KEVIN M. FAWCETT, Ph.D.

Clinical Psychologist • CA License: PSY 24224
3604 Fourth Avenue, Suite #5 • San Diego, CA 92103
(619) 356-0811 • drkevinfawcett@gmail.com • www.drkevinfawcett.com

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Informed Consent

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. Although these documents are long and sometimes complex, please take the time to read through this carefully before signing. When you do 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 client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. 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 on your own.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may at times experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of 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 of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select.

YOUR RIGHTS AS A CLIENT

- You have the right to ask questions about any procedures used during therapy.
- You have the right to decide at any time not to receive therapy from me. If you wish, I will provide you with the names of other qualified professionals whose services you may prefer.
- You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued.

MEETINGS AND FEES

- Therapy sessions are typically scheduled for 45-50 minutes once a week, although the frequency or duration of meetings may be adjusted as needed.
- The fee for your initial evaluation has been set at $_____. Subsequent sessions will be billed at our agreed upon fee of $_____ per session. Payments by cash/check are required at the time of your appointment, unless other arrangements have been made in advance. If at any point you are not able to pay your fee, please communicate this with me so that we can negotiate alternative arrangements.
- In addition to weekly appointments, I charge the above fee for other professional services based on 15-minute increments. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals as part of your treatment (with your permission), preparation of records or 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 all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding.
- 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 which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

CANCELLATION POLICY

Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of one full business day (e.g. for Monday appointments, cancelling by the previous Friday) advance notice is required for rescheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. It is important to note that insurance companies do not provide reimbursement for "no shows" or cancelled sessions. INITIALS _____

CREDIT CARD INFORMATION

A current credit card number must be on file at all times (provided below).

- Your credit card will only be used to pay for missed appointments, late cancellations, and unpaid balances.
- Payment by cash or check is due at the time of your appointment.
- All paid invoices are emailed to the cardholder at the time of charge.

The credit card to remain on file is:

1. Please circle one: ☐ MasterCard ☐ Visa ☐ American Express ☐ Other _____

2. Card Number: _____--_____--_____--_____

3. Expiration Date: _____

4. Security Code: _____

5. Name as it appears on the card: _____

6. Billing address (include zip code): _____

_____

I, _____, authorize Kevin Fawcett to charge my credit/debit card for any missed appointment fees, late cancellation fees, and/or unpaid balances. I understand that I am responsible for all charges.

Signature of cardholder: _____

INSURANCE REIMBURSEMENT

- If you plan on billing an insurance company for your sessions, you will need to complete the "Insurance Reimbursement" form included in this packet.
- I am available to assist you in the determination of your benefits and eligibility according to your health plan and, if contracted with your insurance carrier, will accept assignment of benefits on your behalf. However, you are ultimately responsible for any fees not covered by your provider.
- If I am not contracted with your insurance provider but you still wish to utilize your insurance benefits, you will need to complete the top portion of the "Insurance Reimbursement" form included in this packet. You will be responsible for paying the full fee at the time of service. I can then assist you in attaining reimbursement for your costs by providing you with a monthly "superbill" that you can submit to your insurance provider.

MINORS & PARENTS

- Clients under 18 years of age who are not emancipated can consent to psychological services subject to the involvement of their parents or guardian unless the psychologist determines that their involvement would be inappropriate.
- A client over age 12 may consent to psychological services if he or she is mature enough to participate intelligently in such services, and the minor client either would present a danger of serious physical or mental harm to him or herself or others, or is the alleged victim of incest or child abuse. In addition, clients over age 12 may consent to alcohol and drug treatment in some circumstances.
- However, unemancipated clients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records unless I determine that access would have a detrimental effect on my professional relationship with the client, or to his/her physical safety or psychological well-being.
- Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement is also essential, it is usually my policy to request an agreement with minors [over age 12] and their parents about access to information. This agreement provides that during treatment, I will provide parents with only general information about the progress of the treatment, and the client's attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete.
- Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by state law and/or HIPAA. But, there are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If your insurance coverage pays for any of the costs of your therapy, you are giving your consent for information such as your diagnosis and appointment dates to be shared with your insurance company. I will provide your insurance company with the minimal amount of information required.
- If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is protected by psychologist-client privilege law. I cannot provide any information without your (or your legally-appointed representative's) written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where that party has given you proper notice (when required) has stated valid legal grounds for obtaining PHI, and I do not have grounds for objecting under state law (or you have instructed me not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim, I must, upon appropriate request, disclose information relevant to the claimant's condition, to the worker's compensation insurer.

