Therapist: ________________________
Appointment Date/Time: ___________

Danielle Osier-Tatar, MFT, LADC
2450 Vassar Street, Suite 3-A
Reno, Nevada 89502

Application for Services

Name of Client___________________________________ Referred by:_______________________________________

____
Address City State Zip

Telephone: Home( )_________________ Business ( )_______________ Cell ( ) __________________
May we leave a message? Yes____No____ Yes____No____ Yes____No____

Soc. Sec. or Medical ID #____/____/____ Date of Birth____/____/____ Married ( ) Single ( ) Other ( )

If Client is a Minor, please list Parent or Guardian and address information:

Parent or Guardian:____

____
Address (if different from Client) City State Zip

Employer:____Address:____

Primary Care Physician:__________________________Address (City/State is fine):_________________________

Spouse:____

Soc. Sec or Medical ID #_________/_________/________ Date of Birth: ______ _____ _____

Spouse's Employer:__________________________________ Address:____________________________________

Insured (if not client):__________________________________ **Insurance Co**.______________________________

Address:____

Policy #_________________ Group #__________________ Phone: (____)________________

FAMILY MEMBERS

____ Date of Birth ________/_________/_________

____ Date of Birth ________/_________/_________

I am seeking help because____

____

I understand that a "per session" charge may be made for non-kept appointments or appointments canceled without 24 hour notice.

I agree to pay the per-hour fees or appropriate insurance co-payment for services provided. I understand that I am responsible for the total incurred fee although my insurance may be billed for the service.
I agree to assign insurance benefits for the above mentioned insurance company.

____ _____________________________
Client Signature or Parent/Guardian Date

____ _____________________________
Parent/Guardian (if joint custody) Date

NEW CLIENT INSTRUCTION LIST

Please take a few minutes to fill out the attached forms and bring all items with you for your first session. If you have any questions, please discuss them with your therapist:

1) APPLICATION FOR SERVICES - **Please fill out <u>completely</u>, read responsibility clause and sign and date.**

2) MINDSMATTER OFFICE POLICIES - **Please read, indicate where we may reach you and sign and date.**

3) CONFIDENTIALITY / CLIENT RIGHTS- **Please read, sign and date.** If you would like a copy we would be happy to provide one.

4) HIPPA - PRIVACY PRACTICES NOTICE - **Please check one of the two choices, sign, date and print your name.** Your therapist can provide a copy of the Guidelines if you so choose.

5) 1500 HEALTH INSURANCE CLAIM FORM - **Please sign and date in Box 12 and sign only in Box 13.** Complete top left section ONLY if you did not complete the insurance information on Application for Services.

6) POLICY ON REMINDER PHONE CALLS - **Please indicate your preferred numbers and other options then sign and date.**

7) CHILD and ADOLESCENT CONSENT TO TREAT – (Child Packets only) **Please read, sign and date.** If you have any questions regarding this policy, please discuss with your therapist at the first session.

8) CHILD or ADULT HISTORY FORM and ADULT SYMPTOM CHECKLIST - **Please fill out the appropriate forms for the client - yourself or your child.**

<u>FULL PAYMENT OF FEES / CO-PAY IS EXPECTED AT TIME OF SERVICE.</u>

For your convenience, we accept check, cash and credit/debit cards.
We charge a $25 NSF check fee.

9) IF USING INSURANCE, please bring your insurance card and co-pay with you. IF USING MEDICAID - You/your child must be eligible at the time of each service or you will be responsible for the full fee.

10) IF PAYING CASH, Please bring the full fees with you.

Danielle Osier-Tatar, MFT, LADC
2450 Vassar Street, Suite 3-A
Reno, Nevada 89502
(775) 400-1229

AUTHORIZATION FOR RELEASE OF PSYCHOLOGICAL / PSYCHOTHERAPY RECORDS

(PLEASE PRINT)

______________________________________ ______________________________________
Patient Name at the Time of Treatment Date of Birth

The undersigned hereby authorizes and requests this facility or ___Danielle Osier-Tatar, MFT, LADC_____________, to provide:

☐ Physician ☐ Psychotherapist ☐ Insurance ($1.00 per page) ☐ Attorney ($1.00 per page)

☐ Other Purpose: ____

Name of Person, Organization to whom disclosure will be made: ______________________________________

I understand that the parties in receipt of these records may re-disclose my PHI (Protected Health Information) to persons or entities that are not subject to the HIPAA Privacy Regulations, resulting in my PHI no longer being protected by HIPAA regulations.

