**REBECCA U. ROMO, PSY.D.**
PSYCHOTHERAPY FOR INDIVIDUALS AND COUPLES
CLINICAL PSYCHOLOGY, PSY 17572

Dear New/Returning Client,

Welcome to my practice. Before we begin, I have compiled some necessary information for you.

Although this packet may seem somewhat lengthy, I ask that you please review each section carefully. This packet includes information about psychotherapy services in general (Treatment Expectations, Consent, Confidentiality), my business policies and procedures (including General Policies such as Cancellations and Emergency Contact Options, Electronic Communication and Social Media Policies, Insurance Policies) and the government required HIPPA Notice. Additionally, there is some information I will need from you. Several areas require your initial and/or signature. Please carefully read the areas that you are signing. (Note: If you are not using any insurance coverage for these services, you may skip the Insurance Policies section.)

Feel free to ask any questions you may have regarding anything contained in this packet. If there is an area that you do not feel comfortable signing, leave it blank until we have the chance to discuss it further either in session or by contacting me at 562.293.3095. I encourage you to keep a copy for your own records and for future review. If you would like a signed copy, please ask me and I will provide one for you.

Please bring a photo ID, cash or check (made out to Rebecca Romo, Psy.D.) for payment, and your insurance card (if applicable) to your first appointment.

I look forward to working with you.

Sincerely,
Rebecca U. Romo, Psy.D.

5242 KATELLA AVE., STE 202, LOS ALAMITOS, CA, 90720
P.O. BOX 1405, LOS ALAMITOS, CA, 90720
PHONE / FAX 562.293.3095 DRREBECCAROMO.COM

CLIENT INFORMATION FORM
Please Print

_____ _____ _____
Name of Client Age Date of Birth

_____
Street Address Apt. #

_____ _____
City Zip Code - Four Digits Occupation

Please list contact information where I may reach you.

_____ May I leave a message for you at this number? Yes / No
Home Phone Number

_____ May I leave a message for you at this number? Yes / No
Work Phone Number

_____ May I leave a message for you at this number? Yes / No
Cell Phone Number

_____ May I leave an email for you at this address? Yes / No
Email Address

Please rank order your contact preferences (1-4): Home ____ work _____ cell _____ email _____

Are you currently taking any medications? If so, which ones?

_____ _____
Medication Dosage per day

_____ _____
Medication Dosage per day

_____
Name of Prescribing Physician

_____
Phone Number of Prescribing Physician

_____ _____
Emergency Contact Name Emergency Contact Phone Number

From whom did you hear about my practice? _____

May I contact him/her to thank them for the referral? Yes / No

**Please notify me at your earliest convenience if any of the above information changes.**

**REBECCA U. ROMO, PSY.D.**
PSYCHOTHERAPY FOR INDIVIDUALS AND COUPLES
CLINICAL PSYCHOLOGY, PSY 17572

## INFORMED CONSENT

ABOUT PSYCHOTHERAPY

Participation in therapy may result in a number of benefits to you, including improving relationships, decreasing life stressors, minimizing symptoms and/or resolving the specific concerns that led you to therapy in the first place. Often, the therapy will utilize exploration of your life experiences and perceptions of those experiences in order for me to understand your concerns and to, hopefully, help you work toward improving or resolving these concerns. Psychotherapy requires your very active involvement, honesty, and openness in order for change to occur. At times, you will be asked for feedback about your views on your therapy, its progress, and other aspects of the therapy. It is requested that you respond openly and honestly, as sometimes more than one approach can be helpful in dealing with a certain situation.

During psychotherapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings such as anger, sadness, worry, or fear. As you progress in therapy, you may experience an increase in symptoms while attempting to uncover or work through particular aspects of your life experience. You may be challenged on some of your assumptions or perceptions. Additionally, you may be exposed to different ways of looking at, thinking about, or handling situations, which may result in unpleasant feelings and/or reactions. To maximize your therapy potential, I encourage you to share such responses to your therapy with me.

