DR. SHARON SIEGEL

**AUTHORIZATION FOR TREATMENT**
**ASSIGNMENT OF BENEFITS**

The following is to ensure your understanding of my office policies. Any part may be altered, subject to prior agreement between us.

Each office visit is 45 minutes long. it begins and ends as scheduled, and is yours as a paid visit, even if you are late or absent. My 48-hour advance cancellation policy is intended to cover emergencies or illness only. As feasible, I will reschedule a missed session or late. Cancellation at no charge within one week. However, if this is not possible, and if 48-hour advance cancellation was not received, full payment for the missed session is immediately due and payable.

If you have outpatient mental health insurance, I will bill your insurance company at my usual and customary fee of $145 per session, and advise them of the amount you have paid.

You may call me at (310) 455-3232, Monday through Friday, from 9:00AM. to 6:00PM. I will return your call as soon as possible if a message is left for me. In case of emergency, please call 911. This number rings at home and I answer whenever I am able.

_____

I have read and agree to the above terms. I authorize Dr. Siegel to provide psychotherapy services to me, and agree that payment of insurance benefits be made directly to Dr. Siegel for the services rendered. I further authorize Dr. Siegel to furnish my insurance company with information regarding history, diagnosis, and treatment. I understand that the usual and customary fee is $145 per 45-minute hour. The amount for which I accept responsibility is $_____ per 45-minute hour.

Signature: _____Referred by: _____Date: _____

Print Name: _____Additional Info: _____

Address: _____

City/State/Zip: _____

Home Phone: (  )_____ Cell Phone: (  )_____

Birth Date: _____ Additional Phone(s): (  )_____

Emergency Contact: _____ Relationship: _____

Phone: (  )_____



Marriage and Family Therapist MA# 12947, 125 East Tahquitz Canyon Way, Suite 203, Palm Springs, CA. 92262

DR. SHARON SIEGEL

# INFORMATION AND AUTHORIZATION FOR TREATMENT

The following is written to give you information about your rights and responsibilities, and to ensure that you understand my office policies. Please feel free to discuss any part of this with me.

1. **Confidentiality.** As your therapist, I am legally prohibited from discussing the fact that you are in therapy with me, nor may I reveal the contents of our discussions without your written permission.
However, in the following circumstances, the law and/or professional guidelines supersede your right to confidentiality:

A. Instances of actual or suspected physical or sexual abuse, emotional cruelty, or neglect of a child, an elder or a dependent adult, must be reported to the appropriate protective services.

B. If a client appears to pose imminent violence to another person, or another's property, I must warn that person and inform the appropriate authorities.

C. If your treatment with me is court ordered or if I am served with a subpoena, or if you raise your own psychological state as an issue, I must release information to the court or appear in court

D. If you express a serious intent to harm yourself, ethically I am bound to do whatever is necessary to keep you safe, which may include notifying authorities or others who might be of help.

2. **Sessions.** Each office visit is 45 minutes long. It begins and ends as scheduled, and is yours as a paid visit, even if you are late or absent. Cancellations must be made 48 hours in advance and are intended to cover emergencies and illness only. I will replace missed sessions within one week if I can, by phone or at the office.

3. **Payment.** Payment for services is due at the time of each session, unless we have agreed to a different arrangement. At the outset of treatment, we will agree on a fee, and any fee change will be negotiated in good faith and in the context of your present ability to pay in order to remain in treatment. Fees for writing psychological reports are based on the agreed hourly fee. It is important that we discuss any issues that may arise from our financial arrangements (such as a change in your financial status) so that our work together may continue unencumbered.

4. **Telephone Accessibility.** I will return phone calls made to 310-455-3232 as soon as possible and during business hours. There will be no charge for a call of less than 10 minutes; calls of greater length will be prorated at the agreed rate.



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DR. SHARON SIEGEL

## INFORMATION AND AUTHORIZATION FOR TREATMENT

5.**Patient Rights.** In addition to confidentiality (discussed in paragraph 1), you have the right to terminate your treatment at any time and for any reason. Your only financial obligation is for the fees incurred to date. You have the right to question any aspect of your treatment, and to expect that I will do everything to facilitate any adjunctive or alternative treatment you may need. You have the right to expect that I will maintain a professional and ethical boundary between us during your treatment.

To protect your confidentiality, if we happen to see one another on the street or in public places, I will not acknowledge your presence unless you greet or approach me first (which I welcome, of course). When asked how I know you I will say "I know you in the community".

