Glassman Psychological Services, LLC
9881 Broken Land Parkway, Suite 105
Columbia, MD 21046-3015
Office (410) 695-4703

Intake Forms

Compiled 7/20/2016

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9881 Broken Land Parkway, Suite 105
Columbia, MD 21046
Office (410) 695-4703

Patient Information Form

Complete Legal Name: ◯ Mr./ ◯ Mrs./ ◯ Ms./ ◯ Dr. _____

Address: _____

_____

Please list phone numbers and email addresses where I may leave messages for you. Please only list numbers for which you are granting me permission to contact you. Please place an asterisk by your preferred method of contact if you have one.

Home: _____ Work: _____

Cell:_____ Home Email: _____

Work Email: _____ Other: _____

Please list the address at which you are granting me permission to mail you correspondence:

At the above address? ◯ Yes / ◯ No Different or additional address:

_____

_____

Date of Birth: _____ Age: _____

Marital Status: _____

Please indicate name, address, email and/or telephone number of who referred you to Dr. Glassman:

May I contact this person to thank him/her for referring you? ◯ Yes / ◯ No

What is your relationship with the referring person? _____

Emergency Information

Please list the person I should contact in case of an emergency:

Name: _____

Relationship: _____

Phone Number(s): _____

Current Concerns

Briefly describe your reasons for seeking help at this time: _____

_____

_____

Please circle any of the following problems that pertain to you:

- ☐ Depression
- ☐ Sleep/Insomnia
- ☐ Self-Harm/Suicidal Thoughts
- ☐ Anxiety
- ☐ Panic
- ☐ Stress/Relaxation
- ☐ Health Problems
- ☐ Body Image
- ☐ Eating Disorders
- ☐ Concentration
- ☐ Memory
- ☐ Relationship Problems
- ☐ Shyness
- ☐ Loneliness
- ☐ Friends
- ☐ Alcohol Use
- ☐ Drug Use
- ☐ Prescription Drug Abuse
- ☐ Job Problems
- ☐ Career Decisions
- ☐ School/Education
- ☐ Marital Problems
- ☐ Separation/Divorce
- ☐ Domestic Violence
- ☐ Trauma
- ☐ Grief/Bereavement
- ☐ Family Problems
- ☐ Parenting Issues
- ☐ Reproductive/Fertility Issues
- ☐ Sexual Problems
- ☐ Sexual Orientation
- ☐ Ethnic/Cultural Issues
- ☐ Financial Matters
- ☐ Legal Matters
- ☐ Other problems (please specify):

_____

_____

_____

_____

Health

Name of Physician: _____

Date of Last Exam: _____

Health Problems: _____

_____

_____

Please complete the following medication list (use back of page if necessary):

Medication	Dosage	Condition for which prescribed	Prescribing M.D.
_____			
_____			
_____			
_____			
_____			

Previous Psychotherapy (Use back of page if necessary)

Briefly describe what you sought treatment for: _____

_____

Therapist's name, discipline and location (city and state): _____

_____

Approximate beginning and ending Dates of Treatment: _____

Do you believe therapy was successful? ◯ Yes / ◯ No

What do you think helped? _____

Did your therapist agree to your stopping therapy? ◯ Yes / ◯ No

List your diagnoses: _____

List self-help or support groups you attend: _____

_____

Insurance

If you believe insurance may cover a portion of your treatment, please complete the following information:

Insurance Company: _____

Name of Policy Holder: _____

Group Number: _____

Member Number: _____

Education and Employment

Education: _____

Occupation: _____

For whom do you presently work? _____

Location: _____

Family Information

List family members, and indicate with "*" who lives in your home. Use back of sheet if needed.

Name	Age	Relationship	Occupation

Have you had any involvement with the legal system in the past or presently? ◯Yes / ◯No

Please explain: _____

_____

_____

_____

What else do I need to know about you that might not have been asked about on this form?

_____

_____

_____

_____

Signature: _____ Date: _____

PATIENT INFORMATION: (Please Print) Provider name: Stephanie K. Glassman, Psy.D.

Patient Name:

_____
(Last) (First) (Middle Initial)

Home Address: _____ Apt # _____

_____
City State Zip Code

Home Phone #: _____-_____-_____ Other Phone #: _____-_____-_____ Sex: ◯ Male ◯ Female

Date of Birth: _____/ _____/ _____ Social Security Number: _____-_____-_____
Month Day Year

Marital Status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widow ◯ Partner

Occupation: ◯ Full Time ◯ Part Time ◯ Unemployed ◯ Full Time Student ◯ Part Time Student

Name of Employer / School: _____

Previous Mental Health Treatment (within 2 years): ◯ Psychiatrist ◯ Psychologist ◯ LCSW-C ◯ Other

Mental Health Provider: Name: _____ Phone: ____-____-_____

INSURANCE INFORMATION:

Primary Insurance Company: _____ ID Policy #: _____ Group #:_____

Claims Address: _____ Phone #: _____-_____-_____

_____
City State Zip Code

Policy holder's Name: _____ Date of Birth: ____/____/_____
Month Day Year

Social Security #: _____ Effective Date of Insurance: _____ /_____/_____
Month Day Year

Policy Holder's Employer: _____ Phone #: _____- _____-_____

Patient Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Secondary Insurance (for **Medicare** patients only): ID #: _____

Person Responsible for Account: ◯ Patient ◯ Parent ◯ Other

_____ Date of Birth: ____/_____/_____ Phone # _____-_____-_____
Name (if different from patient)

AUTHORIZATION TO BILL INSURANCE:

Patient or Authorized person's signature: I authorize ProPsych Billing Solutions to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed _____ Date_____

Notice of Separate Practices

All practices in this suite are independent of each other.