At times, psychotherapy may result in changes that were not originally intended. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

I am a licensed psychologist with the California Board of Psychology (PSY17572). I possess a masters and doctorate degree in clinical psychology and I have provided psychological services to adults, adolescents, and children experiencing a variety of difficulties over the past 15 years.

During the course of therapy, I will draw on various psychological approaches according to the problem that is being treated and my assessment of what will best benefit you. These approaches include, but are not limited to: psychodynamic (exploring past and current relationships); analytic (exploring the unconscious processes); behavioral (exploring actions); cognitive (exploring thoughts/beliefs); existential (exploring aspirations/longings); family systems (exploring the interplay of relationships in hierarchical systems); developmental (exploring the physical, emotional and mental challenges of the maturational process); and interpersonal neuropsychology (utilizing current brain research in understanding the interaction between the brain/biological systems and human experience).

By signing this consent for treatment, you are agreeing to engage in the treatment process and to follow the business policies and procedures detailed in the document provided. Usually, the therapy process results in positive changes and the client/therapist relationship is beneficial. However, if you should become dissatisfied with your treatment at any time, I request that you discuss these thoughts and feelings with me. The dissatisfaction may be a necessary component of your therapy or we may discuss other treatment options, including terminating treatment. You may end therapy at any time. If you choose to end your therapy, I can give additional referrals upon request.

Under rare circumstances, I may also terminate the treatment agreement. Such circumstances include situations where there has been a violation of the business policies/procedures (ex. lack of payment for services, repeated missing of scheduled sessions, etc.), a worsening of your condition where other treatments/professionals may be better suited, an unexpected circumstance in my life that may prevent me

from providing quality care for you, or threats/actions against my emotional and/or physical well-being. Under most circumstances where I initiate the termination of therapy, you will receive notice and the opportunity to resolve the circumstance (if possible). Under such circumstances, we will work together toward the termination and other options/referrals will be discussed. However, any circumstances involving threats or actions against my personal safety may result in immediate termination of the treatment contract.

## CONSENT FOR TREATMENT

I request and authorize Rebecca U Romo, Psy.D. to provide psychotherapy services. I understand my active and honest participation in the psychotherapy process is necessary to achieve optimal results. Additionally, I understand that while the course of my therapy is designed to be helpful, there are no guarantees about the outcome of my treatment.

I understand that I have the right to terminate this contract at any time and referrals may be provided to me upon request. I also understand that Dr. Romo may terminate the treatment agreement if necessary.

_____ _____

Client/Legal Guardian Signature Date

## CONFIDENTIALITY

In general, the law protects the confidentiality of all communications between a client and a psychotherapist. This means that under usual circumstances, the information you share with me during our time together remains entirely private. Under the law, I may only release information about your psychotherapy to others with your written permission. However, there are a few legal exceptions where disclosure may be required without your consent.

I am professionally obligated by the State of California to release information when there is a reasonable suspicion of child abuse (including the development, transmission, duplication or use of child pornography), dependent abuse, or elder abuse; or where there is a reasonable suspicion that there is imminent danger to self or others unless protective measures are taken. In such situations, I may be required to take protective measures such as contacting, informing, or warning others. I may also initiate the process for hospitalization.

Disclosure may also be required if you become involved in a legal proceeding. In some judicial proceedings, you have the right to prevent your psychotherapist from providing any information about your treatment. However, in some circumstances, a decision by a judge or an uncontested valid subpoena may result in the loss of confidentiality of your records. It is requested that you notify me in advance if you anticipate any legal proceedings that may involve your mental health/emotional state so that any issues pertaining to confidentially and release of records may be addressed.