Signature: ____

I would like the following information released: ☐ Only those items listed below:

_______ Intake Information _______ Progress Notes _______ Discharge Summary

_______ Record of Appointments _______ Diagnosis _______ Billing Records

_______ Psych Assessment Report _______ Summary of Treatment _______ History

_______ Other: ____

I specifically authorize release of information for the following treatments or procedures that are included in these records. (You must initial those items requested, or they will not be released with the above record.)

____ Drug/Alcohol Abuse Treatment ____ Psychological and Mental Health Treatment ____ Psychotherapy Notes

I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance upon it. I understand that the revocation must be made in writing, and addressed to Danielle Osier-Tatar, MFT, LADC, and delivered or mailed to: Mindsmatter Wellness Center 2450 Vassar Street, Suite 3-A, Reno, Nevada 89502.

This consent will automatically expire 90 days from the date signed. Furthermore, this consent will be revoked upon compliance of this request and will not serve any other future request. I reserve the right to withdraw, in writing, this authorization at any time.

______________________________ ______________________________
Date Signature of Patient

______________________________ ______________________________
Witness Signature of Legal Representative

______________________________ ______________________________
Reason Patient Unable to Sign Relationship

*** * DUE TO CONFIDENTIALITY, WE ONLY FAX UNDER HIPAA GUIDELINES * ***

Danielle Osier-Tatar, MFT, LADC

2450 Vassar Street, Suite 3-A

Reno, Nevada 89502

Child History Form

In order for us to be able to fully evaluate your child, please fill out the following questionnaire to the best of your ability. We realize there may be information that you do not remember or have access to; do the best you can. Thank you!

PATIENT IDENTIFICATION

Name______________________________________ First Appointment Date______________

Birth Date___________________________ Age __________ Sex________________

School_____________________________ Grade________

Religion ____________________________ Natural Mother_____________________

Race_________________________________ Natural Father____________________________

Address____

City____State __________ Zip____________________

Home Phone # __________________ Work #_________________ Cell#____________________

Who is the child currently living with?____

____

REFERRAL SOURCE

Referral Source____

Referral Address _______________________________Phone #______________________________

Do we have your permission to release information to the referring professional when it is appropriate?

Yes ____ No_____

PURPOSE OF THE CONSULTATION

(Please give a brief summary of the main problems)

____

____

____

____

WHAT IS YOUR DESIRED OUTCOME FOR THESE SERVICES?_______________________________________

____

____

____

PRIOR ATTEMPTS TO CORRECT PROBLEMS / PRIOR PSYCHIATRIC HISTORY

(Please include contact with other professionals, medications, types of treatment, etc.)

What do you want this clinician to do for your child, yourself or your family?_________________________

____

____

MEDICAL HISTORY

Current medical problems/medications ____

____

Past medical problems/medications ____

____

Other doctors/clinics seen regularly____

____

Any history of head trauma? (describe) ____

____

Ever any seizures or seizure like activity?____

Any periods of spaciness or confusion?____

Prior hospitalizations (place, cause, date, outcome) ____

____

Prior abnormal lab tests, X-rays, EEG, etc. ____

____

Allergies/drug intolerances (describe) ____

Present Height: _________________ Present Weight:___________________

FAMILY HISTORY

Family Structure (who lives in the current household with the child, please give relationship to the child):

____

____

____

____

____

Family Development (include marriages, separations, divorces, deaths, traumatic events, losses, etc.) ___

____

____

____

____

Current Marital Situation/Satisfaction of Parents____

____

____

Natural Mother's History: Age___________ Outside Work____

School: Highest grade completed ____

Learning problems (specify) ____

Behavior problems (specify) ____

Marriages ____

Medical Problems ____

Childhood atmosphere (family position, abuse, neglect, trauma, illnesses, etc.) ______________________
____
____
____

Has mother ever sought psychiatric treatment? Yes _________ No ____________
If yes, for what purpose? ____
____

Mother's alcohol/drug use history ____

Have any of mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)
____
____
____

Natural Father's History: Age__________ Outside Work_________________________________
School: Highest grade completed ____
Learning problems (specify) ____
Behavior problems (specify) ____
Marriages ____
Medical Problems ____
Childhood atmosphere (family position, abuse, illnesses, etc.) ___________________________
____
____

Has father ever sought psychiatric treatment? Yes _________ No ____________
If yes, for what purpose? ____
____

