Glenn G. Stevenson, L.C.S.W.

Confidential Information Form

Child/Youth's Name _____ Date _____

Date of birth _____ Sex _____ Primary Language _____ School _____

If over 18: Youth's cell phone (____) _____ Email address _____

Mother's Name _____ Date of birth _____

Mother's driver's license no. _____

Mother's home address _____

City _____ State _____ Zip _____

Home phone (____) _____ Work phone (____) _____

Cell phone (____) _____ Email address _____

Okay to leave messages anywhere? ❒ Yes ❒ No If not, please give instructions on where to leave messages:

_____

Mother's employer _____

Mother's work address _____

Father's name _____ Date of birth _____

Father's driver's license no. _____

Father's home address _____

City _____ State _____ Zip _____

Home phone (____) _____ Work phone (____) _____

Cell phone (____) _____ Email address _____

Okay to leave messages anywhere? ❒ Yes ❒ No If not, please give instructions on where to leave messages:

_____

Father's employer _____

Father's work address _____

Confidential Information Form

Other persons living in the household

Name	Sex	Age	Birthdate	Relationship
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____

Immediate family members living outside the home

Name	Sex	Age	Birthdate	Relationship	Location
_____	____	_____	_____	_____	_____
_____	____	_____	_____	_____	_____
_____	____	_____	_____	_____	_____

Child's/youth's significant physical problems _____

_____

Medications child/youth is currently taking:

Medication	Dose	Frequency	Reason for Medication
_____	_____	_____	_____
_____	_____	_____	_____

Who referred you to me?

_____ _____ _____
Person or Agency or Website

Has child/youth been involved previously in counseling? ❑ Yes ❑ No

If yes, please tell me about child's/youth's previous counselor(s):

_____ _____ _____
Name of counselor and credentials Agency Dates

_____ _____ _____
Name of counselor and credentials Agency Dates

Emergency Contact: _____ (____) _____
Name Telephone

Primary reasons for seeking counseling at this time:

_____

_____

_____

I offer a quarterly email newsletter on issues of personal growth for adults. Would you like me to add you to my email list? ❑ Yes ❑ No

Glenn G. Stevenson, L.C.S.W.

Consent for Services

The undersigned client or responsible party (parent, guardian, or conservator of a minor or dependent adult) consents to mental health services by Glenn G. Stevenson, L.C.S.W. These services may include psychotherapy/counseling, case management, referral to other professional services, and other appropriate therapies within normal scope of practice.

The undersigned understands that he/she:

1. has the right to be informed of the services and their purposes that can or will be provided, and reasonable alternatives;

2. has the right to participate in the selection of assessment, treatment, and case management services;

3. has the right to confidentiality, except when he/she signs a written authorization for release of information to a third party, or except in legally mandated/allowed situations, including, but not limited to:
   a. if the therapist is ordered by a court (judge) to release information;
   b. the client (or minor for whom the undersigned gives consent for services) presents a physical danger to self, others, or the property of others;
   c. the therapist has knowledge of, or reasonably suspects, that a child has been physically abused, sexually abused, severely emotionally abused, or that the child's health is endangered due to lack of medical care, food, or clothing, shelter, or supervision;
   d. the therapist has knowledge that an elder or dependent adult has been physically abused, neglected, or abandoned;
   e. the services of an attorney and/or collection agency are required to pursue past due sums;
   f. payment by third parties, health care operations, and other circumstances described in the Notice of Privacy Practices for Glenn G. Stevenson, LCSW

4. has the right to refuse or withdraw consent to treatment at any time;

The undersigned understands that treatment includes the risks of:

1. emotional discomfort
2. expected results not necessarily being realized.

The undersigned understands there will be financial costs incurred as a result of services in accordance with the financial agreement reached with the therapist.

The undersigned understands that all of the above services are voluntary and that this consent for services remains in effect until the client or responsible adult revokes consent or otherwise terminates treatment.

_____	_____	_____
Client Name	Client or Responsible Adult Signature	Date
_____	_____	
Signer's relationship to client	Glenn G. Stevenson, LCSW	

Glenn G. Stevenson, L.C.S.W.

Business Practices and Financial Agreement

My fee is $150 for an in-take session and $120 for subsequent sessions. I accept cash and personal checks. Please check with me if you wish to pay by credit card. If I am in-network with your insurance company, your responsibility will be your copay or coinsurance amount. If you are an Employee Assistance Program (EAP) client, your fee is $0. I will bill your insurance or EAP company upon request. With your signature below, you agree to assign to Glenn G. Stevenson any insurance or EAP benefits that you request I bill.

