Eva Benmeleh, PhD
Licensed Clinical Psychologist

Consent to Treatment and Use of Protected Health Information for treatment, payment, and healthcare operations Acknowledgment of Receipt of HIPAA Privacy Notice

Client's Name: _____

I, the undersigned client and/or guardian, consent and authorize Dr. Eva Benmeleh (My Treetop Center) to administer treatment to the client. Treatment may include any of the following: individual, family, and/or group therapy, psychological assessment, and any other treatment appropriate to the diagnosis. I understand that Dr. Eva Benmeleh originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I consent to the use and disclosure of protected health information about the client for treatment, payment, and healthcare operations. This means that information about client's health will be used by Dr. Eva Benmeleh or disclosed to other people or organizations whenever needed to:

- Provide treatment to client or arrange for treatment by another health care provider
- Arrange for payment for services to client
- Enable other healthcare organizations that provide treatment to client or pay for services to review the quality and appropriateness of care received, conduct other healthcare operations

I authorize the release of medical information necessary to process any of my insurance claims, and I authorize payment of medical benefits directly to Dr. Eva Benmeleh, My Treetop Center for services rendered. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that I will be charged the insurance allowable rate, or standard fee if private pay for any missed appointments that are not rescheduled or canceled within 24 hours of the scheduled appointment time. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or client that in consideration of the services to be rendered to the client he/she hereby individual obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

I fully understand and accept the terms of this Consent and acknowledge the receipt of the Notice of Privacy Policies detailing how my information can be used and disclosed under Federal and State law. I understand the contents of the Notice. I understand that information disclosed pursuant to this consent may be re-disclosed by the recipient of the information. I understand that there is no time limit on this consent. I also understand that I may revoke this consent at any time. I am the client/ guardian of the client who is subject of the health records that will be used or disclosed. I consent to treatment and agree to the use and disclosure of my health information as described in this consent.

_____

Signature of Client (Guardian) Print Name Date

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Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have acted in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a client files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the

Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties, continued

child's welfare, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.

2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- *For Treatment:* If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. An authorization is required for most uses and disclosures of psychotherapy notes.
- *For Payment:* I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- *For Operations:* I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Client's Rights:

- *Right to Treatment:* You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- *Right to Confidentiality*: You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- *Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- *Right to Choose* – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- *Right to Inspect and Copy***:** You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- *Right to Amend* – If you believe the information in your records is incorrect and/or missing important information, you can ask me to make certain changes, also known as amending, to your health information. You must make this request in writing. You must tell

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Client Rights & Therapist Duties, continued

- me the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- *Right to a Copy of This Notice* – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details.
- *Right to Choose Someone to Act for You* – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- *Right to Release Information with Written Consent* – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss the effects of releasing the information in question to that person or agency.
- *Right to Terminate* – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Florida Department of Health, or the Secretary of the U.S. Department of Health and Human Services. Your signature below indicates that you have read this agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPAA notice form.

_____

Client/Legal Guardian Signature Print Name Date

_____

Eva Benmeleh, PhD Licensed Clinical Psychologist #8656 Date

Eva Benmeleh, PhD
Licensed Clinical Psychologist

Authorization for Release of Confidential Psychological Records and Protected Health Information

In order to protect your right to confidentiality, your written authorization is required if you request information to be shared with another person or agency.

I _____ authorize Dr. Eva Benmeleh (My Treetop Center) to:
□ release information □ to obtain information from □ exchange information with

The following (name, address, phone, fax):
_____

All information pertaining to treatment of myself (or my dependent_____):

The following information pertaining to myself (or my dependent_____):
□ assessment □ testing/treatment summary □ recommendations □ treatment progress
□ psychological records

for the purpose(s) of: □ evaluation/assessment □ other (specify) _____

This consent will automatically expire:
□ One (1) year after the date of my signature below □ At the end of evaluation/treatment

You have the right to revoke this authorization in writing at any time by sending such written notification to one of our offices. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

By signing below, you agree to the release of the above information, that the nature of this information has been discussed with you in a manner that you understand, and that you have had an opportunity to have any questions regarding the above release of information explained to you. You are indicating that you understand that Dr. Eva Benmeleh generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information, viewed by persons unknown to you, and no longer protected by the HIPAA Privacy Rule or by Federal or State law or rules.

_____

Signature Print Name Date

_____

Witness Print Name Date

ATTENTION TO AGENCIES AND/OR INDIVIDUALS TO WHOM THIS INFORMATION IS DISCLOSED: If you have received this information in error please contact my office as soon as possible to arrange for the return of the received material. This information may be protected from redisclosure without informed signed consent from the individual or agency to which it pertains. Do not redisclose this confidential information without signed informed consent or as otherwise allowed.

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Social Media Policy

This document outlines Dr. Eva Benmeleh (My Treetop Center) policies related to use of Social Media. If you have any questions about the information within this document, I encourage you to bring them up when we meet. As new technology changes, this policy may be updated. You will be notified in writing of any policy changes and offered a copy of the updated policy.

As in any other public context, you have control over your own description of the nature of our acquaintance, if you choose to disclose a professional relationship. I will not confirm nor deny any professional relationship between myself and clients on any social network sites. I reserve the right to discontinue any social network connection without prior notification. I discourage the use of social network sites for any communication about our therapeutic relationship, including scheduling issues, due to the lack of privacy protections.

SOCIAL MEDIA IS CONSIDERED PUBLIC COMMUNICATION:
Messaging on Social Networking sites such as Twitter or Facebook is not secure. It could compromise your confidentiality to use Wall postings, @replies, or other means of engaging with me online if we have an already established client/therapist relationship. I may not read social media messages in a timely fashion. If you need to contact me between sessions, the best way to do so is by phone or email.

