Tania Davidson, Psy.D. PSY16510
Clinical Psychologist

Outpatient Services Contract

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them in our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular issues you bring to treatment. There are many different methods that Dr. Davidson may use to deal with the problems that you hope to address. These methods include cognitive behavioral, psychodynamic, play therapy with children, parent-child interaction therapy with children and parents, among others.

Psychotherapy can have benefits and risks. Approaching feelings and thoughts that a person has tried not to think about may be painful. Making changes in your thinking or behaviors can be scary and sometimes disruptive. On the other hand, clients find that their relationship with their therapist and the work done in psychotherapy results in benefits such as improved relationships, solutions to specific problems and significant reductions in feelings of distress. It is important to remember that there are no guarantees of what you will experience. There are risks involved with changing. Most people who take these risks in therapy found that it was helpful and that they have benefitted.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, Dr. Davidson will be able to offer you some first impressions of what the work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with Dr. Davidson. Therapy involves a significant commitment of time, money and energy, so you should be very selective

about the therapist you choose to see. If you have questions about Dr. Davidson's procedures, you should discuss them whenever they arise. If your doubts persist, Dr. Davidson will be happy to set up a meeting with another mental health professional for a second opinion.

MEETINGS

Dr. Davidson normally conducts an evaluation that will last from 1 to 4 sessions. During this time, both you and Dr. Davidson can decide if she is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, she usually schedules one 50-minute session per week (one appointment hour of 50 minutes duration) at a time that is agreed upon, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it (or your insurance carrier) unless you provide at least 24 hours advance notice of cancellation. If you cancel or reschedule in less than 24 hours, you will be billed for the session at the rate you normally pay or if you use insurance, at the contracted rate for that carrier. If it is possible, Dr. Davidson will make every effort to reschedule your appointment.

PROFESSIONAL FEES

Dr. Davidson's hourly fee is $150.00. In addition to your weekly appointments, she charges this amount for other professional services you may need, though she will break down the hourly cost if she works for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals that you have authorized, preparation of records or treatment summaries and the time spent performing any other service that you request. If you become involved in legal proceedings that require Dr. Davidson's participation, you will be expected to pay for the professional time even if she is called to testify by another party.

BILLING AND PAYMENT

You will be expected to pay for each session at the time it is held, unless it is agreed otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of financial hardship, Dr. Davidson may negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, Dr. Davidson has the option to use legal means to secure payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information that is released regarding a patient's treatment is his/her name, the nature of services provided and the amount due.

INSURANCE REIMBURSEMENT

In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Dr. Davidson will fill out forms and provide you with whatever assistance she can in helping you receive the benefits for which you are entitled; however, you (not your insurance carrier) are responsible for full payment of the fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, Dr. Davidson will provide you with whatever information she can based on her experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, she will be willing to call the insurance on your behalf.

Due to the rising costs of health care, insurance benefits have become increasingly more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMO's and PPO's 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 number of sessions. While a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. Some managed care plans will not allow Dr. Davidson to provide services once your benefits end. If this is the case, Dr. Davidson will do her best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize Dr. Davidson to provide them with a clinical diagnosis. Sometimes, she has to provide additional clinical information such as

treatment plans or summaries, or copies of the entire chart (in rare cases). This information will become part of the insurance company's files and will likely be stored in a computer. Though all insurance companies claim to keep such information confidential, Dr. Davidson has no control over what they do with this information with a national medical information database. Dr. Davidson will provide you with a copy of any record she submits, if you request it.

Once Dr. Davidson has all the information about your insurance coverage, you and Dr. Davidson will discuss what you can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your treatment sessions. It is important to remember that you always have the right to pay for Dr. Davidson's services yourself to avoid the problems described (unless prohibited by contract).

CONTACTING DR. DAVIDSON

Dr. Davidson is not always immediately available by phone. While she is usually in her office between 10 AM and 8 PM, she will not answer the phone if she is with a client. When she is unavailable, her telephone is answered by voice mail that she monitors frequently. Dr. Davidson will make every effort to return your call on the same day that you make the call, with the exception of weekends and holidays. If you are difficult to reach, please inform Dr. Davidson of some times when you will be available. In emergencies, you may contact Dr. Davidson via cell phone at (714) 305-6479. If you are unable to reach Dr. Davidson and feel that you cannot wait for her to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. Dr. Davidson may be away from her office at times for professional meetings, occasional vacations and professional conferences. Clients are always to be informed well in advance of these planned absences and will have a therapist offered as back-up who can provide interim counseling and support until Dr. Davidson returns.