Practicing in Suite 105 does not imply a joint group practice, a single legal professional entity or employer/employee relationship. All practitioners here maintain separate practice policies that are not subject to any rules or restrictions by any other practice here. Any client/patient entering into treatment with any of the providers here are clients/patients of that practitioner and that practitioner's practice only. All fee-related policies/procedures, including but not limited to insurance arrangements for treatment, evaluation, consultation or otherwise are the domain of the individual practitioner and must be addressed, arranged and determined by and between each practitioner and client/patient. The practices of all providers are separate and independent such that no party has control, authority or liability over the nature, type and function of the other party's practice. No party is responsible for the actions, treatment decisions, practice procedures or debts of any other party. All parties are licensed and insured. They function as separate practices, separately licensed and insured.

I acknowledge that I have read and received this Notice:

_____ _____

Name **Date**

MARYLAND NOTICE FORM

Notice of Psychologist's Policies and Practices to Protect the Privacy of Patient's 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

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *written authorization*. 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 I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer 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 my 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 my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.
- "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, health care operations, or any reasons not disclosed in this notice, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I 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) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reason to believe that a child has been subjected to abuse or neglect, I must report this belief to the appropriate authorities.
- *Adult and Domestic Abuse* – I may disclose protected health information regarding you if I reasonably believe that you are a victim of abuse, neglect, self-neglect or exploitation.
- *Health Oversight Activities* – If I receive a subpoena from the Maryland Board of Examiners of Psychologists because they are investigating my practice, I must disclose any PHI requested by the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not

apply when you are being evaluated or 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 you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.
- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Psychologist'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. However, I am not required to agree to a restriction you request.
- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket* - You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
- *Right to Be Notified if There is a Breach of Your Unsecured PHI* - You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.
- *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 me. On your request, I 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 in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You have the right to inspect or obtain a copy (or both) of Psychotherapy Notes unless I believe the disclosure of the record will be injurious to your health. On your request, I will discuss with you the details of the request and denial process for both PHI and Psychotherapy Notes.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I 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. On your request, I 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 me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you by mail and/or in person during the next session.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Stephanie K. Glassman, PsyD at (410) 695-4703.

If you believe that your privacy rights have been violated and wish to file a complaint with me/my office, you may send your written complaint to Stephanie K. Glassman, PsyD, 9881 Broken Land Parkway, Suite 105, Columbia, MD 21046-3015.

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.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on September 23, 2013.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail and/or in person.

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Acknowledgement of Receipt of the Maryland Notice Form

I acknowledge receipt of the Maryland Notice Form entitled: Notice of Psychologist's Policies and Practices to Protect the Privacy of Patient's Health Information (Rev. 09/23/2013).

Written acknowledgment of this notice is mandated by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Signature: _____

Signature of Parent/Guardian if Minor: _____

Printed Name: _____

Address: _____

_____

Date: _____

Glassman Psychological Services, LLC

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OUTPATIENT SERVICES CONTRACT

Welcome to my practice. I appreciate your trust and the opportunity to assist you. 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 at our next meeting. Once you sign this document, it will represent an agreement between us. I will keep the original document and offer you a copy for your records.

HIPAA

This document contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that mandates privacy requirements and client rights pertaining to the use and disclosure of your Protected Health Information (PHI) in connection with treatment, payment, and health care operations. HIPAA requires me to provide you with a Notice of Privacy Practices, which explains HIPAA and its application to your personal health information in detail. The law requires that at the end of the first session I obtain your signature acknowledging that I have provided you with this information.

About Psychotherapy

Psychotherapy is not easily described in general terms. It varies depending on the personalities of the people involved, as well as the particular problems the client brings. I use eclectic and integrative approaches to psychotherapy, which means that I draw from several theoretical systems to help you. I tailor the methods I use based on the issues you want to address, and I try whenever possible to use techniques that have been supported through research. I see the goal of treatment as a reduction in symptoms, a better understanding of the problem and its solution, and the acquisition of new skills.

I want you at some point to be able to use what you learn in therapy without me, so I do my best to encourage you as soon as possible to practice new ways of thinking and behaving. In order for the therapy to be most successful, you will have to work on things we talk about both during and after our sessions. I may give you reading material, and I may assign you homework. I often take notes during our meetings. You may find it useful to take your own notes both within session and outside of the office.