Father's alcohol/drug use history ____

Have any of father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)
____
____
____

(If Applicable)
Step or Adoptive Mother's History: Age__________ Outside Work________________________
School: Highest grade completed ____
Learning problems (specify) ____
Behavior problems (specify) ____
Marriages ____
Medical Problems ____

Childhood atmosphere (family position, abuse, illnesses, etc.) ____
____
____

Has step or adoptive mother ever sought psychiatric treatment? Yes _________ No _________
If yes, for what purpose? ____
____

Step or adoptive mother's alcohol/drug use history ____

Step or Adoptive Father's History: Age__________ Outside Work_________________________
School: Highest grade completed ____
Learning problems (specify) ____
Behavior problems (specify) ____
Marriages ____
Medical Problems ____
Childhood atmosphere (family position, abuse, illnesses, etc.) ____
____
____

Has step or adoptive father ever sought psychiatric treatment? Yes _________ No __________
If yes, for what purpose? ____
____

Step or adoptive father's alcohol/drug use history ____

Siblings (names, ages, problems, strengths, relationship to patient)_________________________________
____
____
____
____
____
____
____

Family Stresses (Please list current factors that are a source of stress in the family)__________________
____
____
____
____

<u>CHILD'S DEVELOPMENTAL HISTORY</u>

Prenatal events:
Parents attitude toward pregnancy ____
Conception – ease __________ planned ___________________ unplanned ___________________
Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc. ____

Birth and Postnatal period:

Birth weight __________ Length _____________ Labor duration _________________________
Delivery: vaginal ________ C-Section _________ Problems ______________________________
APGAR scores (if known) ______________ Any jaundice? Yes ___________ No _____________
Time in hospital _____________________
Any other complications? ____

Mother's health after delivery ____
Post delivery blues? __________ If yes, how long?____

Primary caretaker for child, first year ____
Thereafter ____

Feeding history: breast vs. bottle ______________ age weaned ___________________________________
Food allergies ____
Current eating problems ____

____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

____
____
____

Separations from mother and/or father: age, duration, reaction to: ________________________

____
____
____

Motor development:
(please write in age events occurred; ages in parentheses are approximate normal limits)
Rolls over (3-5m) _________ Sits without support (5-7m)
Crawls (5-8m) _____________walks well (11-16m) _________________________
Runs well (2y) ___________ rides tricycle (3y) __________________________
Throws ball over hand (4y) ________________________________
Current level of activity ___________________________________
Fine and gross motor coordination ____
Compared to peers ____

Language development:
Several words besides "dada", "mama" (1y) _______________________________
Name several objects – ball, cup (15m) ___________________________________
3 words together – subject, verb, object (24m) ____________________________
Vocabulary _____________ Articulation _______________________________
Comprehension ____

Compared to peers ____
Any current problems ____

Social development:
Smile (2m) _____________ shy with strangers (6-10m) _____________
Separates from mother easily (2-3y) ____________________________
Cooperative play with others (4y) ____
Quality of attachment to mother ____
Quality of attachment to father ____
Early peer interactions ____
Current peer interactions ____
____
Special interests ____
Relationships to family members ____
____
Hobbies/interests ____

Toilet training:
Age reached bowel control: day ______________ night ________________
Age reached bladder control: day ____________ night ________________
Methods used ______________________ ease _______________________
Current function ____

Sexual development:
Gender identity ____
Any problems ____
____

Behavioral/Discipline:
Compliance vs non-compliance ____
Lying/stealing ______________________ rule breaking ___________________________________
Methods of discipline ____
Other problems ____
____

Emotional development:
Early temperament ____
Current personality ____
Mood ____
Habits ____
Fears/phobias ____
Special objects (blankets, dolls, etc.) ____

Ability to express of feelings ______________________________

Physical /Sexual Abuse:

____

____

Drug/Alcohol History ______________________________

____

School History:

Current grade ______________________________

School contact ______________________________

Number of schools attended______________________________

Average grades ______________________________

Homework problems? ______________________________

Specific Learning disabilities ______________________________

Strengths ______________________________

Motivation ______________________________

What have teachers said about the child/teen ______________________________

____

____

Overall strengths – as viewed by parents ______________________________

____

____

Overall strengths – as viewed by the child/teen______________________________

____

____

____

Danielle Osier-Tatar, MFT, LADC

2450 Vassar Street, Suite 3-A

Reno, Nevada 89502

CLIENT RIGHTS

- The client has the right to considerate and respectful care.
- The client has the right to obtain from the therapist complete, current information concerning his/her diagnosis, treatment, and prognosis in terms the client can be reasonably expected to understand. When it is not clinically advisable to give such information to the client, the information should be made available to an appropriate person on his/her behalf.
- The client has the right to receive from his/her therapist information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to, the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation and treatment. When clinically significant alternatives for care or treatment exists, or when the patient requests information concerning treatment alternatives, the client has the right to such information.
- The client has the right to refuse treatment to the extent permitted by law, and to be informed of the clinical consequences of his/her action.
- The client has the right to every consideration of privacy concerning his/her own care. Case discussion, consultations, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his/her care must have the permission of the client to be present.
- The client has the right to expect that all communications and records pertaining to his/her care should be treated as confidential.
- The client has the right to expect reasonable continuity of care. This includes the right to know in advance that appointment times and therapists are available and where.
- The client has the right to examine and receive an explanation of his/her bill regardless of source of payment.
- The client has the right to know the therapists' policies which apply to his/her conduct as a client.

I have read both pages of this document and understand these rights and issues.

Signature____ Date____________________

Danielle Osier-Tatar, MFT, LADC

2450 Vassar Street, Suite 3-A

Reno, Nevada 89502

On Confidentiality

Now that you are involved in counseling, we would like to share with you some ideas on a very important issue, that of confidentiality and trust.

Therapy is a very private matter between the counselor and the person being counseled. We respect the personal and private matters that you choose to share in counseling and do not in any way wish to misuse that trust. Our professional ethics and the Nevada Revised Statutes require that information you provide your therapist remains confidential and that it be shared with others only by your written and informed consent.

There are several exceptions to this basic rule when the therapist is required by law or professional ethics to disclose information to specific other persons. These situations include:

- When there is suspected or acknowledged child abuse.
- When there is suspected or acknowledged abuse of an elderly person.
- When there is strong reason to believe that there is significant danger to yourself or to someone else.
- Infrequently, in matters such as child custody disputes or where the Court is otherwise involved, the Court can order records to be released and counselors can be ordered to testify.
- If legal means are required to collect your bill, information on client status and financial agreements may be disclosed to the Court.
- If your records are protected under the Federal Drug and Alcohol statues, there are occasions when we may not be able to release records even with your permission.

We want you to be clear about these expectations but also to assure you that these are the exceptions to the rule rather than the rule. When such exceptions do occur you will be notified.

If the client is a minor, I understand there must be a degree of confidentiality between the therapist and the minor and that not all information will be discussed with the parent. If your child did inform me of any danger (such as drunk driving, suicidal or self-harm behaviors, or severe bullying) the parent would be notified. Other behaviors such as stealing, skipping school, and drug use may not be reported to the parent.

This is not intended to be a legal description of confidentiality but to provide some basic information for your use. We would be happy to discuss any of these matters further with you if you wish. Please let your therapist know if you have further questions about the confidential nature of your discussions.

Office Policies

Thank you for choosing our practices for your psychological needs. We ask you to read the following information about our procedures and policies. If any questions arise, please discuss them with us.

Philosophy We expect to do everything within our professional competencies to be helpful to you. We know that the best gains in counseling and therapy are achieved by a cooperative effort on the part of the therapist and the client. We welcome your active participation in planning your therapy and encourage you to ask questions whenever they arise.

Location Our office is located at 2450 Vassar Street, Suite 3-A Reno, Nevada 89502.

Confidentiality Law, professional ethics, and our commitment to you require that your therapist not release information about you to anyone, including your spouse/partner or family members, without your written consent or as required by law. If you want your therapist to confer with another professional you will be asked to sign a release of information form. If you disclose child abuse, elder abuse, or the intent to harm yourself or another, your therapist is required to make a report to authorities. If you have any questions about confidentiality, please discuss them with your therapist.

Fees & Billing A session is usually 45-50 minutes and fees will be established prior to or at the time of the first session. Payment by check, cash or credit card is due at the **beginning of a session**. We request that you have your payment ready to give to your therapist when you arrive for a session so the entire time for your session can be devoted to your needs.

Phone calls, consultation reports, and correspondence are charged on a pro-rated basis using the basic per hour fee. These fees are not usually covered by insurance. There is no charge for telephone calls under five minutes. A $25.00 fee is charged for returned checks.

