DEBRA K. SOWALD, PSY.D.
PSYCHOLOGIST
28 E. RAHN RD., SUITE 105
KETTERING, OHIO 45429
(937) 434-6840

I N T A K E I N F O R M A T I O N

PLEASE PRINT CLEARLY:

Client Name_____Age_____Sex_____

Birthdate_____Married_____Single_____Divorced_____Widowed_____

Address_____

City_____State_____Zip_____

Occupation:_____Employed By_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Client's SSN:_____Emergency Contact Name:_____Phone:_____

Reason for Referral:_____

Client Referred By:_____

Financially responsible person (if different)_____

_____Employed by_____

Home Phone:_____Work Phone:_____Cell Phone:_____

SSN:_____Ohio Driver's License #:_____

ASSIGNMENT OF BENEFITS:

I hereby assign all psychological benefits, to include major medical benefits, including Medicare, private insurance, and any other health plan to Debra K. Sowald, Psy.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize Dr. Sowald to release all information necessary to secure payment.

Signed_____Date_____

DEBRA K. SOWALD, PSY.D.
PSYCHOLOGIST
28 E. RAHN RD., SUITE 105
KETTERING, OHIO 45429
(937) 434-6840

Individual, Family, & Group Therapy
Psychological Assessment
Imagery & Senoi Dreamwork

AUTHORIZATION TO RELEASE PHI FROM DR. SOWALD FOR INSURANCE BILLING

Client Name _____ S.S. # _____
Birth Date_____

This form when completed and signed by you, authorizes Dr. Sowald to release protected health information from your medical record to your insurance company and their designated utilization review, managed care, and/or claims payment subdivisions and/or business associates.

I authorize Dr. Sowald to release the following information:
_X__ Assessment and Diagnostic Impression X__ Treatment Plan and/or Outcome _X__
Medications Used and Response to the Medication
_X__ Assessment of Client's Substance Use/Abuse and Recovery
_X__ Client Identifying Information
_X__ Recommendations for Follow-Up
_X__ Psychosocial History
_X__ Admission Summary
_____Other_____
_X__ Treatment Dates and Times
_X__ Indicators of Progress
_X__ Psychological Evaluation
_X__ Discharge Summary

This information should only be released to the Following Insurers and/or their Designees:
_____
_____
_____

I am permitting Dr. Sowald to release this information for the purpose of utilizing my medical benefits to help with payment on my account for professional services rendered by Dr. Sowald.

This authorization shall remain in effect until all claims have been settled.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the above office address. However, your revocation will not be effective to the extent that Dr. Sowald has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Also, revocation of this consent will render the signee and/or guardians responsible for payment in full on this account.

I understand that Dr. Sowald generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

(over)

I release Dr. Sowald from any legal liability resulting from the release of this information with the understanding that Dr. Sowald will exercise reasonable professional safeguards regarding this information.

I have read and understand this document.

Signed this _____ day of _____, 20_____

Signature of Client_____

Signature of Parent or Guardian, if applicable

_____

Signature of Witness

_____

A TRUE PHOTOCOPY HEREOF MAY BE CONSIDERED AS AN ORIGINAL

DEBRA K. SOWALD, PSY.D. PSYCHOLOGIST
28 E. RAHN RD., SUITE 105
KETTERING, OHIO 45429
(937) 434-6840

Individual, Family, & Group Therapy
Imagery & Senoi Dreamwork

NAME:_____DATE_____

CLIENT INFORMATION AND TREATMENT AGREEMENT

Since you are a new client, it is important that I provide you with some information about your treatment, your rights, and my office policies. Please read the following form. I will be pleased to respond to any questions you may have regarding any of this information.

When you sign this document, it will also represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. Psychotherapy can have benefits and risks. There are many different methods I may use to help you deal with the problems that you hope to address. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things you talk about, both while you are at sessions and when you are not. It is my expectation that you will participate as an equal and active contributor to your treatment.

APPOINTMENTS

Appointments are scheduled for 45-minute sessions, often on a once per week basis. However, ongoing therapy is a negotiated process between us, and frequency of sessions is partially your decision. We should periodically

evaluate and discuss the progress and the process of therapy, and re-negotiate the need and frequency of further appointments. You have the right to terminate therapy at any time. When you are ready to terminate therapy, we will have a termination session in order to discuss the progress you have made or any areas of concern, and for me to make any recommendations I deem necessary.

ACCESS TO OFFICE WAITING ROOM

If you have an evening appointment, the building is usually open. However, occasionally a new tenant locks the entrance door without realizing that they have locked you out. You can ring the doorbell to my office on the top left hand side of the outside door frame, and I will come and unlock it. If I do not come within a few minutes of your ringing the doorbell, I may have been temporarily out of the office. Please ring again.

LENGTH OF TREATMENT

For many problems, short-term treatment (between one and twelve sessions) is possible. This is particularly the case when one basic problem is identified and is the focus of treatment. When there are several concerns, or when the issues have lasted over a long period of time or over a variety of life areas, a longer-term treatment is likely.

CLIENT RIGHTS AND PARTICIPATION IN THE TREATMENT PLANNING PROCESS

At all times, you have the right to a full explanation from me about the following aspects of treatment:

1. Methods and techniques used or proposed in your treatment.
2. Known or predictable consequences of refusing the suggested treatment.
3. Known or predictable side effects from the proposed treatment.
4. Reasonable expectations for the duration and outcome of treatment.
5. My training and qualifications.

