LAWRENCE W. FOLEY, PSY.D

LICENSED PSYCHOLOGIST

521 TANGLEWOOD DRIVE

SHOREVIEW, MINNESOTA 55126

OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the *personalities of the psychologist and patient, and the particular problems you hope to address.* There are many different methods I may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I will schedule sessions at a time we agree on. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control.

PROFESSIONAL FEES

My fee is 150-250 dollars per hour. If we meet more than the usual time, I will charge accordingly. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. I charge $300 per hour for professional services I am asked or required to perform in relation to your legal matter. I also charge a copying and retrieval fee as determined by the Minnesota Department of Health per page for records requests.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when such services are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information I will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If necessary, I am willing to call the insurance company on your behalf to obtain clarification.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you

once your benefits end. If this is the case, I will try to assist you in finding another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.***

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by the insurance contract.

CONTACTING ME

I am often not immediately available by telephone. Though I am usually in my office between 9 AM and 5 PM, I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact 911, your county crisis number or the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

CONFIDENTIALITY [for adult patients]

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused or has been abused, I must make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

PATIENT SIGNATURE _____ DATE _____

MINORS

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Me

In the course of my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child.
If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm and the police.
- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I

will need to use my professional judgment to decide whether a parent or guardian should be informed.

- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

> *Example*: If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If you child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.

> *Example*: If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of this State may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $300 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Child/Adolescent Patient:

By signing below, you show that you have read and understood the policies described above. If *you have any questions as we progress with therapy, you can ask me at any time.*

Minor's Signature* _____ Date_____

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. _____ _____

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/ adolescent's treatment. _____ _____

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above. _____ _____

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

* For very young children, the child's signature is not necessary

LAWRENCE W. FOLEY, Psy.D., Licensed Psychologist

521 Tanglewood Drive ◆ Shoreview, MN 55126-2016 ◆ 651/214-6506

CLIENT REGISTRATION FORM (Child)

Name (*First, M.I., Last*) Age Date of Birth

Address
(Street) (City) (State) (ZIP)

HOME Phone ( ) *Please Circle* Female Male

School Attending Current Grade

Mother's Name WORK Phone

Father's Name WORK Phone

Siblings (names and ages)

Physician
and Address Phone

Has your child been involved in prior counseling Yes No WHEN WHERE

INSURANCE INFORMATION

(PLEASE ATTACH COPY OF INSURANCE CARD)

PRIMARY Policy Holder/Responsible Party Date of Birth

Address *(if different from child)*
(Street) (City) (State) (ZIP)

Relationship to Client HOME Phone ( ) Cell / Pager # ( )

Employer [redacted]

Insurance Company Phone # ( )

Insured's ID # Group #

Have you contacted Ins. Co. to verify benefits? Yes No Deductible of $ Met $ Co-Pay

SECONDARY Policy Holder/Responsible Party Date of Birth

Address *(if different from child)*
(Street) (City) (State) (ZIP)

Relationship to Client HOME Phone ( ) Cell / Pager # ( )

Employer SOCIAL SECURITY #

Insurance Company Phone # ( )

Insured's ID # Group #

Have you contacted Ins. Co. to verify benefits? Yes No Deductible of $ Met $ Co-Pay

Parent's Signature *Date*

To be completed by Therapist. FEE AGREEMENT:

DX Axis I Axis II Axis III Axis IV

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◆ ASSIGNMENT OF BENEFITS ◆

Lawrence Foley, Psy.D, L.P. may furnish to my insurance company any information it may need to process my claim. Managed care organizations may also have access to clinical information to monitor treatment plans. My insurance company may pay the above therapist directly for services delivered to me or my children. *I agree that I am responsible for all charges, regardless of insurance coverage.*

Signature _____ Date _____
Client / Parent / Guardian / Authorized Representative

◆ RELEASE OF INFORMATION ◆

I, _____, authorize Lawrence Foley, Psy.D, L.P., or his office manager, to file claims with my insurance company for services I have received and to furnish my insurance company, its authorized representative, and/or other third party payor(s) of such services with the information necessary to process my claims, including, but not limited to treatment summaries and/or documentation to determine my eligibility for services and for prior authorization purposes.

Signature _____ Date _____
Client / Parent / Guardian / Authorized Representative

◆ CONSENT TO TREATMENT ◆

I have read and understood the *Client Information Form.*
I hereby give consent for _____ (client) to receive psychological services. I understand that services to be provided may include assessment, observation, diagnosis, psychotherapy, consultation, and/or crisis intervention.

Signature _____ Date _____
Client / Parent / Guardian / Authorized Representative

◆ FINANCIAL RESPONSIBILITY ◆

I have received and read the information on billing and payment in the *Client Information Form.* I understand and agree to abide by the terms as described. *I understand that I am financially responsible for all charges whether or not they are covered by insurance. 24-hour notice: I understand that I may be billed directly for ~~$60.00~~ 90.00 for missed appointments for which 24-hour notice is not given.*

Signature _____ Date _____
Client / Parent / Guardian / Authorized Representative

LAWRENCE W. FOLEY, PSY.D.
LICENSED PSYCHOLOGIST
521 TANGLEWOOD DRIVE
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651-214-6506
lfoley@lawrencefoleypsyd.com

RELEASE OF INFORMATION

I authorize Lawrence Foley, Psy.D., LP to release all necessary information to A.C.E. Billing, Inc, to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance claim submissions.