There are other areas involving privacy and confidentially specific to my practice:

**Outside Encounters**: Because I carry the responsibility to maintain your confidentiality and have no way of verifying your agreement to being witnessed with me, I make it a practice to not *initiate* contact (wave, say hello, or make introductions) should we encounter each other outside of the therapy office. However, I welcome you to initiate contact if you should so desire and I will then take that as your consent to be able to engage directly with you. Please see the Business Policies and Procedures/Outside Encounters section for further elaboration on this topic.

**Medical Billing/Insurance:** If you choose to go through your insurance and if I am a contracted provider for your insurance company, I will submit claims via a secured online medical billing website. The billing website maintains responsibility for the security of confidential information once it is in their possession. Once billing information has been provided to your insurance company, the insurance company maintains responsibility for the protection of this information and is able to use this information for their purposes including such as processing claims, coordinating other services, and determining or informing the acquisition of future medical insurance benefits.

**Consultations:** As a part of my commitment to provide a high-quality standard of care, I do occasionally consult with other professionals. During such consultations, information shared remains completely anonymous and confidentiality is maintained unless a formal release of information has been signed.

**Trainings/Writings:** As a part of my professional development and commitment to advancing the field of psychology, I may conduct trainings and/or produce written publications which draw from my clinical experiences. In such situations, all identifying information is ommitted or altered to protect confidentiality.

**Technology:** If any technology is used in the transmission of services, such as by cellular phone or internet, every reasonable effort is made on my end to secure privacy. However, there is some risk of compromised privacy when using any portable electronic device or internet service. For these reasons, it is strongly encouraged for the use of these mediums to be limited to administrative issues (scheduling, rescheduling, etc) whenever possible.

**HIPPA:** Additional federal rights and limitations are defined in the HIPAA Notice of Privacy Practices contained within this packet. When state and federal expectations differ, the more restrictive rule prevails.

**What About You?** While I am required by law to maintain your confidentiality, it is important that you know that you are always free to discuss any aspects of your therapy with any person, or in any forum that you choose. Please see further elaboration on confidentiality/privacy considerations in the **Electronic Communication and Social Media Policy /Internet Security and Confidentiality Issues** section.

**I understand the limits of confidentiality as explained in this agreement. Any questions I have regarding confidentially have been answered to my satisfaction.**

_____ _____

**Client/Legal Guardian Signature** **Date**

## BUSINESS POLICIES AND PROCEDURES

**Session Length:** Session length is typically 45 minutes but may vary according to insurance and/or treatment needs. Session time begins at the time scheduled. (Example for a forty-five minute session: 9:00 - 9: 45 or 5:30 - 6:15.) Initial _____

**Payment:** This is a cash office. Payment (cash or check) is required at the beginning of each scheduled session unless we have made an alternative agreement. To maximize your therapy time, I recommend having checks pre-written or considering paying in advance for anticipated sessions. Checks are to be made out to **Rebecca Romo, Psy.D.** Initial _____

**Cancellations:** If you must cancel the session, you will not be charged if the cancellation is received at least 24 hours prior to the appointment time. (For example, if your appointment is at 9:30 am on Wednesday, I must receive notice by 9:30 am Tuesday.) You may request to reschedule a cancelled appointment if desired. If you would like confirmation of your cancellation, please send notification via email with a reply request attached. Initial _____

**Late Cancellations:** You will be billed the full hourly rate (or contracted insurance rate) for sessions cancelled less than 24 hours in advance regardless of reason (ex. illness, loss of transportation, emergencies). Insurance does not cover late cancellations. If you have been using your insurance, it is important to note that for late cancellations, your financial responsibility includes the co-payment and the amount that would have been reimbursed by the insurance company. However, you may request to reschedule an appointment if cancelled prior to the scheduled appointment time. If an alternative appointment time is available for rescheduling AND you attend the rescheduled session, you will not be billed for the late-cancelled session. (Note: If you fail to attend the rescheduled session, you may be billed for BOTH sessions.) If rescheduling is not possible, you will be charged for the late cancellation. If you are late cancelling or approaching the 24 hour window for late cancellations, you may prefer to first leave notice on my office voicemail which will provide me with the most prompt notification of your call. Then follow up with an email if you would like confirmation of receipt. Initial _____