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

- If you threaten bodily harm or death to another person, I am required by law to inform the intended victim and appropriate law enforcement agencies.
- If you threaten bodily harm or death to yourself, I am required to inform the appropriate law enforcement agencies and others (such as a spouse, friend, or an inpatient psychiatric institution) who could aid in prohibiting you from carrying out your threats.
- If you reveal information related to the abuse or neglect of a child, dependent adult, or elderly person, I am required by law to report this to the appropriate authorities.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

PROFESSIONAL RECORDS

- The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. You may request in writing to examine and/or receive a copy of your Clinical Record, except in unusual circumstances that disclosure would physically endanger you and/or others, or where information has been supplied to me confidentially by others.
- You will be responsible for the costs associated with making such copies, including the time it takes to prepare such documents. If I refuse your request for access to your records, you have a right of review, (except for information supplied to me confidentially by others) which I will discuss with you upon request.
- Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents.

CONTACTING ME

- I can be reached at (619) 356-0811, Monday through Friday between 8am and 8pm. Due to my work schedule, I am often not immediately available by telephone. My voicemail is monitored frequently and I will make every effort to return your call within 24 hours, 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 have a counseling emergency after hours, please call the San Diego Crisis Line at 1-800-479-3339 or dial 911. You may also visit the nearest emergency room and ask for the psychologist or psychiatrist on duty.
- If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary.
- IMPORTANT NOTE: Though email, voicemail, and text messages are frequently used modes of communication and may be used to contact me, they are NOT considered confidential. I cannot assure or guarantee your privacy when these forms of communication are used. If you have questions or concerns about this, please make sure to bring them to my attention so that we can discuss a sufficient plan for communicating.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ABIDE BY ITS TERMS DURING OUR PROFESSIONAL RELATIONSHIP AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____	_____
Client Signature (or signature of parent/guardian)	Date
_____	_____
Client Signature	Date
_____	_____
Kevin Fawcett, Ph.D.	Date

KEVIN M. FAWCETT, Ph.D. *Licensed Psychologist PSY24224*

Client Information

Today's Date: _____

A. Demographic Information

Name: _____ Date of Birth: _____ Age: _____
Race/Ethnicity _____ Social Security #: _____
Religious/Cultural Affiliations: _____
Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Living Together

Current Address: _____ Apt.: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____
Email: _____ Preferred method of contact: _____
Contacts will be discreet, but please indicate restrictions: _____

Emergency Contact: _____ Phone: _____
Relationship to you: _____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____
Address: _____
May I have your permission to thank this person for the referral? ☐ Yes ☐ No

C. Chief Concern

1. Briefly summarize your reason(s) for beginning therapy:

2. Have you ever had any of the following problems?

☐ Head Injuries
☐ Stroke
☐ Cancer
☐ Diabetes
☐ Thyroid Disease
☐ Alcoholism
☐ Sleep disturbances
☐ Fainting/Dizziness
☐ Convulsions
☐ Memory Problems
☐ Hallucinations
☐ Crying spells
☐ Appetite Changes
☐ High blood pressure
☐ Heart disease
☐ Meningitis
☐ Loss of consciousness
☐ Severe/Frequent headaches
☐ Drug problems
☐ Depression
☐ Anxiety
☐ Problems with sex
☐ Extreme tiredness
☐ Heart palpitations
☐ Suicidal thoughts
☐ Difficulty concentrating

D. Treatment

1. Have you ever received psychological or therapeutic services before?

☐ Yes ☐ No If yes, please indicate:

When?	From whom?	For what?	Results?

2. Have you ever taken medications for psychiatric or emotional problems?

☐ Yes ☐ No If yes, please indicate:

When?	From whom?	Medication	For what?	Results?

