Christina H. Rasmussen, Ph.D.

PATIENT INFORMATION

Last Name_____ First _____ Middle _____

_____Male _____ Female Date of Birth_____ SS#_____

Address _____City_____ St_____ Zip_____

Home Phone (____)_____ Cell Phone (____)_____Email_____

Employer_____ Address _____

City _____St_____ Zip_____ Phone_____ Ext#_____

Referred by:_____

Primary Care Physician_____Phone:_____

Current Medications:_____

Emergency Contact:_____Phone:_____

PRIMARY INSURANCE INFORMATION

Insured subscriber_____Relation to Insured_____

Date of birth of the Insured subscriber_____

Insurance _____ Insurance Phone# _____

ID# _____ GROUP#_____ Employer: _____

SECONDARY INSURANCE INFORMATION

Insured subscriber_____Relation to Insured_____

Date of birth of the Insured subscriber_____

Insurance _____ Insurance Phone# _____

ID# _____ GROUP#_____ Employer: _____

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was created by the U.S. Congress to increase the privacy of individuals' personal health information. It affects all those who are in contact with medical records or personal health information. For a detailed copy of our HIPAA practices please see "Notice of Privacy Practices".

(please initial)_____ I have received a copy of the "Notice of Privacy Practices"

(please initial)_____ I understand that if I make an appointment and do not cancel that appointment 48 hours in advance, I will be charged for that missed appointment.

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Christina H. Rasmussen, Ph.D. all insurance benefits, if any, otherwise payable to me for services rendered. I authorize therapy necessary for treatment and agree to pay all fees and charges for such treatment if coverage is not available. I also authorize the release of any medical or other information necessary to process insurance claims related to treatment to Christina Rasmussen's private medical billing company PUGET SOUND MEDICAL BILLING AND CONSULTING.

_____ _____

Signature (Parent or Guardian, if applicable) Date

7919 42nd Street West; University Place, WA 98466 Phone: 253-906-1906 Fax: 253-582-5693

Christina H. Rasmussen, Ph.D.
Licensed Psychologist

FORENSIC INFORMED CONSENT CONTRACT

This Forensic Psychological Evaluation is being conducted at the request of

Department of Social and Health Services, Division of Children and Family Services

and is therefore somewhat different than other psychological services. It is important for you to understand how a forensic evaluation differs from more tradition psychological evaluations.

While the results of this evaluation may or may not be helpful to you personally, the goal of this evaluation is to provide information about how you are functioning psychologically to the individual or agency requesting the evaluation.

In most cases, this evaluation is intended for use in some type of a legal proceeding. As such, the confidentiality of the evaluation and the results is determined by the rules of that legal system. If your attorney has requested this evaluation, he/she will receive a copy of my report and will control how it is to be used and who has access to it.

Normally, the results of this evaluation are protected by the attorney-client privilege. Exceptions to this might include a determination on my part that you are dangerous to another person or if you reveal information that a child under the age of **18 years** has been abused. I would also have to release this information if a court orders me to do so. There may be other examples where the laws require me to release the information obtained during the evaluation. We will discuss these situations on a case-by-case basis.

Once a decision has been made to use the report in a legal proceeding, the report and any information pertaining to it will probably be admissible into evidence as well as any other information that was provided concerning your mental health and functioning. If you have any concerns about the use or distribution of my report, you should discuss these issues carefully with your attorney.

If someone other than your attorney requested the evaluation, that individual is my client and he/she has complete authority over the results, including whether or not any information will be released to you or to anyone else. In addition, because the evaluation was requested by another party, and is not for the purpose of treatment or counseling, the confidentiality may have fewer legal protections. I will not release the information unless instructed to do so by the person or entity that hired me or when I am legally required to do so.

Your participation in this evaluation is voluntary. I will not conduct the evaluation without your signature on this document. You also have the right to stop the evaluation at any time. There may be legal consequences if you stop the evaluation; therefore, it would be in your best interest to consult with an attorney before doing so. In addition, if

appointments are not kept or are cancelled within **48** hours of the appointment time, the person requesting the evaluation will incur charges for the unused time that has been set aside for these services.

