Dr. Jennifer L. Bearse, PsyD

800 Officers Row Suite D, Vancouver, WA 98661 (360) 603-9443

Dear Client,

Thank you for considering me as a resource at this time. I look forward to working with you, and I trust that you will experience a professional approach with an atmosphere of warmth and sensitivity to your situation and concerns.

In order to make the best use of our time together, please take time to read and fill out the following documents. I realize it may seem like a lot of information, but taking time to review and complete it now will help us make the best use of our time together and will help you be informed about the process and my policies.

1. INFORMED CONSENT AND OFFICE POLICIES: This document outlines my policies and the therapy agreement. If you agree to these terms, please sign and date the document. At your request, I will provide you with a copy after we review it in our first session.
2. HIPAA NOTICE OF PRIVACY PRACTICES: This describes the federal regulations regarding the use and disclosure of your health information. After reviewing this document, please sign and date the ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.
3. AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS: This document allows me to provide information to your insurance company in order to submit a claim for payment for my services. It also confirms your understanding that you are responsible for all charges not paid by your insurance company.
4. CLIENT INFORMATION FORM: This document will provide me with information that will help me better understand you and the circumstances that are causing you to seek services at this time. Please complete it as thoroughly as possible prior to our first appointment.

Please complete these documents and bring them to your first appointment, along with a copy of your insurance card and photo ID. If you are unsure about any of the information included in these documents, feel free to contact me by phone or email before your appointment, or we can discuss them at our first meeting. **Please read the Appointments and Insurance sections carefully** so you are not caught by surprise by unexpected charges in the event of a late cancellation or no show.

Again, thank you for entrusting me with your mental health care. I consider this to be a privilege, and I will do my best to make the therapy process as comfortable as possible while achieving the goals that you desire. With that in mind, I encourage you to take some time to consider what your goals for therapy are and what outcomes you hope to achieve. This will help ensure that we are working as collaboratively and efficiently as possible to achieve those outcomes.

I look forward to meeting you. Don't hesitate to contact me if you have any questions.

Sincerely,
Dr. Jennifer Bearse, PsyD

Dr. Jennifer L. Bearse, PsyD

800 Officers Row Suite D, Vancouver, WA 98661 (360) 603-9443

Informed Consent and Office Policies

Please read the following information carefully and initial after each section. If you have any questions, please wait to initial and sign this form and we can discuss it together. Your signature at the bottom of this sheet signifies you have read, understood, and agree to abide by these policies, and that you have received a copy of the policies for yourself.

Appointments: Your appointment time is held exclusively for you and cannot usually be filled on short notice. If you fail to keep an appointment, you will be charged for the time as though you attended. **Insurance companies do not absorb costs incurred for this reason,** so please keep track of your scheduled appointments as you will be responsible for this payment. For appointments canceled with less than 24 hours notice (not including weekends or major holidays) **we will charge $50, *no matter what the reason***. As for a missed appointment, insurance companies will not cover this charge, **so *you will be responsible for covering this fee in full***.

INITIAL HERE _____(Patient/and or responsible party)

Insurance: Your insurance policy is a contract between you and the insurance company. You are responsible to check with your insurance company regarding your coverage and to track this coverage as treatment progresses. Some things to keep in mind are: Are you currently covered? Is Dr. Bearse a provider whose services are paid under this plan? What is your annual deductible? What is the percent of coverage? What is the maximum benefit for outpatient mental health coverage? Remember: You are responsible for bills whether insurance pays or not. We will bill your insurance for our services and we will assist you with insurance issues and questions, but we cannot guarantee your benefits or the amounts covered, and we are not responsible for the collection of payments. In some cases, insurance companies may not consider some services reasonable or necessary and may not cover them. In such cases, the person responsible for payment must cover the cost of all services not covered by insurance companies or third party payers. In addition, the person responsible for payment is also responsible for costs not paid by insurance companies or third-party payers after 90 days.