Signature_____ **Date**_____
Client/Parent/Guardian/Authorized Representative

LAWRENCE W. FOLEY, PSY.D, LP

521 TANGLEWOOD DRIVE
SHOREVIEW, MN 55126
651-214-6506

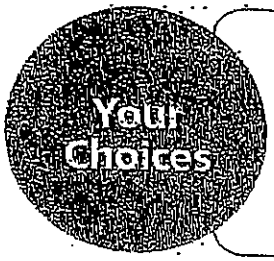
Your Information. Your Rights. Our Responsibilities.

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.**

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➢ *See page 2 for more information on these rights and how to exercise them*



You have some choices in the way that we use and share information as we:

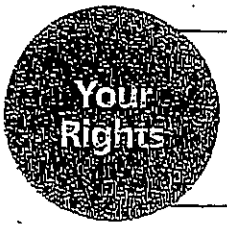
- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

➢ *See page 3 for more information on these choices and how to exercise them*

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➢ *See pages 3 and 4 for more information on these uses and disclosures*



When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	*Example: We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	*Example: We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This Notice of Privacy Practices applies to the following organizations.

LAWRENCE W. FOLEY, PSY.D.

LAWRENCE W. FOLEY, PSY.D
LICENSED PSYCHOLOGIST
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ACKNOWELDGEMENT FORM

I have received the Notice of Health Information Privacy Practices/Rules (laminated forms) and have been given the opportunity to review it and ask questions regarding it.

NAME:_____BIRTHDATE:_____

SIGNATURE:_____DATE:_____

I have read and understand the information in the introduction/office practice document and have had the opportunity to discuss it with my clinician. I am making an informed decision about engaging in this service.

CLIENT/GUARDIAN SIGNATURE:_____DATE:_____

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Authorization to Use or Disclose Protected Health Information

I, _____, understand Lawrence W. Foley Psyd,Inc is authorized by me to use or disclose my/my child's protected health information for a purpose other than treatment, payment, or healthcare operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize Lawrence W. Foley, Psy.D, Inc or any other individual listed below to disclose my protected health information as described on this form to the recipient(s) listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient(s) and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps below.

PATIENTS NAME:_____DATE OF BIRTH:_____
ADDRESS:_____

I authorize Lawrence W. Foley, Psy.D Inc to: ___disclose information to ___Obtain information from:
Name of person/agency, address and phone number:

_____

Regarding: ____Myself, _____My child ____Other_____

Treatment Dates from_____to_____

Information to be disclosed/obtained/exchanged:

____Entire medical record (including psychotherapy notes)
____Discharge Treatment summary
____Psychological Testing
____Medication History
____Other:_____
____Diagnostic Assessment
____Dates of Service
____Medical/Physical information
____Chemical Dependency/abuse Info
____Telephone contact only

Name(s) or class or Person(s) other than current employees or owner authorized by this form to use and disclose the patients protected health information:_____

The purpose of this disclosure is:_____
I understand that I may revoke this consent at any time by written notice, except to the extent that action has already been taken. The written revocation must include patients name and address, the effective date of this authorization, the recipient(s) of the protected health information according to the authorization, the patients desire to revoke this authorization, date of revocation, and the patient/guardians signature.

This authorization shall expire one year from the date on this form or on the date listed:_____

I fully understand and accept the terms of this authorization.

*Patient/Guardian Signature:*_____Date:_____

Witness Signature:_____Date:_____

LAWRENCE W. FOLEY, PSY.D.
LICENSED PSYCHOLOGIST
521 TANGLEWOOD DRIVE
SHOREVIEW, MINNESOTA 55126
651-214-6506

Authorization to Exchange Protected Health Information with Primary Care Physician

Communication between Lawrence W. Foley, Psy.D.,LP and your Primary Care Physician helps to ensure you receive the best possible care. Your signature allows Lawrence W. Foley, Psy.D.,LP to share your Protected Health Information with your physician. Your protected information will only be released with your signed authorization.

Patient Name (print):_____ Date of Birth:_____

Please check one then sign the form below. If you check #3, please provide Physician's information.

1) ____I do NOT wish to release my protected health information to my physician.
2) ____I do not currently have a physician.
3) ____I authorize Lawrence W. Foley, Psy.D.,LP to exchange my protected health information (including dates of visits, progress notes, evaluations, treatment plan, etc), with:

Physician Name: _____ Phone:_____
Physician Address:_____Fax:_____
_____

PATIENT RIGHTS

You are not required to sign this form. You have a right to a copy of this signed authorization. Information disclosed as a result of a signed authorization could be disclosed by the recipient to another party and no longer protected by law. This authorization expires one year from the date of the patient's signature. You may terminate this authorization by submitting a signed written request to Lawrence W. Foley, Psy.D.,LP. I hereby release and agree to indemnify Lawrence W. Foley, Psy.D.,LP, PC, its contractors and employees from all liability, damages, and costs arising from the acts or omissions of other persons or organizations. I have read and understand the above information.

Client/Guardian Signature:_____ Date:_____

To be completed by Lawrence W. Foley, Psy.D.,LP

I have seen this patient from:_____ to _____
Patient Diagnosis:_____
Course of treatment:_____
_____
_____

Please contact me at my office if you would like to discuss further.