Provider's Name Carol Waisman, Ph.D, LCSW

CLIENT INFORMATION - If you have insurance, please list all info as it is listed with your insurance company. Thank you.

Name: _____ **Age:** _____
Last, First MI

Street Address: _____

City, State: _____ **Zip:** _____

Phone: _____ **Cell:** _____ **E-mail:** _____

DOB: _____ ☐**Male** ☐**Female** As listed with insurance **Preferred Name:** _____ **Marital Status:** _____

Employer: _____ **Work Phone:** _____

RESPONSIBLE PARTY INFORMATION (person who is financially responsible to pay co-pays & deductibles due)

Name: _____ **Age:** _____
Last, First MI

Street Address: _____

City, State: _____ **Zip:** _____

Phone: _____ **Cell:** _____ **E-mail:** _____

DOB: _____ ☐**Male** ☐**Female** **Marital Status:** _____

Employer: _____ **Work Phone:** _____

INSURANCE INFORMATION - Insurance Authorization Number: (*see note below)** _____

Primary Ins: _____ **Phone # for Mental Health:** _____

Subscriber's Name: _____ **DOB:** _____ ☐**Male** ☐**Female** As listed with insurance

Subscriber's Address: _____

Relation to patient: _____ **ID/Membership #:** _____ **Group #:** _____

Employer: _____ **Work Phone:** _____

Secondary Ins: _____ **Phone # for Mental Health:** _____

Subscriber's Name: _____ **DOB:** _____ ☐**Male** ☐**Female** As listed with insurance

Subscriber's Address: _____

Relation to patient: _____ **ID/Membership #:** _____ **Group #:** _____

Employer: _____ **Work Phone:** _____

I hereby authorize the above named provider to release any information requested by Reliable MH Billing Services that is needed to bill the above named insurance companies and/or responsible party directly. I hereby authorize the above named provider and Reliable MH Billing Services to release any information requested by my insurance companies that is needed to check my insurance benefits and to submit claims. I authorize any insurance benefits to pay directly to the above named provider.

I understand that I may need prior authorization from my insurance company to see this provider and that it is my responsibility to get the authorization prior to, or on the day of my first appointment with this provider. If an authorization is required by my insurance company and I do not obtain one, I understand that I am financially responsible for the services not covered by my insurance company. Furthermore, I understand that I am financially responsible for the services with the above named provider should my insurance company deny my claims submitted by Reliable MH Billing Services.

I affirm the above to be true, and give my consent for treatment.

_____ _____
Signature Date

Please fax or email this form to Reliable MH Billing Services so that we may check your benefits before your first appointment.
Fax: 760-919-3132 Email: Daphne@ReliableMHBillingServices.com

Client Worksheet

Name_____ Date_____

Current Signs and Symptoms: (please mark each category)

	None	Mild	Moderate	Severe
Depressed Mood	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Suicidal Thinking	☐	☐	☐	☐
Disturbed Sleep	☐	☐	☐	☐
Appetite Changes	☐	☐	☐	☐
Psychomotor Retardation	☐	☐	☐	☐
Significant Weight Loss	☐	☐	☐	☐
Poor Concentration	☐	☐	☐	☐
Poor Grooming	☐	☐	☐	☐
Agitation	☐	☐	☐	☐
Mood Elated	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐
Inappropriate/Labile Affect	☐	☐	☐	☐
Obsessive Thoughts	☐	☐	☐	☐
Tension/Anxiety	☐	☐	☐	☐
Fearfulness	☐	☐	☐	☐
Somatization	☐	☐	☐	☐
Compulsive Behavior	☐	☐	☐	☐
Loose/Inappropriate Associations	☐	☐	☐	☐
Inappropriate Speech	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Impaired Higher Intellectual Functions	☐	☐	☐	☐
Impaired Judgment	☐	☐	☐	☐
Long Term Memory Deficit	☐	☐	☐	☐
Short Term Memory Deficit	☐	☐	☐	☐
Paranoid Ideation	☐	☐	☐	☐
Delusions	☐	☐	☐	☐
Hostility	☐	☐	☐	☐
Violent Behavior	☐	☐	☐	☐
Lawbreaking	☐	☐	☐	☐
Authority Conflict	☐	☐	☐	☐
Disruptive Conduct	☐	☐	☐	☐
Social Isolation	☐	☐	☐	☐
Dissociative Episodes	☐	☐	☐	☐

Current Medications:

☐ Anti-Anxiety ☐ Anti-depressant ☐ Mood Stabilizer ☐ Sedative Hypnotic
☐ Anti-psychotic ☐ Psychostimulant

Current Medications prescribed by: ☐ Psychiatrist ☐ Other Physician

Current Alcohol Use: Drinks per week _____

Other Vitamins and Supplements: _____

Notes: _____

_____

_____

Carol J. Waisman, Ph.D.