Our first few sessions will involve an evaluation of your needs. By the end of our first or second session, I will tell you how I see your case at that point and how I think we should proceed. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. I view therapy as a partnership between us. You define the problem areas to be worked on, and I use special knowledge to help you make the changes you want to make. It requires your very active involvement and best efforts to change thoughts, feelings, and behaviors.

I expect us to plan our work together. We will identify problem areas, goals, methods we will use, and commitments of time and resources we will make. I expect us to agree on a plan that we will both work hard to follow. From time to time, we will look together at our progress and goals. If we think we need to, we can then change our treatment plan, its goals, and its methods.

Change can sometimes be quick and easy, but more often it is slow and frustrating, and you will need to keep trying. There are no instant, painless cures; however, you *can* learn new behaviors as well as ways of looking at your problems that can be very helpful in changing your feelings and reactions.

 Initials _____

Most of my clients see me once a week for several months. After that time, we might decide to meet less often before terminating treatment. The process of ending therapy, called "termination," can be a very valuable part of our work. Stopping therapy should not be done casually, although either of us may decide to end it if we believe it is best. If you wish to stop therapy at any time, I ask that you agree to meet for at least one additional session to review our work together. We will review our goals at that time, as well as the work we have done, any future work that needs to be done, and your choices about how to proceed. If you would like to take a "time out" from therapy to try working on your own, we should discuss it so as to maximize its benefit to you.

Therapy involves a large commitment of time, money, and energy, so I suggest that you be very careful about the therapist you select. If you ever have questions about my procedures, we should discuss them as they arise. If your doubts persist, I would be happy to refer you to another mental health professional for a second opinion.

The Benefits and Risks of Therapy

As with any powerful treatment, there are risks as well as benefits. I recommend that you think about both the benefits and risks when making any treatment decisions. For example, in therapy, there is a risk that clients will, for a time, have uncomfortable levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other negative feelings. They may recall unpleasant memories or talk about family secrets resulting in an exacerbation of problems with people important to them. Therapy may disrupt a relationship, and sometimes people will decide to end the relationship. Sometimes, too, a person's problems may temporarily worsen after the beginning of treatment. In the treatment of some disorders, progress in therapy involves a repetitive pattern of moving ahead and sliding back, but over time, with motivation, proper assistance, and perseverance, many clients eventually achieve their goals. Finally, even with our best efforts, there is a risk that therapy may not work.

While you consider these risks, you should know that the benefits of therapy have been shown by scientists in hundreds of well-designed research studies. People who are depressed may find their mood lifting. Others may no longer feel as afraid, angry, or anxious. In therapy, people have a chance to talk things out fully until their feelings are relieved and/or problems are resolved. Relationships and coping skills may greatly improve, and social and family relationships may become more satisfying. Personal goals and values may become clearer. I do not take clients I do not think I can help, so if I have agreed to work with you, I will enter our relationship with optimism about your progress. Of course, there are no guarantees regarding what you will experience in therapy.

Consultations

If you could benefit from a treatment I cannot provide, I will try to help you to obtain it. You have a right to ask me about other treatments, their risks and their benefits. Based on what I learn about your problems, I may recommend a medical exam or use of medication. If so, I will fully discuss my reasons with you so that you can decide what is best. If you are treated by another mental health professional, I will try to coordinate my services with him/her and possibly also with your medical doctor.

In certain circumstances, the seriousness of a client's condition might require a higher level of care than I can provide in an outpatient setting. If this situation should arise, we would discuss the need for a hospital stay or an admission to a residential treatment program, and I would help you to identify the program that would best meet your needs. With your consent, I would facilitate your transfer to that program by providing information to professionals there.

If for some reason treatment is not going well, I might suggest you see a different therapist or another professional in addition to me. My ethics do not allow me to continue to treat you if my treatment is not working for you. If you wish for another professional's opinion at any time, or wish to transfer to another therapist, I will help you find a qualified person and will provide him or her with needed information with your consent.

 Initials _____

What to Expect from Our Relationship

As a professional, I will use my best knowledge and skills to help you. This includes following the standards of the American Psychological Association (APA). In your best interests, the APA puts limits on the relationship between a therapist and a client, and I will abide by these rules. Below I explain the limits, in hopes that you will not think they are personal responses to you.

First, I am licensed and trained to practice psychology — not law, medicine, finance, or any other profession. I am not able to give you advice from these other professional viewpoints.

Second, state and federal laws as well as the rules of the APA require me to keep what you tell me confidential. You can trust me not to tell anyone else what you tell me, except in certain limited situations. I explain what those are in the "About Confidentiality" section of this brochure. To protect the privacy of those I treat, I try not to reveal who my patients are. If we meet on the street or socially, I may not say hello or talk to you. My behavior will not be a personal reaction to you, but a way to maintain the confidentiality of our relationship.

Third, in your best interests, and following the APA's standards, I can only be your therapist. I cannot have any other role in your life. I cannot, now or ever, be a close friend or socialize with any of my clients. I cannot be a therapist to someone who is already a friend. I can never have a sexual or romantic relationship with any client during or after the course of therapy. I cannot have a business relationship with any of my clients, other than the therapy relationship.