CONFLICTS

If at any time you are displeased with the services I provide, it is important that you talk it over with me. Some clients do this in writing if they feel unable or afraid to do so verbally. I will make every attempt to respond to your concerns or resolve any conflicts.

PSYCHOLOGICAL TESTING

I may suggest psychological testing as a brief and efficient method of gaining information about important aspects of your personality and/or current psychological status, or you may request psychological testing. I will refer you to a colleague of mine if psychological assessment is needed.

CONTACTING YOUR THERAPIST

Due to my work schedule, I am often not immediately available by telephone, and generally will not answer the phone when I am with clients. When you call my phone number (937-434-6840), the call will be answered by my secretary during normal business hours, and by my answering machine or voice mail after normal business hours. When trying to reach me, please leave your name and one or more numbers and times when I can return your call. For non-emergency telephone calls, if my secretary or I do not return your call within 24 hours, please assume that we did not get your message, and call again.

EMERGENCIES

I provide services by appointment. I may not always be available during emergency conditions. If your call is during my evening work hours, call the office and leave a message on the confidential answering machine. In case of an emergency, if I have not returned your telephone call within an hour, please call again repeatedly, until I pick up or call you back.

After-hours and on weekends, I may sometimes be reached on my cell phone, (937) 307-5951 in case of emergency.

Some emergency circumstances may occur at times when I am unavailable and therefore unable to respond. On those occasions, or when you need a guaranteed, very rapid, or immediate response to your call, I recommend that you use one of the publicly funded Emergency Services, which are staffed on a 24-hour basis:

Call "988" for The Suicide and Crisis Lifeline

Crisis Care	224-4646
Suicide Prevention Center	229-7777
Tri-County Crisis Center	335-7148

If you believe you are imminently in danger of harming yourself or someone else, call the police or a reliable friend to transport you to the nearest hospital Emergency Room for immediate care. Do not attempt to contact me first. Do contact me once you are at the hospital to let me know that you are there.

LIMITS ON CONFIDENTIALITY

In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, which are enumerated in my "Notice of Policies and Practices to Protect the Privacy of Your Health Information."

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I will make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. Consultations will be noted in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- I utilize several administrative staff. In most cases, I may need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance.

- All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- I also have contracts with attorneys and other collection specialists. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data, except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, I cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. However, please be aware that I do NO Court work. If you need a psychologist who will participate in your legal case, to any extent, I will be glad to refer you to another psychologist outside my practice.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If you file a complaint or lawsuit against me, I may disclose relevant information regarding you in order to defend myself.
- If you file a worker's compensation claim, you must execute a release so that I may release the information, records or reports relevant to the claim.
- If a court of law issues a subpoena or court order, therapists may, despite efforts to claim Privilege, be ordered by the Court to provide the information specified by the court order.

There are some situations in which I am legally obligated to take actions, which are necessary to attempt to protect others from harm and may require revealing some information about your treatment. These situations are unusual in my practice, but do occur:

- If I know or have reason to suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child, the law requires filing a report with the appropriate government agency, usually the Public Children Services Agency. Once such a report is filed, I may be required to provide additional information.

- If I have reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, the law requires reporting such belief to the county Department of Job and Family Services. Once such a report is filed, I may be required to provide additional information.

- If I know or have reasonable cause to believe that a client has been the victim of domestic violence, I must note that knowledge or belief and the basis for it in the client's records.

- If I believe that a client presents a clear and substantial risk of imminent serious harm to him/herself or someone else and I believe that disclosure of certain information may serve to protect that individual, then I must disclose that information to appropriate public authorities, and/or the potential victim, and/or professional workers, and/or the family of the client.

- I, as a Counselor, am required to report to police if I know that a felony has been or is about to be committed.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and will limit disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have now or in the future with me. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information (PHI) about you in two sets of professional records. One set

constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record if you request it in writing and the request is signed by you and dated not more than 60 days from the date it is submitted. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I charge a copying fee. Please consult me or my secretary for the current charges for copying. If I refuse your request for access to your Clinical Record, you have a right of review, which I will discuss with you upon request.

In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of your conversations during sessions, my analysis of those conversations, and how they impact on your therapy.

They may also contain particularly sensitive information that you may reveal to me, that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record.
While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless I determine that such disclosure would have an adverse effect on you.

CLIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These

rights include requesting that your therapist amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about the policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I will be happy to discuss any of these rights with you.

MINORS & PARENTS

Clients under 14 years of age who are not emancipated and their parents should be aware that Ohio law allows parents to examine their child's treatment records unless the therapist decides that such access would injure the child, or the parents and the therapist agree otherwise. Children between 14 and 18 may independently consent to and receive up to 6 sessions of psychotherapy (provided within a 30-day period) and no information about those sessions can be disclosed to anyone without the child's agreement. While privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, parental involvement is also essential to successful treatment.

For children 14 and over, it is a common therapist practice to request an agreement between the client and his/her parents allowing the therapist to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions, as well as a verbal summary of their child's treatment when it is complete. I will discuss such an arrangement with you personally in the event that I wish for the therapy to proceed in this manner.