Licensed Clinical Social Worker

13323 W Washington Bl #200
Los Angeles, CA 90066
Telephone: (310) 804-7798
drcarolwaisman@gmail.com

The Health Insurance Portability and Accountability Act (HIPAA), a 1996 federal law, provides privacy protections and patient 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. HIPAA requires that I provide you with a Notice of Privacy Policies and Practices (the "Notice") for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached, explains HIPAA and its application to your personal health information in greater detail. Although the Notice is lengthy and sometimes complex, it is very important that you read it carefully.

The law requires that I obtain, at the end of this session, your signature acknowledging that I have provided you with this information. Please sign the attached copy of this letter, acknowledging that I have provided the Notice to you. We can discuss any questions you have about the procedures at our next session.

I acknowledge receiving the Notice of Licensed Clinical Social Workers' Policies and Practices to Protect the Privacy of Your Health Information, dated April 14, 2003.

Date: _____

_____ _____

Client's printed name Client/Guardian's signature

Carol J. Waisman, Ph.D.

Licensed Clinical Social Worker

13323 W Washington Bl #200
Los Angeles, CA 90066
Telephone: (310) 804-7798
drcarolwaisman@gmail.com

Notice of Licensed Clinical Social Workers' Policies and Practices To Protect the Privacy of Your Health Information

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

I. Disclosure for Treatment, Payment and Health Care Operations

I may use or disclose your protected health information (PHI) for certain treatment, payment and health care operations purposes without your authorization. In certain circumstances I can only do so when the person or business requesting your PHI gives me a written request that includes certain promises regarding protecting the confidentiality of your PHI.
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"
  1. Treatment is when I or another health care provider diagnoses or treats you. An example of treatment would be when I consult with another health care provider, such as your family physician or another mental health professional, regarding your treatment.
  2. 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 healthcare or to determine eligibility or coverage.
  3. Health Care Operations is when I disclose your PHI to your healthcare service plan (for example, your health insurer), or to your healthcare providers who contract with your plan to administer the plan, such as case management and healthcare coordination.
- "Use" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- "Disclose" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties, such as the billing company I employ.
- "Authorization" means written permission for specific uses or disclosures.

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:

Carol J Waisman, Ph.D.
Licensed Clinical Social Worker
13323 W Washington Bl #200
Los Angeles, CA 90066
Telephone: (310) 804-7798

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to:

Carol J Waisman, Ph.D.
Licensed Clinical Social Worker
13323 W Washington Bl #200
Los Angeles, CA 90066
Telephone: (310) 804-7798

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 July 3, 2024.

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 or personal delivery.

Dated: July 3, 2024

Carol J. Waisman, Ph.D.

Licensed Clinical Social Worker

13323 W Washington Bl #200
Los Angeles, CA 90066
Telephone: (310) 804-7798
drcarolwaisman@gmail.com

Psychotherapy Guidelines

This is designed to explain a variety of issues which often come up in the course of clients' sessions. Please take the time to read it carefully. After you do so, I would be glad to answer any questions, hear any reaction, or respond to any suggestions you may have.

Appointment Times – Individual sessions are 45 minutes. Some group, family or couples sessions may be scheduled for longer intervals.

Payment – Fees are paid at each session. If you have a need or preference to pay on a different payment schedule, talk to me so that we can make an alternative plan.

Cancellations – If you need to cancel an appointment, you may reschedule within the same week provided that we can find a mutually agreeable time. If you need to cancel and cannot reschedule you are responsible for payment for the missed session. (I will fill your reserved time with any person standing by for an appointment on a cancellation basis.)

Insurance – Out-Of-Network
I am Out-of-Network (non-preferred, non-participating) with your insurance company, I will collect payment from you in full at each visit and Reliable MH Billing Services will submit a claim to your insurance company for payment (payable to you).

Telephone Charges – I am available for consultation by telephone at times other than your scheduled appointments. For telephone calls lasting longer than 5 minutes, you will be charged a fee proportionate to your regular session fees.

Confidentiality – Whatever transpires in therapy is confidential, privileged information. You are the holder of the privilege. I will not release any information about you or your therapy unless you give me written permission to do so. A therapist, however, is required by law to inform the proper persons and authorities if a patient intends to harm himself or herself, or another person, or in cases of actual or suspected child abuse or neglect, or elder abuse. If you participate in group therapy, you agree not to discuss what transpires among the members and therapist outside of the therapy sessions.

Signature_____ Date _____

Print Name_____