

QUALIFICATIONS OF THERAPIST

Please take this time to note the following, which has been documented to better acquaint you with Ira Dressner's background, as well as assist you in understanding your professional relationship.

Ira Dressner, LCSW is a Licensed Clinical Social Worker. He is a graduate of the New York University School of Social Work.

His focus is:

1. Working with emotional and physical trauma using EMDR.
2. Working with couples to enhance their communication skills and intimacy.
3. Working with high school and college students who may have ADHD, depression, and academic and social challenges.
4. Working with people who have addictions and are in 12 Step programs and Recovery.
5. Working with families; parents and their high school and college level children.

After finishing social work school he went for advanced training at the Washington Square Institute and was awarded a Certificate in Psychoanalytic Psychotherapy. He was trained in EMDR in 1997 and has used that therapeutic technique very effectively in his practice.

His passion is that traumas from the past be replaced with a life of happiness, connection, and purpose.

EMERGENCY CONTACT

If you have an emergency after regular office hours please call me at 1-917-841-9393. If I am not available, you can call the Maricopa County Crisis Line at 602-222-9444, or any other hospital of your choice. If it is a life threatening emergency, call 911.

CLIENT RIGHTS

- You have the right to decide not to receive counseling from me. If you wish, I can provide you with the names of other qualified therapists.
- You have the right to end therapy at any time.
- You have the right to ask questions about the procedures used during therapy.
- You have the right to ask questions about the counseling techniques and to prevent the use of certain therapeutic techniques if you feel uncertain of them.
- You have the right to participate in setting goals and evaluating progress toward meeting them.
- You have the right to have all that you say treated confidentially and be informed of the state laws placing limitations on confidentiality in the counseling relationship. Under certain circumstances, I may be required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required to inform you of my actions in this regard. These situations are as follows: (a) If you threaten grave bodily harm or death to self or another person, I am required by law to inform the intended victim and appropriate law enforcement agencies; (b) If a court of law issues a subpoena; (c) If you have given me information concerning non-accidental injury and neglect to minors or incompetent adults.

(CONTINUED ON NEXT PAGE)

CLIENT RESPONSIBILITIES

- Set and keep appointments with your therapist. Appointments scheduled and **cancelled without at least 24-hour notice are subject to full charge.**
- Pay your fees in accordance with the arrangement you have pre-established with your therapist.
- Help plan your therapy goals.
- Keep me informed of your progress toward meeting your goals.
- Inform me of any problems you have which may have an effect on your progress or which may be potentially harmful to yourself or others.

RISKS AND BENEFITS OF THERAPY

Psychotherapy may involve the risk of remembering unpleasant events and can arouse intense emotions of fear, anger, anxiety, depression, frustration, loneliness or helplessness.

The benefits from therapy may be that you will be better able to handle or cope with your family or other social relationships, thus experiencing more satisfaction from those relationships. Another possible benefit may be a better understanding of your personal goals and values; this may lead to a greater maturity and growth as a person.

You should know that a therapist is not a physician and cannot prescribe medication or perform any medical procedures. If medical treatment is indicated, I will recommend a physician for you, or you can choose any physician whom you wish to see.

You should also understand that I cannot guarantee that the goals of therapy will be attained; however, I will offer to do my part as your therapist to apply all the knowledge and resources that I have to help you attain your therapy goals.

If you have any questions or concerns about anything that occurs in this office, please let me know. My main objective is to provide you with productive visits.

By my signature below, I consent to receive therapy from Ira Dressner and acknowledge that I have read the above information and understand it.

Client's Signature

Date

Family Psychology Associates

14045 North 7th Street Suite 4 Phoenix, Arizona 85022 Phone 602.993.4595 Fax 602.993.7440

Pat Huish, Ph.D. | Joalene Whitmer, M.C., LPC | Mary DeGuilio, M.C., LPC
Ira Dressner, LCSW | Liana Dressner, LCSW

SECTION A - CLIENT OR GUARDIAN of MINOR INFORMATION:

If treatment is for a minor, the legal guardian should complete Section A with his/her information and put an * next to the child's name in Section B.

Today's Date: _____

Male Female

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Date of Birth: _____ Age: _____ Birthplace: _____ SS #: _____

Street Address: _____ Apt# _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Education(years): _____ E-mail address: _____

Employer: _____

SPOUSE INFORMATION:

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Date of Birth: _____ Age: _____ Birthplace: _____ SS #: _____

Street Address: _____ Apt# _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Education: (years) _____ E-mail address: _____

Employer: _____

Marital Status: Married Single Divorced Widowed Separated

Date of Marriage(s) _____ Date of Divorce(s) _____

SECTION B - CHILDREN: (if a child is the client please put * by each child's name)

NAME	BIRTH DATE	AGE	LIVING WITH YOU	GRADE	SCHOOL

SECTION C - ADDITIONAL INFORMATION:

Emergency Contact Person: Full name _____ Phone # _____

Address: _____

Family Physician: _____ Phone # _____

Religious Preference (if any): _____

HISTORY:

List any medications patient is currently taking: _____

What is the reason for this visit? (Chief Complaint):

What do you wish to change or accomplish by seeking counseling at this time?

