INITIAL

PAPERWORK

FOR

CARRI LAGER, Ph.D.
Licensed Psychologist

-Please read pages 1-4 and sign/date page 4 (these policies will be discussed in more detail at the beginning of our intake appointment)

-Please read the "Notice of Privacy Practices Disclosure" on page 5 and sign the acknowledgement form on page 6

-Please complete all requested information on pages 7-8

-If planning to try to use insurance to pay for part of my services now or in the future, please complete page 9 to the best of your knowledge

-Please bring this paperwork (pp. 5-10) to your first appointment.

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Welcome to My Practice

Realize Your Unique Path

I sincerely appreciate the opportunity to work with you and support your decision to enter into therapy. Please read the following information regarding my qualifications, professional services, and business policies and then sign to confirm that you have read and understand these items. Once signed, this will represent an agreement between us. In addition to general information about my practice, you will be provided with a summary of the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The law requires that I obtain your signature to acknowledge that I have provided you with this information. All of this data is provided to assist you in making informed decisions regarding my services. Please feel free to ask questions at any time. You will receive a copy of these forms for your records. Please note that although I share this office with other mental health professionals, I work independently and will be responsible for maintaining your confidentiality.

Your Therapist's Qualifications/Theoretical Orientation:

I earned my Ph.D. in Counseling Psychology from Loyola University Chicago with a focus on developmental and multicultural issues in psychotherapy and a combined Masters Degree and Specialist Degree (M.Ed./Ed.S.) in Mental Health Counseling from one of the nation's top ranked Counselor Education programs at the University of Florida. I am currently licensed by the Florida Department of Health to practice clinical psychology independently.

I have over ten years of clinical training and experience working with diverse children, adolescents, young adults, adults, and couples within university counseling centers, outpatient centers, inpatient child/adolescent and substance abuse hospitals, and school settings. My clients sought treatment for a variety of presenting issues ranging from short-term transitional concerns to more long-standing, deep-rooted issues. Some of my specialties include the treatment of anxiety disorders, eating disorders, LGBTQ issues, addictions, and grief/loss. I have an integrative treatment approach and philosophy based on the individual needs of my clients that combines evidence-based cognitive-behavioral, solution-focused, relational, and acceptance-based approaches.

I have found that there is too often an emphasis on "problems" or "what's wrong" with individuals that seek therapy, often creating a negative stigma. My therapeutic style is unique in that I take ample time to thoroughly understand the issues that bring my clients into treatment while simultaneously discovering, highlighting, and utilizing their strengths and successes to carefully develop focused and realistic treatment goals. This is done in the context of considering each client's unique cultural background and life experiences. My aim is to help restore your sense of well-being and balance as quickly as possible by fostering self-reliance, self-acceptance, and self-awareness in a caring, accepting environment. I view the therapeutic relationship as a primary agent of change and work to ensure this relationship develops into one that is both safe and collaborative.

What to Expect:

Please be aware that therapy can have benefits and risks. You may find that some of what we discuss brings up difficult feelings such as sadness, anger, guilt, or frustration. I encourage you to openly explore your experience with me during each session and be honest about areas of our work that you find challenging. Some of the potential benefits that you may obtain through the course of therapy include healthier relationships, creative solutions to issues, greater self-awareness and strength, and a significant reduction in feelings of distress. While there are no guarantees of what you will experience, therapy tends to be most successful when you actively participate both within and between our meetings.

The initial session will be spent getting to know you by exploring relevant history (e.g., psychological treatment history, medical history, nature of the issues that will be the focus of your treatment) and beginning to develop a plan of action that we will revisit as needed on an ongoing basis. My style is collaborative because I believe that each person is the expert of their life. We will work together to develop both short-term and long-term goals and

consistently measure our progress toward achieving them. It is my role to foster greater self-awareness so a unique path toward a sense of balance can be realized. Should you decide to pursue a therapeutic relationship with me, subsequent sessions will be 50 minutes in length, typically once per week during a time that we mutually agree upon (see fee structure below). It is important for you to communicate any questions, concerns, or other issues that may arise during the course of treatment. If you find that working with me is not a good match, I would be happy to refer you to another mental health professional in the community.

Minors

If you are under 18 years of age, please be aware that the law may provide your parent(s)/legal guardian(s) the right to examine your treatment records. In order to establish a trusting and open relationship with you, it is my policy to request that your parent(s)/legal guardian(s) agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I determine that there is a high risk of you harming yourself or someone else. In this case, I will make every effort to discuss my concern with you and inform you of my intention to express that concern to your parent(s)/legal guardian(s). In addition, if you tell me that you are being abused, I am legally required to report this to the Florida Department of Child and Family Services (DCFS) immediately. At the end of our treatment, I will prepare a written summary of our work together to present to your parent(s)/legal guardian(s) and we will discuss it before I give it to them.