FOLLOWING/LIKING MY PROFESSIONAL PAGE MAY IMPLY ENDORSEMENT:
I keep a Facebook Page for my professional practice to allow people to share my blog posts and practice updates. You are welcome to view my Facebook Page and read or share articles posted there, and comment on them. However, referrals from other clients are one of my best sources of business. My website and Facebook Fan page are intended to let others know who I am as a professional and to make it easy to refer those you feel would benefit from my services. I will not confirm nor deny any professional relationship between clients on any social network site. I will not ask you to "like" my page or endorse me on other business pages during the time you are in my treatment.

Acknowledgement of Review of Social Media Policy
By signing below, I am indicating that I have read this document, understand my rights as a client, and accept the responsibility as stated. I have been offered a printed copy of the Social Media Policy and all questions regarding these policies have been answered to my satisfaction.

_____

Client Name Date

_____

Eva Benmeleh, PhD Date

If desired, a copy of this form can be provided.

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ADULT PERINATAL INTAKE

GENERAL INFORMATION

Name:_____ Today's Date:_____
Your age: _____ Date of Birth (DOB):_____
Address:_____
Cell phone:_____ Email: _____
Emergency Contact: _____

INSURANCE INFORMATION

Insurance Company:_____ Name of Insured:_____
Insured's Member ID #:_____ Insured's Group #:_____
OB Name & Phone: _____
Family Doctor Name & Phone: _____
Psychiatrist Phone: _____
Referred by: _____

PRESENTING PROBLEM

What is the main reason you're seeking help? (Please include how long you've had these symptoms or problems): _____
_____

What are your goals for therapy?_____
_____

STRENGTHS AND RESOURCES

What do you consider to be your strengths? _____
_____
_____

POST PARTUM

How many weeks are you postpartum? _____
Name of Baby: _____ Male ☐ Female ☐
Baby's D.O.B: ____/____/____ Due Date: ____/____/____ Baby's Birth Weight: _____
Number of Pregnancies? _____ Was this a planned pregnancy? Yes ☐ No ☐
Number of Children? _____ Have you ever been given fertility meds? Yes ☐ No ☐

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Where did you have your baby (hospital/birthing center): _____

How was your pregnancy (complications/placenta previa/diabetes/bed rest/amnio/testing concerns)? _____

_____

Tell me about your labor and delivery (vaginal/cesarean/medication for pain relief/ doula): _____

_____

_____

Was your baby in the NICU? If yes, please tell me why and for how long: _____

_____

_____

Breast or Bottle Feeding? _____

_____

Are there any feeding concerns? (latching/gaining weight/reflux) _____

_____

Are you currently on any medication/supplements/herbs/birth control? _____

_____

_____

Last Physical Exam: _____ Thyroid Test: Y□ N □ Date: _____
Vitamin D Test: Y□ N □ Date: _____ Anemia Test: Y □ N □ Date: _____

Have you experienced or been diagnosed with any of the following? (Please check all that apply):

	Before Pregnancy	During Pregnancy	Postpartum	Treatment
Depression				
Anxiety				
Panic Attacks				
Obsessive Compulsive Behavior				
Bipolar Disorder				
Psychosis				
Traumatic Birth				

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PREGNANT MOMS

Number of Pregnancies? _____ Was this a planned pregnancy? Yes ☐ No ☐

Number of Children? _____ Have you ever been given fertility meds? Yes ☐ No ☐

How is your pregnancy (complications/placenta previa/diabetes/bed rest/ amnio/ testing concern? _____

_____

_____

Are you experiencing any sadness or anxiety during your pregnancy? _____

_____

_____

_____

_____

Partner's Name: _____

How is he/she doing? _____

_____

Is he/she worried about how you are doing? _____

_____

_____

MEDICAL/ PSYCHOLOGICAL HISTORY

When did you first experience depression or anxiety? What treatments have you tried? Therapy? Groups? Meds? What worked? What didn't?)

_____

_____

_____

Please list history of current and past medication:

Medication name	Dosage	Prescribed by:	Time period taken:

History of medical concerns/hospitalizations/surgery:_____

_____

Describe your home arrangements/who lives with you? _____

_____

Who do you talk to when you need to talk? Do they know how you are feeling? _____

_____

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EMPLOYMENT HISTORY

Are you currently employed? Yes No
Please describe your current work or academic situation: _____
_____

Do you enjoy your work/school? Is there anything stressful about it? _____

_____

FAMILY HISTORY

Who raised you? _____

How did your parents get along? _____

How would you describe your current relationship with your parents? _____
_____

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	YES, Whom?		YES, Whom?
Anxiety		Obsessive Compulsive Behavior	
Bipolar		Schizophrenia	
Depression		Substance Abuse	
Domestic Violence		Suicide Attempt	
Eating Disorder			

HISTORY of TRAUMA

Have you ever been sexually abused, molested, raped?
_____
_____
_____

Have you ever been physically abused? Are you being physically abused now?
_____

Was the incident reported: _____ Relationship with the perpetrator: _____
_____

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RISK ASSESSMENT

Lethality/ Risk Assessment	YES	NO
Do you have a history of suicidal attempts?		
Do you have a history of self-harming behaviors?		
Do you have a history of homicidal behaviors?		
Have you ever tried to harm others or threatened to harm others?		
Have you ever caused significant damage to property in the past		
Do you have a history of aggression?		
Is there a history of suicidal or homicidal behaviors in your family?		
Do you possess or has access to a lethal weapon?		
Do you have a history of assaultive behavior?		

If yes, to any of the following interventions were taken:

- ☐ Client voluntary agreed to admission/examination in a crisis stabilization unit
- ☐ Certified for involuntary admission/examination in a crisis stabilization unit