PROFESSIONAL RECORDS

The laws and standards of the profession require that Dr. Davidson keep treatment records. You are entitled to receive a copy of your records, or she can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, it is recommended that you review them with Dr. Davidson so that the contents can be discussed. Clients will be charged an appropriate fee for her professional time spent in responding to information requests.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is Dr. Davidson's policy to request an agreement from parents that they agree to give up access to your records. If they agree, Dr. Davidson will provide them with only general information about your work together, unless she feels that there is a high risk that you will seriously harm yourself or another person. In this case, Dr. Davidson will notify them of her concern. She will also provide them with a summary of your treatment when it is complete. Before giving parents/guardians any information, Dr. Davidson will discuss the matter with you, and, if possible, do her best to handle any objections you may have with what she is prepared to discuss.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychotherapist are protected by law, and Dr. Davidson can only release information about your treatment to others with your written permission. There are a few exceptions.

In most legal proceedings, you have the right to prevent Dr. Davidson from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order her testimony if he/she determines that the issues demand it.

There are some situations in which Dr. Davidson is legally obligated to take action to protect others from harm, even if she has to reveal some information about the client's treatment. For example, if Dr. Davidson believes that a child or an elderly/disabled person is being abused, she is required to file a report with the County agency.

If Dr. Davidson believes that a client is threatening serious bodily harm to another, she may be required to take action to protect others. These actions may include notifying the potential victim, contacting the police or seeking hospitalization for the client. If the client threatens to harm him/herself, she may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection and safety for the client.

These situations have occurred rarely in Dr. Davidson's practice. If a similar situation occurs, Dr. Davidson will make every effort to discuss it with you fully before any action is taken.

There are times when Dr. Davidson consults with other professional colleagues to gain greater insight and receive feedback on her work. This is an essential part of professional practice that most psychologists practice in order to provide the highest quality of treatment. If Dr. Davidson consults on her work with a client, she will not use your name or any other identifying information. If you feel that Dr. Davidson is in need of getting better information about a topic of concern for you, please let her know: she is always open to your suggestions and concerns and encourages collaboration.

All other disclosures of information, even to say that you are receiving treatment, must be authorized by you and all other information remains protected and confidential.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss with Dr. Davidson any questions or concerns that you have at the next meeting. She will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and Dr. Davidson is not an attorney. If you request, she will provide you with relevant portions or summaries of the State laws regarding these issues.

OTHER RIGHTS

You have the right to ask questions about anything that happens in therapy. Dr. Davidson is always willing to discuss how and why she has decided to do what she is doing, and to consider alternatives that may work better. You can request that Dr. Davidson try something else you think may be more helpful. You can request information about Dr. Davidson's training in working with your particular problem, and can always choose to see another therapist if you choose. You are free to end therapy at any time and can decline services altogether if desired.

Responsibilities of a Therapy Client

1. Clients are responsible for coming to their appointment on time, as scheduled. If clients are late, the session will end on time and not run into the next client's appointment time.

2. Clients who are using insurance are responsible for paying their copayment at each appointment unless other arrangements are made with Dr. Davidson.
3. The client is responsible for informing Dr. Davidson of any change in insurance coverage, address and phone number and emergency contacts.

CONSENT TO PSYCHOTHERAPY

I have read this statement, had sufficient time to be sure that I considered it carefully, and understand it. I consent to the use of a diagnosis in billing, and to release that information and other information necessary to complete the billing process. I understand my rights and responsibilities as a therapy client, and Dr. Davidson's responsibility to me. I agree to receiving assessment and/or treatment with Dr. Davidson as described. I know that I can end therapy at any time, and that I can refuse any requests or suggestions made by my Dr. Davidson. I agree to abide by the terms of this contract for the duration of our professional relationship.