Even though you might invite me, I will not attend your family gatherings, such as parties or weddings. As your therapist, I will not celebrate holidays with you or give you gifts. I also do not receive gifts from my patients. These practices are intended to protect you and your therapeutic relationship with me, and I follow them out of respect for you and our work together.

About Confidentiality

Release of Records

I will treat with great care all the information you share with me. It is your legal right that I keep our sessions and my records about you private. I will ask you to sign a "release-of-records" form before I talk about you or send my records about you to anyone else. In general, I will tell no one what you tell me. I will not even reveal that you are receiving treatment from me, but any information that you share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

Group Therapy

Confidentiality in group therapy is a special situation. In group therapy, the other members of the group are not therapists. They are not bound by the same professional ethics and laws as me. You cannot be certain that they will always keep what you say in the group confidential, although I ask them to do so. Whether in a group therapy situation or not, please never disclose the name or identity of any other patient under my care.

Contractors

I also use contractors for professional services, such as billing, accounting, administrative assistance, equipment repair, etc. All professionals I hire for such services agree to maintain your confidentiality, and I do my utmost to ensure that they have the most minimum exposure to your private information necessary to do their jobs. I also work in a suite, which I share with other mental health professionals. We are separate practices, but we share office equipment, a waiting area, and for two of us, a receptionist. Faxes, mail or other pieces of information related to you might be seen by those people as a consequence of working in shared space, but I do my best to minimize their exposure to private data.

 Initials _____

Consultations with Other Therapists

There are two situations in which I might talk about part of your case with another therapist.

First, when I am away from the office for a few days, I may have a trusted fellow therapist "cover" for me. This person would be available to you in emergencies; therefore, he or she needs to know about you. Of course, this therapist is bound by the same laws and rules as I am to protect your confidentiality.

Second, I sometimes consult other therapists or other professionals about my clients. This helps me in giving high-quality treatment. These persons are also required to keep your information private. Your name will never be given to them, and they will be told only as much as they need to know to understand your situation. I will note consultations in your Clinical Record.

Insurance Company Requests

As part of cost control efforts, an insurance company will sometimes ask for more information on symptoms, diagnoses, and my treatment methods. It will become part of your permanent medical record. I will let you know if this situation should arise. Please understand that I have no control over how these records are handled at the insurance company. My policy is to provide only as much information as the insurance company needs to pay your benefits.

Confidentiality is *not* protected in the following situations:

- If you were sent to me by a court or an employer for evaluation or treatment, the court or employer expects a report from me. If this is your situation, please talk with me before you tell me anything you do not want the court or your employer to know. You have a right to tell me only what you are comfortable revealing.

- If you are involved in court proceedings and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-client privilege law. I cannot provide any information without your written authorization or a court order. If you are involved in or are contemplating litigation, you should consult with your attorney to determine whether a court would likely order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- If you make a serious threat to harm yourself and/or another person, the law requires me to try to protect you and/or that other person. I cannot promise never to tell others about threats you make. If I know that a client has a propensity for violence and that person indicates that he/she has the intention to inflict imminent physical injury upon a specified victim(s), I may be required to take protective actions. These actions may include establishing and undertaking a treatment plan that is calculated to eliminate the possibility that the client will carry out the threat, seeking hospitalization of the client and/or informing the potential victim or the police about the threat.

  If I believe that there is an imminent risk that a client will inflict serious physical harm or death on him/herself, or that immediate disclosure is required to provide for the client's emergency healthcare needs, I may be required to take appropriate protective actions, including initiating hospitalization and/or notifying family members or others who can protect the client. If such a situation arises, I will limit my disclosures to what is necessary.

- If I have reason to believe that a child or vulnerable adult has been subjected to abuse or neglect, or that a vulnerable adult has been subjected to self-neglect or exploitation, the law requires that I file a report with the appropriate government agency, usually the local office of the Department of Social Services and State's Attorney. Once such a report is filed, I may be required to provide additional information. The reporting law includes past incidents you may tell me regarding

 Initials _____

physical, sexual, or emotional abuse that happened to you as a child, even if the perpetrator is deceased or you do not know the person's name or current status.

- If you commit a crime against me, my family or my friends (e.g., stalking, stealing, identity theft, hacking email accounts, harassing, threatening, etc.), you agree by signing this contract to waive your right to privilege, which means that I will disclose whatever information from your records is necessary for my protection and/or that of others I know, and I may testify in court against you. In these situations, I would terminate our relationship and provide you with referrals to other therapists.

Sessions

I normally conduct an evaluation that will last from 1 to 4 sessions. During this time, we can both decide whether I am the best person to provide the services you need in order to meet your treatment goals. If you choose to begin psychotherapy, I will usually schedule one 45-minute session per week at a time we agree upon, although some sessions may be longer or more frequent depending on your therapeutic needs. Once you schedule an appointment, you will be expected to keep it. If you do not show for your session or cancel without providing 24 hours notice, you will be expected to pay for the session. I typically try to reschedule missed or cancelled appointments for the next available time to maintain treatment continuity.

