this with you beforehand and request written release from you if I judge this to be in your best in your best interest.
- On occasion, clinicians consult with colleagues about their work. If your case were ever discussed it would be confidential and without your name or identifying information.

V Release of Information

Please sign below to show that you have read and understand this information.

Signature

Date

Contract of Understanding Regarding Legal Matters and Subpoenas
Linda S. Stead, LCSW
Statement of Position

Therapy is relationship that is built on trust and compassion but balanced with honesty and neutrality. The goal is the healing of hurts and wounds of the heart and spirit. It is my belief that it is disruptive to the healing process of therapy when a therapist is asked to provide “opinion” or chart notes in regards to a client’s civil suits or disputes. What a therapist may be forced legally to say in front of a judge or to the attorney may not be information the therapist feels that the client is therapeutically ready to hear. The client may feel hurt and betrayed. Chart notes may be inaccurate and are certainly incomplete as a few sentences are written to encapsulate an entire session. Also, the demand of a subpoena for a therapist to drop everything and appear in court creates stress and upset for a therapist. All these things are damaging to the therapeutic relationship and to the underlying goal of facilitating healing and personal growth.

THEREFORE:

If you are currently involved in a legal issue and intend to use therapy as an adjunct to your legal defense or prosecution, be aware that I may terminate our professional relationship and you may be charged \$250 per hour for services required in relationship to the legal issue. Further, I will charge in the same way many attorneys do (by 10 minute increments) for these services. These fees will not be covered by your insurance and they will be due immediately rather than after the court decision.

If we are already engaged in the therapy process and you later make the decision to engage in a legal dispute in which you wish to use your therapy notes or my expertise as to the negative affects you have suffered in relation to the issue at hand, **PLEASE CONSULT WITH ME FIRST BEFORE YOUR ATTORNEY SERVES ME WITH A SUBPEOPNA**. Also be aware that you may be charged \$250 per hour for all legal related matters, including the time I use dealing with the server of that subpoena. These fees will not be covered by your insurance and they will be due immediately rather than after the uncertain court decision is made.

In the case of child custody and divorce, my stance is the same. Involving a child’s therapist in a court battle between parents may damage the child’s current therapy relationship but may also interfere with the child’s ability to trust any therapist or the therapeutic process for the foreseeable future. The above financial costs will apply as well.

I attest that I have read, understand and agree to the above conditions.

Signature

Date



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OFFICE POLICY INFORMATION

OFFICE HOURS: I currently am in the office Monday, Tuesday and Wednesday, 10 AM to 6:30 PM.

FINANCIAL POLICY: You will be asked to pay the portion of your visit that is not covered by your insurance. I bill primary and secondary insurances. If you do not have insurance, full payment is expected at the time of service; I accept cash, check or credit/debit cards. Please be sure we have accurate and up-to-date information. If you have any changes of address, phone, or insurance information please give me the update immediately.

INSURANCE: Your health insurance may or may not cover mental health care services. I am a member of several panels and networks. Please check with your insurance company to verify your outpatient mental health benefits; these may differ from your regular medical benefits. Check to see whether I am listed on your insurance company's mental health panel. Preauthorization is often required. Please familiarize yourself with your insurance requirements. Lack of pre-authorization may result in non-payment by your insurance company.

I bill insurance as a courtesy. However, I wish to stress that our contract for payment is with you, not the insurance company. Please understand that if there is a problem with payment from your insurance company you will still be required to pay your bill with me. I may be able to supply you with benefit information as quoted by your insurance company, but I still do not assume responsibility for the accuracy of this information. I do not guarantee payment from your insurance company. Please understand that I may not be able to calculate your portion of the bill correctly until your claim has been processed by your insurance company. I reserve the right to collect any unpaid amount from you.

APPOINTMENTS: You will always be seen as promptly as possible. Please check in with the receptionist when you first arrive, then have a seat in the waiting room. She will let me know that you are here. The office door is locked at 5 PM so if your appointment time is after 5 PM you can text me at (541)772-5993 to let me know you are here. To contact me at other times please call (541)772-5993 to leave me a voicemail. I prefer voicemail rather than text or email as I check it often. Once you are an established client I encourage you to use my online scheduling program to make or cancel appointments. It's easy and convenient. You can find that at www.schedulicity.com or go to very bottom of the Contact Me page of my website at www.lend-an-ear.com where you will find a link to Schedulicity.

CANCELLATIONS AND MISSED APPOINTMENTS: If you must cancel or change an appointment, please give me 24 hours notice, except in the case of an emergency. If you cancel giving less than 24 hours notice or do not show up for an appointment, you may be charged for the time reserved. Insurance will not pay for this charge.

EMERGENCY SERVICES: Outside my regular office hours, as an established client you may call me at (541)646-7959 if you are having a psychiatric emergency. Please do not text or email, as I may not get that communication in a timely way. Also note that appointment cancelations are not an emergency. Just leaving me a voicemail is sufficient.