Office Procedures: Cancellation Policy/Fees:

If you are unable to attend an appointment, it is your responsibility to cancel your session at least 24 hours in advance of the session by calling the office. Failure to do so will result in being charged for the session. **The fee for cancellation without a 24-hour notice or for a "No Show" is $75.00.** This fee cannot be billed to your insurance company. Certain exceptions will be made to this policy in the event of an emergency. Therapy works the best with clients being committed to showing up for appointments and several cancellations might hinder your progress. Additionally, not showing up or calling may take the possibility of an appointment from another client. If 24-hour notice is provided, I will attempt to find another time in which to see you as soon as possible.

The fee for both intake and regular 50-minute individual or couples sessions is $150. Fees for other services will be discussed on an individual basis. Sliding scale-fees are available, based on economic need and availability. Payment can be made via cash, personal checks, Visa, MasterCard, or American Express. You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement (see below section on "Insurance Reimbursement").

Past Due Account

If your account has not been paid for sixty days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment (e.g., collection agency or small claims court). If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount that is due.

Legal Fees

If you are involved in a legal matter I am advising you that I am not for hire as an expert witness nor do I go to court for my clients. By signing this document you are acknowledging and agreeing that you will not involve me in your legal case. In the case that I am court ordered to be involved in any litigation, I charge a flat rate of $1,000.00 paid in advance per day to appear in court regardless of the amount of time I spend in court. Additionally, I charge a rate of $250 per hour for time spent in depositions, consulting with attorneys, or writing legal reports. Your signature below indicates your acknowledgement and agreement that these fees will be paid in advance.

Insurance Reimbursement:

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your therapy. If you have an insurance policy, it will usually provide some coverage for mental health treatment. Due to the rising costs associated with health care, insurance benefits have become increasingly more complex. Managed health care plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. Also, these plans are often limited to short-term treatment approaches (e.g., less than 12 sessions/year). As such, it may be necessary to seek approval for more therapy after a certain number of sessions have been utilized. While short-term treatment can be very effective for some individuals, others find that they require more services after insurance benefits end. It is also important for you to keep in mind that most insurance companies will require you to authorize me to provide them with a clinical diagnosis or other information such as treatment plans or summaries. This information will then become part of the insurance company files and will most likely be stored in a computer. Though all insurance companies claim to keep this information confidential, I have no

control over what they do with it once it is in their hands. In some cases, they might share this information with a national medical information databank.

I am currently an out-of-network provider with all insurance companies. Filing directly with your insurance company is a relatively easy process and I will help you with it throughout treatment. Most insurance companies will reimburse you between 50% to 80% of your out-of-network costs depending on your plan and deductible. First, you will need to call your insurance company and ask about your mental health "out-of-network benefits."

Questions that you might ask your insurance company include*:*

- Do I have out-of-network benefits to see a licensed psychologist?
- If so, what percentage do you cover?
- What is the deductible, and how much of the deductible have I met?
- What is my co-pay for a session if I see an out-of-network provider?
- How many sessions are covered, and in what time period?
- Do I need to obtain pre-authorization for sessions?

I can help you bill your insurance company for payment of their portion of the charges by providing you with what is called a "Superbill" that you submit directly to your insurance company at the end of each month or session, whichever you prefer. This bill will provide your insurance company with all of the necessary information from me that is needed to process your claim and consider it for reimbursement. However, *you* are responsible for the fee due at the time of each visit. I cannot guarantee that your insurance carrier will cover services provided. It is your responsibility to verify your specific contractual requirements and/or exclusions of your policy by discovering answers to the above listed questions prior to our initial contact.

If you are a policy holder for an insurance company in which I am an in-network provider, I will be happy to file for you or provide you with a receipt for filing for reimbursement. Should I file for you, *payment in full for the initial session is required, and your co-payment and any subsequent un-reimbursable portion of fees will be made when services are provided.* If your carrier makes payments to you directly, you are responsible to pay each session in full at the time of service. Please feel free to discuss any billing matters with me.

Once we have all of the information about your coverage, we will discuss what we can expect to accomplish with the available benefits and what will occur should they run out before you feel ready to end our sessions. Please remember that you will always have the right to continue working with me by paying for my services yourself to avoid the potential issues discussed above (unless prohibited by contract).

