Lisa Hanusch, PhD

Licensed Psychologist #34393

Phone: 512.814.5472 - www.LisaHanuschPhD.com - **Email**: Lisa@lisahanuschphd.com

INFORMATION AND CONSENT STATEMENT

This form is to help define the terms of our relationship and to obtain information from you that will assist me as we go forward.

QUALIFICATIONS

I have a PhD in Clinical Psychology from the University of Tulsa. I am licensed by the Texas State Board of Examiner's of Psychologists (License # 34393).

NATURE OF COUNSELING

My services to you will be professional and ethical as defined by the Texas State Board. My desire as a Psychologist is to cultivate a warm, safe, open and rigorously honest relationship in which to process the nature of your presenting issues and to share with you my professional opinions regarding your situation. My intent is to help you - either individually - or as a couple - to get unstuck and to move forward.

If, for some reason, you believe I have not complied with the ethical and professional guidelines of my profession, the following contact information is available to you.

Texas State Board of Examiners of Psychologists
333 Guadalupe
Tower 2, Room 450
Austin, TX 78701
1-800-821-3205 (24 hr number)
www.tsbep.state.tx.us

CONFIDENTIALITY

Discussions between you and I are confidential. No information will be released without your written consent unless mandated by law. **Possible exceptions** to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is an issue; situations where I have a duty to disclose, or where, in my best judgment, it is necessary to warn or disclose; fee disputes between myself and you; a negligence suit brought by you against me; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to my attention when you and discuss this matter further. By signing this Information and Consent Form, you are giving consent to me to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding myself harmless from any departure from your right of confidentiality that may result.

ELECTRONIC COMMUNICATION

Email and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through their systems. And faxes can easily be sent erroneously to the wrong number/address. Please notify me if you decide to avoid or limit the use of email/fax communication. In addition, please do not use email or faxes for emergencies.

FINANCIAL POLICY AND FEES

50 minute individual session	$200
50 minute couples session	$250

If you wish to seek reimbursement for my services from your health insurance company, I will be happy to provide you with an invoice with diagnosis information needed to submit to your insurance company. All reimbursements from the insurance company should be sent directly to you. Please do not assign any insurance payments to me.

Health insurance companies require that I diagnose and disclose your mental health condition to them in accordance with DSM V standards of diagnosis. Any diagnosis made will become part of your permanent insurance records. Please speak with me regarding any specific questions concerning this.

CANCELLATION POLICY

In the event that you will not be able to keep your appointment, please notify me at 512-814-5472 24 hours in advance of your appointment. If I do not receive such advance notice, you will be responsible for paying the full fee of the session you missed.

EMERGENCIES

I ask you to agree to the following regarding crisis type emergencies. In the event of a crisis that you feel you are unable to handle alone please do the following:

1. Contact a trusted friend or family member for assistance. If you are unable to contact them or need additional support, you will:
2. Contact my number at 512.814.5472 and leave a clear message that you have an emergency. If you are unable to reach me in a timely manner, you will:
3. Call the Austin Help Line at 512-472-4357. If you are still in need of assistance you contact Seton Hospital at Shoal Creek at 512-324-2000; or Austin Lakes Hospital at 512-544-5253; or go to your nearest emergency room.

I have read and understand the information presented thus far to me.

Print Client Name Date

Client Signature Date
(or signature of legally responsible adult if client is minor)

CONFIDENTIAL BACKGROUND QUESTIONNAIRE

Client's name: Age

Address:

Contact Phone Numbers: (Home/Work/Mobile)

Email Address:

Sex: M _____ F _____ Date of Birth: _____ Occupation_____:

Date of Initial Appointment: Referred by:

Presenting Problem Areas

(Please check all that are all applicable to you):

Self Esteem		Drug or Alcohol Abuse	
Relationships		Eating Disorder	
Financial		Depression	
Marital		Anxiety	
Health		Trauma	
Spiritual		Grief	
Sexual		Family or kids	

CONFIDENTIAL BACKGROUND QUESTIONNAIRE (continued):

In your own words describe why you are seeking counseling:

Describe briefly the history of your main problem(s) from onset to the present:

Social/Educational History:

Single	Dating	Married	Divorced

If married, how long? Your age when married? If divorced, date

Children / Ages

CONFIDENTIAL BACKGROUND QUESTIONNAIRE (continued):

Others currently residing in your household:

Present Employment:

Spouses Employment:

Highest Educational Grade Completed:

College Degree? What In? Year? From?

