Confidential

Property of:

Sea Change, LLC

Kimberly A. Popkey, MA, LPC, CEDS, SEP

Sea Change, LLC
Kimberly A. Popkey, MA, LPC, CEDS, SEP
Client Information Sheet

Client Name: _____ Today's Date: _____
SSN: _____ DOB: _____ Gender: _____ Age: ____
Home Address: _____
_____
Home/Cell Phone: _____ Work Phone: _____
Employer: _____
Employer Full Address: _____
May I contact you at work if necessary? YES NO
May I leave confidential information on your voice mail if necessary? YES NO
Email (if it is confidential): _____
How were you referred to treatment? _____
_____

Emergency Contact: _____ Phone: _____
Relationship: _____
May relevant information be relayed to this person? YES NO
Financially Responsible Party: _____ Phone: _____
Full Address if different from self: _____
Insurance Company: _____ Policy # _____
Group # _____ Policy Holder's Name: _____
SSN: _____ DOB: _____
Policy Holder's Employer: _____

Insurance Members only: I authorize the release of any medical or other information necessary to process claims. I authorize payment of medical benefits to Sea Change, LLC for service rendered.

Signature of patient/authorized person: _____

Sea Change, LLC
Kimberly A. Popkey, MA, LPC, CEDS, SEP

CLIENT CONTRACT AND CONSENT FOR TREATMENT

1) **PATIENT RIGHTS**: Clients will be treated with dignity and respect and in a way that treats them equally without regard to gender, age, race, religion and/or disability.

2) **TREATMENT PLANNING**: After a thorough assessment, treatment goals and recommendations will be discussed with the client. Clients are expected to be an integral part of assessment, goal setting, implementation of the agreed upon treatment plan, and continual evaluation of the efficacy of the therapy. Clients have the right to refuse treatment at any time; however, any noncompliance with specific treatment recommendations must be discussed thoroughly with the therapist. In addition, a written statement of chosen noncompliance with treatment recommendations may be requested.

3) **THERAPY SESSIONS**: Typical sessions are 45-50 minutes in duration. 25-30 minute and 75-80 minute sessions are also available, when appropriate.

4) **AVAILABILITY**: You may reach me by calling my voice mail and leaving a message as to the urgency of your call. You may also e-mail me at kimberlyap@msn.com. I try to be available to you; however, if I do not get back to you in the time needed due to my schedule, time off, continuing education/conferences, etc., and you need help, please call EMPACT CRISIS Hotline at (480) 784-1500 or the Banner Helpline at (602) 254-4357. Should you need to process any issues between sessions, over the phone, that requires more than 5 minutes, I will be happy to serve you according to a pro-rate of my fee.

5) **CANCELLATION POLICY**: Because time has been specifically reserved for you, **a 48-hour notice is required for all** cancellations. If less than a 48-hour notice is given, a **$125.00 fee** will be charged and due at the next visit. Since insurance companies do not reimburse for late cancellations or no-show appointments, **YOU ARE FULLY RESPONSIBLE FOR ALL CHARGES THAT RESULT FROM LATE CANCELLATIONS OR NO_SHOWS**.

6) **PAYMENT**: Payment in full is required at the time services are rendered. If for any reason you are unable to pay in full at the time of service, please discuss alternative arrangements. Please make all checks payable to *Kimberly A. Popkey, MA, LPC, CEDS, SEP and/or Sea Change, LLC*. There is a $25.00 fee for any returned checks.

7) **CONFIDENTIALITY**: All information discussed will be held in confidence. Clients will give verbal permission before the therapist will share information with any other individuals involved in the therapy (as with couples' or family therapy). To ensure quality of care, case discussion/consultation may be sought with other colleagues. Any other disclosure to other entities will require written "Release of Information," signed by the client. Situations which represent exceptions to confidentiality, in which I am legally and/or ethically required to disclose information include: any immediate intention to commit suicide, any incidents of child abuse, any incidents of elder abuse, any immediate threats to harm yourself or another person, or in cases where patient records and/or therapist is court subpoenaed.

8) **CONSENT FOR TREATMENT**: I hereby certify that I, being of sound mind and judgements, have read and understand the above treatment terms and contract. I give my consent to be evaluated and treated by Kimberly A, Popkey, MA, LPC, CEDS, SEP. I understand that my therapist or myself may discontinue this treatment contract at any time.

_____ _____

Patient Signature Date

Sea Change, LLC
Kimberly A. Popkey, MA, LPC, CEDS, SEP
8300 N. Hayden Road, Suite A-117
Scottsdale, AZ 85258
(480) 451-9800 – Office
(480) 467-0248 – Fax

OUTPATIENT SERVICES CONTRACT/CONSENT

Welcome to Sea Change, LLC. This document contains important information about my professional services and business policies. Please read it carefully and note any questions you might have in order for us to discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and the patient as well as the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings, such as, sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who have gone through it. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. However, there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another health care professional for a second opinion.

