INTAKE FORM

Please fill out this form and bring it to your first session.

Name:____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years)

____
(Last) (First) (Middle Initial)

Birth Date:_______Age:_________Gender:________

Marital Status:
- Never Married
- Domestic Partnership
- Married
- Separated
- Divorced
- Widowed

Please list any
children/age:____

Address:____

Home Phone:______________ May we leave a message?_______________
Cell Phone:________________May we leave a message?_______________

Email:_____________________________May we email you?___________
Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):_________________________________

8. How many times per week do you drink alcohol? ___________________

9. How often do you engage in recreational drug use?
   - o Daily
   - o Weekly
   - o Monthly
   - o Infrequently
   - o Never

10. Are you currently in a romantic relationship?______________________
If yes, for how long?______________
On a scale of 1-10, how would you rate your relationship?_______________

11. Please list any significant life changes or stressful events have you experienced recently:
____
____
____

FAMILY MENTAL HEALTH HISTORY:

In the section below please identify if there is a family history of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please Circle	Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? ___________
If yes, what is your current employment situation?_____________________

Do you enjoy your work? Is there anything stressful about your current job?

____

2. Do you consider yourself to be spiritual or religious? ________________
If yes, please describe your faith or belief:___________________________

3. What do you consider to be some of your strengths?

____

____

4. What do you consider to be some of your weaknesses?

____

____

5. What would you like to accomplish in therapy?

____

____

Please list any previous mental health services (psychotherapy, psychiatric services, etc.)____

Are you currently taking any prescription medications? If yes, please list:

____

Have you ever been prescribed psychiatric medication? If yes, please list and provide dates: ____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

3. How many times per week do you generally exercise?______________
Types of exercise? ____

4. Please list any difficulties you experience with your appetite or eating patterns.____

5. Are you currently experiencing overwhelming sadness, grief or depression? ___________
If yes, for approximately how long?______________________________

6. Are you currently experiencing anxiety, panic attacks or do you have any phobias? ___________
If yes, when did you begin experiencing this?_______________________

7. Are you currently experiencing any chronic pain?__________________
If yes, please describe:_______________________________________

Paula DeFrisco, L.C.S.W., Inc.

Client Information:
(Who will be seen in therapy)

Name:____ Date:___________________

Address:_____________________________________City, State, Zip__________________

Home Phone:_________________________ Is it okay to leave message here? Y N

Cell Phone: __________________________ Is it okay to leave a message here? Y N

Date of Birth:____________ Employer/Name of School:__________________________

Parent/Guardian Information:
(Person Responsible for the Bill)

Name: ____ Relationship:______________

Address: ____________________________________ City, State, Zip:_________________

Phone Numbers: ____

Who to contact in case of emergency: ____

Primary Insurance Plan:

Name of Company: ___________________________________ Phone:_______________

Address for Claims: ____

Name of Insured: ____________________________________ Birth Date: _____________

Insured's Employer:____

Policy Number: _______________________________ Group Number:_______________

CoPay: ________ Deductible:________ Deductible Left: ________ Yearly Max:________

Authorization #: __________________ Number of Sessions Authorized:____________

DISCLOSURE STATEMENT

Clinician's Name: **Paula DeFrisco**
Clinician's Degrees, Credentials, Licenses: **M.S.W., University of Denver, 1999; L.C.S.W., California License # LCS 27899**
Business Phone: **805-235-2800**

The practice of both licensed and unlicensed persons in the field of psychotherapy is regulated by the California Board of Behavioral Sciences. The California Board of Behavioral Sciences is located at 1625 North Market Blvd, Suite #S-200, Sacramento, CA 95834. The phone number is 916-514-7830.