Under Ohio law, a non-residential parent is entitled to the same access as a residential parent to the child's records, including psychotherapy records. This is true unless the court has determined by way of a court order that it is not in the best interest of the child for the non-residential parent to have access to that information.

PROFESSIONAL FEES

The fee for a 45-minute diagnostic session (your first appointment) is $150.00. All subsequent services are billed at $125.00 per 45-minute session or $200.00 per 60 minutes of service. Services for which clients are billed at this usual rate include psychotherapy; letters; consultations; travel time for out of office services; telephone counseling, and other services of a professional nature. There is no charge for brief routine telephone calls, but telephone consultations will be billed at the rate of $50.00 for 15 minutes of time. Services not covered by medical insurance, such as letter writing or treatment summaries, must be paid for in advance of the service.

The "Women's Psychotherapy Group for the Treatment of Anxiety and Depression," which meets every other Thursday evening from 7:00 P.M. to 9:00 P.M., is $50.00 per session. A $50.00 charge will be made unless a member's attendance is canceled 24 hours in advance.

Payment is due at the time of service. Other financial arrangements can sometimes be negotiated at the client's request, which should be done at the initial session. **For clients who have insurance co-payments: In some cases, you may be able to pay only your co-payment at the time of service. If this is the case, be certain to pay the co-payment at the beginning of the session. YOU SHOULD ALWAYS COME PREPARED TO PAY YOUR CO-PAY. Payment may be made by cash or check. You may be assessed a $5.00 re-billing fee for each session you fail to pay your co-payment.**

At your request, my secretary can provide a statement showing the activity on your account. We will also bill your primary insurance company on approximately a bi-weekly basis. However, if the insurance billing becomes very time consuming (i.e., if your insurance company makes extraordinary demands for information) we reserve the right to bill you an additional charge for that time. If you have more than one insurance company, we will bill the first insurance company. While we are willing to bill the secondary insurance company, it is preferable for you to pay your co-pay to us, then for you to bill your secondary insurance company to reimburse you, as you can keep better track of your own account. If you wish to file for secondary insurance benefits yourself, my secretary will prepare insurance billing forms for you to submit at your request.

If you are on Medicaid, you do not have a co-pay. You must be currently covered on Medicaid for the month that services are rendered. If coverage has ceased, you will be expected to pay the full fee out-of-pocket or through a medical insurance company. Medicaid currently covers only 24-25 psychotherapy sessions per year, plus up to 8 psychological testing sessions per year. I will refer you elsewhere if you need psychological testing in addition to the psychotherapy that I will do with you. Please keep track of your sessions, so that you do not exceed the allowed amounts.

We bill most insurance companies electronically.

If your account is in arrears, interest at a rate of 2% per month may be added to your balance. This may continue for each month that payment is in arrears. You will be charged my banking fee (currently about $26) plus $10 for returned checks.

If you fail or refuse to make payment, as agreed or negotiated, I reserve the right to obtain the services of a collection agency or attorney. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. Please note: You are responsible for all collection expenses and attorney fees required as a result of non-payment of your full account balance. This can include late fees, interest, attorney fees, court fees, and garnishment fees, if applicable. I reserve the right to discharge clients for repeated or prolonged failure to pay for services.

NO COURT APPEARANCES

I do NO Court work. If you need a psychologist who will participate in your legal case, to any extent, I will be glad to refer you to another psychologist outside my practice.

CANCELLATIONS AND MISSED APPOINTMENTS

When you schedule an appointment with me, I reserve the appointed time for you. I consider appointments to be an important commitment on both my part and yours. If you find it unavoidable to cancel a scheduled appointment, I ask that you do so as soon as you become aware that you will not be able to attend. Missed appointments not canceled at least 24 hours in advance of the scheduled appointment time will be billed at the usual rate ($125.00 for most sessions, $150.00 for intake sessions; $50.00 for psychotherapy group sessions). **Insurance companies do not reimburse for late cancellations or missed appointments. You will be expected to pay for the missed session at the time of the next appointment.**

In the event that you arrive for your appointment intoxicated or under the influence of illegal drugs, I may refuse to see you at that time. However, you will be billed for that session. The judgment of whether you are intoxicated/under the influence is at my discretion.

INSURANCE REIMBURSEMENT

It is your responsibility to investigate your insurance coverage before entering into a treatment contract with me. You are responsible for all charges incurred, regardless of the amount paid by your insurance company, unless other arrangements have been made between our organization and your insurance company or managed care organization. It is also important for you to know that insurance companies do not pay for telephone consultations, consultations with school personnel and other professionals, written reports or correspondence, missed appointments, and some other services. Sometimes insurance will not pay for services if the condition being treated has been treated in the past. Finally, some insurance companies do not cover psychological/mental health services at all.

If your insurance coverage changes in any way during the course of treatment, you must notify me and provide me with a copy of your new insurance card as soon as it goes into effect. If you fail to notify me of insurance coverage cancellations or changes, you will be expected to pay for all non-covered services out-of-pocket.

Insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can sometimes be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that professionals provide it with information relevant to the services that are provided to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Additionally, we do reserve the right to release the minimum necessary information in order to collect payment from your insurance company. That might include, if the insurance company does not pay in a timely manner, filing a Prompt Pay complaint with the Ohio Department of Insurance. The complaint would include information the Department requires to process the complaint. This information might become publicly available as it may be releasable by the Department as part of a public records request.