Your signature below indicates that you have read and understood this information, that you agree to it, and that you have received a copy of this notice.

_____ _____

Signature of Client Date

A:inf-authtrtmt5-03



Marriage and Family Therapist MA# 12947, 125 East Tahquitz Canyon Way, Suite 203, Palm Springs, CA 92262

DR. SHARON SIEGEL

# NOTICE: PROTECTED HEALTH INFORMATION (PHI)

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

## I LEGAL OBLIGATION REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of identifying information 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 for this health care. I must provide you with Notice about my privacy practices, and such Notice must explain how, when and why I will 'use" and "Disclose" your PHI. A "use" occurs when I share, examine, utilize, apply or analyze such information within my practice; a "disclosure" occurs when PHI is released, transferred, has been given to, or is otherwise divulged to a third party outside my practice. I reserve the right to change the terms of this Notice and my privacy policies at any time by putting any changes in writing and promptly offering them to you. This Notice is available at my office for review at any time.

## II USE AND DISCLOSURE OF INFORMATION

For some uses and disclosures, I will need your prior authorization; for others, I do not.

**A. Uses and disclosures relating to treatment, payment, or health care operations do not require your prior written consent.** I can use and disclose your PHI without your consent in the following circumstances:

1. **For treatment**. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a physician, with your written permission, I can disclose your PHI to that physician in order to coordinate your care.
2. **To obtain payment for treatment.** I can disclose your PHI to bill and collect payment for the treatment I provide to you (e.g., to your insurance company, to others who process my health care claims or to a collection agency.
3. **For health care operations**. I can disclose your PHI to operate my practice. For example, I might use it to evaluate the quality of health care services you received. I may also provide your PHI to my accountant, attorney, consultants and others to ensure I am complying with applicable laws.
4. **Other disclosures.** I may also disclose your PHI to others without your consent in certain situations. 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 (e.g., 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.



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**B.** Certain uses and disclosures do not require your consent. I can use and disclose your PHI without your consent or authorization in the following circumstances:

1. **When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement.** For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. **For public health activities.** For example, I may have to report information about you to the county coroner.
3. **For health oversight activities.** For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization
4. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
5. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, I may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
6. **For specific government functions.** I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
7. **For workers' compensation purposes.** I may provide PHI in order to comply with workers compensation laws.
8. **Appointment reminders and health related benefits or services.** I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

**C. Certain uses and disclosures require you to have the opportunity to object.**
**Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend or other person whom you indicate being involved in your care or in the payment for your health care, unless you object in whole or in part to giving me written authorization to release information. The opportunity to consent may be obtained retroactively in emergency situations.

**D. Other uses and disclosures require your prior written authorization.** In any other situation not described in sections A, B and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.



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## III YOUR RIGHTS REGARDING YOUR PHI

**A. The right to request limits on uses and disclosures.** You may ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to comply with it. If I accept it, I will put any limits in writing and abide by them, except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

**B. The right to choose how I send PHI to you.** You may ask that I send information to you at an alternative address (e.g., at your work). Or by an alternative means (email rather than regular mail). I am obliged to agree to your request, provided that I can easily send the information in the format requested.

**C. The right to see and get copies of your PHI.** In most cases, you have the fight to look at or get copies of your PHI that I have. Such request must be in writing, and I will respond within 30 days of receipt. If I do not have your PHI, I will direct you to the source that does. If I feel it necessary to deny your request, I will notify you of my reasons in writing and explain your right to have my denial reviewed.

The charge for copies of your PHI will be no more than $.25 per page, agreed in advance. Provided you agree, I may provide you with a summary or explanation of your PHI, rather than the complete PHI.

**D. The right to obtain a list of the disclosures I have made.** Upon request, I will provide, within 60 days, a list of disclosed PHI. This will not include uses or disclosures to which you have already consented nor those made for national security purposes, to corrections or law enforcement personnel. The list will include disclosures made in the last six (6) years, or shorter if requested. It will include the date of the disclosure, to whom PHI was disclosed, a description of the information disclosed, and the reason for the disclosure. The list will be provided at no charge; however, subsequent requests in the same year will be provided at a reasonable charge.

**E. The right to correct or update your PHI.** If you believe there is a mistake in your PHI or that a piece of important information is missing, you may request, in writing, that I make the correction. I will respond within 60 days of receipt of the request I may deny your request, in writing, if in my opinion, the PHI is (i) incorrect and/or incomplete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons and explain in a written statement of disagreement. If you do not appeal, you have the right to request that my denial be attached to all future disclosures of your PHI If I approve your request, I will make the change to your PHI, tell you that I have done so, and tell others who need to know about the change(s).