Generally speaking, the information provided by and to a client(s) during therapy sessions is legally confidentially if the therapist is a certified school psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed professional counselor, a licensed psychologist or an unlicensed psychotherapist practicing under the supervision of a licensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. A release of information signed by a client(s) is required in order for a therapist to obtain or release any information regarding a client's therapy. There are exceptions to the general rule of legal confidentiality as required by law, including: reporting child abuse, reporting and preventing threats to harm self or others (suicide, homicide), responding to a court subpoena/order, and in response to legal action. If a client participates in psychoeducational groups and/or group therapy, it is necessary for the client(s) to agree to protect and respect the privacy of other group members. Client(s) need to agree not to share personal information, including the names of other group members, with people outside of the group.

You are entitled to receive information about a therapist's methods of therapy, techniques used, duration of therapy (if known) and the fee structure. You may seek a second opinion from another therapist or you may terminate therapy at any time. In addition, sexual intimacy between a therapist and a client is never appropriate. If sexual intimacy occurs, it should be reported to the State Grievance Board. If you have any questions or would like additional information, please feel free to inquire.

I have read all the preceding information and understand my rights as a client.

Client Signature(s):____

____

____

Therapist Signature:___________________________________Date:______________

Paula DeFrisco, L.C.S.W., Inc.
1540 Marsh St., Suite 242
San Luis Obispo, CA 93401
805-235-2800

Fee Agreement and Contract

Full payment for services (or insurance co-payment) is due at the time of your appointment. In some instances, I may choose to bill you on a monthly basis. Telephone sessions must be paid for prior to your next scheduled session or within one week after the phone session, whichever is sooner. You may pay by check, money order, or cash, whichever is most convenient for you. Please be aware that if you cannot or do not pay for sessions in a timely manner, I will not be able to continue working with you. If you are experiencing unexpected financial difficulties, please let me know so we can adjust services to better fit your financial needs, as I would not want to have to end services abruptly in the middle of our working together. Sessions must be cancelled within 24 hours advance to avoid being charged for the session. You will be charged my full fee for canceling less than 24 hours in advance, however I do make exceptions in cases of illness or emergency.

Therapy Services: **$165.00 per hour (50-minute session)**

Providing comprehensive service to you and your family sometimes requires work above and beyond the therapy hour. This could include phone calls or consultations with outside providers, letters written at your request, and court testimony. Fees for these services are listed below.

Additional Services	**Fees**
School visits, attending meetings at your request	$135.00 per hour
Legal work (depositions, testifying in court, phone testimony)	$150.00 per hour
Letter writing for court, school, other	$100.00 per hour

While there is no charge for phone calls to check in briefly between sessions or to discuss scheduling or billing, phone calls, emails, or consultation of 15 minutes or more will be billed as follows:

Phone calls/consultation/emails (over 15 minutes)	$100.00 per hour, billed in 15-minute increments.

I, the undersigned, agree to a fee of __________per session, or if I am using insurance, I agree to pay a co-payment of ___________. There will be an interest fee of up to 1.5% per month (18% per year) applied to balances after 60 days. It is understand that client fees not paid in a timely manner will be forwarded to collections, and you will be responsible for any collections fees incurred. Checks returned for insufficient funds will be charged a $30.00 processing fee. Should your insurance company fail to pay for services after authorization is received, you will be responsible for fees incurred at the above rates.

My signature below indicates my agreement to pay all fees as outlined by this contract.

____ ______________
Signature of client/parent/guardian Date

____ ______________
Signature of client/parent/guardian Date

Paula DeFrisco, L.C.S.W., Inc.

1540 Marsh St., Suite 242
San Luis Obispo, CA 93401
805-235-2800

Welcome to my psychotherapy practice. I look forward to working with you.

The following is important information regarding my policies and procedures. If you have any questions or concerns, please feel free to ask.

Confidentiality

I will diligently protect your confidentiality rights as required by law. Therapy needs to be a safe and private place to do your work. Please be aware that there are certain exceptions to confidentiality to which I am also legally bound.