Once you have all of the information about your insurance coverage, you can discuss with me what can be expected to be accomplished with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. **It is important to remember that you always**

have the right to pay for all services yourself to avoid the problems described above [unless prohibited by contract].

You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS, AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

I_____
have read and understand the above information and policies and agree to abide by those policies. Specifically, I will pay $_____ at each session. Insurance forms to primary insurance company will be submitted by staff for Debra K. Sowald, Psy.D. I authorize the staff to release any information necessary for third-party claim submissions and/or payment for services. Any exceptions to this agreement are noted below. This agreement will remain in affect until re-negotiated in writing, between myself and Debra K. Sowald, Psy.D.

IF YOU HAVE ANY QUESTIONS ABOUT MY PRIVACY, PROFESSIONAL, OR FINANCIAL POLICIES, PLEASE ASK ME ABOUT THEM BEFORE SIGNING BELOW. PLEASE SIGN TWO COPIES. RETURN ONE COPY TO THE OFFICE AND RETAIN ONE COPY FOR YOUR OWN INFORMATION. THANK YOU.

_____ Date_____
Signature of client and/or Responsible Party
(parent or guardian if a minor)

_____ Date_____
Signature of spouse and/or Co-responsible Party

Behavioral Health/Primary Physician Patient Care Communication Form

Patient Name:	Date of birth:
Primary Physician Information Name: Address: Phone: Fax: ☐ Patient does not have a primary physician	**Behavioral Health Clinician Information** Name: DEBRA K. SOWALD, PSY.D. PSYCHOLOGIST Address: 28 E. RAHN RD. STE 105 KETTERING, OH 45429 Phone: (937) 434-6840 Fax: (937) 436-9408

AUTHORIZATION TO DISCLOSE INFORMATION

I understand that records or information about my mental health or alcohol and drug abuse treatment and counseling are confidential; they are protected by applicable state and federal laws, and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that any information about me concerning AIDS, HIV infection, and AIDS-Related Complex and the performance of any tests, counseling, and the results and treatment thereof cannot be released without my authorization. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire 60 days from the date signed.

To Patient: Please check one option below: I, _____
(Print patient's name)

A. ____ DO authorize any information on my care to be shared between the providers listed above to facilitate my treatment.

B. ____ DO authorize information on my care with the following limitation (check any):
☐ Medications only ☐ Information to primary physician only ☐ Other_____

C. ____ DO NOT authorize any information on my care to be shared between my behavioral health clinician and my primary physician, names above, for the purpose of facilitating my treatment.

_____ _____
Signature of patient or guardian Date

To be completed by Behavioral Health Clinician (if the patient authorized disclosure)

Diagnosis and/or brief description of presenting problem:

_____

Treatment Plans/Recommendations:

_____

Current Psychotropic Medication:

_____

Comments/information requested from primary physician:

_____

Behavioral Health Clinician Signature: Date:

To be completed by Primary Physician (if the patient authorized disclosure)

Please provide the information requested as well as any other information relevant to this patient's treatment (attach pages or forms from patient's chart as needed):

Primary Physician Signature: Phone/Fax: Date:

To providers: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and certain state laws. The Federal rules and the state laws prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is not sufficient for those purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client ID #_____

Contract Number:
Patient:
Claim Number:
Date of Service:

Dear:

Before we can process your claim, we need to know if you, your spouse or your dependents are currently covered by another health insurance company. Therefore, complete the form below and return this letter to us in the enclosed envelope **within 14 days to avoid unnecessary denial of this claim.** To protect your privacy and properly update your membership file, we regret that we cannot accept this information by phone. Thank you

1. Do you or any member of your family have health care insurance with another company?

_____ Yes – Family coverage _____ Yes – Single coverage _____ No
Spouse's birthdate _____

2. If spouse's coverage has terminated, please provide cancellation date. _____

3. Do you or any member of your family have Medicare Part A coverage? _____ Yes _____ No
Medicare part B coverage? _____ Yes _____ No

4. Is the patient a dependent child whose natural parents are divorced or separated? _____ Yes _____ No
If "Yes", give the name of the parent ordered by the court to maintain health care as "Name of Insured" in the section below and attach a copy of the court order.

If you answered "Yes" to any of these questions, please fill out the following regarding the other insurance:

Name of Insured _____ Birthdate _____ Social Security Number _____
Employer, Union or Sponsoring Organization of Insured _____
Effective Date _____ Cancelled Date _____ Employment Status _____ Active _____ Retired
Employer's Street Address _____
Employer's City, State, Zip Code _____
Insurance Company Name _____ Policy Number _____
Insurance Company's Street Address _____
Insurance Company's City, State, Zip Code _____
Insurance Company's Phone Number _____

I hereby certify the above statements are true and correct to the best of my knowledge, and authorize any insurance company, employer, or hospital to release all information with respect to myself and any of my dependents which may affect the benefits under this or any other plan providing benefits or services.

_____ _____
Your Signature Date

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

DEBRA K. SOWALD, PSY.D.
PSYCHOLOGIST
28 E. RAHN RD., SUITE 105
KETTERING, OHIO 45429
(937) 434-6840

Individual, Family, & Group Therapy
Psychological Assessment
Imagery & Senoi Dreamwork

Notice of Our Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Dr. Sowald may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*

– *Treatment* is when your therapist provides, coordinates or manages your health care and other services related to your health care. An example of treatment would occur if your therapist consults with another health care provider, such as your family physician.