Are you or have you ever been suicidal? YES NO

Have you ever been in therapy before? YES NO

If yes, please state where and when:

Do you drink alcoholic beverages? YES NO

If so, how much per week? _____

Have you ever been told you have a drinking problem? YES NO

If so, by whom? _____

Are you or have you ever been treated for any mental illnesses? YES NO

If yes, please explain: _____

Are you presently in good general health? YES NO

Are you currently being treated for any physical illnesses? YES NO

If yes, please explain: _____

Do you have any family history of the following mental or emotional challenges?
___Depression ___Schizophrenia ___Anxiety ___Anger ___Phobias

Comments: _____

Is there anything else you feel is necessary for the practitioner to know regarding your situation?

CONTACT INFORMATION:

Occasionally we may have a need to contact you outside your office visits. Please check the boxes of the ways we may contact you:

- Home Phone Cell Phone Work Phone Email

Permission to leave a message (with name): _____

Do **NOT** leave a message at: _____

Explain _____

PRIMARY INSURANCE

It is important that you call your insurance to verify the details of your “**out-patient behavioral health**” coverage. Sometimes, the coverage details are different than medical coverage. Since any charges not covered by your insurance are your responsibility, we strongly recommend that you call your insurance company prior to your first visit to ensure that the information you enter below is complete and accurate.

If you are not using insurance, please write “no insurance” below.

Patient's name: _____ Policy Holder's Name: _____

Patient's Relationship to Policy Holder: _____

Insurance Company Name: _____

Employer: _____

Member ID #: _____ Group #: _____

Phone #: _____

Is this provider covered as an “**in-network**” provider or as an “**out-of-network**” provider?: _____

What is your Deductible?: _____ Is the Deductible met?: _____

How many visits are allowed per year?: _____

What is your Co-Pay / Co-insurance?: _____

Is an Authorization needed?: _____ Obtained?: _____ Authorization Number: _____

Number of sessions authorized: _____

Billing Address for claims: _____

I authorize the release of any necessary information to my insurance carrier or other agent preparing claims for payment of my office charges. I also request and authorize payment of benefits be paid directly to the counselor or party who accepts assignment/participates. If assignment is not accepted, I understand that I am responsible for the full amount charged for services. I understand I am responsible for paying my deductible and the portion of each session not covered by my insurance.

Client (or Responsible Party) Signature: _____ **Date:** _____

IMPORTANT INFORMATION CONCERNING INSURANCE

If you have insurance, we will help you receive maximum benefits available through your insurance. However, we cannot guarantee coverage or payment. Benefits and descriptions of coverage are provided as a courtesy only and we cannot guarantee their accuracy. The benefits are an agreement between the employer group (or individual party) and the health benefit firm that administers the policy – *we are not a party to this contract*. Submitting insurance claims is a courtesy that we extend to our clients - all charges are your responsibility from the date of service.

You are responsible for your deductible and co-pays/co-insurance not covered by your insurance. These payments are due at the time of your visit.

Communication is essential. If any of the above policies are unclear to you, please direct your inquiries to the office manager. Your satisfaction is very important to us! If you feel that there are extenuating circumstances in your case, please immediately bring these to the attention of our office manager. If you don't tell us, we won't know.

I certify that I have read and do understand these policies. Furthermore, I understand that I do assume full financial responsibility for my care should my insurance carrier decline payment for services rendered at Family Psychology Associates.

Client (or Responsible Party) Signature: _____ **Date:** _____

FINANCIAL POLICY

Please initial each of the following and sign at the bottom of this page.

If you are using insurance:

____ I agree to give accurate and complete insurance information or pay the full session fee at the time of service.

____ I understand that payment of copays, coinsurance, and deductibles are due at the time services are rendered. (unless other arrangements have been made with our office)

____ I understand that if my insurance requires a prior authorization, I am responsible for obtaining the prior authorization.

If you are NOT using insurance:

____ I understand that full payment is due at the time services are rendered. (unless other arrangements have been made with our office)

All Clients:

____ I understand that a late fee of \$25 will be applied to all charges that have not been paid within 30 days.

____ I understand that an additional late fee of \$40 will be applied to all charges that have not been paid within 60 days.

____ I understand that any account greater than 60 days delinquent may be turned over to a licensed collection agency without notice and any legal, attorney, and collection agency fees incurred in collection of outstanding accounts will be assessed against the delinquent account and are the client's responsibility.

