

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 IN-PERSON SERVICES DURING  
COVID-19 PUBLIC HEALTH CRISIS**

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

**Decision to Meet Face-to-Face**

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

**Risks of Opting for In-Person Services**

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

**Your Responsibility to Minimize Your Exposure**

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, my other staff and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. \_\_\_\_
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. \_\_\_\_
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. \_\_\_\_
- You will wear a mask in all areas of the office. \_\_\_\_
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me or staff. \_\_\_\_
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. \_\_\_\_
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. \_\_\_\_
- You will take steps between appointments to minimize your exposure to COVID. \_\_\_\_
- If a resident of your home tests positive for the infection, you will immediately let me and my staff know and we will then begin or resume treatment via telehealth. \_\_\_\_

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

**My Commitment to Minimize Exposure**

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

**If You or I Are Sick**

You understand that I am committed to keeping you, me, my staff and all of our families safe from the spread of this virus. If you show up for an appointment and I or my office staff believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I or my staff test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

**Your Confidentiality in the Case of Infection**

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

**Informed Consent**

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

\_\_\_\_\_ Date

Patient/Client Signature

\_\_\_\_\_ Date

Clinician Signature



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**PSYCHOLOGIST**  
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**(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 \_\_\_\_\_



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**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:

Assessment and Diagnostic Impression  Treatment Plan and/or Outcome   
Medications Used and Response to the Medication  
 Assessment of Client's Substance Use/Abuse and Recovery  
 Client Identifying Information  Treatment Dates and Times  
 Recommendations for Follow-Up  Indicators of Progress  
 Psychosocial History  Psychological Evaluation  
 Admission Summary  Discharge Summary  
 Other \_\_\_\_\_

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  
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Individual, Family, & Group Therapy  
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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:
<b>Primary Physician Information</b>	<b>Behavioral Health Clinician Information</b>
Name:	Name: DEBRA K. SOWALD, PSY.D. PSYCHOLOGIST
Address:	Address: 28 E. RAHN RD. STE 105
Phone:                      Fax:	KETTERING, OH 45429
<input type="checkbox"/> Patient does not have a primary physician	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.

This form prepared by The Health Improvement Collaborative of Greater Cincinnati in collaboration with behavioral health providers. This form may be copied and reprinted.



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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA [ ] [ ] [ ] PICA [ ] [ ] [ ]

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER
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 SEX
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED
7. INSURED'S ADDRESS (No., Street)
8. PATIENT STATUS
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
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

Table with 10 columns: A. DATE(S) OF SERVICE, B. PLACE OF SERVICE, C. EMG, D. PROCEDURES, SERVICES, OR SUPPLIES, E. DIAGNOSIS POINTER, F. \$ CHARGES, G. DAYS OR UNITS, H. EPSDT Family Plan, I. ID. QUAL., J. RENDERING PROVIDER ID. #

PHYSICIAN OR SUPPLIER INFORMATION

24. FEDERAL TAX I.D. NUMBER SSN EIN
25. PATIENT'S ACCOUNT NO.
26. ACCEPT ASSIGNMENT? (For govt. claims, see back)
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE

30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
31. SERVICE FACILITY LOCATION INFORMATION
32. BILLING PROVIDER INFO & PH #

**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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.



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.



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

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**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**



Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_  
 Grade: \_\_\_\_\_ Advisory Teacher: \_\_\_\_\_ Pod: \_\_\_\_\_

DIRECTIONS: Read the following list and draw a circle around the number of each problem that troubles you.

- |  |   |
|--|---|
| 1. Afraid of tests.                            | 34. Upset about someone's death.                    |
| 2. Being a grade behind in school.             | 35. Trouble relating to boys/girls.                 |
| 3. Being afraid of making mistakes.            | 36. Being Stubborn.                                 |
| 4. Trouble in math.                            | 37. Hard to stop bad habits.                        |
| 5. Trouble in spelling or grammar.             | 38. Not controlling my temper.                      |
| 6. Trouble with reading.                       | 39. Having bad nightmares, trouble sleeping.        |
| 7. Trouble in writing.                         | 40. Bashful, shy.                                   |
| 8. Trouble in science.                         | 41. Don't know how to make friends.                 |
| 9. Trouble in social studies.                  | 42. Being left out of things.                       |
| 10. Poor memory.                               | 43. Never chosen as a leader.                       |
| 11. Afraid to speak up in class.               | 44. Being teased.                                   |
| 12. Underweight.                               | 45. Upset about moving.                             |
| 13. Overweight.                                | 46. Not getting along with a brother.               |
| 14. Too clumsy and awkward.                    | 47. Not getting along with a sister.                |
| 15. Having poor posture.                       | 48. Arguing with my parents.                        |
| 16. Too short for my age.                      | 49. Having no regular allowance.                    |
| 17. Too tall for my age.                       | 50. Not feeling loved.                              |
| 18. Can't hear well.                           | 51. Not allowed to run around with the kids I like. |
| 19. Getting tired easily.                      | 52. Five things I like about myself are:            |
| 20. Don't have much fun.                       | A. _____  |
| 21. Scared a lot of the time.                  | B. _____  |
| 22. Don't know what to do when I'm mad.        | C. _____  |
| 23. Don't know what to do when I'm sad.        | D. _____  |
| 24. Don't know what to do when I'm scared.     | E. _____  |
| 25. Being nervous, worrying.                   | _____   |
| 26. Feelings hurt too easily.                  | _____   |
| 27. Hurting other people's feelings.           | _____   |
| 28. Feeling no one cares about me.             | _____   |
| 29. Sometimes wishing I were dead.             | _____   |
| 30. Finding it hard to talk about my troubles. | _____   |
| 31. Afraid to try new things by myself.        | _____   |
| 32. Hard to give compliments to others.        | _____   |

DIRECTIONS: Write "yes" or "no" in each space.

- \_\_\_\_ 54. I would like to talk individually with the counselor.  
 \_\_\_\_ 55. I would like to be in a counseling group to solve some problems I have.



**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  
2 8 E . R A H N R D . , S U I T E 1 0 5  
( 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
<input type="checkbox"/> move to a new place	_____	_____
<input type="checkbox"/> significant separation from a parent	_____	_____

Event	Year	Describe
<input type="checkbox"/> loss of someone very close	_____	_____
<input type="checkbox"/> frightening experiences	_____	_____
<input type="checkbox"/> change of school	_____	_____
<input type="checkbox"/> serious illness or injury in family	_____	_____
<input type="checkbox"/> death in family	_____	_____
<input type="checkbox"/> change in family's financial status	_____	_____
<input type="checkbox"/> promotion	_____	_____
<input type="checkbox"/> loss of job	_____	_____
<input type="checkbox"/> change of job	_____	_____
<input type="checkbox"/> separation or divorce	_____	_____
<input type="checkbox"/> brother or sister leaving home	_____	_____
<input type="checkbox"/> marriage of sibling	_____	_____
<input type="checkbox"/> emotional difficulties	_____	_____
<input type="checkbox"/> legal problems	_____	_____
<input type="checkbox"/> 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:\_\_\_\_\_

\_\_\_\_\_