- *Payment* is when Dr. Sowald is reimbursed for your healthcare. Examples of disclosures related to payment include, for example, when Dr. Sowald discloses your PHI to your health insurer in order to obtain reimbursement for your health care or to determine eligibility or coverage.

- *Health Care Operations* are activities that relate to the performance and operation of the overall practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "*Use*" applies only to activities within Dr. Sowald's practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of Dr. Sowald's practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Dr. Sowald may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when Dr. Sowald is asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes that your therapist has made about conversations occurring during a private, group, joint, or family counseling session, which your therapist will have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) Dr. Sowald has relied on that authorization; or (2) if the 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.

III. Uses and Disclosures with Neither Consent nor Authorization

Dr. Sowald may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If, in a professional capacity, your therapist knows or suspects that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, your therapist is required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or a municipal or county peace officer.

- **Adult (over 60) and Domestic Abuse:** If your therapist has reasonable cause to believe that an adult (over 60) is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, she is required by law to immediately report such belief to the County Department of Job and Family Services.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, if the therapist providing treatment is licensed in Ohio as a Psychologist; the psychologist will not release this information without written authorization from you or your personal or legally-appointed representative, or a court order. The foregoing Psychologist/Client Privilege does NOT apply to other non-medical mental health service providers; you should ask the therapist assigned to you about their status in this regard, if court involvement seems likely to occur. Also, 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 your therapist believes that you pose a clear and substantial risk of imminent serious harm to yourself or another person, she may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to your therapist an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and she believes that you have the intent and ability to carry out the threat, then she is required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).

- **Worker's Compensation:** If you file a worker's compensation claim, Dr. Sowald may be required to give your mental health information to relevant parties and officials.

IV. Patient's Rights and Dr. Sowald's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Dr. Sowald is not required to agree to a restriction you request.

- *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 not want a family member to know that you are seeing a mental health professional. Upon your written request, Dr. Sowald will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in Dr. Sowald's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Dr. Sowald's may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, your therapist will discuss with you the details of the request process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Dr. Sowald may deny your request. On your request, your therapist will discuss with you the details of the amendment process.

- *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 (as described in Section III of this Notice). On your request, your therapist will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from Dr. Sowald upon request, even if you have agreed to receive the notice electronically.

Dr. Sowald's Duties:

- We are 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.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide notice thereof to all clients who are currently maintaining active accounts with Dr. Sowald, via U. S. mail.

V. Complaints

If you are concerned that Dr. Sowald has violated your privacy rights, or you disagree with a decision made about access to your records, you may Dr. Sowald, Privacy Officer, at (937) 434-6840.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

Dr. Sowald reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide active clients with a revised notice by U.S. mail, within 30 days of the effective date of policy changes.

NAME_____ DATE_____

Information Concerning and Acknowledgment of Informed Consent to Communicate Via Email or Text

Email or Text: Your Clinical File will include either an annotation of or a copy of all email or text communications sent to or received by the Provider in connection with your therapy. There are limitations and risks in connection with the use of email or text communications, including but not limited to privacy, confidentiality, and related limitations and risks.

Please also see the document entitled, "Client Information and Acknowledgment of Informed Consent to Treatment", for additional information and disclosures.

Consent: By my signature below:

a. I hereby give my informed consent to communicate with Debra K. Sowald, Psy.D. via email or text;

b. I understand that I have the right to refuse or withdraw the informed consent given above;

c. I acknowledge that I have read and understood all information contained herein and that I have been given an opportunity to ask questions concerning this document;

d. I acknowledge that I have been given a signed copy of this document.

Signature of Client: _____

Date: _____

Signature of Parent, Guardian or
Responsible Party of a Client who is a Minor:_____

Date: _____

Client Information:

Name of Client:_____
Last First Middle

Other Possible Names:_____

Date of Birth: _____Phone: _____

Address: _____

City: _____ State _____ Zip Code: _____

NAME_____ DATE_____

DEBRA K. SOWALD, PSY.D.
PSYCHOLOGIST
28 E. RAHN RD., SUITE 105
KETTERING, OHIO 45429
(937) 434-6840

Individual, Family, & Group Therapy
Imagery & Senoi Dreamwork
EMDR

Informed Consent for Electronic Communications and Telepsychology Treatment Sessions

What is telepsychology?

Telepsychology is a way to visit with healthcare providers, in this case, Dr. Sowald, through the use of an electronic device such as a computer, smartphone, tablet, iPad, or Chromebook.

Are there potential disadvantages or risks of telepsychology for me?

- You and Dr. Sowald won't be in the same room, so it may feel different from an office visit.
- Dr. Sowald may not be able to attend to all of the cues, especially nonverbal ones, as in person, and so may be less accurate in reading emotional cues.
- In rare cases, it is possible Dr. Sowald may decide you still need an office visit.
- Technical problems may interfere on occasion with the start of your session, or during the course of the session itself. **If this should occur, please have your telephone available and waiting, and Dr. Sowald will call you.** Together, the two of you can decide whether to re-attempt using the virtual program or simply continue the session telephonically.
- Because communication is occurring over an electronic medium, it is not possible for us to guarantee that a third party cannot somehow cut into the signal and follow along with the call. However, there are things that you can do, and that we will do, to try to minimize those risks: We agree to:

  1) Contact you from a secure internet connection, not public Wi-Fi.