Signed: (Client or Parent/Guardian)

____

Date: ____________

Witness: ____

Tania Davidson, Psy.D.
580 Beech Avenue, Suite B
Carlsbad, CA 92008
(760) 729-5900

Client Information

Instructions: Please fill out this form as completely as possible and please print or write legibly. If you need more room to complete any section, continue writing on the back of that page. For couples and family therapy, each person should complete a set of all four pages. If certain questions do not apply to you, write NA. If you have questions or concerns about any items, please discuss them with Dr. Davidson. All information is CONFIDENTIAL.

Your Name (First, Middle Initial, Last)

____

Address____

City/State/Zip____

Phone #s: Home ____

Work__________________________________ **Cell:** _______________________________

Email :________________________________**Ok to Email Statements/Invoices?**______________

Do you want us to use discretion when calling you or leaving messages at any of the phone #s?

No____ Yes____ (If Yes, please be specific) ____

Age_________ **Birth Date**________________ **Social Security #** ______________________________

Occupation____

Employer____

Single____ Married____ (# years_______) Partnered____ (# years_______) Separated____ Divorced____

Widowed____ Other____ (specify)____

Names and ages of children____

____

Spouse's/Partner's Name____

Age________

Spouse's/Partner's Occupation____

Significant medical problems you have or had_______________________________________

____

Current Physician: _________________________________ **Phone #** ______________________

Current medications you are taking____

____

If you have had any previous mental health and/or substance abuse treatment (outpatient and inpatient), list the type and approximate start and end dates for each:

____

____

____

____

____

If you are currently working with any mental health professionals (including psychiatrists), list their names, profession, phone number and address and length of time you have been working with them:

____

____

____

____

Primary Insurance Information
Insurance Company and Type (HMO, PPO, etc.) ____

Member ID #_________________________________

Group/Plan#_________________________________

Insurance Phone # (for benefit or claims information from your card)

____

Claims address (from your card)
____

____

Are you the policy holder? Yes___ No___ If no, complete the following about the policy holder:

Policy holder's name____

Address & Phone # (only if different than yours)____

____

Birth Date____________________ **Social Security #** _______________________________

Employer____

Your relationship to policy holder____

PLEASE PROVIDE YOUR INSURANCE CARD TO BE COPIED

SIGNATURES

Please sign in all the appropriate places:

ALL CLIENTS SIGN HERE

I certify that all the information I have provided above is accurate to the best of my knowledge. If any of the information changes I will provide updated information to Dr. Davidson as soon as possible.

____ ________________________

Client Signature **Date**

CLIENTS USING INSURANCE ALSO SIGN IN BOTH PLACES BELOW
I authorize the release of any clinical, benefits or other information between Tania Davidson, Psy.D. and my insurance company/companies that is necessary to process insurance claims for me or my dependents. Clinical information may include current and/or past symptoms, previous mental health treatment, diagnosis/diagnoses, treatment plan and/or goals, progress reports, copies of clinical notes or other clinical information.

____ _______________________________

Client Signature or Parent/Guardian Signature for Minors **Date**

I authorize payment of health insurance benefits to Tania Davidson, Psy.D.. for services provided. I understand that I am responsible for knowing my insurance coverage, and am ultimately responsible for all payments, including copays or other uncovered services.

____ _______________________________
Client Signature or Parent/Guardian Signature for Minors **Date**

For co-payments and/or services not covered by insurance, the following information is needed:

Client Name: ____

Name on Card: ____

Date: ____

Type of Card: VISA ❒ MasterCard ❒ Exp. Date: _____/______

Card Number: ______________-_______________-_______________-______________

Verification/Security Code (3 digit code on back of card by signature line):_______________

