

Sandra Paulsen PhD
WA Licensed Psychologist #3111

CLIENT REGISTRATION

First Name	M.I.	Last Name	Today's Date act
Street Address			Home Phone
City			Work Phone
State			Cell Phone
Zip			Fax Number:
E-mail			Patient Birth Date
Spouses's Name			Patient Soc Sec
Party Responsible for Bill			

INSURANCE INFORMATION *(If applicable)*

This is a cash pay practice. If you request it, I will prepare a monthly insurance claim form for you to submit to your insurance company. Please ***request a claim form when you want one.***

Please note that I am NOT a Medicare provider. If you are Medicare eligible or become Medicare eligible during your treatment, your initial here acknowledges that you understand that I will not prepare insurance forms for you to submit to Medicare, nor will I bill Medicare on your behalf. _____

Subscriber Name if not self	Subscriber Birthdate if not self
Company Name	Company Address
Date of Accident/Injury (if applicable)	Contact Person & Phone number
Membership # or Claim #	Physician Referral
Group	Insurance Co Phone
If Spouse is Member, Spouses Soc Security No.	

PLEASE CHECK ANY OF THE PROBLEMS THAT APPLY TO YOU

- | | | |
|--|---|---|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Divorce | <input type="checkbox"/> Friends |
| <input type="checkbox"/> Shyness | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Unhappiness |
| <input type="checkbox"/> Separation | <input type="checkbox"/> Self control | <input type="checkbox"/> Work |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Stress | <input type="checkbox"/> Tiredness |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Headaches | <input type="checkbox"/> Ambition |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Memory | <input type="checkbox"/> Making decisions |
| <input type="checkbox"/> Relaxation | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Concentration |
| <input type="checkbox"/> Legal matters | <input type="checkbox"/> Inferiority feelings | <input type="checkbox"/> Health problems |
| <input type="checkbox"/> Energy | <input type="checkbox"/> Career choices | <input type="checkbox"/> Marriage |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Stomach trouble |
| <input type="checkbox"/> Education | <input type="checkbox"/> Appetite | <input type="checkbox"/> My thoughts |
| <input type="checkbox"/> Temper | <input type="checkbox"/> Being a parent | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Children | <input type="checkbox"/> Fears | <input type="checkbox"/> Others _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Suicidal thoughts | _____ |
| <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Finances | _____ |

When were you last examined by a physician?
List any major health problems for which you currently receive treatment.
List any medications you are now taking.
Briefly describe your reason for seeking help.
Have you ever received psychological help or counseling of any kind before? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please explain.
Please provide any additional information that you feel may be useful to us in assisting you.

FREQUENTLY ASKED QUESTIONS AND TREATMENT CONTRACT

Fees

1. **WHAT ARE THE FEES?** The usual fee is \$150 per 45 minute session, which is subject to periodic change. Additional time, including between session phone calls, is billed proportionally to the above rate. A 90-minute session is a double session, and is \$300. Psychological testing and forensic activities or report writing have separate fee schedules.

Payment

2. **WHAT IS THE PAYMENT PROCEDURE?** You should plan to pay in full at the time of your visit. If you wish, I will create an insurance form for you at intervals of about one month for you to submit to your insurance company to reimburse you. Please be aware that you are financially responsible for payment whether or not your insurance company reimburses you. It is your responsibility to research and be aware of your own coverage and its limitations. Changes in your ability to pay may necessitate termination or changes in our treatment frequency or duration.

Cancellations

3. **WHAT HAPPENS IF I MISS A SESSION?**
 - o For single sessions, canceling with 24 hours notice will avoid being charged in full.
 - o For double sessions, canceling with **48 hours** notice will avoid being charged in full.
 - o Frequent cancellations, even with proper notice, may disrupt your care and my schedule, and should be avoided.

Records

4. **WILL ANY RECORDS BE KEPT?** I keep a record of the health care services I provide you. You may ask me to see and copy that record. You may also ask me to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so. You may see your record or get more information about it at the number below.