Messages/Phone Consultations/Emergencies

Messages are checked and returned as soon as possible, typically within 24 hours. Please leave both day and evening phone numbers and whether or not I can leave a message for you. I am available by phone for brief questions and concerns. However, phone conversations that extend beyond twenty minutes will constitute phone sessions and be charged according to my hourly rate (pro-rated if less than fifty minutes).

If you have an emergency, please call my office. However, if I am unavailable due to other client commitments, please hang up and dial 911 immediately or go to the nearest hospital emergency room.
Here are some additional, alternative numbers:

Police/Fire/Poison Control: 911
Jupiter Hospital ER: 744-4460
Oakwood Mental Health Center-Crisis and Stabilization: 844-9741
Crisis Line: Palm Beach/Martin/St. Lucie Counties: 211
Child Abuse Registry: 1-800-342-9152

Client Rights & Responsibilities/Confidentiality:

Your consent to receive treatment is voluntary and you may decide to withdraw from or discontinue treatment at any time without penalty. You are responsible for making timely payments, arriving to appointments on time or providing at least 24-hour notice if you cannot attend a scheduled meeting, to be open and willing to examine any roadblocks we should encounter in fulfilling treatment goals, and for fully participating in the therapeutic process.

In general, the privacy of all communications between a psychologist and client is protected by law and I can only release information about our work to others with your written permission (with a signed "Release of Information" form). However, there are several situations that would require me to break confidentiality. These include the following: (1) when you are determined to be an immediate danger to yourself or identifiable others, (2) suspected cases of child or elderly person abuse, and (3) when required by law (e.g., subpoena). In my experience, these situations have rarely occurred. Should such a need arise to break confidentiality, I will make every effort to fully discuss it with you before taking any action. HIPAA laws also protect you; please see "Notice of Privacy Practices" below. In certain situations, I may deem a consultation with other mental health professionals to be appropriate in order to provide you with the best possible treatment, similar to requesting a second opinion. If such a consultation does occur, identifying information, such as your name, will not be discussed during these consultations.

If you are the guardian or parent of a minor using my services, to maintain a trusting relationship with your child, I will attempt to maintain their privacy but may provide you with general treatment progress updates and, when appropriate, to discuss your participation in treatment.

By signing below, you agree that you have read Dr. Carri Lager's office policies and procedures as well as your rights and responsibilities, understand the above information, and agree to the terms of therapy stated above. You have the right to terminate therapy at any time and may ask for referral sources. It is usually best for therapists and clients to make mutual decisions about termination of treatment. Your signature below indicates that you are giving your consent for Dr. Carri Lager to treat you in therapy. If applicable, your signature also indicates that Carri has permission to treat any of your minor children that you bring to therapy.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

_____ _____

Carri Lager, Ph.D., Licensed Psychologist Date

Dr. Carri Lager, Licensed Psychologist, PA
900 South US Hwy 1, Suite 101 Jupiter, FL 33477

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the client, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

I may use and disclose your medical records only for each of the following purposes: treatment, payment, court-order, disclosure of child, persons with disabilities or elderly abuse or neglect, any matters required by law, in self-defense in a malpractice suit, in the case where you are HIV positive and disclose you are engaging in sex with a partner who is uniformed of your health status, if you intend to harm yourself or another, and health care operations. Of course, I would be willing to share information with any other professional, agency, or insurance company that you wish, provided that you sign a Release-of-Information form.

- Treatment means providing, coordinating, or managing health care related services by one or more health care providers provided you sign a release of information.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review provided you sign a release of information. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running a practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

I may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you, if you choose not to receive a reminder please notify me, however, you will be billed $50 for the missed session if you do not call to cancel 24 hours in advance.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information. Including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. I am, however, not required to agree to a requested restriction. If I do agree to a restriction, I must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from me by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected information
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from me upon request.

Dr. Carri Lager, Licensed Psychologist, PA
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this company has the right to change its Notice of Privacy Practices from time to time and that I may contact this company at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name _____

Relationship to Client _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the client's signature in acknowledgement on thus Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____ Signature _____

Client Information (Couples Form):

Welcome! Thank you for choosing the private practice of Dr. Carri Lager, Licensed Psychologist, PA. Please complete this form in ink. All information will be kept strictly confidential.