E. Family History

Have any of your BLOOD RELATIVES ever had any of the following:

	WHO?	
☐ Depression		
☐ Anxiety		
☐ Suicide Attempts		
☐ Schizophrenia		
☐ Psychiatric Treatment		
☐ Alcoholism		
☐ Drug Problems		
☐ Neurological Disorder		
☐ Other (_____)		

F. Significant Relationships

	Name of person	Your age when started	Person's age when started	How long	Reason for ending
Current					
First					
Second					
Third					

G. Current Living Situation

1. Please describe your current living situation, including any family members or roommates living with you:

2. Children (and ages):

H. Education/Employer (or for child, parent's current employer)

Highest grade/degree completed? _____ College/Graduate Major(s): _____

Employer: _____ Occupation: _____

Address: _____ Phone: _____

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Health Information Form

A. Identification

1. Client's Name: _____ Date: _____

B. History

1. Starting with childhood and proceeding up to the present, please list *all* major diseases, illnesses, accidents/injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have:

Age	Illness/Diagnosis	Treatment received and result
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Describe any allergies you have:

Allergy	Reactions you have	Medications you take
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. List *all* medications or drugs you are taking or have taken in the past year (prescribed, over-the-counter, or otherwise):

Medication/Drug	Dosage (how much?)	Taken For	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Have you done any kinds of work where you have been exposed to toxic chemicals
   ☐ Yes ☐ No

C. Medical Care

Primary Doctor/Clinic	Address/Contact info	Last visit
_____	_____	_____
_____	_____	_____

Reason for last visit: _____

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D. Health Habits

1. What kinds of physical exercise do you get?

2. How much coffee, cola, tea, or other sources of caffeine do you consume each day?

3. Do you try to restrict your eating in any way? How? Why?

4. Do you have any problems with sleep?

E. Chemical Use

1. Have you ever felt the need to cut down your drinking? ☐ Yes ☐ No
2. Have you ever felt annoyed by criticism of your drinking? ☐ Yes ☐ No
3. Have you ever felt guilty about your drinking? ☐ Yes ☐ No
4. How much beer, wine, or hard liquor do you consume each week, on the average?

5. How much tobacco do you smoke or chew each week? _____
6. Which drugs (not medications prescribed for you) have you used in the last 10 years?

F. For Women Only

1. Menstrual period experiences:
   i. How regular are they? _____
   ii. How long do they last? _____
   iii. How much pain do you experience? _____
   iv. Other experiences during your period? _____
2. Please list all of your pregnancies:

Age	Miscarriage	Abortion	Child born	Problems/Complications
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____

3. Menopause:
   i. If your menopause has started, at what age did it start? _____
   ii. What signs/symptoms have you had?

G. Other

1. Any other medical or physical problems you are concerned about:

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Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- ☐ I have no problem or concern bringing me here
- ☐ Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Children, child management, child care, parenting
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Coping with prejudice/societal pressure
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ☐ Emptiness
- ☐ Failure
- ☐ Family problems
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits

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- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage
- ☐ Memory problems
- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems
- ☐ School problems (see also "Career concerns…")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ☐ Sexual orientation issues
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems—too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Weight and diet issues
- ☐ Withdrawal, isolating
- ☐ Work problems, employment, workaholism/overworking, can't keep a job

Have you ever had any thoughts of wanting to harm yourself? ☐ Yes ☐ No
Have you ever had any thoughts of wanting to harm someone else? ☐ Yes ☐ No
Have you ever seen or heard things that others can't see or hear? ☐ Yes ☐ No

Any other concerns or issues:

- ☐ _____
- ☐ _____
- ☐ _____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is: _____

CALIFORNIA NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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

I. Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for certain *treatment, payment, and health care operations* purposes without your *authorization*. In certain circumstances I can only do so when the person or business requesting your PHI gives me a written request that includes certain promises regarding protecting the confidentiality of your PHI. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment and Payment Operations"*
    - *Treatment* is when I provide or another healthcare provider diagnoses or treats you. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist, regarding your treatment.
    - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - *Health Care Operations* is when I disclose your PHI to your health care service plan (for example your health insurer), or to your other health care providers contracting with your plan, for administering the plan, such as case management and care coordination.
- "*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.
- *"Authorization"* means written permission for specific uses or disclosures.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment and payment operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke or modify all such authorizations (of PHI or psychotherapy notes) at any time; however, the revocation or modification is not effective until I receive it in writing.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** Whenever I, in my professional capacity, have knowledge of or observe a child I know or reasonably suspect, has been the victim of child abuse or neglect, I must immediately report such to a police department or sheriff's department, county probation department, or county welfare department. Also, if I have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional wellbeing is endangered in any other way, I may report such to the above agencies.