**No Shows:** You will be billed the full hourly rate (or contracted insurance rate which includes the co-payment and the amount that would have been reimbursed by the insurance company) for missed sessions (or sessions cancelled during the scheduled appointment time) regardless of reason (forgetting, emergency, illness). No Show appointments may not be rescheduled. If you would like to schedule a new appointment and an opening exists, you may request to schedule an additional appointment during the week. (You will be financially responsible for the missed appointment and for the newly scheduled appointment.) More than 1 No Show may result in the termination of the treatment contract. Initial _____

**Contacting Me Outside of Session:** You may leave a message at any time – 24 hours a day/ 7 days a week at **(562) 293-3095** or by email at **romo3095@gmail.com.** Non-emergency messages will be returned when I am in the office. Please use the **phone voicemail** for any emergency messages. Emergency messages will be returned as soon as possible within a 24-hour period. When leaving a message, please leave a phone number where you may be reached from a blocked line. Remember to speak slowly and clearly when leaving your phone number. If you requested a return phone call and did not hear from me during the expected time frame, please call again. There may have been some technical difficulty. Non-administrative contact or emergency calls will be billed at the pro-rated rate. Insurance does not cover phone or email contact.
Initial _____

**Blocked Phone Number:** Please note that if you request a return phone call and I am not in the office, I will be returning the call from a blocked number. On caller ID, the number usually reads "Restricted" or "Unknown Caller." If you have your phone programmed to prevent calls with ID blocking from being accepted, I will not be able to return your call until the next time I am in the office or until you provide another number where blocked numbers are accepted. Initial _____

**In Case of Emergency:** If you need immediate assistance for a life-threatening emergency, dial **911** or go to the nearest hospital emergency room**.** In cases of suicidal emergency, you may also contact the Suicide Hotline 24 hours a day at **(310) 391-1253** or **(877) 727-4747**. If you are experiencing a psychological emergency and would like to reach me, please leave a message on my voicemail **(562) 293-3095** indicating a number where you can be reached, the nature of the emergency, and if you would like for me to contact you. I check my messages frequently between the hours of 7 a.m. and 7 p.m. Monday through Friday, and periodically on Saturday, Sunday and holidays. I will contact you as soon as I possibly can. Emergency sessions may be available. Emergency phone calls may be billed on a pro-rated basis. Initial _____

**Service Fees:**

| | | |
|---|---|---|
| 90791 | Intake/Initial Diagnostic Interview | $200 |
| 90832 | 30-min Psychotherapy Session | $150 |
| 90834 | 45-min Psychotherapy Session | $175 |
| 90837 | 55-60 min Psychotherapy Session | $200 |
| 99372 | Phone Session (pro-rated in 15 min intervals) | Variable |
| 96101 | Psychological Testing and Interpretation | |

| | | |
|---|---|---|
| (ex. BFIS, ESQ, Other) | $100/hr | |
| 96103 Psychological Testing By Computer | | |
| (ex. ASRS, PHQ-9, GAD-7, OQ-45) | $30/day | |
| Report/Letter Writing (pro-rated in 15 min intervals) | Variable | |
| Extensive Email/Carepaths messaging | Variable | |
| Other Requested Services (trainings, meetings, travel, etc.) | Variable | |
| Case Management/ Consultation | $30/15 min | |
| Administrative Services | No Charge | Initial _____ |

**Outstanding Payments:** Payments are due at the time services are rendered. However, on occasion, it may not be possible to pay at the time of session (forgot checkbook, boss paid late, etc.). In such cases, if more than two sessions are outstanding, further sessions may not be scheduled until the balance is brought up to date. If your account has been outstanding for more than 90 days and a good faith effort has not been demonstrated toward taking care of the balance, I reserve the right to use legal means to secure payment. This may involve hiring a collection agency or going through small claims court. (If such legal action is necessary, the costs will be included in the claim.) Please discuss any financial concerns with me as soon as they become apparent so that we may be thoughtful about how best to proceed in your care. Initial _____