- It is my policy to report child abuse and neglect to the proper authorities.
- It is also my policy to take actions if I am seriously concerned that you may harm yourself or someone else. Such action may include notifying the proper authorities, notifying your emergency contact person, or seeking an order for a voluntary or involuntary hospitalization. Because your safety and well-being is of the utmost importance, these actions may be taken without your consent, however I will discuss any action I take with you.
- I must comply if I am subpoenaed or court ordered to a court proceeding in which I am required to testify about your work with me. Know that I will only testify if I am legally court ordered or subpoenaed into court. Being contacted by a lawyer or simply being present at a court hearing does not require me to provide any information to the court.

My other policies regarding confidentiality are:

- If I am unable to collect my agreed upon fee from you, I may send your name and contact information to a collection agency.
- If you file an official complaint or lawsuit against me, your right to confidentiality will be waived according to California law.
- In the interests of doing best practice, I may also consult with another mental health professional regarding your work with me. Some circumstances of your situation may be revealed, however I will not reveal your identity without your consent. Any other mental health professional I may consult will also protect your confidentiality as required by law.
- If you choose to use your health insurance company to pay for services, you will need to give your insurance or managed care company consent to obtain required confidential information from me for the purpose of determining eligibility for reimbursement.
- When I am away from my office for a few days, I may ask another licensed therapist to cover emergencies for me. I will tell this therapist only what he or she must know in order to be helpful in the case of an emergency.

Scheduling

Please arrive on time. Session normally will not be extended beyond the scheduled hour. If you arrive early, please have a seat in the waiting room. I will be out to greet you at the scheduled time. If you do arrive late, we will use the remaining time for your session, and will end as scheduled. You will still be charged the full session fee.

Changing Your Appointment/Missed Appointment

Your session time is reserved exclusively for you. If you need to cancel or reschedule your appointment you are required to give at least 24 hours notice of these charges. Late cancellation and missed appointments will be charged the normal session fee as outlined in my fee agreement. Please be aware that you will be personally responsible for any late notice or missed appointment fees, as insurance cannot be billed for these charges. Exceptions will be made for emergencies.

Alternatives to Canceling or Rescheduling/Telephone Sessions
If weather conditions, illness, or other problems will prevent you from attending your scheduled session I will be happy to conduct your session by telephone. Occasional telephone sessions are an effective way to keep your therapeutic progress going when life's surprises temporarily get in the way.

Session Length
A standard session usually lasts for 50 minutes to one hour. Sessions may also be scheduled for 1 ½ or 2-hour time frames if more time would be beneficial to you. Billing will be pro-rated in 15-minute increments at ($20 each) to reflect the time used beyond the initial hour.
I often do EMDR with my clients to help resolve intense trauma issues. Occasionally if we are in the middle of a particularly intense or difficult issue at the end of your scheduled time, you will have the option to extend your time. Again, pro-rated fees will be charged for each 15-minute increment. If you are in the process of working on a difficult issue and do not wish to – or don't have the time to – extend your session, please let me know at the beginning of our appointment so I can do my best to help you contain and put away the issues you are addressing. It is important to me that you leave the session settled and feeling comfortable about continuing with the rest of your day.

Availability

Phone Calls
If you wish to make or change an appointment, or if you have a question, please feel free to call or text me any time. If I am not available, please leave a message and I will do my best to return your call within one business day.

Emergencies
If you are having a crisis and need my help, you may call at any time for an emergency 15-minute session at no charge. If you do not reach me immediately, please leave a message stating this is an emergency and where you can be reached. I will call back as soon as possible. If further time is needed, beyond the 15-minute emergency session, we will either agree to a formal phone session at the usual fee, or we may schedule an emergency session at the office as soon as possible.
Emergency phone sessions are for true emergencies ONLY. Please respect this privilege and use this option appropriately.

Other Emergency Contacts
If I am not available to you during a major emotional crisis or you feel your safety or emotional stability is in serious jeopardy, please call 911.