INITIAL HERE _____(Patient/and or responsible party)

Fees: My rates are as follows: $300 for an initial evaluation, $250 for subsequent 55-minute sessions, $200 for 45-minute sessions, and $100 an hour for other professional services (telephone conversations, meetings/consultations with other professionals). Participation in legal proceedings are $300 an hour and $180 an hour for preparation and travel time. **Payment (or co-payment/coinsurance) by cash, check or credit card is expected at the time of the visit unless other arrangements have previously been made.** A $25.00 fee is applied for returned checks. These rates are subject to change.

INITIAL HERE _____(Patient/and or responsible party)

Billing: Unpaid balances may be turned over to an attorney or to a collection agency for collection and you will be held responsible for any legal or collection costs incurred.

INITIAL HERE _____(Patient/and or responsible party)

Medicaid: I am not a Medicaid provider. Because of that, Medicaid will not allow me to bill them for your claims, even with the intent of billing your secondary insurance. You have the choice to pay privately or find a Medicaid provider to serve you.

INITIAL HERE _____(Patient/and or responsible party)

Drugs and Alcohol: A client who attends an appointment under the influence of drugs and/or alcohol may not be seen. This will be treated as a missed appointment and billed accordingly.

INITIAL HERE _____(Patient/and or responsible party)

Phone Contact/Emergencies: I use a cellular phone as my primary business line and, therefore, cannot guarantee absolute privacy. This is also true of email correspondence. Messages can generally be left for me 24 hours a day, though messages left after business hours may not be checked until the following day. I will return phone calls as soon as possible, at a maximum within 48 hours. Please feel free to call again if you have not heard back from me in that timeframe. In the case of an emergency, call 911 or the Clark County Crisis Line at 360-696-9560, or go to your nearest emergency room.

INITIAL HERE _____(Patient/and or responsible party)

Confidentiality and the Release of Information: Your participation in treatment and all information about you is confidential and will not be disclosed to anyone without your written consent. The only exceptions are: a) cases of suspected abuse or neglect of a child or vulnerable adult, b) cases where I believe you present a clear and imminent danger to yourself or to another person, c) cases where a court subpoenas me to testify or subpoenas my records, d) cases of medical emergency, or e) cases where an insurance company is helping to pay your fee and requires information about diagnosis and/or reports about treatment.

INITIAL HERE _____(Patient/and or responsible party)

HIPAA Notice of Policies and Practices: We are committed to preserving the privacy of your personal health information. Additionally, we are required by Federal law (Health Insurance Portability and Accountability Act, known as HIPAA), and by State law to protect the privacy of your personal information and to offer you a Notice that describes (a) how clinical information about you may be used and disclosed and (b) how you can get access to this information. Please ask for a copy of the *HIPAA Notice of Policies and Practices* should you wish to have a complete copy for your records.

INITIAL HERE _____(Patient/and or responsible party)

Patient Consent to Treatment: Your signature below indicates that you have read this agreement and agree to its terms. You consent to the use of a diagnosis in billing, and to the release of that information and other information necessary to complete the billing process. You agree to pay the stated fees. Your signature also serves as an acknowledgment that you have received the *HIPAA Notice of Policies and Practices* described above.

_____ _____

Signature Date

_____

Please print patient name

_____ _____

Signature of financially responsible party if not patient Date

_____

Please print your name and relationship to patient

Dr. Jennifer L. Bearse, PsyD
800 Officers Row Suite D, Vancouver, Washington 98661
(Revised 8/2013)

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical and psychological information about you may be used and disclosed, and how you can get access to this information.

I am required by federal and state law to maintain the privacy of your health information, and to provide you with a description of our privacy practices. This notice will tell you how your provider will use medical information here in this office, when and how it can be shared with other professionals and organizations, and how you can see it. If you have any questions, I will be happy to help you understand our procedures and your rights.