**Financial Need:**
I am willing to work within certain limits to accommodate times of high financial need. Please speak with me directly if you have questions regarding services or fees. Initial _____

**Outside Encounters:** Due to the realities that life occurs outside of the therapy consulatation room there is a chance that we may accidentally encounter each other outside of the office in the community (Costco, post office, community events, etc.) As mentioned prior, because I carry the responsibility to maintain your confidentiality and have no way of verifying your agreement to being witnessed with me, I make it a practice to not *initiate* contact (wave, say hello, or make introductions). Instead, I will respect your privacy unless you decide that you would like to make contact with me. This allows you the ability to regulate the degree of contact and/or disclosure that you may want in any public setting and to consider the context of the people and environment around you. My recommendation is for you to consider what feels most comfortable to you. If contact is made, people nearby may observe the interaction and ask you how you know me. I encourage you to think through your comfort level with this possibility. You are welcome to handle the situation in any manner that you think is best. Should you wish to say hello or wave, I welcome your efforts, and I will view any initiation on your part as authorization for me to respond in kind. However, please know that in such unanticipated encounters, you are under no obligation to make contact or acknowledge me. I respect your privacy wishes. Initial _____

**Me Contacting You:** If I need to contact you outside of session time, I most typically will contact you by phone if it is an urgent or timely matter such as the need to cancel or reschedule an appointment due to illness or emergency within 24 hours of your appointment. For all other needs – such as responding to rescheduling or confirmation requests, I most typically will reply via email so that all information can be logged by both parties (such as session times/dates, etc.) Please note that I will never ask for you to send any sensitive information via email. Should you receive any such request from my account, please call me directly before responding to the request to verify it's authenticity and so that I may be able to respond quickly to any potential unauthorized use of my account. Initial _____

**Feedback/Complaints/Questions:** If you have any feedback, questions and/or complaints regarding any aspect of your therapy with me, I encourage you to speak directly to me about it. My hope is that you will discover that I welcome such feedback and will be interested in finding the best possible solution for any issue at hand. There is also a feedback document through the client portal on the **Carepaths** site that is HIPPA secure. Using other business or social sites to communicate indirectly with me about your feelings about our work is not recommended as there is a very high probability that I may never see it. If you feel I have done something harmful or unethical and you do not feel comfortable discussing it with me or if you would like to

verify my professional standing, you may contact the Board of Psychology, which oversees licensing, and they can verify my qualifications and/or review the services I have provided.

**Board of Psychology**
**1422 Howe Avenue, Suite 22**
**Sacramento, CA 95825**
**1-866-503-3221**
**bopmail@dca.ca.gov** Initial _____

**Signing this document indicates that you have read and agree to abide by the business policies and procedures described above.**

_____ _____

**Client/Legal Guardian Signature** **Date**

## Electronic Communication and Social Media Policy

**Email Communications to** romo3095@gmail.com. As email is not completely secure or confidential, it is highly recommended that this email be used for non-urgent administrative purposes (cancelling or scheduling an appointment more than 28 hours in advance, referral names/numbers, updating address or phone information, etc) and preferably not for sharing personal or clinical information (thoughts/beliefs, wonderings, reactions, observations, forwarding other communications, etc.) or other highly sensitive identifying information (insurance identification numbers, social security numbers, bank data, etc.) If you choose to communicate with me via email, be aware that all emails are retained in the logs of your and my service provider. While it is unlikely that anyone would be looking at these logs, they are, in theory, available to be read by the system administrator of the Internet service provider. You should also know that any emails I receive from you and any responses I send to you become a part of your legal medical record. All highly personal and identifying information is best respected and secured by sharing directly during session time or, on rare occasion, by telephone.