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IV **FILING A COMPLAINT ABOUT MY PRIVACY PRACTICES**

If you think that I may have violated your privacy rights, or you disagree with any decision I made about access to your PHI, you may discuss such complaint with me. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, DC 20201. I agree to take no retaliatory action against you should you decide to file such a complaint.

V **CONTACT FOR INFORMATION AND QUESTIONS ABOUT THIS NOTICE OR ABOUT MY PRIVACY PRACTICES**

If you have any questions about this Notice or about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me.

a:phi5-03



Marriage and Family Therapist MA# 12947, 125 East Tahquitz Canyon Way, Suite 203, Palm Springs, CA 92262

DR. SHARON SIEGEL

**SERVICE AGREEMENT**

This agreement is between Sharon Siegel, PhD/LMFT [my therapist] and me,_____

*Print Client's Name*

**Electronic Communications.** Email, eFax, Fax, and text messages are not encrypted and are not secure. I choose to release my therapist from any liability and to not hold her liable for any possible adverse consequences if I choose to communicate with her and her office via email, eFax, Fax, text message, or any other un-secure means of electronic communication else.

**Duty to Warn.** My therapist has the duty to inform the Department of Child Protective Services, or Elder Abuse Services, if I reveal to her that I or someone I know is actively endangering or abusing a minor or elder. She also has the duty to inform the Police Department if I reveal to her that I am going to physically hurt myself or someone else.

**Medical Consents.** My therapist does not recommend or prescribe any medications for any reason. Appropriate practitioners are recommended for medications management, follow up and changes. My therapist is not liable if I encounter ill effects from taking medications prescribed by others.

**Pregnancy.** Psychiatric medications may be detrimental to the fetus. [If I am female] I will use birth control so I will not be pregnant while I take psychiatric medication. I will discuss pregnancy and medications with the prescribing practitioner and I will not hold my therapist liable if there are any adverse effects to my fetus due to my taking psychiatric medications.

**Suicide.** I will not attempt to end my life while I am under the care of my therapist. If I have strong urges to end my life, I will call 911 or go to the nearest Emergency Room so I can be evaluated and treated before I do anything to harm myself. My family and I will not hold my therapist liable if I attempt to or succeed in ending my life.

**Treatment Outcome.** The treatment of mental disorders, relationship problems, and other mental conditions require different tools such as medication, therapy, after-session assignments, support groups, and/or habit changes. There is ample evidence that these tools work for some people some of the time. However, there is no guarantee that any of these tools will work for my specific condition. I am willing to accept that going into treatment.

**Public Encounter.** At times I may encounter my therapist in a public setting. She wants to protect my privacy and will not acknowledge me unless I acknowledge her before she addresses me. My therapist will be glad to acknowledge me if I am first to make contact in public, although she will never disclose the nature of our therapy relationship.

**Termination of Treatment.** The therapist-client relationship is maintained between my therapist and me for as long as I continue to receive treatment. If I cancel my appointment or if I do not show up for my appointment, and I do not contact my therapist within three months of the last appointment, my therapist will assume that I no longer want to be under her care, at which time she will no longer be responsible for my treatment. Our therapist-client relationship will be terminated as evidenced by three months of no contact from me.

| _____ | _____ | _____ |
|---|---|---|
| Client's Signature | Date | Sharon Siegel, PhD/LMFT |



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DR. SHARON SIEGEL

# QUESTIONNAIRE

Name_____
Today's Date: _____ Current Time:_____

What is the reason for your visit?_____

_____

**HISTORY OF PRESENT ILLNESS** How do the following symptoms describe you?
0= Not true. 1= True sometimes. 2= True 50% of the time. 3= True most of the time.

__Extremely depressed
__Not interested in anything
__Feel worthless (or guilt-ridden)
__Have low energy or fatigue
__Have difficulty concentrating
__Have poor appetite (or I overeat)
__Feel restless (or slowed down)
__Have trouble with sleep
__Think about death a lot
__Feel hopeless about my situation
__Have low self-esteem
__Am not interested in sex
__Feel anxious or tense
__Have anxiety/panic attacks
__Isolate, don't go out
__Have poor memory
__Have paranoid feelings
__Have alcohol/drug craving
__Can't keep commitments
__Have arguments/conflicts
__Have recurrent, disturbing dreams
__Am disturbed by certain images
__Avoid certain people or places
__Am irritable or easily frustrated
__My thoughts are going very fast
__Have difficulty relating to others
__Can't tune out the voices in my head
__Am bothered by physical illness
__Can't stop certain repetitive thoughts
__Can't stop certain behaviors

| Name of medication | Milligram per tablet | No. of tablets per dose | 1,2, or 3 times daily | Starting date | Describe side effects, if any |
|---|---|---|---|---|---|
| | | ½ 1 1½ 2 3 | | | |
| | | ½ 1 1½ 2 3 | | | |
| | | ½ 1 1½ 2 3 | | | |
| | | ½ 1 1½ 2 3 | | | |