2) Only contact you from a private space, where no other people can hear.
3) Whenever possible, use encrypted software for video calls so that the calls cannot be hacked into.

We suggest that you also protect yourself by using a secure internet connection and locating yourself in a space where you can have privacy from interruption and from being overheard by others.

- In the event of a mental health or other emergency, since you will not be in the therapist's office, there will need to be a contingency for providing emergency care. For this reason, each time there is a telepsychology session, it is the client's duty to provide the therapist with:
  1) A telephone number where you, the client, can be immediately reached,
  2) The physical location where you are located during the session (in case we need to contact police, fire, or EMT services), and
  3) The name and telephone number of a person who can reach you quickly should an emergency occur.

What other things do you want me to know?

1) We agree that we will not record your sessions electronically, and will only record information from your sessions in your file. You retain full rights to confidentiality of the information you share during telepsychology sessions. We also ask you to agree never to record our sessions.
2) Dr. Sowald has selected the electronic platform used for video sessions and will teach you how to use it for your sessions. You will need to use either a smartphone or a device with a webcam for these sessions.
3) In the event that you cannot be at a session, it is essential that you let Dr. Sowald know, well in advance, that you will not be in attendance.
4) If you are a minor, your parents must also consent to your use of telepsychology sessions.
5) It is assumed that where telepsychology services are in use, the therapist and client also are likely to be in communication by other electronic methods as well, including telephone, text, and/or email. By agreeing to telepsychology services, you are also agreeing to be contacted on occasion by these other means as well.
6) Your non-simultaneous contacts, such as emails and text messages, will be answered when Dr. Sowald is available to answer them, which may be very late at night, or into the next morning. All written telepsychology communications are stored in your treatment file.

If you sign this document, you agree that:

- We talked about the information in this document.
- Your questions have been answered.
- You want a telepsychology visit.

Your name (please print) (or your guardian, if required) Date

---

Your signature (or your guardian, if required) Date

A telephone number where you can be immediately reached: _____

The physical location where you are located during the session (in case we need to contact police, fire, or EMT services):

_____

_____

The name and telephone number of a person who can reach you quickly, should an emergency occur:

_____

Phone numbers for the Emergency resources in your geographical area:

_____

DEBRA K. SOWALD, PSY.D.
PSYCHOLOGIST
28 E RAHN RD SUITE 105
KETTERING, OH 45429

CONSENT TO TREAT A CHILD/ADOLESCENT

Part I: In order for us to treat a minor child (under 18 years of age) we must have the written consent of the child's parent(s) or legal guardian(s). Please indicate your consent for us to treat your child by signing the following statement:

I, _____, state that I have the legal right to authorize DEBRA K. SOWALD, PSY.D. to provide mental health services to _____ (DOB:_____) and do herewith authorize said services.

_____

Signature **Date**

Part II: As a rule, parents or legal guardians have a right to complete access to all information concerning the adolescent or child involved in therapy with us. However, our experience suggests that in order for many child and/or adolescent clients to feel comfortable in therapy, it is beneficial to offer them the opportunity to talk with the therapist and to know that what they tell the therapist will not get back to their parents (except in cases of imminent danger to the client or others, or where the therapist considers the information to be so serious that the parents' ultimate responsibility for the child's welfare dictates that the parents be kept informed).

We ask that you consider this issue in the therapy with your child. If you are willing to agree to this informal waiver of your right to full disclosure, we ask that you do the following:

a) indicate your agreement by signing the form below, and
b) tell your child that you have agreed to allow him/her to talk with us with a spirit of privacy, and that you will not insist that we relate all that your child tells us back to you.

_____

Signature **Date**

_____

Signature **Date**

DEBRA K. SOWALD, PSY.D.
PSYCHOLOGIST
28 E. RAHN RD., SUITE 105
KETTERING, OHIO 45429
(937) 434-6840

Individual, Family, & Group Therapy
Psychological Assessment
Imagery & Senoi Dreamwork

Please take time to check items which apply concerning _____.
Date _____. Person completing questionnaire _____.

_____ 1) Often fidgets with hands or feet or squirms in seat (in adolescents, may be limited to subjective feelings of restlessness).

_____ 2) Has difficulty remaining seated when required to do so.

_____ 3) Is easily distracted by extraneous stimuli.

_____ 4) Has difficulty awaiting turn in games or group situations.

_____ 5) Often blurts out answers to questions before they have been completed.

_____ 6) Has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension), e.g., fails to finish chores.

_____ 7) Has difficulty sustaining attention in tasks or play activities.

_____ 8) Often shifts from one incomplete activity to another.

_____ 9) Has difficulty playing quietly.

_____ 10) Often talks excessively.

_____ 11) Often interrupts or intrudes on others, e.g., intrudes into other children's games.

_____ 12) Often does not seem to listen to what is being said to him/her.

_____ 13) Often loses things necessary for tasks or activities at school or at home (e.g., toys, pencils, books, and assignments).