- **Elder or Dependent Adult Abuse:** If I, in my professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these or if I reasonably suspect such, I must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency.

I do not have to report such an incident if:

1) I have been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect;

2) I am not aware of any independent evidence that corroborates the statement that the abuse has occurred;

3) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and

4) in the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

- **Health Oversight:** If a complaint is filed against me with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services that I have provided you, I must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; or 3) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides me with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified me that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.

- **Serious Threat to Health or Safety:** If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.

- **Workers' Compensation**: If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of the your initial examination, and at subsequent intervals as may be required by the administrative director of the Worker's Compensation Commission in order to determine your eligibility for worker's compensation.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my

mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

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

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at 619-356-0811 or 3604 Fourth Avenue, Suite #5, San Diego, CA 92103 for further information.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services

Department of Health & Human Services, Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C. 20201.
(877) 696-6775 or (202) 619-0257

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on February 9, 2012.

I will limit the uses or disclosures that I will make as follows: Unless required by law or when in good faith, to avert a serious threat to health or safety of a person, I will not disclose information to others without your knowledge and I will request that you sign an Authorization form to consent to the release.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in writing by mail or in person.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I, _____, do hereby acknowledge receipt of this office's Notice of Psychologists' Policies and Practices.

Print Name of Client (Parent/Guardian if minor)	Signature	Date
Print Name of Client (Parent/Guardian if minor)	Signature	Date

In the event this request is made by the individual's personal representative:

_____
Please Print Name

_____
Signature of Personal Representative

_____
Date

_____
Legal Authority of Personal Representative

For Office Use Only

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

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify): _____

KEVIN M. FAWCETT, Ph.D. *Licensed Psychologist PSY24224*

Insurance Reimbursement

Client name: _____ **DOB**: _____ **SSN**:_____

Mailing Address: _____

Insurance: _____ **Policy #:** _____

Plan: _____ **Group #:** _____ **Group Name:** _____

Insurance Mailing Address: _____

Insurance Phone: _____

If the insurance plan is under someone else's name:

Primary Subscriber: _____ **Phone**:_____

Subscriber mailing address: _____

My insurance company has told Dr. Kevin Fawcett that the following apply to services, but they do not automatically guarantee payment for any service that he may provide to me.

Co-pay: $_____ **Deductible:** $_____ **% Coverage:** _____

No coverage [ ] **Client Reimbursement Accepted:** _____ **Agreed upon fee**: $_____

I hereby give Dr. Kevin Fawcett permission to bill my insurance company for services he has provided me or to _____. I also authorize Dr. Fawcett to release all necessary information that the insurance company may require to enable him to obtain full payment for his services. I also authorize the use of my signature on all health claim forms for myself or my dependent who has received services from Dr. Fawcett.

I also agree to pay Dr. Fawcett all amounts owed for service provided by him should my insurance company not fully reimburse him for his services. Such amounts include but are not limited to: co-pays, deductibles, co-insurance (the percentage not covered as shown above), or services not covered for any reason, **including fees associated with "no shows" or late cancellations**. If such payment is more than 30 days late, I authorize Dr. Fawcett to charge the remaining balance to my credit card on file.

In the event that Dr. Fawcett is not a contracted provider with my insurance company, I understand that I will be responsible for attaining reimbursement for the costs of therapy, unless other arrangements have been made in advance. I also understand that I am responsible for paying the full fee at the time of service and that, if requested, I will be provided with a monthly "superbill" to submit to my insurance provider for reimbursement.

_____ _____

Signature (Parent or guardian for a minor) Date

3604 Fourth Avenue, Suite #5 . San Diego, CA 92103
Phone: (619) 356-0811 . Email: drkevinfawcett@gmail.com . Web: www.drkevinfawcett.com