*Go to the last page if you need more space to complete the above*

Any **medication allergies?** Y N If so, which one and what happened?_____

**PAST PSYCHIATRIC HISTORY** Outpatient Treatments

| Name of psychiatrist or therapist | Age started | Reason for visit/Treatment given/ List of medications if applicable | Age ended | City and State |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

*Go to the last page if you need more space to complete the above*

Circle or underline all **psychiatric medications** you have taken before, **but are not taking currently:** Abilify, Adderall, Ambien, Anafranil, Antabuse, Ativan, Buspar, Campral, Celexa, Cogentin, Concerts, Cymbalta, Depakote, Dexedrine, Effexor, Elavil, Geodon, Haldol, Invega, Klonopin, Lamictal, Lexapro, Librium, lithium, Lunesta, Luvox, Mellaril, Meridia, Metadate, methadone, Methylin, Navane, Neurontin, Pamelor, Paxil, Pristiq, Prozac, Remeron, Restoril, ReVia, Risperdal, Ritalin, Rozerem, Seroquel, Serzone, Strattera, Suboxone, Subutex, Tegretol, Thorazine, Tofranil, Topamax, Trazodone, Trilafon, Trileptal, Valium, Vistaril, Vyvanse, Wellbutrin, Xanax, Zoloft Zyprexa. Other_____



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DR. SHARON SIEGEL

# QUESTIONNAIRE

All diagnoses you have received from your previous psychiatrists and therapists: _____

_____

How many times have you stayed in a psychiatric hospital? _____ When was the very first time?
Age:_____For what reason?_____

How many times have you tried to end your life before?___ With what means?_____

_____

The last two **psychiatric hospitalization** experiences, starting with the **last** one:

| Name and location of Hospital | Your age | For how long? | Reason | Voluntary? |
|---|---|---|---|---|
| | | | | Yes No |
| | | | | Yes No |

## Destructive behaviors

| Have you ever done the following? | When was the first time? (age) | When was the last time? (age) | Have you ever done the following? | When was the first time? (age) | When was the last time? (age) |
|---|---|---|---|---|---|
| Bang your head against the wall | | | Binged on food/meals | | |
| Cut on yourself (to feel better) | | | Induced vomiting | | |
| Tried to end your life | | | Used laxatives to lose weight | | |

**Trauma:** List all physical, sexual assaults, domestic violence, you have encountered in the past, starting with the earliest

| Who did what to you? | Age when it began | When it ended | how many times or how often? | Told anyone? |
|---|---|---|---|---|
| | | | | Yes No |
| | | | | Yes No |

*Go to the last page if you need more space to complete the above*

**MEDICAL HISTORY Please check all medical illnesses you have or have had:**

Arthritis__ Asthma__ Cancer__ Crohn's disease__ Diabetes__ Glaucoma__ heart disease__ hepatitis__ High blood pressure__ HIV__ Kidney disease__ Liver disease__ Lower back pain__ Migraine headache__ Peptic ulcer disease/GERD__ Seizure__ Stroke__ Thyroid disease__

List more here if they have not been mentioned: _____

Ever lost consciousness? **Y N** If so, what age and what happened?: _____

Ever had head trauma? **Y N** If so, what age and what happened:_____



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DR. SHARON SIEGEL

# QUESTIONNAIRE

## FAMILY PSYCHIATRIC HISTORY

Do you have any blood relatives with histories of mental illness, psychiatric hospitalizations, or "nervous breakdowns"? Y N If so, If so, please describe:_____

Anyone with alcohol or drug problems? **Y N** If so, please describe: _____

Anyone with a history of suicide attempts? **Y N** If so, please describe:_____

## SUBSTANCE HISTORY

Ever felt you should cut down on your alcohol intake? **Y N**

Have people annoyed you by criticizing your drinking? **Y N**

Ever felt guilty about your drinking? **Y N** Ever drank to steady your nerves or to get rid of a hang over? Y N