THERAPY SESSIONS

I normally conduct an evaluation that will last from 1-2 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration), once per week, at a time we both agree upon; however, some sessions may be longer or more frequent. Once an appointment is scheduled, you will be expected to pay for the session unless you provide **48 hours** advanced notice of cancellation, otherwise, a **$125.00** no-show/late cancellation fee will apply.

PROFESSIONAL FEES

My hourly fee is **$175.00**. In addition to weekly appointments, I charge this amount for other professional services you may need, although I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than **5 minutes**, attendance at meetings with other professionals you have authorized me to see on your behalf, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, even if I am called to testify by another party.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. *(In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan).* You will be responsible for all charges denied and/or not covered by insurance. Please make all checks payable to Sea Change, LLC and/or Kimberly A. Popkey, MA, LPC. There is a $25.00 fee for any returned checks.

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

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 treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment; however, you (not your insurance company) are responsible for full payment of my fees.

It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can, based on my experience, and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I would be willing to call the insurance company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans, such as, HMOs and PPOs, often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches, designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have provided additional clinical information, such as, treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be in a computer. Although all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their possession. In some cases, they may share the information with a National Medical Information Databank. I will provide you with a copy of any report that I submit, if you request it.

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

CONTACTING ME

I am often immediately available by telephone. While I am in my office and with a client, I will not answer the phone. When I am unavailable, my telephone is answered by a voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it. If you are difficult to reach, please inform me of some times when you will be available. Any telephone conversations lasting longer than **5 minutes** will result in a fee of $1.00 per minute. In emergencies, if you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the counselor/therapist/psychiatrist on-call. In addition, you may also call the help line at (602) 254-HELP (4357). If I will be unavailable for an extended time (ie. vacation, conferences, etc.), I will provide you with the name of a colleague to contact should it become necessary.

PROFESSIONAL RECORDS

As I am sure you are aware, I am required to keep records of our work together. As these records contain information that can be misunderstood by someone who is not a mental health professional, it is my general policy that patients may not review them; however, I will provide, at your request, a treatment summary, unless I believe that to do so would be emotionally damaging. If that is the case, I will be happy to send the summary to another mental health professional that is working with you.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they 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 feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss. (At the end of your treatment, I will prepare a summary of our work together for your parents, and we will discuss it before I send it to them).

CONFIDENTIALITY

In general, the law protects the privacy of all communications between a patient and a counselor/therapist, and I can only release information about our work to others with your written permission. However, there are a few exceptions.

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

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person, is being abused, I must file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep this information confidential. If you do not object, I will not tell you about these consultations, unless I feel that it is important to our work together.

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

CONSENT FOR TREATMENT

I hereby certify that I, being of sound mind and judgements, have read and understand the above treatment terms and contract. I give my consent to be evaluated and treated by Kimberly A. Popkey, MA LPC, CEDS, SEP. In addition, I also recognize that Kimberly Popkey or myself may discontinue this contract at any time.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client Signature_____ **Date**_____

Parent/Guardian Signature (if necessary)_____

Provider Signature_____ **Date** _____

Kimberly A. Popkey, MA, LPC, CEDS, SEP
Licensed Professional Counselor

Sea Change, LLC
8300 N. Haydon Road, Suite A-117
Scottsdale, AZ 85258
(480) 451-9800 – Office
(480) 467-0248 – Fax

Authorization to bill Visa/MasterCard

I, _____, hereby authorize Sea Change, LLC to bill my VISA/MASTERCARD:

Account #: _____Exp Date: _____

Name as it appears on card: _____

Security code: _____ Zip Code: _____

Cell #: _____

For any of the following reasons:

- Psychological Services
- Insurance Co-pays
- Appointment No-Shows
- Late cancellations (a 48 hour business day advanced notice is required for all cancellations).
- Outstanding Account Balances

Being delivered to: _____
(please indicate self and/or name of authorized patient)

I, furthermore, understand that I am fully responsible for all patient charges resulting from treatment with Sea Change, LLC regardless of whether or not these services/charges are covered by insurance.

Last, this agreement will remain in effect unless and/or until such time that this authorization is revoked in writing.

_____ _____
Authorized Signature Date

Sea Change, LLC
Kimberly A. Popkey, MA, LPC, CEDS, SEP

HIPAA NOTICE OF PRVACY PRACTICES

Kimberly A. Popkey, MA, LPC, CEDS, SEP is dedicated to maintaining the privacy of your personal health information (PHI). Each time a patient visits this office a record is made that describes the treatments and services rendered. Federal law outlines special privacy protections and individual rights related to the information we maintain that identified you as a patient. PHI Included demographic data and facts about your past, present or future physical or mental health. My office has put in place policies and procedure to help protect your health information. I am required to provide this notice outlining my legal duties and responsibilities related to the use and disclosure of PHI, Privacy Practices and examples of how your information may be used or disclosed.