I. What Is Protected Health Information?

Protected health information (PHI) is information in your treatment record that identifies you (i.e. name, date of birth, etc.). Each time you visit me, information is collected about you and your health, and recorded in your health care records. PHI is likely to include information such as your personal history, reasons for coming to treatment, your diagnoses and treatment plan, progress notes for each session, records or reports from other providers or agencies who have treated or evaluated you, psychological test scores, information about medications you took or are taking, and billing and insurance information.

II. Privacy And The Laws About Privacy

I am required to tell you about privacy because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires me to protect the privacy of your PHI, to tell you about your rights and my legal duties in regard to your PHI, and to tell you about our privacy practices. I am obligated to obey the rules described in the most current version of this notice.

III. Uses And Disclosures With Your Consent

I may use and disclose PHI for purposes of treatment, payment, and health care operations. “Use” applies to activities within my office that help to manage the services I provide. “Disclosure” applies to activities outside the office, such as releasing, transferring, or providing access to other individuals or organizations. “Consent” refers to your agreement to the policies described in this document, which you indicate through your signature on the “Acknowledgment of Receipt of Notice of Privacy Practices.”

Treatment. I will use your medical information to provide you with psychological treatments or services such as individual, family, or group therapy; psychological or educational testing; treatment planning; or measuring the benefits of services provided. I may share your PHI with others who provide treatment to you, such as your physician, or if/when I refer you to other healthcare professionals. I may also receive PHI from other healthcare professionals involved in your care, which will go into your records here.

Payment. I may use your information to bill you, your insurance, or others, so that I can be paid for the treatments provided to you. I may contact your insurance company to find out what services your insurance plan covers. I may have to tell your insurance company about your diagnoses, the treatments you have received, treatment plan, and your progress in order to be reimbursed for my services.

Healthcare operations. I may use your PHI for activities related to the performance, operation, and maintenance of the practice, such as quality assessments, business-related matters such as audits and administrative services, and for case management or care coordination. For example, I may hire a billing service to submit bills to insurance companies. Under the law, providers of such services are called “business associates.” To protect your privacy, any business associates will agree to safeguard your information, and they will receive only the PHI required to do their job. I may also use and disclose PHI to schedule appointments with you or to provide you with appointment reminders.

IV. Uses And Disclosures That Require Your Authorization
I may use and disclose your PHI for purposes outside of treatment, payment, and healthcare operations with your written authorization. An authorization is specific, written permission above and beyond general consent. When information is disclosed for purposes other than treatment, payment, and healthcare operations, such as consulting with a child's teacher, I will obtain an authorization form from you before releasing the information. You may cancel your authorization in writing at any time. I would then stop using or disclosing your information for that purpose. Of course, I cannot take back any information already disclosed or used with your permission.

V. Uses And Disclosures That Do Not Require Your Consent Or Authorization
I may use or disclose your PHI without your consent or authorization under circumstances such as those described below. If any of these situations arise, I will attempt to discuss it with you before taking action, and will disclose only necessary information.

Abuse or neglect: If I have reasonable cause to believe that a child, elderly person, or other vulnerable adult has been abused, exploited, or neglected, I am required to report my suspicion to law enforcement and to the Department of Social and Health Services.

Legal proceedings: If you are involved in a lawsuit or legal proceeding, and I receive a subpoena, discovery request, or other lawful process, I may have to release PHI.

Law enforcement: I may be required to release information to law enforcement officials.

Government oversight: As a health care provider, I am subject to oversight by federal and state agencies. If a government agency makes a lawful request, I may be required to disclose PHI as part of audits, inspections, or investigations.

Veterans and military personnel: I may be required to disclose PHI of current or past members of the armed forces, security, or intelligence services to government authorities, or to benefit programs relating to eligibility and enrollment.

Worker's compensation: I may be required to disclose PHI to workers' compensation and disability programs to the extent necessary to comply with laws relating to programs that provide benefits for work-related injuries or illness.

Threat to safety: I may use or disclose PHI if I believe it is necessary to prevent a serious threat to you or to someone else.

Medical emergency: In the event of a medical emergency or involuntary commitment, I may disclose PHI to facilitate treatment.