The evaluation itself consists of three separate parts: an oral interview, psychological testing, and observations with you and your child(ren). In addition, it may be necessary for me to review other related materials such as court records, depositions, transcripts, medical records, etc.

If, at any time, you have a question about any aspect of the evaluation or these procedures, pleased feel free to ask me. In addition, if at any time you need a break from the evaluation, please let me know and we will stop. Once the evaluation is completed, and with the permission of the requesting party, I may be able to have a meeting with you to explain the results and answer any questions you might have.

I have read and agree to the above: _____

Date: _____

WASHINGTON 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. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

"***PHI***" refers to information in your health record that could identify you.

"***Treatment, Payment and Health Care Operations***"

- ***Treatment*** is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
- ***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*** are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

"***Use***" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"***Disclosure***" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

Initials_____

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. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care 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 all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

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: If I have reasonable cause to believe that a child has suffered abuse or neglect, I am required by law to report it to the proper law enforcement agency or the Washington Department of Social and Health Services.

Adult and Domestic Abuse: If I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, I must immediately report the abuse to the Washington Department of Social and Health Services. If I have reason to suspect that sexual or physical assault has occurred, I must immediately report to the appropriate law enforcement agency and to the Department of Social and Health Services.

Health Oversight: If the Washington Examining Board of Psychology subpoenas me as part of its investigations, hearings or proceedings relating to the discipline, issuance or denial of licensure of state licensed psychologists, I must comply with its orders. This could include disclosing your relevant mental health information.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided to you and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a

subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety: I may disclose your confidential mental health information to any person without authorization if I reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.

Worker's Compensation: If you file a worker's compensation claim, with certain exceptions, I must make available, at any stage of the proceedings, all mental health information in my possession relevant to that particular injury in the opinion of the Washington Department of Labor and Industries, to your employer, your representative, and the Department of Labor and Industries upon request.

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 and psychotherapy notes 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.

Initials_____

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 post a revised notice in my waiting area and supply copies of the revised notice to patients upon request. In addition, current patients will be asked to read and sign a revised notice.

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 Dr. Rasmussen at (253) 906-1906

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to Dr. Rasmussen at 7919 42nd Street West; University Place, WA 98466

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

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

I acknowledge receipt of this notice

Patient Name_____ Date_____

Signature of Patient (or legal guardian if patient is a minor)_____

Professional Profile

Christina H. Rasmussen, Ph.D., is a licensed clinical psychologist in private practice, specializing in health psychology as well as maintaining a general clinical practice. Dr. Rasmussen has experience working with adults, children, and adolescents. She is also experienced in providing intellectual and personality assessments as well as child custody and forensic evaluations.

The primary focus of psychotherapy is to help the patient learn about her or himself, in an effort to understand and accept oneself and learn to identify and change thoughts and behaviours contributing to symptoms. Dr. Rasmussen generally uses a self-psychology or analytical approach geared toward identifying the origin of the presenting symptoms. For illness related issues and where appropriate, Dr. Rasmussen also uses imagery and dream interpretation in identifying and working through the psychological issues related to specific symptoms.

Dr. Rasmussen has facilitated numerous workshops and presentations on stress management, mind-body issues, anxiety and depression management and other areas of interest since 1991.

Dr. Rasmussen completed her doctoral degree in Clinical Psychology with an emphasis in Health Psychology from the California School of Professional Psychology, a program approved by the American Psychological Association (APA). She completed internship training at Washington State University, Pullman.

Dr. Rasmussen is a member of the APA, Washington State Psychological Association, California Psychological Association, and San Joaquin Psychological Association. She is a preferred provider for various health maintenance and managed care organizations in the Puget Sound area. Dr. Rasmussen has published several research articles in the area of Death Anxiety. Her teaching experience includes being an adjunct faculty member at the Washington School of Professional Psychology in Seattle, the California School of Professional Psychology and National University both in Fresno, California and currently the University of Washington where she teaches psychology courses.

Dr. Rasmussen adheres to the professional ethical standards established by the American Psychological Association. If you have any questions about the ethics and laws pertaining to the practice of psychology you can contact Dr. Rasmussen directly, or contact the Washington State Psychological Association at (800) 275-9772.