Confidentiality

5. **IS WHAT I TELL YOU CONFIDENTIAL?** Information given in the sessions may not be divulged to anyone else without your consent. Washington State law defines exceptions to this rule, however, including especially:
- certain court proceedings in which your records might be eligible for subpoena,
 - cases in which a serious crime is about to be committed or child, elder, or vulnerable adult abuse has been determined or suspected,
 - if you are in imminent danger to yourself or others, and
 - your insurance company may require minimal information to justify treatment
 - state law defines other exceptions to confidentiality in RCW 70.02.050, attached, which are unlikely, but which are permitted by law.

Responsibilities

6. **WHAT ARE MY RESPONSIBILITIES WHILE IN TREATMENT?** The major responsibility you have is to keep me informed of changes that occur in your emotions or behavior during treatment. While in most instances, treatment will result in a decrease in uncomfortable emotions and undesired behavior, it is possible that strong feelings of anger, sadness and/or depression may surface for a period of time during the course of treatment. If this occurs for you, it is important to notify me about it as soon as possible. You have the right to refuse treatment and it is your responsibility to choose the provider and treatment modality that best suits your needs.

Emergencies

7. **IN CASE OF EMERGENCY.** If a situation arises which you believe to be a psychological emergency, you should call me at the number I will provide for you. During non-business hours, it may take up to 24 hours for me to return the call. If the situation is critical and can not wait for up to 24 hours, you should go to the emergency room.

If the specific situation arises in which you feel like you want to harm yourself (suicide) or hurt someone else, you must promise to talk to me about the thoughts or plans before acting upon them. Again, if you feel that you cannot wait until the next regular appointment to discuss such thoughts, you must call me, or if I am not available, contact the Suicide and Crisis Center, call 911, or go to the emergency room.

About Dr Paulsen

8. My training is as a licensed psychologist, with a PhD and MA from the University of Hawaii, Manoa, and a BA from UC Berkeley. I have been licensed in good standing in several states, since 1987. My practice is a general practice of psychology, with an emphasis on trauma, early childhood issues, and performance enhancement. My therapeutic orientation is eclectic, with cognitive-behavioral, psychodynamic and systems being key elements. My most frequently employed methods are ego state therapy, EMDR, imagery, somatic experiencing, cognitive-behavioral, psychodynamic and systems interventions. Go to www.bainbridgepsychology.com for more information.

About The Institute

9. BIIP is an umbrella name for a group of solo practitioners; it is not a group practice. There is no collaboration on cases unless specifically arranged. Each practitioner is solely responsible for his/her clients according to the terms of her license. For more information, go to www.bainbridgepsychology.com.

I have read the above and will abide by the terms described above.

Signature

Date

For clients asking that insurance forms be prepared: I have received (or been offered and declined) a copy of the HIPAA required forms "Psychotherapy Services Agreement" and "Notice" that provide further information to augment this form.

Signature

Date

RCW 70.02.050

Disclosure without patient's authorization.

(1) A health care provider or health care facility may disclose health care information about a patient without the patient's authorization to the extent a recipient needs to know the information, if the disclosure is:

- (a) To a person who the provider or facility reasonably believes is providing health care to the patient;
- (b) To any other person who requires health care information for health care education, or to provide planning, quality assurance, peer review, or administrative, legal, financial, actuarial services to, or other health care operations for or on behalf of the health care provider or health care facility; or for assisting the health care provider or health care facility in the delivery of health care and the health care provider or health care facility reasonably believes that the person:
 - (i) Will not use or disclose the health care information for any other purpose; and
 - (ii) Will take appropriate steps to protect the health care information;
- (c) To any other health care provider or health care facility reasonably believed to have previously provided health care to the patient, to the extent necessary to provide health care to the patient, unless the patient has instructed the health care provider or health care facility in writing not to make the disclosure;
- (d) To any person if the health care provider or health care facility reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of the patient or any other individual, however there is no obligation under this chapter on the part of the provider or facility to so disclose;
- (e) To immediate family members of the patient, including a patient's state registered domestic partner, or any other individual with whom the patient is known to have a close personal relationship, if made in accordance with good medical or other professional practice, unless the patient has instructed the health care provider or health care facility in writing not to make the disclosure;
- (f) To a health care provider or health care facility who is the successor in interest to the health care provider or health care facility maintaining the health care information;
- (g) For use in a research project that an institutional review board has determined:
 - (i) Is of sufficient importance to outweigh the intrusion into the privacy of the patient that would result from the disclosure;
 - (ii) Is impracticable without the use or disclosure of the health care information in individually identifiable form;
 - (iii) Contains reasonable safeguards to protect the information from redisclosure;
 - (iv) Contains reasonable safeguards to protect against identifying, directly or indirectly, any patient in any report of the research project; and
 - (v) Contains procedures to remove or destroy at the earliest opportunity, consistent with the purposes of the project, information that would enable the patient to be identified, unless an institutional review board authorizes retention of identifying information for purposes of another research project;
- (h) To a person who obtains information for purposes of an audit, if that person agrees in writing to:
 - (i) Remove or destroy, at the earliest opportunity consistent with the purpose of the audit, information that would enable the patient to be identified; and
 - (ii) Not to disclose the information further, except to accomplish the audit or report unlawful or improper conduct involving fraud in payment for health care by a health care provider or patient, or other unlawful conduct by the health care provider;
- (i) To an official of a penal or other custodial institution in which the patient is detained;
- (j) To provide directory information, unless the patient has instructed the health care provider or health care facility not to make the disclosure;
- (k) To fire, police, sheriff, or another public authority, that brought, or caused to be brought, the patient to the health care facility or health care provider if the disclosure is limited to the patient's name, residence, sex, age, occupation, condition, diagnosis, estimated or actual discharge date, or extent and location of injuries as determined by a physician, and whether the patient was conscious when admitted;
- (l) To federal, state, or local law enforcement authorities and the health care provider, health care facility, or third-party payor believes in good faith that the health care information disclosed constitutes evidence of criminal conduct that occurred on the premises of the health care provider, health care facility, or third-party payor;
- (m) To another health care provider, health care facility, or third-party payor for the health care operations of the health care provider, health care facility, or third-party payor that receives the information, if each entity has or had a relationship with the patient who is the subject of the health care information being requested, the health care information pertains to such relationship, and the disclosure is for the purposes described in RCW [70.02.010](#)(8) (a) and (b); or
- (n) For payment.

(2) A health care provider shall disclose health care information about a patient without the patient's authorization if the disclosure is:

- (a) To federal, state, or local public health authorities, to the extent the health care provider is required by law to report health care information; when needed to determine compliance with state or federal licensure, certification or registration rules or laws; or when needed to protect the public health;
- (b) To federal, state, or local law enforcement authorities to the extent the health care provider is required by law;
- (c) To federal, state, or local law enforcement authorities, upon receipt of a written or oral request made to a nursing supervisor, administrator, or designated privacy official, in a case in which the patient is being treated or has been treated for a bullet wound, gunshot wound, powder burn, or other injury arising from or caused by the discharge of a firearm, or an injury caused by a knife, an ice pick, or any other sharp or pointed instrument which federal, state, or local law enforcement authorities reasonably believe to have been intentionally inflicted upon a person, or a blunt force injury that federal, state, or local law enforcement authorities reasonably believe resulted from a criminal act, the following information, if known:
 - (i) The name of the patient;
 - (ii) The patient's residence;
 - (iii) The patient's sex;
 - (iv) The patient's age;
 - (v) The patient's condition;
 - (vi) The patient's diagnosis, or extent and location of injuries as determined by a health care provider;
 - (vii) Whether the patient was conscious when admitted;
 - (viii) The name of the health care provider making the determination in (c)(v), (vi), and (vii) of this subsection;
 - (ix) Whether the patient has been transferred to another facility; and
 - (x) The patient's discharge time and date;
- (d) To county coroners and medical examiners for the investigations of deaths;
- (e) Pursuant to compulsory process in accordance with RCW [70.02.060](#).

(3) All state or local agencies obtaining patient health care information pursuant to this section shall adopt rules establishing their record acquisition, retention, and security policies that are consistent with this chapter. 2007 c 156 § 12; 2006 c 235 § 3; 2005 c 468 § 4; 1998 c 158 § 1; 1993 c 448 § 4; 1991 c 335 § 204.]