Billing Address:____

City:______________________ State: ____________________ Zip:________________

CLIENT HEALTH HISTORY

Patient Name:____
Marital Status:______________________
Person completing form (if other than patient):___________________________
Relationship:______________
Name of Guardian (if applicable): _______________________________
Contact person in case of emergency: _________________**Relationship**:___________
Phone #:___________
Primary Care Physician: _______________________________________
Date of Last Exam: _____________
Current Medical Condition(s):
____
____
Any peri-natal or developmental abnormalities? No___ Yes___ (Please explain on back of form)
Are you currently taking any prescription or "over the counter" medication(s)? No___ Yes___
If Yes, please identify the name, current dosage, and date began for each: ________________________
____
Do you have any allergies? No___ Yes___ If yes, please list: ___________________________________
____
Have you received any Psychological/Psychiatric treatment before? No___ Yes___
If Yes, please show the total number of outpatient visits you have had: _____
What was your age at the first visit? _____
Have you had any inpatient/hospital treatment for mental health or substance abuse? No___ Yes___
[If Yes, please list facility(ies) date(s) and length(s) of stay(s)]: ___________________________________
____
What caused you to get help now?
____
____
____
Do you smoke cigarettes? No___ Yes___ If yes, how many per day? _____________
How much alcohol do you drink per week on average? _____ drinks per week
Have you had problems with your drinking (legal, health, work, relationship?)
No___ Yes___ If Yes, please explain: ____
____
Please answer whether or not you are experiencing any of the following symptoms:
Suicidal Thoughts/Impulses .... N____ Y____
Homicidal Thoughts/Impulses .... N____ Y____
Appetite Problems .... N____ Y____
Sleep Problems .... N____ Y____
Physical Complaints .... N____ Y____
Anger/Irritability .... N____ Y____
Isolation/Social Withdrawal .... N____ Y____
Anxiety/Panic .... N____ Y____
Phobia .... N____ Y____
Bingeing/Purging .... N____ Y____
Poor Impulse Control .... N____ Y____
Violence Toward Others .... N____ Y____
Destruction of Property .... N____ Y____
Strange or Unusual Behavior .... N____ Y____
Confused or Irrational Thinking .... N____ Y____
Bothersome Repetitive Thoughts or Behaviors N____ Y____
Self-mutilation .... N____ Y____

HIPAA NOTICE OF PRIVACY PRACTICES

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

II. IT IS YOUR THERAPIST'S LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
By law, your therapist is required to insure that your PHI is kept private. The PHI constitutes information created or noted by your therapist that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you. Tania Davidson, Psy.D. or employees of Dr. Davidson are required to provide you with this notice about our privacy procedures. PHI is disclosed when your therapist releases, transfers, gives, or otherwise reveals it to a third party outside of the offices of Dr. Davidson. With some exceptions, your therapist may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, your therapist is always legally required to follow the privacy practices described in this notice. Any changes will apply to PHI already on file with Dr. Davidson. You may request a copy of this notice from your therapist.

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

A. Uses and disclosures related to treatment or health care operations do not require your prior written consent.

1. **For treatment.** Your therapist may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, your therapist may disclose your PHI to her/him in order to coordinate your care.

2. **For health care operations.** Your therapist may disclose your PHI to facilitate the efficient and correct operation of our Center. Examples: Quality control – Your therapist might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services.

3. **Other disclosures.** Examples: Your consent isn't required if you need emergency treatment provided that your therapist attempt to get your consent after treatment is rendered. In the event that your therapist tries to get your consent but you are unable to communicate with him/her (for example, if you are unconscious or in severe pain) but your therapist thinks that you would consent to such treatment if you could, he/she may disclose your PHI.

B. Certain other uses and disclosures do not require your consent. Your therapist may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: Your therapist may make a disclosure to the appropriate officials when a law requires him/her to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.

2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.

3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.

4. If disclosure is compelled by the client or the client's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.

5. To avoid harm. Your therapist may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of person or the public.

6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if your therapist determines that disclosure is necessary to prevent the threatened danger.

7. If disclosure is mandated by the California Child Abuse and Neglect Reporting law. For example, if your therapist has a reasonable suspicion of child abuse or neglect.

8. If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law. For example, if your therapist have a reasonable suspicion of elder abuse or dependent adult abuse.

9. If disclosure is compelled or permitted by the fact that you tell your therapist of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, your therapist may need to give the county coroner information about you.

11. For specific government functions. Examples: When requested, your therapist may disclose PHI in the interests of national security.

12. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to a subpoena for mental health records or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

13. The therapist is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that may be of interest to you.

14. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.