Because of the inability to guarantee timeliness in the receipt of email communications, it is preferred for all cancellations within 28 hours of the appointment to be made by phone where you will benefit from the date and time stamp on the office voicemail. Cancellations received by email within 24 hours of the scheduled appointment time will be charged the late cancellation fee. Any time discrepancies for email cancellations will be determined by the provider based on the time the email was received/read (not transmitted).

If you wish to reschedule an appointment and prefer to do this through email, please be aware that while I may send you a series of available appointment times, those same times may have changed by the time your response is received. I will send either a confirmation email or phone message to confirm your next scheduled appointment time.

If you feel comfortable with the potential security issues described above, and if you are able to manage administrative issues via email, please note that I may be better able to respond more promptly to administrative communications done through email – such as email scheduling requests, cancellation confirmations, new appointment confirmations, etc. - especially when I am out of the office. However, as life balance and boundary setting is important for mental health, I reserve the right to respond to non-emergency messages within normal business hours.

Please note that any lengthy non-administrative email communications will be charged a pro-rated rate. Email communications are not to be a substitute for face-to-face psychotherapy.

Initial _____

**Carepaths Messaging and Clinical Documents:** In efforts to create a more secure means of electronic communication, I have an ONC certified secured electronic records and messaging system that can be

accessed at **romo.carepaths.com** or by clicking on the Patient Login widget at the bottom of my home page at drrebeccaromo.com. You will be given a username and password to access this service. The client portal provides a secure way to update identifying information (address, phone numbers, insurance numbers, etc.), the ability to take online assessments and give session feedback, as well as the ability to send secured messages. Please note that this system is NOT the most timely way of communicating and is NOT useful for scheduling/rescheduling tasks. If you send a secured message, it is recommended that you also leave me a voicemail or email notifying me that you have left information for me there as the carepath's system does not send me notifications directly. All communications sent through the Carepaths' system are a part of your legal medical record.

Please note that any lengthy Carepaths messages will be charged a pro-rated rate. Use of the Carepath's Assessment tools will be billed per day of use. Insurance may cover some of the the assessment expense. Carepaths' communications are not to be a substitute for face-to-face psychotherapy. Initial _____

**Text Messaging:** Because text messaging is a very unsecure, impersonal, and informal mode of communication, I do not text message nor do I respond to text messages from anyone in therapy with me. Please note that my office number **562-293-3095** does not receive texts. Initial _____

**Social Media:** I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.) In addition, if I find that I have accidentally established an online relationship with you, I will cancel that connection. Because these types of social contacts can create significant security risks for you, I do not believe it is in your best interests to have me participate in your online life. However, there may be times when something occurring in your online life is of significance for your therapy. In such times, I request for you to share such information within the course of your own face to face therapy ( such as to show me a video you posted on your Facebook account from your phone while in session.) Initial _____

**Accidental/Intentional Electronic Crossings:** While I tend to not engage in a wide variety of social media platforms, there is a possibility that you may encounter me by accident through social or professional media sites. If that occurs, please discuss it with me during our time together. Online exposures have the potential to compromise the professional relationship and it is important that we discuss any issues that may arise early on. In addition, please do not try to contact me through any social media site (including LinkedIn or other professional sites). I will not respond and will terminate any online contact no matter how accidental. I believe that such contacts can blur the therapeutic boundary, and can compromise your confidentiality, as well as our respective privacy. If you have any questions about this, please bring them up when we meet and we can talk more about it. Initial _____

**Web Searches On You:** It is not a regular part of my practice to search for clients through internet options (Google, Facebook, etc.). I believe that voyeurism is detrimental to the therapeutic relationship and will not participate in searches for non-professional reasons. However, there may be times when internet-based information may be accessed to verify, validate, or gain information pertinent to our work together and/or if your safety is in question. Please notify me if you have any concerns regarding this policy. Initial _____