Religious Denomination (now): In childhood:

Current Local Church affiliation:

I would describe my spiritual life now as:

HEALTH HISTORY

Your current physical health: very good ____ good ____ average ____ poor ____

When was your last complete physical exam?

Findings:

Known medical problems:

What prescription or non-prescription medications are you taking currently, in what dosages, and for what reasons?

Any recent or ongoing sleep or appetite changes or difficulties:

Previous psychotherapy or counseling:

From:	To:	where/who:

Problem/Reason:

From:	To:	where/who:

Problem/Reason:

From:	To:	where/who:

Problem/Reason:

Other information or comments you may think helpful:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW
PSYCHOLOGICAL AND HEALTH INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO IT,

PLEASE REVIEW IT CAREFULLY.
YOUR PRIVACY IS IMPORTANT.

OUR COMMITMENT TO YOU AND YOUR PRIVACY

I understand that it is sometimes frightening to be asked to sign something that might seem only loosely understandable to you, and that is why I wanted to take a moment and explain the purpose of the new Federal HIPAA legislation and how it applies to you. HIPAA stands for the Health Insurance Portability and Accountability Act, and it was passed because of concerns about the handling of confidential health information in an age of electronic records and rapid information sharing. I want you to understand that I take your privacy very seriously, as well as my obligation to safeguard your protected health information (PHI). It is therefore very important to me that you understand my policies and legal requirements as well as your own rights and options. With this in mind, what follows is a description of my disclosure policies, an explanation of my duties to you, as well as an account of your rights under the law.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I may use or disclose your protected health information (PHI), for treatment, payment, and health care purposes with your consent.

- PHI: Refers to information in your health record that could identify you.
- Treatment: I may use or disclose your health information to a physician or therapist providing treatment to you.
- Payment: I may use or disclose your health information to obtain payment for services I provide to you.
- Health Care Operations: I may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, business related matters such as audits and administrative services, case management and care coordination.
- Use: Refers to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- Disclosure: Refers to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your authorization is obtained. Authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I have requests for information for purposes outside of treatment, payment and health care operations, I will obtain authorization before releasing information. I also will obtain authorization before releasing psychotherapy notes. Psychotherapy notes are notes that are we write during private, group, joint, or family counseling sessions. These notes have a greater legal protection than PHI.

As a client, you may revoke all authorizations (PHI and psychotherapy notes) at any time, provided that each revocation is in writing. You may not revoke authorization if the authorization has already been obtained and acted on or if authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

I may use or disclose PHI without your consent or authorization in the following circumstances, as required by law:

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I am required to report it within 48 hours to the proper authorities.
- **Elderly or Disabled Person Abuse:** If I have cause to believe that an elderly or disabled person has been, or may be abused, neglected, or exploited, I are required to report it to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against us with the State Board of Examiners of Social Work, they have the authority to subpoena confidential mental health information that is relevant to the complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If I determine that there is a probability of physical injury by you to yourself or others, or that there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.

CLIENT'S RIGHTS AND THERAPISTS' DUTIES

Client's Rights:

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a requested restriction.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may want to keep it confidential that you are seeing a therapist. Upon your written request, your bills may be sent to an alternative address).
- Right to Inspect and Copy: You have the right to inspect a copy of your PHI. Psychotherapy notes that are kept separate from PHI are protected.
- Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. The request may be denied, but the details of the amendment process will be discussed.
- Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization. Upon request, details of the accounting process will be discussed.
- Right to a Paper Copy: You have the right to obtain a paper copy of this notice.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this document after notification.
- If revisions to policies and procedures occur, you will be provided with such revisions at your next office visit.

QUESTIONS AND COMPLAINTS

If you have questions about this notice and your rights to privacy and your records, you may contact me at 512.814.5472. If you believe your privacy rights have been violated and wish to file a complaint, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

I support your right to the privacy of your health information. I will not retaliate in any way if you choose to file a complaint with me or with the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

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For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
-
- Communication barriers prohibited obtaining an acknowledgement
-
- An emergency situation prevented us
-
- Other (please specify) _____