I request that you do not bring other people to your therapy sessions without discussing the appropriateness of it with me first. If you bring a guest unannounced, that person, unless a minor, will be asked to wait for you in the waiting area while you meet with me to discuss the matter. Also, I cannot provide monitoring of children in the waiting room, so please do not leave children there without appropriate adult supervision. Pets are not allowed on the premises. If you bring unattended children or pets, you will not be seen that day for therapy yet will be responsible for paying the fee.

Fees, Payments, and Billing

Once we determine your payment strategy, we will discuss what we can expect to accomplish with the resources that you have available. We also will discuss options should we determine that from the outset you cannot afford therapy or that after you begin treatment, you need to end our sessions prematurely due to financial constraints.

Individual, couple's, and family psychotherapy sessions: My current fee for 45-minute psychotherapy sessions is $160. I charge $280 for a 45-50 minute individual evaluation session that includes chart set-up and mailing release forms after you leave the office.

Extended sessions: Occasionally it may be better to continue a session, rather than stop or postpone work on a particular issue. Sessions that are extended beyond 10 minutes will be charged on a prorated basis; (i.e., $35 per 10 minute increment).

Group psychotherapy sessions: I charge $280 for a 45-minute individual evaluation session that includes chart set-up and mailing release forms after you leave the office. I charge $80 for each 45-minute group session.

Late cancellation/Missed session fee: Not showing for or canceling a scheduled appointment with less than 24 hours notice will result in a charge for the full fee of service.

Insurance reports: I will not charge you for time I spend making routine reports to your insurance company. However, I will bill you for any extra-long or complex reports the company might require. The company will not cover this fee. I charge $35 per 10-minute increment for report writing.

Telephone conversations: Telephone conversations lasting longer than 10 minutes will be billed at the rate of $35 per 10-minute increment.

 Initials _____

Legal involvement: If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge 10-minute increments of $60.00 each, for preparation and attendance at any legal proceeding and for any court-related services, such as consultations with lawyers and depositions.

Other services: Charges for other services, such as hospital visits, consultations with other therapists, or home visits will be based on the time involved in providing the service at my regular fee schedule of $35 per 10-minute increment. Some services may require payment in advance.

Payment is due at the time of service by cash, check, credit card or money order. If there are insufficient funds in your account, or if your payment method is rejected for any other reason, you will be charged a fee of $25. Payment schedules for other professional services will be arranged once you request them. I usually do not send bills; however, if we have agreed that I will bill you, I ask you to pay the bill within 5 days of when you receive it. In circumstances of unusual financial hardship, I may be willing to negotiate a payment installment plan.

If you have not paid your bill for more than 60 days and have not made arrangements with me for installments, I have the option of using legal means to secure payment, such as turning the matter over to small claims court or a collection agency. If such legal action is necessary, I will include its costs in the claim. This process would require that I disclose otherwise confidential information. In most collection situations, the only information I would release regarding a client's treatment is his/her name, the nature of services I had provided, and the amount due.

I will assume that our agreed-upon, fee-paying relationship will continue as long as I provide services to you unless you inform me otherwise in person, by telephone, or by certified mail. You have a responsibility to pay for any services you receive before you end the relationship. If you wish to continue therapy but do not pay your bills in a timely fashion, I will most likely talk with you about discontinuing therapy and referring you to another therapist.

I periodically review the fee schedule, and I will notify you at least 30 days in advance of any changes. If you have any problem with my charges, my billing, your insurance, or any other money-related point, please bring it to my attention. Such problems can interfere greatly with our work. They must be worked out quickly and openly.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate resources you have available to pay for your treatment. I am an in-network provider for only a few insurance companies; however, if I do not take your insurance, but you have a policy with out-of-network benefits, your sessions might be partially reimbursed. Most insurance plans cover a portion of licensed psychologists' fees although the percentages and amounts vary widely. I recommend that if you plan to use your insurance, you determine prior to treatment exactly which mental health services your insurance policy covers as well as the reimbursement rates. You may call your plan administrator if you have questions about your policy. Although I submit claims for insurances for which I am a provider, I expect clients to file their own claims for out-of-network benefits and to receive their insurance reimbursements directly in those cases. For those seeking out-of-network benefits, I am willing to complete forms or provide other reasonable assistance at your request, and I will provide you monthly financial statements at the beginning of each month for services I provided in the preceding month. These statements will contain standard information you will need to process any out-of-network claim.

You should be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or in rare cases copies of the entire record. This information will become part of the insurance company's files and will probably be stored in a computer. Although all insurance companies claim to

 Initials _____

keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they might share the information with a national medical information databank.

Maryland law prevents insurers from making unreasonable demands for information, but there are no specific guidelines about what unreasonable includes. If I believe that your health insurance company is requesting an unreasonable amount of information, I will call it to your attention and we can discuss what to do. You can instruct me not to send requested information, but this could result in claims not being paid and an additional financial burden being placed on you. 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. If you wish to see me but not use an insurance I take, you may be able to do so, but it might depend on contracts I have signed to become paneled with those insurance companies. If it is your wish not to use an insurance I take, please discuss it with me.