Ever had drunk driving arrests? **Y N** How many times?____ Ever blacked out from drinking? **Y N** How many?__

Ever had the "shakes" when you cut down on your usual alcohol intake? **Y N**

Ever had a seizure from alcohol withdrawal? **Y N**

What is your drug of choice?_____When was the last use?_____

What was the longest period that you had been clean or sober?_____When (ages) ?_____to_____

## Alcohol & Drug History:

| | Ever been addicted to it? | Age of first use | During heaviest use, how much money per day? | How many times to rehab programs? | Recently, how much money per week? | How often do you use now? | Age or Date of last use |
|---|---|---|---|---|---|---|---|
| Alcohol | Y N | to | | | | | |
| Marijuana | Y N | to | | | | | |
| Cocaine | Y N | to | | | | | |
| Speed | Y N | to | | | | | |
| Heroin | Y N | to | | | | | |
| LSD or PCP | Y N | to | | | | | |
| Ecstasy | Y N | to | | | | | |

**If you are using pain medications currently, please complete the following:**

| Name of pain medication | Dosage | Age of 1st use | Age of heaviest use | Average # of tablets/day | During heaviest use, how much money per day? | Recently, how much money per week? | # of tablets yesterday |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |



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# QUESTIONNAIRE

## SOCIAL HISTORY

Who do you live with now?_____
Marital status: Single__ Married/Partnered__ Divorced__ Widowed__ Separated__ Other_____
Parental Status: No Children__ Biological Parent__ Step-parent/Co-parent__ Foster Parent__ Grandparent__ Other____
Sexual orientation: Straight__ Bi__ Lesbian__ Gay__ Transgender__ Questioning__ Queer__
Age of first marriage:_____ # of marriages____ # of children living with you:_____ Ages:_____
# of children **not** living with you:_____ Ages_____

**Check the type of places you have lived in during the past year:**

| With Family | With Friends | Apartment /House | Section 8 Housing | Board & Care | Homeless Shelter | Drug Rehab | On the Street | Outside of U.S. | Other (pleae explain) |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

**Development**

Where were you born?_____ Where were you raised?_____
Who Raised You?_____ How old were you when you stopped living with your father?_____
How old were you when you stopped living with your mother?_____ What was your childhood like?_____
_____ Ever been to foster home? **Y N** If so, from what age to what age_____ Number of brother and sisters you grew up with:_____ Their ages?_____
**Education:** How far did you go in school?_____ Please describe any difficulties you had in school, if any:_____ Any special education? **Y N**
If so which grades?_____
**Your grades:** In elementary school: **A B C D F** In junior high: **A B C D F** In high school: **A B C D F**
**Occupation:** What is your current occupation?_____ How long have you been doing this? _____
What other jobs have you done in the past:_____
**Legal:** How many times have you been arrested?_____ Have you ever been involved in any lawsuit before **Y N**

| Name of jail or prison | What did you do? | What was the sentence? | Age you went in | Age you came out |
|---|---|---|---|---|
| | | | | |
| | | | | |

*Add another if you need more space to complete the above*

Are you on probation or parole? **Y N** If so, when and how will it end?_____
**Military:** Ever been in the military: **Y N** Describe the experience:_____
Are you service connected **Y N** If so, what percentage and for what reason?_____
**Social:** Attend church/temple/synagogue regularly? **Y N** Religion:_____
Name your hobbies & leisure activities:_____

**CURRENT FUNCTIONING**

How often do you talk to your parents?_____To your brothers and sisters?_____
Do you have any plans to end your life? **Y N** If so, What are your plans?_____
Do you have any serious intentions to hurt anyone? **Y N** Who?_____ What are your plans?_____
What did you do yesterday all day?_____
What activities did you do last week that were enjoyable?_____



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# QUESTIONNAIRE

## STRESSORS

**Check all things that bother you:**

Parents/Relatives conflict____ Partner/Spouse conflict___ Roommates/Siblings conflict__ Problems at work___
Getting along with other people___ Lack of friends___ Housing ___ Can't see a doctor____ Health Issues ____
Legal problems___ Money___ Appearance___ Age ___ Can't think clearly___ Spiritual concerns___
Lack of transportation____ Sexual orientation____ Other_____ (Please explain)



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DR. SHARON SIEGEL

# AUTHORIZATION FOR RELEASE OF INFORMATION

By signing this document, I _____ (hereinafter "Patient") hereby authorize Dr. Sharon L. Siegel (“Provider") to disclose mental health treatment information and records obtained in the course of Provider’s treatment of me, including but not limited to Provider' s diagnosis, to the following individual/organization:_____

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing, I understand that I have the right to revoke this authorization at any time, unless Provider has taken action in reliance upon it. And I also understand that, to be effective, such revocation must be in writing and received by Provider.