15. If disclosure is otherwise specifically required by law.

C. Certain uses and disclosures require you to have the opportunity to object.

1. Disclosure to family, friends, or others. Your therapist may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other uses and disclosures require your prior written authorization. In any other situation not described in Sections IIIA, IIIB and IIIC above, your therapist will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that your therapist hasn't taken any action subsequent to the original authorization) of your PHI by your therapist.

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

A. **The right to see and get copies of your PHI.** In general, you have the right to see your PHI that is in your therapist's possession, or to get copies of it; however, you must request it in writing. If your therapist does not have your PHI, but he/she knows who does, the therapist will advise you how you can get it. You will receive a response from your therapist within 30 days of him/her receiving your written request. Under certain circumstances, your therapist may feel he/she must deny your request, but if he/she does, your therapist will give you, in writing, the reasons for denial. Your therapist will also explain your right to have the denial reviewed. If you ask for copies of your PHI, your therapist will charge you no more than $.25 per page. Your therapist may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. **The right to request limits on uses and disclosures of your PHI.** You have the right to ask that your therapist limit how much he/she use and disclose your PHI. While your therapist will consider your request, he/she is not legally bound to agree. If your therapist does agree to your request, he/she will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that your therapist is legally required or permitted to make.

C. **The right to choose how your therapist sends your PHI to you.** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). Your therapist is obliged to agree to your request providing that he/she can give you the PHI, in the format you requested, without undue inconvenience.

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

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

F. **The right to get this notice by email.** You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES. If in your opinion, your therapist has violated your privacy rights, or if you object to a decision your therapist made about access to your PHI, you are entitled to file a complaint with the therapist. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about the therapist's privacy practices, he/she will take no retaliatory action against you.

Tania Davidson, Psy.D. PSY16510

Licensed Clinical Psychologist

800 Grand Avenue Suite A16

Carlsbad, CA 92008

I, ______________________________ certify that I have received the Notice of Privacy Practices detailing The Health Insurance Portability and Accountability Act (HIPAA) of 1996 as it pertains to Mental Health Records:

Client Signature: ____ Date: _______________

Witness: ____ Date: _______________

Tania Davidson, Psy.D. PSY16510

Licensed Clinical Psychologist

CLIENT'S BILL OF RIGHTS

You have the right to:

- Receive respectful treatment that will be helpful to you
- Receive a particular type of treatment or end therapy without any obligation
- A safe environment free from sexual, physical and emotional abuse
- Report unethical and illegal behavior by a therapist
- Ask questions about your therapy
- Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, ;professional association membership, specializations and limitations
- Refuse electronic recording or request it if you wish
- Refuse to answer any questions or disclose any information you choose not to reveal
- Know the limitations of confidentiality and the circumstances in which a therapist is legally obligated to disclose information to others
- Know if there are supervisors, consultants, students or others to whom your therapist will discuss your case
- Request and receive a summary of your chart including the diagnosis, your progress and type of treatment

- Receive a second opinion at any time about your therapy or your therapist's methods
- Request that the therapist inform you of your progress

__________________ Initial

Tania Davidson, Psy.D. PSY16510
Licensed Clinical Psychologist

NO-SHOW AND CANCELLATION POLICY

This is my declaration of agreement regarding missed or cancelled appointments. I understand and agree to the following:

1. It is my responsibility to notify Dr. Davidson (760) 729-5900 at least 24-hours prior to the scheduled appointment if I am unable to keep the scheduled appointment.
2. I agree that I will be billed the insurance contracted rate or the regular fee if I pay out of pocket in the event that I miss an appointment or fail to cancel at least 24-hours prior to the scheduled appointment.
3. If I violate this policy, I agree to be charged for the session automatically by credit card (complete below).

Patient: ____

Clinician: ____

Date: ____

Type of Card: VISA ❒ MasterCard ❒ Exp. Date: _____/______

Card Number: ________________-_________________-_________________-________________

Verification/Security Code (3 digit code on back of card by signature line):________________

Billing Address:____

City:__________________________ State: ______________________ Zip:__________________

580 Beech Avenue, Suite B Carlsbad CA 92008

(760) 729-5900

Office location is on the corner of Beech and Roosevelt in Carlsbad Village across the street from the Post Office. There is a small parking lot to the side of the building and street parking.