Healthcare providers: As a result of state regulations adopted by the Washington State Department of Health, I am required to report another healthcare provider in the event of a final determination of unprofessional conduct, a determination of risk to patient safety due to a mental or physical condition, or if I have actual knowledge of unprofessional conduct by another licensed provider. *Note: If you yourself are a healthcare provider, and we believe that your behavior is a clear and present danger to your patients or clients, I am also required to report you.*

VI. Your Rights Concerning Your Health Information
HIPAA provides you with the following rights regarding your clinical record and disclosures of your PHI. Requests must be made in writing.

Right to request restrictions: You have the right to ask me to limit the use and disclosure of your PHI. Although I am not required to agree to a restriction you request, if I do agree, I will honor the request except when it is against the law, in

an emergency situation, or when the information is necessary to treat you.

Right to confidential communications: You have the right to ask me to communicate with you about your health and related issues in a particular way, or at a certain place that is more private for you. For example, you can ask me to call you to schedule appointments at home, rather than at work, or to send mail to someplace other than your home address.

Right to inspect records: You have the right to look at the health information I have about you, such as your medical and billing records. You can get a copy of these records, but I may charge you for postage and a state-determined rate for copying. I may deny access to PHI under some circumstances. If I do so, I will explain any options you may have for a review of that decision.

Right to amend: If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation. This request must be made in writing, and include the reasons you want to make the changes. If I do not approve your request, I will tell you why, and explain any right you may have to file a written statement of disagreement.

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

Right to an accounting: You have the right to request an accounting of disclosures of PHI to which you did not consent or provide authorization. I am not required to account for disclosures of PHI for treatment, payment, or healthcare operations, or for which you provided consent or authorization.

VII. If You Have Questions Or Problems

If you need more information or have questions about the privacy practices described above, please speak to me. If you have concerns about how your PHI has been handled, or if you believe your privacy rights have been violated, please contact me immediately so I can address your concerns together with you. If this does not resolve your concerns, you have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services. I can provide you with the form for the complaint. Filing a complaint will not limit your care here, and I will not take any actions against you if you complain.

Complaints may be filed with:

Health and Human Services Region 10 – Seattle (Alaska, Idaho, Oregon, Washington)
U.S. Department of Health and Human Services
2201 Sixth Avenue - M/S: RX-11
Seattle, WA 98121-1831
Voice Phone - (206)615-2010 FAX - (206)615-2087 TDD - (206)615-2296

VIII. Effective Date, Restrictions, And Changes To Privacy Practices

The effective date of this notice is July 18, 2011. I can reserve the right to change the terms of this notice. All changes will be consistent with state and federal law. The revised notice will be effective for all PHI that I maintain, including for PHI collected previously. I am not obligated to tell you when the notice changes, but will post the revised notice in the front office. You are entitled to request a paper copy of the current notice at any time.

Dr. Jennifer L. Bearse, PsyD
800 Officers Row, Suite D
Vancouver, Washington 98661

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your signature below acknowledges that:

1. You have had an opportunity to review and ask questions about the Notice of Privacy Practices, and have been offered a paper copy.
2. You agree that protected health information (PHI) may be used and disclosed by Jennifer L. Bearse, PsyD to conduct treatment, payment, and health care operations as described in the Notice of Privacy Practices.

Printed Patient Name	Date Of Birth
Patient Signature (if patient is age 14 or older)	Date
Printed Name Of Parent/Legal Guardian	Relationship To The Patient
Parent/Legal Guardian Signature (if patient is a minor)	Date

FOR OFFICE USE ONLY

I, Dr. Jennifer L. Bearse, PsyD, have attempted to obtain written acknowledgment of receipt of the Notice of Privacy Practices from the client named above, but acknowledgment could not be obtained because:

_____ The client or personal representative refused to sign
_____ Communication barriers prohibited obtaining the acknowledgment
_____ An emergency situation prevented us from obtaining acknowledgment
_____ Other (specified below)

_____

_____

Jennifer L. Bearse, PsyD	Date

****

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Jennifer L. Bearse, PsyD to:

- Furnish my insurance company with any/all information requested concerning my present claim(s).
- Bill my insurance company and accept payment from that company on my behalf for all services relating to my case.