Clinical Work connected with Court/other Legal Proceedings:
For Independent Evaluations of children or adolescents, or any other work connected with Court and/or Attorneys, my standard rate is $200.00 per hour, payable in the form of a <u>minimum retainer</u>* of $2500 at initiation of this process.
Services covered under the retainer include:

1) Case consultation with attorneys
2) Research and/or preparation of materials for use in evaluation
3) Intake processes & documentation conducted with parents
4) Time evaluating the child/adolescent/adult
5) Preparation of reports for attorneys
6) Travel & expenses connected with Court appearances
7) Time "lost" from ongoing clinical practice

*This retainer can be divided 50/50 between the parents of a child/children being evaluated, or by the client's attorney(s).
Refunds are sent to Payor(s) (clients/parents/attorneys) for unused funds.

Insurance As a service to you, we bill most major insurance companies. However, it is important that you understand:

1. Your insurance policy is a contract between you, your employer and the insurance company. Our relationship is with you, not with your insurance company.
2. **<u>All charges are your responsibility</u>** whether your insurance company pays or not. Not all services are a covered benefit in all contracts.
3. You are required to pay unpaid deductibles and co-payments at the beginning of each session.

4. Any balance that accumulates because of a discrepancy between your payment and the insurance company's is your responsibility. If you need to make arrangements for payment on an account, please discuss this with our office staff. An 18% annual interest rate is charged on accounts not paid in a timely fashion. *Delinquent accounts are turned over to Collection Services of Nevada*.
5. If you belong to an HMO or MCO, the company may limit the number of visits they authorize. If you wish to continue in therapy longer than the number of visits authorized, you will be responsible for the full fee.

Cancellations If you must cancel an appointment, we require that you leave a message **AT LEAST 24 HOURS IN ADVANCE** on voice mail or by text. You will be expected to pay the full fee, not just the co-pay, for any missed individual or group session which is not canceled 24 hours in advance. Insurance companies rarely pay for missed sessions.

Office Hours Office hours are Monday and Wednesday through Friday from 9:00 a.m. to 6:00 p.m. You may leave voice messages or texts during that time or during those hours on Tuesdays, as well.

Phone Calls We have voice mail to supplement our regular office hours. We do return calls promptly. However, after-hours it may take up to 24 hours to return a call and up to 48 hours on weekends. If your call is urgent, please indicate that in your message. We do not usually return non-emergency calls Friday through Sunday.

Please hold routine questions about insurance or business matters until your next scheduled session. We give priority to returning urgent calls during breaks between sessions.

We usually make a courtesy reminder call the working day before your appointment. By signing this form you agree to have us call you to remind you of your appointment. Please initial below where we may call or leave a message.

Initial: _______ Please only call me at home.
_______ Please only call me on my cell.
_______ Please only call me at the office.
_______ Please call me at any of my numbers.
_______ **Please do not call me.**

Please remember this call is a courtesy only and you are still responsible for coming at your appointed time or canceling 24 hours in advance.

Emergency In an emergency, if you need to speak to someone immediately, call the Crisis Call Line at 323-0111, call 911, or go to the emergency room nearest your home.

Referral If you were referred to us by a physician, employee assistance program, or other professional, we would like to acknowledge the referral. By signing this form, you are giving us permission to do so. Please let us know if you do not want to acknowledge the referral.

I have read these policies and I agree to abide by them.

_________________________________ _______________
Signature Date

_________________________________ _______________
Signature Date

Danielle Osier-Tatar, MFT, LADC
2450 Vassar Street, Suite 3-A
Reno, Nevada 89502

PRIVACY PRACTICES NOTICE

Mindmatter Wellness Center
strictly adheres to the regulations mandated by the

Health Insurance Portability and Accountability Act
(HIPAA, Title II)

Copies of the *INFORMATION PRACTICES NOTICE,*
describing the Privacy Practices and Guidelines
set forth as a result of this legislation,
are available for review or receipt upon request.

ACKNOWLEDGEMENT

_____ I hereby acknowledge that I have read the above and choose not to receive a copy of the Privacy Practices and Guidelines at this time. I have been made aware that I can request, at any time, to review or to obtain a copy of the *INFORMATION PRACTICES NOTICE* for Mindsmatter Wellness Center.

_____ I requested and have received a copy of the *INFORMATION PRACTICES NOTICE* for Mindsmatter Wellness Center.

Signature: ___________________________________ Date:__________________

Print Name: __________________________________

Signature of Therapist:____