Contacting Me

I often am not immediately available by telephone, such as during times when I am with another client. You may leave a message with my receptionist or on my confidential office voicemail, which my receptionist and I monitor during work hours. You should know that in addition to my office phone, I use a cell phone as well as email for correspondence in my practice. If you choose to communicate with me via e-mail or cell phone, including text messaging, please be aware that I cannot guarantee that it will not be intercepted during transmission by a third-party. You assume responsibility for accidental disclosures of personal information as a result of others having access to your e-mail and/or cell phone account, including an employer. A copy of e-mail and text message exchanges containing information other than appointment scheduling will be retained in your record. I also retain your actual voicemail messages, which come into my email account automatically transcribed. Please use my cell phone only for urgent safety matters and emergencies.

If you are concerned about the confidentiality of our communication by cell phone or email, please make that concern known to me as soon as possible, as well as your preference for how you would like me to contact you.

Although I care greatly about your calls, I keep telephone contact short and will encourage you to schedule an in-person session if your concern is likely to involve a significant amount of unscheduled time. If you call and leave a message for me during normal business hours (Monday , Tuesday and Thursday from 9:00 a.m. to 5:00 p.m., Wednesday from 1:00 pm to 5:00 pm, and Friday from 9:00 a.m. to 3:00 p.m.), I will do my best to return your call during business hours on the same day. If you leave a message for me outside of normal business hours and need to speak with me urgently, please call my cell phone and indicate that information in your message, and I will call you back as soon as I am able. If I have not called you back promptly and you need to speak with someone urgently, I suggest you call a crisis hotline, such as Grassroots at (410) 531-6677. I do not provide a 24-hour crisis hotline service. You may or may not reach me after hours. In the event of an emergency, such as a situation in which you have already harmed yourself or others or feel likely to harm yourself or others imminently, immediately call 911or go to the nearest emergency room for assistance, and have the attending doctor call me on my cell phone, so we can share information to help you.

When I am out of town, I usually check my voicemail messages regularly. However, if I will be unavailable for an extended time without access to my voicemail, I will provide on my voicemail greeting the name and phone number of a crisis service and/or colleague for you to contact if necessary. I may also provide you that information on a slip of paper before I leave. If you know you will wish to see another therapist while I am away, please ask me in advance, so I can find someone for you to see.

Professional Records

The laws and standards of my profession require that I keep treatment records. Pursuant to HIPAA, I may 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.

In addition, I may also keep a set of Psychotherapy Notes, which are for my own use and are designed to assist me in providing you with the best treatment. They are kept separate from your Clinical Record. While the contents of Psychotherapy Notes vary from patient to patient, they can include the contents of our conversations, my analysis of those conversations, and how they impact your therapy. They also may contain particularly sensitive information that you reveal to me that is not required to be included in 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.

Review of Records

If you wish to review your records, you must put your request in writing. You may add to and/or correct your records and you may have copies of them. You may not examine records created by anyone else and sent to me. In rare situations, I may temporarily remove parts of records before showing them to you, or give you only a summary. This would happen if I believe that the information would be harmful to you, but I would discuss it with you beforehand. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review contents in my presence, or have them forwarded to another mental health professional, so you can discuss them. You may also examine and/or receive a copy of your Psychotherapy Notes unless I determine that such information does not exist or cannot be found, or such disclosure would be injurious to your health or well being. As stated above, patients will be charged an appropriate fee for any time spent in preparing information requests. In most circumstances, I am allowed to charge a copying fee per page and to charge for certain other expenses, such as postage. If I refuse your request for access to your Clinical Record, you have a right of review, which I will discuss with you upon your request.

Record Storage and Retention

In regard to record storage, I keep some documents, such as signed forms, in a locked file cabinet. Other records will be encrypted on computer to which only I, or limited computer, financial, or clerical service personnel have access. I also send financial and other records by fax, mail and/or email to service personnel as needed to maintain the efficient workings of my practice. These people have made a commitment to HIPAA compliance, but these forms of communication come with some risk to your confidentiality. If you do not want your records recorded or sent in a particular manner, please let me know as soon as possible, so we can discuss your concerns.

For adult patients, I am not required to keep records beyond 7 years, so your records here will likely be destroyed 7 years after the end of our work together. Until then, I will keep all records in a safe place. Records of minors are kept until they reach the age of majority (21 years old) unless they begin therapy late in their teens and the 7 year hold period ends after the age of majority.

Records Transfer

If I must discontinue our relationship because of illness, disability, or other unforeseen circumstances, I ask you to agree to my transferring your records to another therapist who will assure their confidentiality, preservation, and appropriate access.

Family and Couple's Therapy

If we do family or couple's therapy (where there is more than one client), and you want to have my records of this therapy sent to someone, all of the adults present will have to sign a release.