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Effective Date: 12/01/2004

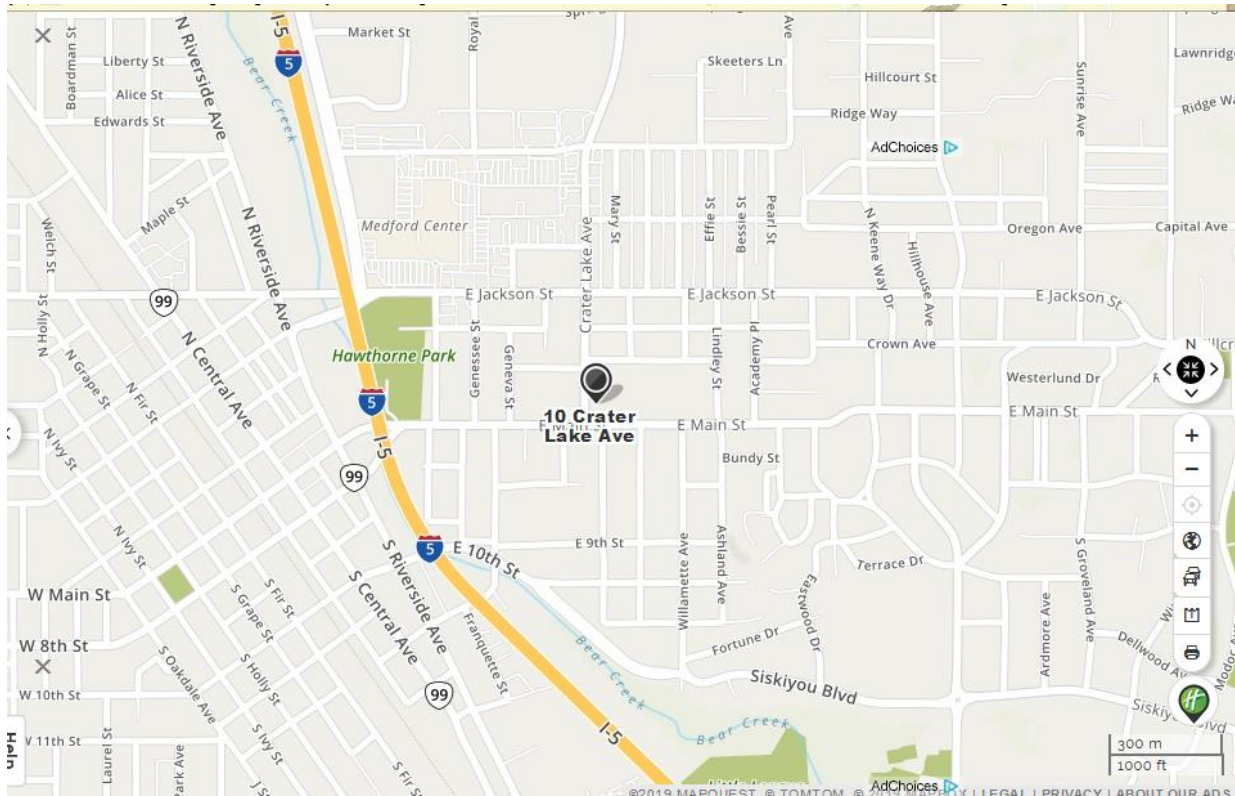
PATIENT PRIVACY NOTICE

I am committed to preserving the privacy of your personal health information. In fact, I am required by law to protect the privacy of your clinical information and to provide you with a notice describing:

HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION

- I am required by law to have your written consent before I use or disclose to others clinical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that I provide to you and the related administrative activities supporting your treatment.
- I may be required or permitted by certain laws to use and disclose your clinical information for other purposes without your consent or authorization.
- As my client, you have important rights relating to inspecting and copying your clinical information that I maintain, amending or correcting that information, obtaining an accounting of my disclosures of your clinical information, requesting that I communicate with you confidentially, requesting that I restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.
- I have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. I may revise our NOTICE from time to time. The effective date at the top right hand of this page indicates the date of the most current NOTICE in effect.
- You have the right to receive a copy of my most current NOTICE in effect. If you have not yet received a copy of my current NOTICE, please ask and I will provide you with a copy.
- If you have any questions, concerns or complaints about the NOTICE or your clinical information, please contact **Linda Stead, LCSW at 541-772-5993.**

DIRECTIONS TO
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From the South:

1. Come up Riverside Ave and turn right on 8th street. You will go under the underpass and come out on E. Main St. Turn left at the stop light onto Crater Lake Ave., then immediately turn right into the Estate Building parking lot.
2. Or you can come from the freeway via Highland continuing straight through the traffic circle, turn left onto E. Main, then right onto Crater Lake and immediately turn right into the parking lot of the Estate Building.

From the North:

1. Come down Central Ave and turn left on 8th street. That will take you under the underpass and you will come out on E. Main. Turn left at the stop light onto Crater Lake Ave., then immediately turn right into the Estate Building parking lot.
2. Option is to come via Crater Lake Ave heading south toward town. Just before the end of Crater Lake Ave. turn left into the parking lot of the Estate Building.