(1) Name _____ Date_____
First Middle Last

Client's Date of Birth _____

Address_____ City_____ State____ Zip_____

(2) Name _____ Date_____
First Middle Last

Client's Date of Birth _____

Address_____ City_____ State____ Zip_____

Day Phone: (1)_____ (2)_____ Okay to Contact? Yes No

Cellular Phone: (1)_____ (2) _____ Okay to Contact? Yes No

E-Mail: (1)_____ (2)_____ Okay to Contact? Yes No

(1) May I leave a message on your answering machine/voicemail? Yes No
(2) May I leave a message on your answering machine/voicemail? Yes No

Gender _____ _____ Ethnicity (optional) _____ _____

Sexual Orientation (optional) _____ _____

Religious/Spiritual Affiliation (optional) _____ _____

Do you currently have a job? Yes No Yes No

Employer 1 _____ Employer 2 _____

Occupation 1 _____ Occupation 2 _____

Level of Education 1 _____ Level of Education 2 _____

What is your marital/relationship status? _____ Number of dependents? _____

Are you currently involved in any legal matters that could require me to provide records or testimony to a judicial authority? Yes No If yes, please explain:

In case of emergency, whom may I contact?
Name:
Phone:
Relationship:

What is the current state of your health 1: Excellent Good Fair Poor
What is the current state of your health 2: Excellent Good Fair Poor

(1) Do you have any current medical problems? Yes No If yes, please describe:
(2) Do you have any current medical problems? Yes No If yes, please describe:

(1) Client's Primary Doctor _____ Phone#_____

If applicable, Psychiatrist _____ Phone # _____

Are you currently taking, or within the past 6mos have you taken any medications? Yes No
If yes, please list names, dosages:

(2) Client's Primary Doctor _____ Phone#_____

If applicable, Psychiatrist _____ Phone # _____

Are you currently taking, or within the past 6mos have you taken any medications? Yes No
If yes, please list names, dosages:

(1) Do you have a disability (optional)? Yes No If yes, type:
(2) Do you have a disability (optional)? Yes No If yes, type:

(1) Have you previously received therapy? Yes No

If yes, with whom did you work with and when was your last visit?

Briefly describe your reason(s) for seeking therapy at this time_____
_____
_____
_____

(2) Have you previously received therapy? Yes No

If yes, with whom did you work with and when was your last visit? _____

Briefly describe your reason(s) for seeking therapy at this time_____
_____
_____
_____

How did you hear about my services?

Would you be interested in participating in a stress/anxiety group? Yes No

Please check any of the following that apply to you as a couple:

Anxiety	□	Health Related Issues	□
Chronic Stress	□	Gastrointestinal Issues	□
Communication Issues	□	Coping with Recent Medical Diagnosis	□
Frequent Arguments	□	Trauma (emotional, physical, sexual)	□
Religious/Spiritual Issues	□	Grief/Loss	□
Family of Origin Issues	□	Difficulty Maintaining Employment	□
Financial Issues	□	Indecision	□
Work/Family Balance	□	Anger Issues	□
Parenting Issues	□	New Parent Transitional Issues	□
Difficulty Relaxing	□	Coping with the Loss of a Child	□
Sexual Issues	□	Sexual Identity Issues	□
Pre-Marital Concerns	□	Low Energy/Motivation	□
Issues with Friends	□	Mood Swings	□
Difficulty with Assertiveness	□	Perfectionism	□
Depressed Mood	□	Feelings of Inferiority	□

Crying Often	□	Coming Out Issues	□
Cultural Identity Issues	□	Social Isolation	□
Poor Time Management	□	Suicidal Thoughts	□
Legal Issues	□	Alcohol/Substance Abuse	□
Other addictions (sexual, internet)	□	Other, please list in the space below	□

Preferred Method of Payment:
VISA MASTERCARD AMERICAN EXPRESS PERSONAL CHECK CASH

Credit Card # to be kept on file for payment: _____

Expiration Date: _____ Security Code: _____ Billing Zip Code: _____

IF YOU ARE TRYING TO USE INSURANCE, MUST ALSO HAVE:

Insurance Company _____

Insurance Company Phone # _____

Policy Holder's Name _____ DOB: _____

Policy Holder's Social Security # _____

Policy # _____ Group # _____

QUESTIONS FOR INSURANCE COMPANY (OUT-OF-NETWORK BENEFITS)

Do you have out-of-network benefits to see a Licensed Psychologist? Yes No Not sure

If so, what percentage do they cover? _____

What is the deductible, and how much of the deductible have you met? _____

_____

What is your co-pay for a session if you see an out-of-network provider?

$_____

How many sessions are covered, and in what time period? _____

Do you need to obtain pre-authorization for sessions? Yes No It Depends, please

explain: _____