Records

Records include identifying information, dates, and types of sessions, an assessment and diagnosis, a treatment plan, progress notes, and any consultations or collateral contacts made. My private psychotherapy notes are kept separate and are further protected from unauthorized access. Your records will be stored safely with attention to your privacy for at least 10 years as required by California Statute. They will only be released with your written permission and direction, and if you were seen in couples or family sessions, all adults present will have to sign the release. It is my policy to not release an entire record, even with your consent. Instead, I may summarize the content related to the request. You will be granted reasonable access to your record, but not my psychotherapy notes. You may request, in writing, an amendment to your record. If you choose to read your record, it is my policy to be present in order to respond to any questions or confusion you may have about the recordings.

Court Testimony

If you become involved in a divorce or a custody dispute, I want to make clear that I will not provide evaluations or expert testimony in court related to custody decisions. You should hire a different mental health professional for these purposes. This position is based on three reasons: (1) My statements will be seen as biased in your favor because we have a therapeutic relationship; (2) the testimony might affect our therapeutic relationship, and I must put this relationship first; and

(3) the testimony might affect my therapeutic relationship with your child(ren). It is important to me that they view my office as a safe place to work through their issues.

Ending Therapy

Ending therapy will usually be agreed upon mutually, however you are free to end therapy services at any time.
Please keep in mind that therapy works at both conscious and unconscious levels, stirring up powerful thoughts and emotions that may need continued therapeutic processing to be resolved. Strong feelings can bubble up unexpectedly for days or even weeks after a session if not properly addressed. It is crucial that you become aware of the feelings and thoughts that may arise after a therapy session and that you feel confident in your skills and knowledge to manage whatever may come up. If you wish to end services, please let me know as soon as possible so we can schedule a final session to ensure that your issues are appropriately contained or resolved.
Also, please be aware that, in certain circumstances, I may end services with you even if you wish to continue. This may occur if you are not able or willing to meet the terms of our fee agreement, if you have a need for special services outside the area of my expertise, or a prolonged lack of progress in our work together. Should this occur, know that I will discuss the circumstances with you and I will help you make other, more appropriate, arrangements to meet your needs, including referrals to other resources.

I have read the preceding information and understand my rights and responsibilities as a client.

Client signature(s)____ Date:_____________

____ Date:_____________

Guardian Signature for minor(s) ________________________________ Date: _____________

Therapist Signature: ____ Date: _____________

Notice of Privacy Practices
OF
Paula DeFrisco, L.C.S.W., Inc.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions or requests about this Notice, please contact me at 805-235-2800.

My practice is required by State and Federal law to maintain the privacy of Protected Health Information. In addition, the Practice is required by law to provide clients with this Notice of Privacy Practices explaining my legal duties and privacy practices with respect to your mental health information, and to request that you sign the attached written acknowledgement that you received a copy of this Notice. This Notice describes how the Practice may use and disclose your Protected Health Information. This Notice also describes your rights regarding your Protected Health Information and how you may exercise your rights.

"Protected Health Information" (PHI) is information the Practice has created or received about your physical or mental health condition, the health care I provide to you, or the payment for your health care. It could be reasonable used to identify you. It includes your identity, diagnosis, dates of service, treatment plan, and progress in treatment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Permissible Uses and Disclosures Not Requiring Your Written Authorization: Your mental health information may be used and disclosed in the following ways.

- **Treatment:** Your mental health information may be used and disclosed in the provision and coordination of your healthcare. For example, this may include coordinating and managing your health care with other health care professionals. Your mental health information may be used and disclosed when I consult with another professional colleague, or if you are referred for medication, or for coverage arrangements during my absence. In any of these instances only information necessary to complete the task will be provided.
- **Payment:** Your mental health care information will be used to develop accounts receivable information, to bill you, and with your consent to provide information to your insurance company or other third party payer for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, dates and types of service, and other information about your condition and treatment, but will be limited to the least amount of information necessary for the purposes of the disclosure.
- **Health Care Operations:** Your mental health information may be used and disclosed in connection with our health care operations including quality improvement activities, training programs and obtaining legal services. Only necessary information will be used or disclosed.
- **Required or Permitted by Law:** Your mental health information may be used or disclosed when I am required or permitted to do so by law or for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or to take action regarding imminent danger to others; (d) when the client is a danger to self or others or gravely disabled; (e) when a coroner is investigating the client's death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.
- **Contacting the Client:** You may be contacted to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.