____ I understand that I am required to give at least 24 hours notice to cancel an appointment. If I fail to give sufficient notice, I will pay the Late Cancel/Missed Appointment Fee of \$80 for the session.

X _____
SIGNATURE OF CLIENT AND/OR RESPONSIBLE PARTY DATE

X _____
PRINT NAME

NOTICE OF PRIVACY PRACTICES
FAMILY PSYCHOLOGY ASSOCIATES

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.

Why we are providing you with this notice:

We are required by the Federal Law known as the Health Insurance Portability and Accountability Act (HIPAA) to give you this Notice. This Notice will tell you about the ways in which we may use and disclose health information about you and will describe your rights and our obligations regarding the use and disclosure of that information.

Your Health Insurance:

This Notice applies to the information and records we have about your health, health status, and the health care services you receive from Family Psychology Associates. This information and records relate primarily to counseling services you receive from us.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

FOR TREATMENT.

We may use or disclose health information about you to facilitate counseling and other health treatment. For example, your counselor might disclose information about you to another Family Psychology Associates counselor so that the counselor can determine the most appropriate care for you.

FOR PAYMENT:

We may use and disclose health information about you in order to be paid for the services rendered to you. This may include contacting your health insurer to determine the existence of insurance coverage for services you receive, sending copies or excerpts of your health information to your health insurer to receive payment, and using your health information for our own internal management of the billing process. By way of example a bill sent to your insurance company may include information that identifies you and the procedures used to provide services to you.

APPOINTMENT REMINDERS AND TREATMENT ALTERNATIVES:

We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards, or letters) or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

FOR HEALTH CARE OPERATIONS:

We may use and disclose health information about you in order to run our office and make sure that you and our other clients receive quality care. For example, we may use your health information to evaluate the performance of our staff or to contact you to remind you of your appointments.

Please notify us in writing if you do not want us to contact you to remind you of your appointments.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION.

Except where otherwise required or authorized by law, we will not use or disclose your health information for any purpose without your written authorization. If you authorize us to use or disclose health information about you, you may revoke your authorization, in writing, at anytime. If you revoke your authorization, we will no longer use or disclose your health information for the reasons covered by your written authorization, but we cannot take back any uses or disclosures we have already made with your permission

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

- You have the following rights with regard to your health information:
- You may inspect and copy your health information with certain exceptions.
- If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information.
- You may obtain an accounting of our disclosures of your health information. This is a list of all of our disclosures of your health information for purposes other than treatment, payment and health care operations.
- You have the right to request that we restrict or limit our use or disclosure of your health information to only treatment, payment or health care operations. We are not required to comply with your request.
- You may request that we communicate with you about your health matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, work, or by mail.

If you want to exercise any of these rights, please contact the Director, in writing at the office where you are receiving counseling.

PERSONS INVOLVED IN CARE:

We may use or disclose health information to notify information of (including or locating) a family member, your personal representative or another person responsible for assisting you to obtain healthcare services. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event you become incapacitated, or during an emergency, we may disclose your health information to others, including healthcare providers, on the basis of our professional judgment. We will also use our professional judgment and our experience with common practice to make reasonable inferences in your best interests.

REQUIRED BY LAW:

We may use or disclose your health information when we are required to do so by law, including disclosures for use in judicial and administrative proceedings, or to law enforcement officials, or to the proper authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

CHANGES TO THIS NOTICE

We have the right to change this notice. If we do so, the new notice will apply to the health information we may already have about you and to the health information which we receive in the future. We are required to abide by the most current notice that is in effect. We will post a summary of the most current notice in our office. You are entitled to receive a copy of the most current notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Family Psychology Associates, please contact, Pat C. Huish, Ph.D., Director, 602-993-4595. You will not be penalized for filing a complaint. All complaints must be submitted in writing.

You have the right to receive a paper copy of this notice.

This notice is effective April 14, 2003.

Family Psychology Associates

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Family Psychology Associates, concerning how the use or disclosure of Protected Health Information will be handled by the practice.

Date: _____

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Description of Personal Representative Authority

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CONSENT FOR TREATMENT OF A MINOR:

If treatment is for a minor, please also complete this consent form. This form must be completed by **BOTH** parents of the minor. If this is not possible, you must call our office before your appointment to let us know.

I, _____, hereby grant Family Psychology Associates permission to provide outpatient behavioral services to my child, _____.

I understand that any information given to Family Psychology Associates will not be shared with anyone without written permission, except where required by law (for example: danger to self, or others, or suspected child abuse). I have been informed of my rights as a patient of Family Psychology Associates. I understand I may withdraw my consent at any time by notifying Family Psychology Associates in writing.

Date: _____

Signature of First Parent / Legal Guardian of Minor

Date: _____

Signature of Second Parent / Legal Guardian of Minor