**Web Searches On Me:** Currently, there is an incredible amount of information available about individuals on the internet, some of which may be known to that person and some of which may be inaccurate or unknown. I understand that searches are often a way that people find out information and that you may seek information about me through these means. If you encounter any information about me through web searches other than through my professional website or professional pages, I invite you to discuss what you found during our session time so that we can address any potential impact on our work together. Initial _____

**Website:** I have an ever-evolving website at ***drrebeccaromo.com*** to facilitate ease in the provision of administrative and informational resources for your use. I welcome any feedback and/or suggestions that may improve your experience of the website as I am interested in providing the most effective/helpful experience for my clients. Initial _____

**Business Review Sites:** You may find my psychology practice on such sites as Yelp, Healthgrades, etc..or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business intended to be listed on their site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client. The American Psychological Association's Ethics Code states that is unethical for psychologists to solicit testimonials. Likewise, please note that mental health professionals cannot respond to any comments or postings because of confidentiality restrictions. Should you find any reviews about my practice, I encourage you to discuss these findings with me so that we may talk about any impact such reviews could have on our work together. Initial _____

**Internet Security and Confidentiality Issues:** While I am required by law to maintain your confidentiality, it is important that you know that you are always free to discuss any aspects of your therapy with any person, or in any forum that you choose. As in personal relationships where it may be helpful to share with trusted individuals what you are experiencing, including experiences in therapy, you may feel compelled to share aspects of your psychotherapy through social media. If you feel thus compelled, I encourage you to keep in mind that most postings are public and may be viewed by unintended viewers (including potential employers, coworkers, spouses, children, friends, relatives, exes, neighbors, coaches, not-good-for-you-others, etc.). If you intend to post anything related to your therapy, I encourage you to consider creating a pseudonym for use on public sites that is not linked to your regular email or friend networks for your own privacy and protection. If you feel compelled to post information on your private accounts, I encourage you to stay up to date regarding your privacy settings and the settings of the site you use. Initial _____

While the uses of electronic means becomes a greater part of our daily lives, it is hard to foresee what the future may hold for other electronic mediums and platforms for communicating. In this quickly advancing world of technology, I will do my best to keep you posted of any changes that may directly effect our work as the information comes available.

If you have any questions regarding the policies and procedures listed above, please discuss them with me.

**Signing this document indicates that you have read and agree to abide by the Social Media Policy described above.**

_____ _____

**Client/Legal Guardian Signature** **Date**

## Insurance Policy

**About Insurance:** If you plan on using your insurance benefits for any portion of payment for these services, please note that I do not have control over any aspect of the rules set by the insurance plan for their reimbursement and that the involvement of insurance may limit your rights as a client. These restrictions may include their decision to limit the number of sessions, to decide when you must complete your treatment, or to require you to have a medication consultation or be placed on medication if their reviewing professional deems it appropriate. They may also decide that you must see another therapist in their network rather than me, if I am not on their list. Please note that the use of insurance will most likely result in the release of identifying data, including the requirement to provide a diagnosis and use specific diagnostic codes, and on occasion, may require the entire record or in depth-consultation through "peer review", as required by the insurance plan. In these reviews, significant details are often requested and may or may not be used by the insurance company toward what I view to be in your own best interests. While I make every effort to prevent unnecessary information from being shared, it is not always possible to restrict information acess in order to preserve your benefits based on the requirements for coverage in your plan. Please also note that I am not responsible for any ramifications on future insurance benefits based on services provided. Initial _____

## Utilizing Insurance Benefits:

It is your responsibility to verify your elegibility and benefits provided by your insurance plan. In contacting your insurance, the following are helpful questions to ask:

- Is Rebecca Romo, Psy.D. (PSY17572) a covered provider on my plan for providing mental health services?
- What are my mental health benefits?
- Does this coverage include individual, family/couple, and/or testing services?
- What is the coverage amount per service?
- How many therapy sessions does my plan cover?
- Are there diagnoses or mental health treatments that they will not cover? (diagnosis ex: 314.9; CPT code ex: 90847, 90839, 9084; etc.)
- What is my deductible, if any? Do I need to pay my deductible for my mental health benefits?
- What is my copayment? Coinsurance?
- If Dr. Romo is not a covered provider, how much does my insurance reimburse for an out-of-network provider? (Please note that the company will often quote a percentage up to their allowable amount. This amount may be different than my fees for the same services. You are responsible for differences between the insurance company's fee schedule and the actual session fee. For in-network plans, I have contractual arrangements that set the fee and you will only be responsible for the co-insurance, copayment and/or deductible fees.)
- When does my coverage begin? End?
- Is pre-authorization required? If so, how do I get pre-authorized?
- Where do I send the billing statement from my mental health provider?
- What information must be included on the billing statement? Do I need to have my therapist include a diagnostic code in addition to the billing code?

If I am a contracted provider (in-network), I will submit billing on your behalf and track payments received.

If I am out-of-network, you will be responsible for full payment of services directly to me at the time services are rendered. I will provide you with a receipt of payment for the services rendered for you to submit to your insurance company. Your insurance plan will reimburse you directly according to your plan's provisions. I will track your payments and any balances due for the services received. However, it is your responsibility to track any reimbursements you expect to receive from your insurance provider and that these reimbursements are in accordance to your plan. Initial _____

## Release of Information Authorizing Insurance Utilization

I, _____, agree to have information released pertaining to my case and treatment as required by my insurance company. I understand that the information disclosed may include identifying information, diagnosis and type of treatment recommended. Further, I understand that the insurance company may request copies of my treatment records.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information. I understand that I am granting permission for the extent of my treatment unless otherwise designated. I further understand that if, at any time, I desire to revoke this consent, I must do so in writing.

_____ _____

Client Signature Date

**REBECCA U. ROMO, PSY.D.**
PSYCHOTHERAPY FOR INDIVIDUALS AND COUPLES
CLINICAL PSYCHOLOGY, PSY 17572

# HIPAA NOTICE OF PRIVACY PRACTICES

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

**II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).**

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

**III. HOW I WILL USE AND DISCLOSE YOUR PHI.**
I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

**A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.** I may use and disclose your PHI without your consent for the following reasons:

**1. For treatment.** I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.
**2. For health care operations.** I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
**3. To obtain payment for treatment.** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
**4. Other disclosures.** Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

**B. Certain Other Uses and Disclosures Do Not Require Your Consent.** I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
4. **If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations**, such as the Privacy Rule that requires this Notice.
5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by the California Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.
8. **If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
13. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
14. **For Workers' Compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.

15. **Appointment reminders and health related benefits or services.** Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer**.**
16. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. **I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other heath-related benefits and services that may be of interest to you.**
18. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
19. **If disclosure is otherwise specifically required by law.**

### C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

**1. Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

**D. Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

### IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI These are your rights with respect to your PHI:

**A. The Right to See and Get Copies of Your PHI.** In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

**B. The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

**C. The Right to Choose How I Send Your PHI to You.** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

**D. The Right to Get a List of the Disclosures I Have Made.** You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

**E. The Right to Amend Your PHI.** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

**F. The Right to Get This Notice by Email (if available)** You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

### V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you**.**

### VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Rebecca Urrutia Romo, Psy.D., 5242 Katella Ave., Ste. 202, Los Alamitos, CA 90720, (562)293-3095.

### VII. EFFECTIVE DATE OF THIS NOIICE

This notice went into effect on April 14, 2003.

## I acknowledge receipt of this notice.

**Client/Legal Guardian Signature** **Date**

5242 Katella Ave., Ste 202, Los Alamitos, CA, 90720

P.O. Box 1405, Los Alamitos, CA, 90720

PHONE / FAX 562.293.3095 DrRebeccaRomo.com