This disclosure of information and records authorized by Patient is required for the following purpose:

Exchange of information per the above named’s request.
Reimbursement for services rendered.

The specific uses or limitations on the types of medical information to be discussed or disclosed are as follows: diagnosis, prognosis, treatment plan.

Patient has the right to refuse to sign this form.

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rule, although such information may be protected by applicable California law.

This authorization shall remain valid until_____.

_____ _____
Patient Signature Date

_____ _____
Witness Date



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1500

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS \| MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | NPI | 1114050937 |
| 2 | | | | | | | | NPI | |
| 3 | | | | | | | | NPI | |
| 4 | | | | | | | | NPI | |
| 5 | | | | | | | | NPI | |
| 6 | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN 954112691 ☒

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

Sharon L. Siegel, PhD/MFT
125 E. Tahquitz Cyn. Way
Suite 203
Palm Springs, CA 92262-6464

a. NPI b.

33. [illegible] TION

Sharon L. Siegel, PhD/MFT
125 E. Tahquitz Cyn. Way
Suite 203
Palm Springs, CA 92262-6464

310
455-3232

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

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APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

## REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

## BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

## SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

## NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended; 42 CFR 411.24(a) and 424.5(a) (6); and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR CHAMPUS CLAIMS:** PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

## MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary for the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

---

Sharon L. Siegel, PhD/MFT
125 E. Tahquitz Cyn. Way
Suite 203
Palm Springs, CA 92262-6464

# ALERT®

# Wellness Assessment - Adult

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can and then review your responses with your clinician. Please shade circles like this ●

Client Last Name , First Name Date of Birth: (mm/dd/yy) / /

Subscriber ID Authorization #

Clinician Last Name , First Name Today's Date: (mm/dd/yy) / /

Clinician ID/Tax ID Clinician Phone - State MRef ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

***For questions 1-16, please think about your experience in the past week.***

| **How much did the following problems bother you?** | *Not at All* | *A Little* | *Somewhat* | *A Lot* |
|---|---|---|---|---|
| 1. Nervousness or shakiness | ○ | ○ | ○ | ○ |
| 2. Feeling sad or blue | ○ | ○ | ○ | ○ |
| 3. Feeling hopeless about the future | ○ | ○ | ○ | ○ |
| 4. Feeling everything is an effort | ○ | ○ | ○ | ○ |
| 5. Feeling no interest in things | ○ | ○ | ○ | ○ |
| 6. Your heart pounding or racing | ○ | ○ | ○ | ○ |
| 7. Trouble sleeping | ○ | ○ | ○ | ○ |
| 8. Feeling fearful or afraid | ○ | ○ | ○ | ○ |
| 9. Difficulty at home | ○ | ○ | ○ | ○ |
| 10. Difficulty socially | ○ | ○ | ○ | ○ |
| 11. Difficulty at work or school | ○ | ○ | ○ | ○ |

| **How much do you agree with the following?** | *Strongly Agree* | *Agree* | *Disagree* | *Strongly Disagree* |
|---|---|---|---|---|
| 12. I feel good about myself | ○ | ○ | ○ | ○ |
| 13. I can deal with my problems | ○ | ○ | ○ | ○ |
| 14. I am able to accomplish the things I want | ○ | ○ | ○ | ○ |
| 15. I have friends or family that I can count on for help | ○ | ○ | ○ | ○ |

16. In the past week, approximately how many drinks of alcohol did you have? ☐☐ Drinks

**Please answer the following questions only if this is your first time completing this questionnaire.**

17. In general, would you say your health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
18. Please indicate if you have a serious or chronic medical condition:
    ○ Asthma ○ Diabetes ○ Heart Disease ○ Back Pain or Other Chronic Pain ○ Other Condition
19. In the past 6 months, how many times did you visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? *(answer only if employed)* ☐☐ Days
21. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? *(answer only if employed)* ☐☐ Days
22. In the past month have you ever felt you ought to cut down on your drinking or drug use? ○ Yes ○ No
23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ○ Yes ○ No
24. In the past month have you felt bad or guilty about your drinking or drug use? ○ Yes ○ No

9626

Clinician: Please fax to (800) 985-6894

Rev. 2007