I acknowledge that I am responsible for all charges not covered by my insurance. **I agree that if costs or fees are incurred in connection with the collection of this account, I will pay all such costs and fees, including, but not limited to, collection costs, attorney's fees and all court costs.** I understand that failure to resolve any outstanding balance may result in my account being referred to a collection agency if it remains delinquent without a response from me.

NOTICE OF INFORMATION PRACTICES

Notice: We keep a record of the health-care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it from our office staff. The fees for copying records, searching for records or editing records are as follows:

Copying	$1.00 per page for the first 30 pages
	$0.75 for each additional page
Scanning	$0.10 per page
Searching	$15.00 per search

All copies will be released upon receipt of payment.

_____ _____

Patient's signature (if 18 or older) Date

_____

Print Name

_____ _____

Responsible Party signature (if for a minor) Date

_____

Print Name

Dr. Jennifer L. Bearse, PsyD

800 Officers Row Suite D, Vancouver, WA 98661 (360) 603-9443

Client Information Form

Today's date: _____

Patient's name: _____

Date of birth: _____ Age: _____ Social Security Number: _____

Gender: Female Male Transgender Non-binary Other _____

Cultural/Ethnic group:_____ Marital/Relationship Status:_____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Cell phone: _____ Home Phone_____

Okay to leave message? _____Yes _____No

Email: _____

Referred by: _____

INSURANCE INFORMATION

Company: _____ Phone: _____

Address:_____

City, State, Zip:_____

ID Number: _____ Group Number: _____

Primary Insured: _____

Primary Insured DOB:_____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____

Primary Phone: _____Secondary Phone: _____

FAMILY and RELATIONSHIP HISTORY

FAMILY OF ORIGIN:

Please list the members of your family of origin (**parents, siblings, other**, use back if more space is needed):

Name	Relationship	Age	Occupation	Lives with you?

Is there any family history of:

___Depression ___Anxiety ___Dementia ___Attention deficit/hyperactivity disorder
___Alcohol abuse ___Drug abuse ___Schizophrenia ___ Bipolar/Manic Depressive Disorder
___Imprisonment ___Suicide ___Eating disorders ___Obsessive/Compulsive Disorder
___ Sexual Abuse ___Borderline PD ___Dissociative Identity Disorder
___Other mental health issues:_____

Are there any special circumstances related to your childhood (adoption, separation, divorce, homelessness, etc.)?

Were you raised with any particular religious or cultural beliefs?

What are your current relationships like with your family of origin?

CURRENT FAMILY:

Please list members of your current/immediate family (**spouse, partner, children, chosen family, other**, use back if more space is needed):

Name	Relationship	Age	Occupation	Lives with you?

How would you describe your social and relationship history (introvert, extrovert, sporadic, stable, etc)?

Who do you consider to be your primary social supports right now?

Have you experienced any of the following types of trauma or circumstances?

___Neglect ___Emotional abuse ___Physical abuse
___Sexual abuse ___Loss of a loved one ___Natural disaster
___Teenage pregnancy ___Parental substance abuse ___Victim of assault
___Sex trafficking ___Parents separated or divorced ___Victim of hate crime
___Unwanted pregnancy ___Lived in foster home ___Homelessness
___Multiple family moves ___Violence in the home ___Terrorism
___School bullying ___Financial problems ___Refugee/immigration trauma
___Parental illness ___Other:_____

EDUCATION

Highest level of education: _____ Current school: _____

Location:_____

EMPLOYMENT

Employer: _____ Occupation: _____

Address: _____ Phone: _____

Describe any relevant work or school issues:

MILITARY EXPERIENCE (if applicable)

Branch of service:_____ Date enlisted/drafted:_____

Discharge date:_____ Type of discharge:_____ Rank at discharge:_____

Combat experience: _____Yes _____No Wounded in Action: _____Yes _____No

LEGAL

Are you involved in any legal activities (civil, criminal, custody, probation/parole, etc.)? Please describe, use back if more space is needed:

_____

History of felony/misdemeanor charges?