_____ 14) Often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking.

_____ 15) Onset of the above symptoms was before the age of seven.

****

VISUAL PROCESSING:

_____ 16) Has difficulty participating successfully in schoolwork.

_____ 17) Has poor balance.

_____ 18) Has irregular eye movements.

_____ 19) Gross motor movements appear awkward or clumsy.

_____ 20) Overreacts motorwise to unexpected touch and/or sound.

_____ 21) Has difficulty with Physical Education activities.

_____ 22) Motor activity involves unnecessary or inefficient movement of body parts.

_____ 23) Has difficulty with eye-hand tasks.

_____ 24) Written work is poorly spaced and disorderly.

_____ 25) Has difficulty folding paper or drawing lines as directed by teacher.

_____ 26) Does not use one hand consistently for writing and other motor tasks.

_____ 27) Immature patterns noted for prehension (grasping things) in non-pencil tasks.

_____ 28) Lacks right to left and top to bottom orientation.

_____ 29) Displays associated reactions and occasional mirroring in the non-used hand, when one hand is called on for specific skill performance.

_____ 30) Has poor organizational skills and gets disorganized under stress.

_____ 31) Expresses himself/herself extremely clearly, but social skills seem two years younger than peers.

_____ 32) Is very well coordinated, but overreacts or underreacts to frustration.

_____ 33) Has limited emotional control, and is unable to moderate his/her feelings.

_____ 34) Seeks peer approval by acting out and behaving aggressively.

_____ 35) Is confused about time and space relationships.

_____ 36) Has poor abstract reasoning skills.

_____ 37) Has difficulty copying geometric forms.

_____ 38) Does only part of his/her assignments, and the ones s/he does complete s/he usually rushes through, seldom going back to correct errors.

_____ 39) Exhibits poor emotional control and stability.

_____ 40) Is very impulsive and takes on an almost driven quality.

_____ 41) Tends to dawdle, to be disorganized, and to be unaware of the consequences of his/her actions.

_____ 42) Shows difficulty in these areas: impulsivity, a need for immediate gratification, suggestibility, and concerned only with himself/herself and his/her problems.

_____ 43) Requires more support and guidance than his/her peers.

****

AUDITORY PROCESSING

_____ 44) Needs to learn to Stop - Look - Listen - Then Speak.

_____ 45) Has trouble in the classroom when the noise level is high or there is consistent movement.

_____ 46) When certain parts of information are not "heard," due to distraction or someone not speaking directly to this student, s/he may feel s/he did not hear the information. S/he therefore may not follow the directions.

_____ 47) Shows indications of auditory short-term memory problems.

_____ 48) Does not always use complete or grammatically correct sentences when speaking. This also is evident in written schoolwork.

_____ 49) Exhibits difficulties with identifying and explaining causes of events. May also appear to repeatedly make mistakes, without realizing that this behavior is inappropriate.

_____ 50) In the classroom, this student exhibits a primitive defense response to detecting motion at the periphery of the visual field by turning and looking at what has moved, to determine the need for "fight" or "flight".

_____ 51) Tends to hurry through more difficult tasks and does not want to attempt those that s/he is unsure of.

D E B R A K . S O W A L D , P S Y . D .
P S Y C H O L O G I S T
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(9 3 7) 4 3 4 – 6 8 4 0

Individual, Family, and Group Therapy
Psychological Assessment
Imagery & Senoi Dreamwork

FAMILY QUESTIONNAIRE

1. GENERAL INFORMATION

Child's Name:_____Date:_____
Age:_____Date of Birth:_____Sex:_____Home Phone:_____
Mother's Name:_____If not natural mother, give relation-
Ship:_____Work Phone:_____
Father's Name:_____ If not natural father, give relation-
Ship:_____Work Phone:_____
If not presently with the child, please give name and whereabouts of
biological parent(s):_____
Legal Custodian of child, if other than natural parent(s): _____
Is child adopted?_____ If yes, what age was child when adopted?_____
Please list all children, including those by previous and subsequent
marriages, and any deceased children with date of death:

Name	Birthdate	Grade or Occupation	Living in Household?

Name of person(s) completing this form:_____
Name of family physician: _____
Address: _____

CHILD'S CURRENT PROBLEMS AND THEIR HISTORY

1. Describe the child's current problem(s) (medical, behavioral, emotional):
_____
_____
_____
_____
_____
_____
_____
_____
_____
2. When did the current problems start or when were they first noticed?
_____
3. Is the child aware of the problem(s)?_____If yes, how is this awareness expressed:_____
4. Has the possibility of evaluation been discussed with the child?_____ If yes, what was the child's reaction?_____
5. List all professionals and agencies which have been involved in the current problem(s), dates of contact, and whether it was beneficial:
_____Date:_____beneficial?_____
_____Date:_____beneficial?_____
_____Date:_____beneficial?_____
6. Has the child had medical, behavioral, or emotional problems other than the current one(s)? ___no___yes. If yes, please specify and list agencies involved and dates of contact.
_____Date:_____beneficial?_____
_____Date:_____beneficial?_____

CHILD'S EDUCATION

1. School your child is presently attending:_____
Address:_____
Phone:_____Grade:___Principal:_____
Teachers:_____
2. How does your child do in school, in terms of grades, ability, and behavior?_____
_____
3. Has your child repeated any grades?____If yes, provide what grade and the reason for repeating the grade:_____

4. Has your child required special help in any of the schools attended? ____
Dates_____School_____Nature of help:_____Beneficial?_____
Dates_____School_____Nature of help:_____Beneficial?_____
5. Child's behavior problems in school:_____
_____

IV. CHILD'S DEVELOPMENT

A. Please list any problems encountered during the pregnancy and/or delivery and the first weeks of life:_____
_____
B. Was the child administered oxygen at birth? _____
Early development:
1. Was your child an easy-to-care-for infant?_____If not, please explain:
_____
2. Was your child an easy-to-care-for toddler?_____If not, please explain:_____
3. Please list any problems encountered in the first three years of life:_____
_____
4. If your child has started puberty, has the onset appeared to cause any difficulties?_____If yes, please give details_____
5. Has your child ever behaved or talked in a way that was not sexually appropriate for a boy/girl or his/her age?_____If yes, give details:
_____

Does the child exhibit any of the following: (Write a star on the left of those which are of special concern to you.)

