Joanne Baum, Ph.D., LCSW, CAC III

Phone: (303) 670-3948
www.support4families.com
www.respectfulparenting.com
drjobaum@gmail.com
Licensed in Indiana and Colorado

Name: _____ Date: _____

Address: _____

_____

Date of Birth: _____

Home Phone Number: _____ Work Phone:_____

Cell Phone: _____ E-Mail:_____

Partner/Spouse Name _____

If children, how many_____ How many living with you _____

Names and Dates of Birth of Child(ren): _____

_____

_____

Emergency Contact Name: _____ Phone:_____

Hobbies: _____

Briefly, can you say what prompted you to make this appointment and what would you like to work on/resolve/alleviate? _____

_____

_____

_____

_____

Rate Your level of fitness _____ excellent ____ good _____ fair ____ poor

Rate Your stress level _____ high _____ moderate _____ low

Primary Physician _____ Phone _____

Referred By _____

May I thank your referral source? _____ Yes _____ No

GENERAL INFORMATION

Name of My Business: Joanne Baum, PhD & Support 4 Families
Degrees, Credentials, Licenses Education: I have a PhD in Social Welfare, a Master's Degree and a Bachelor's Degree in Social Work from the University of Wisconsin. I am a Licensed Clinical Social Worker and a Certified Addictions Counselor Level III. I am now licensed in Colorado and Indiana. If you are interested in more details about my professional background please ask and I can send you a copy of my resume.

All sessions with Joanne Baum, PhD, LCSW, CAC III in Colorado are electronic through a HIPAA compliant company which will handle our video sessions and email. All attempts have been made to keep sessions confidential using private internet connections, and a HIPAA compliant video system. By signing this document you are agreeing to these kinds of electronic sessions and email correspondence. In addition, Dr. Joanne Baum meets with people in Bloomington, Indiana in person can use VSee to see people throughout the state of Indiana.

FEES

The cost of a 50 minute outpatient session is $180.00. (A sliding fee scale can be discussed if necessary.) Phone calls and emails (for the purposes of consultation & coordinating treatment with you, family members, significant others, or other professionals involved in this case) will be prorated based on the agreed upon fee. Charges will accrue for Dr. Baum's time reading or writing: letters, documents, emails, or reports as needed. Sessions going longer than 50 minutes will be prorated if you've been given the option of continuing and you agree to going longer and being charged for a longer session, or if you've asked for a long session.

PAYMENT POLICY

If you are meeting with Dr. Baum in person you may pay by check or cash at the end of each session. A credit card can be used if necessary. A check or cash are preferred for in person sessions. If you are meeting with Joanne using VSee a credit card charge for the amount of the session will be charged following each session with the credit card number you have provided. If extra time is used in between sessions with activities described in the paragraph above, the credit card on file will be charged following the activity.

CHARGES FOR LATE AND CANCELED APPOINTMENTS

I ask for 48 hours advance notification if you are unable to meet during your appointment time or you will be charged for the appointment unless a "true emergency" prevents you from being present. Please call my cell 303-670-3948 and/or email me drjobaum@gmail.com. This advance notice allows Dr. Baum to offer your time slot to someone else. If you do not show up, or call less than 48 hours prior to your appointment, and it isn't a true emergency, you will be charged the full amount for your session unless Dr. Baum can fill your slot. Emergency situations are evaluated on an individual basis. If you are late for an appointment you will be charged the full fee as well, unless there was a "true emergency" making it impossible for you to be present at the beginning of your session. If you are going to be late for an appointment, please call 303-670-3948 and let us know.

DISCLOSURE STATEMENT

I am licensed in Indiana and Colorado. The practice of psychotherapy is regulated by the Colorado State Department of Regulatory Agencies and the Indiana Professional Licensing Agency. If you have any questions, concerns or complaints about my services I would appreciate if you would talk to me directly first and we can try and resolve any issues you are troubled about. You can also go directly to the State Grievance Board if you are not comfortable speaking with me: In Colorado: LCSW Grievance Board, 1560 Broadway, Suite 1340, Denver CO 80202. (303) 894-7766. In Indiana: Indiana Professional Licensing Agency, Behavioral Health and Human Services Licensing Board. 402 W. Washington St. Room W 072, Indianapolis IN 465204. (317)-234-2054

CLIENT RIGHTS

You will receive a copy of the entire HIPAA form including the Notice of Privacy Practices, which outlines your rights in more detail. Please read the entire Notice, sign the Acknowledgment Form and return it to your therapist. You are entitled to receive information about methods of therapy, techniques used, the duration of therapy (if known) and fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers or certifies the licensee.