If a balance equal to two sessions remains outstanding, I generally do not schedule additional sessions until a payment arrangement has been made. Balances outstanding beyond 30 days are subject to a 1% per month (13.8% per annum) financing fee. Checks returned for insufficient funds are subject to a $30 fee. I charge a $25 fee for letters or forms that I complete for third parties (for instance, disability paperwork). In the event legal action is required to pursue or collect past due sums, the client agrees to pay reasonable attorneys' fees, cost of suit, and/or other collection costs.

Sessions are 50 minutes to an hour. If you need to cancel your appointment, please notify me at least 24 hours before your appointment time. Cancellations made less than 24 hours in advance will be charged at one-half my rate per session, or if you are an in-network client, your full copay. For in-network clients with zero copay, late cancellations are charged $30. Regular attendance in counseling according to the agreed frequency is important to reach your goals. If you cancel or do not show for an excessive number of appointments, I reserve the right to discontinue the counseling.

Generally, I work with clients as long as the client wishes and is making progress. Still, I reserve the right to terminate therapy. Reasons for stopping treatment include, but are not limited to, not paying fees, not following treatment recommendations, conflicts of interest, not participating in therapy, the client's needs are outside my scope of competence or practice, or the client is not making adequate progress. You have the right to stop therapy at any time.

I provide outpatient psychotherapy services and am not always available for emergency situations. In the event of a mental health emergency when I am not available, I ask the client to call 911. Between sessions, I can be reached directly or by leaving a message at 714-468-9963.

I provide therapy as a treating therapist to alleviate mental disorders and life problems. I do not provide therapy in anticipation of testimony in legal proceedings. However, if I respond to a subpoena issued on your behalf, you will be billed for my time and other costs.

This practice, Self Sense Counseling and Coaching, is owned and operated by Glenn G. Stevenson, L.C.S.W.

If you have any concerns or complaints about your treatment, I invite you to discuss them with me. I will endeavor to resolve any grievances to your satisfaction and within my limits of doing so.

Client Agreement

I, _____, understand these business practices and agree to pay the professional fees for psychotherapy and any other charges as stipulated above. I also acknowledge receiving a copy of Glenn G. Stevenson, L.C.S.W.'s Notice of Privacy Practices.

_____	_____	_____
Client or Responsible Adult Signature	Date	Glenn G. Stevenson, LCSW

Glenn G. Stevenson, L.C.S.W.

Notice of Privacy Practices

Effective Date: June 1, 2021

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The privacy of your medical information is important to me. I understand that your medical information is personal and I am committed to protecting it. I create a record of the care and services you receive in my practice. I need this record to provide you with quality care and to comply with legal requirements. This notice will tell you about the ways I may use and share medical information about you. It also describes your rights and my duties regarding the use and disclosure of medical information.

MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your protected health information (PHI), which includes information that can be used to identify you that I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this notice about my privacy practices, which must explain how, when, and why I will use and disclose your PHI. A "use" of PHI occurs when I utilize, examine, apply, analyze, or share such information within my practice. PHI is "disclosed" when I release, transfer, or otherwise divulge it to a third party outside my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. I am also legally required to follow the privacy practices described in this notice.

However, I reserve the right to change the terms of this notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this notice and post a new copy of it in my office. You may also request a copy of this notice from me or view a copy of it in my office.

HOW I MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following section describes different ways that I use and disclose medical information. Not every use or disclosure will be listed. However, I have listed all of the different ways I am permitted to use and disclose medical information***. I will not use or disclose information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to me.*** If you revoke a written authorization I will stop any future uses and disclosures of your PHI to the extent that I have not already taken action based on your prior written authorization.

I may use and disclose your PHI without your consent for the following reasons:

1. For Treatment. I may use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns, if I have any. I may disclose your PHI to physicians, psychiatrists, psychologists, marriage and family therapists, clinical social workers, and other health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I may disclose your PHI to your psychiatrist to coordinate your care.

2. For Payment. I may use and disclose your PHI to bill and collect payment for the treatment and services I have provided to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. For Health Care Operations. I may use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. If your health plan decides to audit my practice in order to review competence or performance, or to detect possible fraud or abuse, I may use or disclose your mental health records. I may also provide your PHI to my bookkeeper, accountant, attorney, consultants, or others to further my health care operations. To protect your information, I require business associates to safeguard your information.