_____

DUII/DWI, etc.:_____

MEDICAL INFORMATION

Physician's name: _____ Phone: _____

Address:_____

Date of most recent medical examination/procedure:

_____

Do you have a history of any of the following medical conditions?

___A serious accident	___Surgery	___Allergies
___A head injury	___Meningitis	___Hospitalizations
___High fevers	___Hearing problems	___Headaches
___Vision problems	___Asthma	___Loss of consciousness
___Ear infections	___High blood pressure	___Miscarriage
___Stomach aches	___Diabetes	___Pregnancy/childbirth complications
___Abortion	___Chronic pain	___Sexually transmitted disease
___Cancer	___Heart problems	___Speech/language problems
___Seizures	___Thyroid problems	___Other _____

Please describe any checked items, noting your age at the time of onset:

Do you experience any serious concentration or memory problems?

Current Medications: ____ None

Prescribed Medications	**Dosage**	**Date First Prescribed**	**Prescribed by**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current over-the-counter medications and supplements: (please include vitamins, herbal remedies, etc.)

Allergies and/or adverse reactions to medications

Are you currently on or do you plan to apply for disability?

CHEMICAL USE HISTORY

Substance Type	**Current Use** (within the last 6 months)				**Past Use**			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Hallucinogens								
Heroin/opiates								
Methamphetamines								
Inhalants								
Other								

Have you ever had withdrawal symptoms when trying to stop using any substances? ___Yes ___No

If Yes, please describe:

PREVIOUS MENTAL HEALTH TREATMENT:

Type of Treatment	Yes	No	Start/End Dates	Provider Name/Reason for Treatment
Counseling or Psychiatric Care				
Drug/Alcohol Treatment				
Medication for mental health problems				
Psychiatric Hospitalization				
Self-Help/Support Group				

Are you currently experiencing suicidal thoughts? _____ Yes _____No

Do you have any history of suicidal thoughts or attempts? _____ Yes _____No

If Yes, when?_____ By what method?_____

Are you currently engaging in or have you recently engaged in self-harm (cutting, burning, picking, etc)?

_____ Yes _____ No

Do you have any other history of self-harm? _____ Yes _____ No

If yes, please describe:

Have you ever purposely hurt someone else? _____Yes _____No

If yes, how and when?

Please check behaviors and symptoms that occur to you more often than you would like:

___Aggression/fighting
___Alcohol abuse
___Anger
___Arguments/conflicts
___Anxiety
___Avoiding people
___Body image concerns
___Chest pain
___Computer addiction
___Disorganized thoughts
___Depression/Sadness
___Disorientation
___Distractibility
___Dizziness
___Drug abuse
___Dysregulated eating
___Elevated mood
___Excessive sweating
___Fatigue
___Frequent illness
___Gambling
___Hallucinations
___Headaches
___Heart palpitations
___High blood pressure
___Hopelessness
___Impulsivity
___Intrusive thoughts
___Irritability
___Isolation
___Judgment errors
___Loneliness
___Low Energy
___Low Self Esteem
___Memory impairment
___Mood swings
___Muscle Tension
___Nervousness
___Nightmares
___Panic attacks
___Perfectionism
___Phobias/fears
___Physical Pain
___Poor concentration
___Recurring thoughts
___Poor judgment
___Sexual addiction
___Sexual difficulties
___Sleeping problem
___Speech problems
___Stress
___Suicidal thoughts
___Trembling
___Violent behavior
___Weight change
___Withdrawing
___Work difficulties
___Worrying
___Worthlessness

___Other (specify): _____

TODAY'S VISIT

Please describe what brought you here today:

_____

_____

_____

What are your goals for therapy?_____

_____

_____

_____

Is there any other information you feel I should know before the intake?