Lisa Strohman JD, PhD
8757 East Bell Road
Scottsdale, AZ 85260
480.650.1720 Cell

Private & confidential - Patient information

Today's date _____

Name (Last, First, Middle Initial) _____

Birth date _____-_____-_____ Age ____ Gender ____M____F Patient SS#_____-_____-_____

Address _____ City_____ State____ Zip_____

Home Telephone (_____)_____ Work Telephone (_____)_____

Cell Phone (_____)_____ E-Mail _____

Marital Status: ____married _____Single _____ widowed_____ Divorced_____ Separated ____#of years

Name of Spouse / significant other / Parent / Guardian: _____

May we contact them if necessary? _____

Your occupation _____

Referred by _____ Phone (_____)_____

Address _____ City_____ State____ Zip_____

May we be in contact with the referral source? ___Y ___N

Emergency Contact _____ Relationship _____

Telephone (_____)_____ Other Telephone (_____)_____

Child of divorce ___Y ___N Custody status _____

Has the patient had previous psychological care? ___Y ___N

If yes, please select one: _____Inpatient care _____Outpatient care

Family Members/others Now in Household:

Name	Relationship	DOB/Age	Birthplace	Occupation	Marital Status

Children living away from home?

Original Family Members:

Name	Relationship	DOB/Age	Birthplace	Occupation	Marital Status

Please provide the following information about your general health and your health history. Please Circle P for personal health history. Circle F for areas of family history.

P F Alcohol use/Drug use
P F Allergies: pollen, dust, animals
P F Allergies: medications
P F Asthma, Bronchitis
P F Arthritis, Gout
P F Eating disorder: anorexia, bulimia
P F Bone/joint condition
P F Back, neck, spine, disc problem or injury
P F Birth defects/ Deformity
P F Blood disease: anemia, leukemia
P F Blood vessel, circulation disorder
P F Breast disease
P F Breast implants (L/R)
P F Broken bones/ bone disease
P F Cancer of any type
P F Concussion/head injury
P F Diabetes
P F Ear/Nose/Throat disease or infection
P F Epilepsy/seizure disorder, convulsions
P F Hysterectomy
P F Female organ irregularity, abnormal Pap, menstrual
P F Gallbladder
P F Heart problem or condition
P F Hepatitis/liver disorder
P F Hernia
P F Hypertension, blood pressure disorder
P F Hormonal/Thyroid/Pituitary disorder
P F HIV/Aids
P F Immune system disorder, Lupus
P F Stomach/ colon/ Crohn's disease
P F Intestinal disorders
P F Kidney/Urinary tract condition or infection
P F Lung condition or infection
P F Male organ irregularity or condition: prostate, impotence
P F Nervous system conditions
P F Mental: nervous, depression, anxiety
P F Migraines/Headaches
P F Muscle/Tendon disorders
P F Prosthetic implant/ artificial limbs
P F Reconstructive/Cosmetic surgery
P F Sexually transmitted diseases
P F Skin disorders/lesions/cancer
P F Steroid use: Prednisone, anabolic
P F Stroke
P F Tumors, cysts, polyps, growths
P F Ulcers, digestive disorders
P F Weight problems

Has there been any family psychiatric history? _____

_____

_____

_____

Current & Past Medications (please indicate by circling past or current med)

C	P		C	P		C	P	
C	P		C	P		C	P	
C	P		C	P		C	P	
C	P		C	P		C	P	
C	P		C	P		C	P	

Have you ever been hospitalized? If yes, please state when, where, why: _____

_____

Have you ever had surgery? If yes, please state type of surgery and when, where, why: _____

_____

_____

Please check any of the following areas that you have experienced:

[ ] Head Injury [ ] Loss of consciousness [ ] Seizures [ ] convulsions [ ] other neurological diagnosis

Please briefly describe your family when you were growing up: _____

_____

_____

_____

Please list any events from your childhood / or adulthood that has had a profound effect on your life: _____

_____

_____

_____

Highest grade completed _____ Degree _____ Where _____

How many hours a week are you employed? _____

How often do you spend time with others? _____

Please show history of substance abuse:

	Current	Past		Current	Past
Alcohol			Hypnotics		
Tobacco			Diet pills		
Caffeine (tea, coffee, soda)			Narcotics / Pain		
Cocaine			Nerve pills		
Marijuana			Sleeping pills		
Stimulants			Others (specify)		

For Child /Adolescent Patient

At what age did problems begin? _____

Does the child get along with siblings? _____

Describe any difficulties the child has at school _____

Has the child been held back any grades? Y N

Has the child been in special classes? Y N

Has any psychological testing been done at school? _____

Has your child ever been in trouble with the law? Y N

If so, please describe: _____

Has your child been in trouble for drugs or alcohol use? Y N

Did either parent experience similar conditions as children? Y N

_____

Besides the above condition has your child ever behaved in a way that seemed especially unusual or different? _____

_____

_____

_____

Developmental

Describe any problems mother had during pregnancy and difficulties during delivery: _____

Birth Weight: _____ Oxygen: Y N Incubator: Y N

Blood Transfusions: Y N

Abnormalities: _____

When were the developmental milestones met?

Verbal: _____ Motor: _____

Other: _____

Psychologist- Patient Agreement

This agreement has been prepared to help Dr. Strohman's patients understand how the business office operates with respect to the psychologist-patient relationship. Please read all of the information contained in this agreement and indicate your confirmation by signing this document.