4. For Appointment Reminders or Other Health-Related Information. I may use or disclose your PHI to contact you to provide appointment reminders. If I do not reach you directly, I may leave this information on your answering machine, voicemail, or with a person answering the phone. I will endeavor to follow your instructions on where to leave messages. I may also contact you to inform you of treatment alternatives, other health care services, or other health care benefits that may be of interest to you.

5. In Case of Patient Incapacitation or Emergency. I may disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent is not required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

6. When Required by Law. I may use or disclose your PHI when federal, state, or local law requires me to do so. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies or law enforcement personnel about victims of suspected abuse or neglect.

7. For Judicial or Administrative Proceedings. I may, and sometimes am required by law, to disclose your health information for a judicial or administrative proceeding. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.

8. For Law Enforcement. I may, and sometimes am required by law, to disclose your health information to a law enforcement official. For example, I may have to use or disclose your PHI in order to identify or locate a suspect, fugitive, material witness, or missing person, or in response to a search warrant.

9. For Public Health Activities. As required by law, I may disclose your protected health information to public health or legal authorities charged with overseeing, preventing, or controlling disease, injury, or disability.

10. For Health and Safety Concerns. I may use or disclose you protected health information to avert a serious threat to health or safety. For example, I may disclose your protected health information if you are in such a mental or emotional condition as to be dangerous to yourself or to the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger, and/or if you tell

me of a serious, imminent threat of physical violence to be committed by you against a reasonably identifiable victim or victims.

11. For Specialized Government Functions. Subject to certain requirements, I may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determination for Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

12. For the Coroner/Medical Examiner. To help the coroner/medical examiner carry out his/her duties, I may share protected health information if disclosure is compelled or permitted in the event of your death to determine the cause of death.

I may use and disclose your PHI in the following situations after you have had the opportunity to object:

1. Disclosures to Family, Friends, or Others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

RIGHTS YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights with respect to your PHI:

1. **The Right to Request Restrictions on My Uses and Disclosures**. You have the right to request restrictions or limitations on my uses or disclosures of your protected health information. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, you may not limit the uses and disclosures that I am legally required to make.

2. The Right to Choose How I Send Protected Health Information to You. You have the right to request that I send confidential information to you to at an alternate address (for example, your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request as long as it is reasonable and you specify how or where you wish to be contacted. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

3. The Right to Inspect and Receive a Copy of Your Protected Health Information. In most cases, you have the right to inspect and receive a copy of your PHI, but you must make the request to inspect and receive a copy of such information in writing. Your right to inspect and receive a copy of your PHI is not absolute, and in certain situations, I may deny your request. If I do, I will tell you in writing my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than $0.25 per page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the protected health information as long as you agree to the summary or explanation and to its cost in advance.

4. The Right to Receive a List of the Disclosures I Have Made. You have the right to receive a list of disclosures of your PHI that I have made up to six years prior to the date on which the accounting is requested. The list will not include disclosures made for treatment, payment, or health care operations;

disclosures made to you; disclosures you authorized in writing; disclosures permitted or required by the federal privacy rule; disclosures for research or public health purposes that exclude direct patient identifiers; disclosures made for national security or intelligence; or disclosures made to correctional institutions or law enforcement personnel. I will respond to your request for an accounting of disclosures within 60 days of receiving such request. The list I will give you will include disclosures made in the six years prior to the request unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in a 12-month period, I may charge you a reasonable, cost-based fee for each additional request.

5. The Right to Amend Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (a) accurate and complete, (b) not created by me, (c) not part of the information permitted to be inspected or copied, or (d) not part of my records. My written denial will state the reasons for the denial. If I approve your request, I will make the change to your PHI and tell you that I have done it. You also have the right to request that I add to your record a statement of up to 250 words concerning any statement or item that you believe to be incomplete or incorrect.

6. The Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it by e-mail.

QUESTIONS AND COMPLAINTS ABOUT MY PRIVACY PRACTICES

If you have questions about this notice please ask me. If you think that I may have violated your privacy rights, you may file a complaint with me:

Glenn Stevenson, LCSW
515 E. 1st St., Suite D
Tustin, CA 92780
714-468-9963

You may file a complaint by simply providing me with a written statement specifying the manner in which you believe the violation occurred, the approximate date of such occurrence, and any details that you believe will be helpful to me. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint with me or with the Secretary about my privacy practices.