 Initials _____

New and Expanded Client Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records 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 my policies and procedures recorded in your records; and the right to a paper copy of this Outpatient Services Contract, the attached Maryland Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Minors

If you are under eighteen years of age and are not emancipated, the law may provide your parents the right to examine your treatment records. I usually ask parents of teenagers to agree to obtain on an ongoing basis only general information from me about your treatment to allow you the most privacy possible. If they agree, I will not usually contact them except to coordinate scheduling, to discuss financial matters, or unless I feel there is something very important to address, such as potential harm to self or others. In this last case, I would notify them of my concern and recommendations. At the end of your treatment, if you are still a minor, I will summarize our work together for your parents, usually in a meeting to which you will be invited.

Other Points

If you ever become involved in a divorce or custody dispute, I will not provide evaluations or expert testimony for you in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: (1) My statements will be seen as biased in your favor because we have a therapy relationship; and (2) the testimony might affect our therapy relationship, and I must put this relationship first.

Doing follow-up and outcome research is educational. As a professional therapist, I naturally want to know more about how therapy helps people. To understand therapy better, I might collect information about patients before, during, and perhaps up to a few months after therapy. Therefore, I might ask you to complete questionnaires about different parts of your life, such as relationships, changes, concerns, attitudes, and other areas. I ask your permission to take what you might write on these questionnaires and what I would have in my records and use it in research or teaching that I might do in the future. Your name would never be mentioned, and all personal information would be disguised.

If, as part of our therapy, you create and provide to me records, notes, artwork, or any other documents or materials, I will return the originals to you if you make written request at the time I receive the materials from you. These materials, if possible, will be scanned into your electronic medical record, and originals will likely be shredded or otherwise properly disposed of unless you request them in writing.

Statement of Principles and Complaint Procedures

It is my intention to fully abide by all the rules of the American Psychological Association (APA) and by those of my state license.

Problems can arise in our relationship, just as in any other relationship. If you are not satisfied with any area of our work, please raise your concerns with me at once. Our work together will be slower and harder if your concerns with me are not worked out. I will make every effort to hear any complaints you have and to seek solutions to them. If you feel that I, or any other therapist, have treated you unfairly or have broken a professional rule, please tell me. You may also contact the state or local psychological association and speak to the chairperson of the ethics committee. He or she can help clarify your concerns or tell you how

 Initials _____

to file a complaint. You may also contact the Maryland Board of Examiners of Psychologists, the organization that licenses those of us in the independent practice of psychology.

In my practice as a psychologist, I do not discriminate against clients because of any of these factors: age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. This commitment is required by federal, state, and local laws and regulations. I support values of equal opportunity, human dignity, and racial/ethnic/cultural diversity. If you believe you have been discriminated against, please bring this matter to my attention immediately.

Our Agreement

I, the client (or his or her parent or legal guardian), understand that I have the right not to sign this form. My signature below indicates that I have read and discussed this agreement. It does not indicate that I am waiving any of my rights except to that of privilege in cases of criminal activity against the therapist or against anyone with whom the therapist has a relationship. I understand that I may choose to discuss my concerns with you, the therapist, before I start (or the client starts) formal therapy. I also understand that any of the points mentioned above may be discussed and may be open to change. If at any time during the treatment I have questions about any of the subjects discussed in this document, I may talk with you about them, and you will do your best to answer them.

I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy with you.

I understand that no specific promises have been made to me by this psychologist about the results of treatment, the effectiveness of the procedures used by this psychologist, or the number of sessions necessary for therapy to be effective.

If I plan to use my insurance to pay for sessions, I authorize Glassman Psychological Services, LLC and the billing service hired by Glassman Psychological Services, LLC, which is ProPsych Billing Solutions, to release to my insurance company or their contractor of psychological services any medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to Glassman Psychological Services, LLC for evaluation and treatment rendered.

I have read, or have had read to me, the issues and points in this brochure. I have discussed those points I did not understand and have had my questions, if any, fully answered. I agree to act according to the points covered in this document. I hereby agree to enter into therapy with the psychologist whose signature is below (or to have the client enter therapy) and to cooperate fully and to the best of my ability, as shown by my signature here.

_____ _____

Signature of client Date

_____

Printed name

_____ _____

Signature of person acting for client Date

_____

Printed name

 Initials _____

Relationship to client:

◯ Parent ◯ Legal guardian
◯ Health care custodial parent of a minor (less than 14 years of age)
◯ Other person authorized to act on behalf of the client _____

Unless you are the parent, please provide documentation of your legal right to act for the client.

If you are the parent giving consent, by signing this contract you attest that all other parents/guardians are aware of and agree to the services being rendered.

I, the psychologist, have met with this client (and/or his or her parent or legal guardian) for a suitable period of time, and have informed him or her of the issues raised in this document. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe that this person is not fully competent to give informed consent to treatment. I agree to enter into therapy with the client, as shown by my signature below.