- **Crimes on the Premises or Observed by the Provider:** Crimes that are observed by the therapist, crimes that are directed toward the therapist, or crimes that occur on the premises will be reported to law enforcement.
- **Business Associates:** Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, Protected Health Information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the Protected Health Information released to them.
- **Involuntary Clients:** Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.
- **Family Members:** Except for certain minors, incompetent clients, or involuntary clients, Protected Health Information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of the discussion. However, if the client objects, Protected Health Information may not be disclosed.
- **Emergencies:** In life threatening emergencies, the Practice will disclose information necessary to avoid serious death or harm.

Uses and Disclosures Requiring Your Written Authorization or Release of Information:

Except as described above, or as permitted by law, other uses and disclosures of your mental health information will be made only with your written authorization to release information. When you sign a written authorization, you may later revoke the authorization in writing as provided by law. However, that revocation may not be effective for actions already taken under the original authorization.

- **Psychotherapy Notes:** Psychotherapy notes are maintained separate from your mental health record. These notes will be used only by me and disclosure will occur only under these circumstances: (a) you specifically authorize their use or disclosure in a separate written authorization; or (b) I (the author of the notes) use them for your treatment; or (c) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; or (d) if you bring legal action and I have to defend myself ; and (e) certain limited circumstances defined by law.

Paula DeFrisco, L.C.S.W., Inc.
1540 Marsh St., Suite 242
San Luis Obispo, CA 93401
805-235-2800

Acknowledgement of Receipt of Notice of Privacy Rights

I, ____, acknowledge that I received a copy of the Notice of Privacy Practices for Paula DeFrisco, LCSW.

____ ____________________
Signature of Client or Personal Representative Date

____
If not the client, please print your name and legal authority to sign for the client.

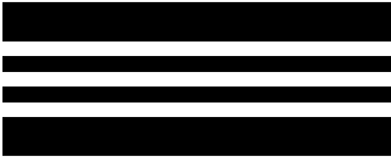
____________________*For Practitioner Use Only*_____________________________________

I attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining acknowledgement
- ❑ Client was incapable of signing
- ❑ Other (specify) ____

____ ____________________
Signature of Client or Practitioner Date

PLEASE
DO NOT
STAPLE
IN THIS
AREA



APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) 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

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

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? PLACE (State) YES NO

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 FROM MM | DD | YY TO MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

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. ___ . __
2. ___ . __
3. ___ . __
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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

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

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

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 HCFA, 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 Humans 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 to 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.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Paula DeFrisco, L.C.S.W., Inc.

Authorization for Release of Information

I, ___________________________________, hereby authorize Paula DeFrisco, LCSW, and
Client

_________________________________, at _________________ to exchange information.
Name Telephone

The type of information to be disclosed:

Evaluations______ Medical/Hospital Records_______
Diagnosis _____ Psychological/Medical Test Results ______
Treatment Plan ______ Mental Health Record Summary ______
Course of Treatment ______ Psychotherapy Notes ________
Other ________________________

The purpose of such disclosure:

Ongoing Treatment ______ Medical Care ______ Consultation _____
Evaluation ______ Transfer ______ Legal Issues ______
Coordination of Care ______ Health Benefit Utilization______
Other_________________________

Exceptions: ____

The designated information about me ( ) may or ( ) may not be transmitted by fax, electronic mail or other electronic file transfer mechanisms. Paula DeFrisco, LCSW and the above designated person ( ) may or ( ) may not discuss by telephone the content of the information released.

This consent is in effect until ____________________. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in section 12.43.218 CRS and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPPAA privacy regulations.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing information, if known, have been explained to me.

_________________ ____
DATE NAME OF CLIENT 0R PERSONAL REPRESENTATIVE