CONFIDENTIALITY

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12/43/218 of the Colorado Revised Statutes and the HIPAA Notice of Privacy Rights you were provided as well as other exceptions in Colorado, Indiana, and Federal law. For example, Mental Health professionals have a "duty to report" if they think someone is a danger to themselves or others and are required to report suspected child abuse or elder abuse to

authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

INSURANCE PROCEDURES

Dr. Baum is not on insurance lists. If you request, Dr. Baum will give you a bill at the end of each month, which you can submit to your insurance for possible out of network reimbursement.

CLIENT AGREEMENT

By signing below you are indicating you have read and understood the above statements on fees, payment policies and right/responsibilities as a client. You have had an opportunity to discuss these conditions with your therapist and been given the opportunity to ask any questions you may have had. If you had questions they have been answered to your satisfaction. You understand and agree to meet your financial responsibilities in receiving treatment and services in this practice setting. By signing below you are agreeing to all the terms of this document.

Client Prints Name:_____

Client's or Responsible Party's Signature: _____

Date Signed:_____

If Signed by Responsible Party, please state relationship to client and authority to consent:

_____

Joanne Baum, Ph.D., LCSW, CAC III
Phone: (303) 670-3948
drjobaum@gmail.com
www.support4families.com
www.respectfulparenting.com

NOTICE OF PRIVACY PRACTICES

This Notice Describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully

Your health record contains personal information about you and you r health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending you a copy in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment We many use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment –related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment

activities, employee review activities, licensing, and conducting or arranging for other business activities. For example we may share your PHI with third parties that perform various business activities (e.g. billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training purposes or teaching purposes PHI will be disclosed only with your authorization.

Required by Law Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. They types of uses and disclosures that may be made without your authorization are those that are:

- ❑ Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as social work licensing board or the health department)
- ❑ Required by Court Order
- ❑ Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission We may disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI we maintain for you. To exercise any of these rights, please submit your request in writing to Joanne Baum, Ph.D. who acts as the Privacy Officer at Joanne Baum, Ph.D.

- ❑ Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.

- ❑ Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- ❑ Right to an Accounting of Disclosures. You have the right to request an accounting of certain other disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-monthperiod.
- ❑ Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- ❑ Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way at a certain location.
- ❑ Right to a Copy of this Notice. You have the right to a copy of this notice,

COMPLAINTS

I am licensed in Indiana and Colorado. The practice of psychotherapy is regulated by the Colorado State Department of Regulatory Agencies and the Indiana Professional Licensing Agency. If you have any questions, concerns or complaints about my services I would appreciate if you would talk to me directly first and we can try and resolve any issues you are troubled about. You can also go directly to the State Grievance Board if you are not comfortable speaking with me: In Colorado: LCSW Grievance Board, 1560 Broadway, Suite 1340, Denver CO 80202. (303) 894-7766. In Indiana: Indiana Professional Licensing Agency, Behavioral Health and Human Services Licensing Board. 402 W. Washington St. Room W 072, Indianapolis IN 465204. (317)-234-2054

NOTICE OF PRIVACY PRACTICES
Receipt and Acknowledgment of Notice

Patient/Client Name (Print) _____
Date of Birth _____ Social Security Number _____

I hereby acknowledge that I have been given an opportunity to read and receive a copy of Joanne Baum, Ph.D. Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Dr. Baum at 303-670-3948.

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative* Date

---

If you are signing as a personal representative of an individual, please describe your legal authority to act for third individual (power of attorney, healthcare surrogate, etc.

- ❑ Patient/Client Refuses to acknowledge Receipt:

Signature of Staff Member Date