	Yes	No
1. fears	___	___
2. much fantasy	___	___
3. much daydreaming	___	___
4. hallucinations (Seeing, hearing, smelling, tasting, feeling things which do not exist)	___	___
5. disorientation (confused regarding who he/she is, date, time, or place)	___	___
6. self-destructive behavior	___	___
7. suicidal thoughts or attempts	___	___
8. nervous habits or tics (e.g., nailbiting) state which:_____	___	___

	Yes	No
9. fitful sleeping	___	___
10. nightmares	___	___
11. sleep walking	___	___
12. poor attention or concentration	___	___
13. difficulty following instructions	___	___
14. difficulty solving problems	___	___
15. poor memory	___	___
16. poor coordination	___	___
17. poor speech articulation	___	___
18. stuttering	___	___
19. compulsive speech (can't seem to stop talking)	___	___
20. loss of memory	___	___
21. repeating words or sentences	___	___
22. repeating (echoing) what others say	___	___
23. no speech	___	___
24. difficulty distinguishing left from right	___	___
25. eating non-food material (Pica)	___	___
26. vandalism	___	___
27. fire setting	___	___
28. verbal aggression	___	___
29. physical aggression	___	___
30. cruelty to animals	___	___
31. lying	___	___
32. drug use, alcohol usage	___	___
33. smoking	___	___
34. stealing	___	___
35. bed-wetting	___	___
36. soiling	___	___
37. running away	___	___
38. sexual activity	___	___
39. poor appetite	___	___
40. headaches	___	___
41. hyperactivity	___	___
42. repetitive worries (obsessions)	___	___
43. repetitive behaviors (compulsions)	___	___
44. disorganized	___	___
45. other: describe_____		

CHILD'S HEALTH

1. Does your child have any allergies? ____If yes, please give details:
_____
2. Has your child ever had fever above 105 degrees?_____If yes, please Give child's age at the time and the cause:_____
3. Has this child had any significant accidents or injuries (including broken Bones)?_____If yes, give details_____
4. Has your child ever lost consciousness?____If yes, give details:_____
_____
5. Has your child ever been hospitalized?_____If yes, give details_____
_____
6. Has your child had any operations?_____If yes, give details_____
_____
7. Has your child ever had seizures (convulsions)_____If yes, give details:
_____
8. Has your child ever received medications in the past for emotional, physical, learning, or behavioral problems?_____If yes, please give the following details:
Problem: _____
Age when first prescribed: _____
Medication:_____Daily Dose:_____
Times per day:_____Taken since: (date)_____
Who prescribed the medication(s)?_____
Is it helping?_____Side effects? _____

9. Is the child presently taking any other medications?____If yes:
Problem: _____
Age when first prescribed _____
Medication:_____Daily Dose:_____
Times per day:_____Taken since: (date)_____
Who prescribed the medication(s)? _____
Is it helping?_____Side effects? _____

10. Please describe any occurrences of birth defects, mental retardation, nerve disease (cerebral palsy, epilepsy) and psychiatric condition in the immediate family and the child's blood relatives:
_____
_____

VI. SIGNIFICANT EVENTS

1. Have any of the following events occurred in your family? If so, please Describe:

Event	Year	Describe
___move to a new place	____	_____
___significant separation from a parent	____	_____

Event	Year	Describe
___loss of someone very close	___	_____
___frightening experiences	___	_____
___change of school	___	_____
___serious illness or injury in family	___	_____
___death in family	___	_____
___change in family's financial status	___	_____
___promotion	___	_____
___loss of job	___	_____
___change of job	___	_____
___separation or divorce	___	_____
___brother or sister leaving home	___	_____
___marriage of sibling	___	_____
___emotional difficulties	___	_____
___legal problems	___	_____
___other (specify)	___	_____

VII. FAMILY

1. List relatives or others living in the household.

Name	Age	Relationship	Grade or Occupation

2. Marital History

   A. How would you describe your marital relationship? _____
   _____

   B. Have you sought outside help with regards to marital problems? ____
      If yes, please give details. _____
   _____

3. Have any family members had problems with substance abuse (drugs, alcohol)?____If yes, please give details_____
4. Have any family members been involved in incest (sexual interaction between a parent and child or between the children)?_____If yes, please give details: _____
_____

5. Has any family member been sexually, physically, or emotionally abused? _____If yes, please give details:_____
_____
_____

6. Please describe any problems that occurred while the child's father was growing up:_____
_____

7. Please describe any problems that occurred while the child's mother was growing up: _____
_____

8. Please describe any problems that occurred while the child's adoptive, step, or foster parent(s) or guardians were growing up:_____
_____
_____