_____ _____
Stephanie K. Glassman, PsyD Date

___ Copy accepted by client ___Copy kept by psychologist *(Rev. 04/19/2016)*

Initials _____

Glassman Psychological Services, LLC

Stephanie K. Glassman, PsyD
9881 Broken Land Parkway, Suite 105
Columbia, MD 21046-3015
Office (410) 695-4703

Authorization to Disclose/Obtain Protected Information

Patient's Name: _____
First Middle Last

Date of Birth: _____

This release authorizes Stephanie K. Glassman, Psy.D. to:

☐ Send information to the individual, agency, organization identified below:
☐ Receive information from the individual, agency, organization identified below:

Name: _____

Address: _____

_____

Phone(s): _____

Email: _____ FAX: _____

Purpose of release:

☐ To provide ongoing treatment
☐ To coordinate treatment efforts with family/concerned persons
☐ Other (Specify): _____

Information to be released: _____

I hereby request and authorize the release of information as specified above. I understand that the confidentiality of my records is protected by Federal and State Law and cannot be released or disclosed without my written permission unless otherwise provided for in the law. I understand that by law I need not consent to the release of this information; however, I choose to do so willingly and voluntarily for the purpose specified above. I understand that I may revoke this consent/authorization under the HIPAA Privacy Rule or state law, whichever gives me more rights, and I may do so at any time except to the extent that action has been taken in reliance on my consent. I understand that the information disclosed may be subject to redisclosure by the recipient and is no longer protected by the HIPAA Privacy Rule. I also understand that signing this form does not necessarily constitute an agreement on Dr. Glassman's part that she will provide me services. Unless sooner revoked or fulfilled, this consent will automatically expire a week after termination of services with Dr. Glassman.

_____ _____
Signature of Patient Date Signature of Witness Date

_____
Signature of Parent/Guardian if Minor Date

(Rev. 09.14.2015)

Glassman Psychological Services, LLC
9881 Broken Land Parkway, Suite 105
Columbia, MD 21046-3015
Office (410) 695-4703

Credit Card Recurring Payment Consent Form

Patient's Name: _____
First Middle Initial Last

Name as it appears on Card:_____

I authorize Stephanie K. Glassman, Psy.D to charge my credit card recurrently for professional services and associated charges as follows:

90791 – Diagnostic Evaluation (45-50 minute)	$280
90832 – 30-Minute Psychotherapy (16-37 minutes with patient and/or family member)	$105
90834 – 45-Minute Psychotherapy (38-52 minutes with patient and/or family member)	$160
90837 – 60-Minute Psychotherapy (= or > 53 minutes)	$210
90846 – 45-50-Minute Family Psychotherapy without patient present	$180
90847 – Family Psychotherapy with patient present	$180
90853 – Group Psychotherapy	$ 80
90785 – Add-on code for session complexity	$ 60
90839 – Psychotherapy for crisis (first 60 minutes)	$220
90840 – Add-on code for each additional 30 minutes of a crisis session	$110
Phone consultation (charged for each 10-minute increment)	$ 35
Professional consultation (charged for each 10-minute increment)	$ 35
Session Extension (charged for each 10- minute increment)	$ 35
Court appearance (charged per 10-minute increment)	$ 60
Forensic meetings (charged per 10-minute increment)	$ 60

Missed visits will be charged at the full fee of the service

I understand that I may cancel this authorization for future charges at any time by notifying Dr. Glassman.

Type of Card: ◯ Visa ◯ MasterCard

Card Number: _____

Expiration Date: _____/_____ 3-Digit Security Code: _____

Cardholder's Billing Address for this Credit Card:

_____
Street City State Zip Code

Cardholder's Signature: _____

Today's Date: _____

Stephanie K Glassman, PsyD
9881 Broken Land Parkway, Suite 105
Columbia, MD 21046-3015
(410) 695-4703

Is There a Problem?

If you are not satisfied with your experiences in my practice, I want to hear from you.

If you have a problem with anything about my practice, please speak with me first. I am interested in all of your questions and concerns. These may be related to insurance, bills, or payment, your therapy, the privacy of your records, etc.

As the privacy officer, I am responsible for responding if you believe there has been a violation of the confidentiality or the privacy of your records. I will help clarify and fix the situation.

If you are still not satisfied with my initial response or the problem continues, please fill out this simple form so I can investigate it. I will try my best to fix it, and to repair any damage that has been done. Bringing a problem to my attention will not in any way limit your care here or cause me to take any actions against you.

If you wish to remain anonymous, you do not have to fill in the lines marked with an asterisk (*). But if you want a response from me, please do complete those items. Thank you.

*Client's name: _____ *Date of birth: _____

*Client's address: _____

*Phone: _____

What is or was the problem?

_____

_____

_____

_____

What would you like to see done about the problem?

_____

_____

_____

_____ _____

*Signature of client or his or her personal representative Date

_____ _____

*Printed name of client or personal representative *Relationship to the client

*Description of personal representative's authority:

_____

Note: If a name is given on the form, a response must be made to this person within 30 days from when you, the privacy officer, receive this form. Indicate action(s) taken on a separate page.

 last revised: 09/20/2013