I, Kimberly A. Popkey, MA, LPC, CEDS, SEP will abide by the terms of this notice. I may revise this notice at any time. The new notice will be posted in the office in a prominent location. You can request a copy of the most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present or future.

I, Kimberly A. Popkey, MA, LPC, CEDS, SEP may use your PHI for the following purposes without your authorization:

Treatment: I may disclose your PHI to physicians, psychiatrist, psychologist and other health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist or PCP is treating you, we may disclose your PHI to him/her in order to coordinate your care. Also, I may use your health care information to inform you of treatment options or other health-related services which may be of interest to you. Example: I may mail you a notice of an upcoming group or new program.

For Health Care Operations: I may disclose your PHI to facilitate the efficient and correct operation of the practice. Examples: Quality control – we might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professions who provided you with theses services. I may also provide your PHI to my attorney, accountant, consultants and others to make sure that I am in compliance with applicable laws.. I may need to use and disclose your information to remind you of appointments or to change an appointment.

To Obtain Payment: I may use and disclose your PHI to bill and collect payment for the treatment and services I provide to you. Example: I might send or share, verbally, your PHO to your insurance company or health plan in order to get authorization or payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as, billing companies, claims processing companies, and others that process health care claims for my office.

Other Disclosures: Examples: Your consent is not required if you need emergency treatment provided in that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me, but I think that you would consent to such treatment if you could, I may disclose your PHI.

YOU HEALTH RECORD IS THE PHYSICAL PROPERTY OF SEA CHANGE, LLC AND KIMBERLY A. POPKEY, MA, LPC, CEDS, SEP. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR FIRGHTS REGARDING INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THSESE ITEMS MUST BE MADE IN WRITING TO MY PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. I WILL PROVIDE YOU WITH APPRORATE FORMS TO EXCERSIZE THSES RIGHTS. I WILL NOTIFY YOU, IN WRITNG, IF YOUR REQUESTS CANNOT BE GRANTED.

Restrictions on Use and Disclosure: You have the right to request restrictions on how I use and disclose your health care information. This includes requests to restrict disclosure of your health care information to only certain individual, or entities, involved in your care, such as, family members and insurance companies. I am not required to agree with your request. If I agree, I am bound to the agreement unless disclosure is otherwise required or authorized by law.

Confidential communication: You have the right to request that I communicate with you in a particular manner or at a certain location. For example, you may request I only contact you at home. I will accommodate reasonable requests.

Access: You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. My office will schedule appointments for record inspection. I may charge a fee for providing you copies of your records. Under special circumstances, I may deny your request to inspect and/or copy your records. You may request a review of this denial.

Record Amendment: You have the right to request amendments to your health records creased by and for my practice, if you feel I am incorrect or incomplete. I may accept or deny your request. If I deny you r request, you have the right to provide a statement of disagreement or rebuttal statement.

Accounting Disclosures: You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures I have made of your records. Upon your request, I will provide this information to you free, one time, during each 12-month period. There may be a fee for additional copies.

Copies of Notice: You have the right to request that I provide you with a paper copy of this notice of Privacy Practices.

To Make a Compliant about My Privacy Practices: If you feel your privacy rights have been violated, you have the right to file a written complaint with my office at the address listed below. You may also file a complaint with the Secretary of the Department of Health and Human Services at 20 0indepence Avenue, S.W., Washington, D.C. 20201. There will be no retaliation for filing a complaint.

If you have questions about the notice, please contact Privacy Officer:

Kimberly A. Popkey, MA, LPC, CEDS, SEP
Sea Change, LLC
8300 N. Haydon Road, Suite A-117
Scottsdale, AZ 85258
(480) 451-9800– Office
(480) 467-0248 – Fax

Effective Date of this Notice: 12/04/2018

Sea Change, LLC
Kimberly A. Popkey, MA, LPC, CEDS, SEP
8300 N. Haydon Road, Suite A-117
Scottsdale, AZ 85258
(480) 451-9800 – Office
(480) 467-0248 – Fax

SIGNATURE PAGE

CANCELATIONS: Since scheduling an appointment involved the reservation of time specifically for you, a **minimum of 48 business hours is required for re-scheduling or canceling an appointment**. A $110.00 fee per individual session will be charged for sessions missed without such notification. Insurance companies do not reimburse for misses sessions; THEREFORE, payment of this fee is the responsibility of the client. _____ (initials please)

I/we acknowledge that I have read the document titled **CLIENT CONTRACT AND CONSENT FOR TREATMENT** carefully; have had the opportunity to ask question; understand the agreement, policies and information; agree to comply with them and agree to begin treatment:

_____
Client/Patient/Guardian (Print)

_____
Date

_____
Signature

I/we acknowledge receipt of the **HIPAA NOTICE OF PRIVACY PRACTICES.**

_____
Client/Patient/Guardian (Print)

_____
Date

_____
Signature