

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

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.

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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

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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.

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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) _____

Christina H. Rasmussen, Ph.D
License # PY 2478
4919 42nd St. West
University Place, WA 98466
(253) 906-1906

Financial Agreement

I agree to be financially responsible for all fees associated with services rendered to the patient named below. The fees for services are as follows:

- Initial visit.....\$250
- 50 minute session.....\$155
- 25 minute session.....\$ 77.50
- Forensic service (in office).....\$250
- Forensic services (all depositions and all out of office forensic services) per hour.....\$250
- Child custody/Psychological evaluation (50 minutes).....\$250
- Group psychotherapy 50 minutes.....\$ 75
- Group psychotherapy 75 minutes.....\$ 150

I understand that services are payable when rendered unless specific exceptions are made in advance. It is understood that payment will be made by the 10th of the month for services rendered during the previous month. A finance charge comprised of a periodic rate of 1.5% per month on the unpaid balance for an annual percentage rate of 18% will be charged if the account is not paid within 30 days from the date services are rendered.

Should a delinquent account be referred for collection, I agree to pay all fees and expenses incurred in the collection of debts including but not limited to attorney and court fees. There will be a \$40 charge on any returned checks. There is a full charge for missed appointments not cancelled **48 hours** in advance. The telephone answering service will accept cancellations during non-office hours, seven days per week, 24 hours per day.

It is further understood that I intend to pay any and all charges incurred for services and that there is a reasonable probability that I will be able to meet the financial obligations noted herein. (Statement required by Robbins-Rosenthal Fair Debt Collection Finances Act). I agree to notify you of any change in my employment, name, address, or telephone number.

Patient's Name	Date	Responsible Person's Address (If different from patient's)
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Patient's signature (parent or guardian if patient is a minor)	Witness	Date
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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.