- *All payments are due at the time of service. We provide you with a "superbill", which is a receipt that functions as a claim and can be sent in with a copy of your insurance card for re-imbursement.*
- *There is a 24 hour cancellation policy for appointments. The full session fee for the appointment will be charged if not cancelled 24 hrs ahead.*
- *We do send confirmation emails as a courtesy to our patients. However, we are not always able to reach you. Confirmation emails are only a courtesy. Please keep track of your own appointments.*
- *Sessions are 50 mins. Telephone time and extending the session beyond 50 mins will be charged accordingly.*

Please Initial _____

Confidentiality Policy

All patient records will remain confidential unless otherwise instructed in writing by the patient, if subpoenaed by a court of law, if the patient presents a physical danger to self or others, or child/elder abuse/neglect is suspected.

Health Insurance Plans

Dr. Strohman is not contracted with any insurance companies. Patients may elect to file claims individually. A Super Bill/receipt will be provided at the time of visit, providing the appropriate mechanism for patients to file the claim with their insurance plan.

The diagnosis and treatment information required on the claim form is often forwarded by the patient's insurance plan to the Medical Information Bureau (MIB). The patient's health history then becomes available to other insurance companies without the patient realizing he/she has given consent (usually in the fine print during the application process). Therefore, Dr. Strohman believes that the release of any diagnostic information through the claims filing process may present a potential risk that could be personally damaging to unknowing patients. Therefore, Dr. Strohman wants each patient to be aware of any potential risk of releasing medical information should an inappropriate party have access to the MIB national database.

Medicare Part B Entitlement Policy

Dr. Strohman will gladly treat patients over the age of 65, but she does not participate in the Medicare Part B program. Medicare eligible patients must sign a Waiver of Medicare Part B Entitlement, indicating that services provided in Dr. Strohman's office will not be claimed against the Medicare Part B Program, but instead is the patient's financial responsibility. Current laws require this waiver to be signed by Dr. Strohman and the patient.

Payment Policy & Terms

A $25.00 fee will be charged for any returned check. The patient agrees to pay all charges, in accordance with the Payment Policy outlined in this agreement. Should Dr. Strohman's office be forced to incur collection charges or legal fees, the patient agrees to pay them in full.

Termination Policy

Dr. Strohman reserves the right to terminate any patient who violates treatment protocol, is generally non-compliant, or who willfully disregards other treatment objectives that could support positive clinical outcomes.

Protocol for secure Storage, Transfer, and Access to Client Records on Termination of the Practice

In the event of my terminating my practice, I will notify active clients that they may locate me by calling me directly at a number provided to them by letter or direct verbal communication or by contacting the Arizona State Psychological Association or the Arizona State Board of Psychologist Examiners, who may contact me directly and convey the request. For reasons of personal privacy, I will only provide direct access to current or recent (six months) clients via providing them with telephonic contact numbers. I will maintain a professional telephonic contact number for a period of three to six months, depending on circumstances at the time of closing of my practice. Inactive clients may contact me via the Arizona Psychological Association or the Arizona State Board of Psychologist examiners.

I will maintain current contact information with the Arizona Psychological Association and the Arizona State Board of Psychologist examiners for the period of time required to maintain records. I will post two notices in the paper (two weeks apart) regarding the close of the practice and information for locating medical records.
I will respond in a timely manner to client requests for copies or access to their medical records. Unless prohibited by illness or temporary travel unavailability I will respond within 30 days or other legally or ethically responsible requirements. I will dispose of unclaimed records after the current legal and/or legally specified time requirements by destroying records so that no confidential information remains in usable form. In the event that circumstances require, I will forward record access and responsibility to another professional who will respond to record requests in accordance with legal and professional standards.

Patient Responsibilities

Each patient is responsible for providing accurate contact information as well as billing information. If telephone numbers and/or addresses change, patients must inform Dr. Strohman's business office. Furthermore, the patient understands that the examination and treatment provided by Dr. Strohman is limited to outpatient psychology services. This does not necessarily constitute total or definitive psychological care. Further evaluation and treatment may be required in some cases. It is the patient's responsibility to obtain follow up medical care for general health as needed, or when advised to do so by Dr. Strohman.

I have read, understand, and accept, the provisions of this agreement, and have no questions about the policies outlined herein. I understand that if I violate any provisions of this agreement, my treatment may be terminated. I understand that this agreement is binding in the State of Arizona and that the provisions are for my protection and for the protection of Dr.Strohman. The original copy of this agreement will become a part of my private medical record.

_____ _____

Patient/Guardian Signature Date

Lisa Strohman JD, PhD

8757 East Bell Road
Scottsdale, AZ 85260
480.650.1720

Medicare Opt Out Private Contract

• I Lisa Strohman JD, PhD have not been excluded from Medicare under [1128] §§1128, [1156] 1156 or [1892] 1892 of the Social Security Act. I, Lisa Strohman JD, PhD, have opted out of participating in Medicare as a provider.

• I the Medicare beneficiary or my legal representative accept full responsibility for payment of charges for all services furnished by Dr.Lisa Strohman.

• I the Medicare beneficiary or my legal representative understand that Medicare limits do not apply to what Dr. Lisa Strohman may charge for items or services furnished.

• I the Medicare beneficiary or my legal representative agree not to submit a claim to Medicare or to ask Dr. Lisa Strohman to submit a claim to Medicare.

• I the Medicare beneficiary or my legal representative understand that Medicare payment will not be made for any items or services furnished by Dr. Lisa Strohman that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

• I the Medicare beneficiary or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and that the I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

• The expected or known effective date and expected or known expiration date of the opt-out period is October 1, 2013 (effective date) and October 1, 2015 (expiration date).

• I the Medicare beneficiary or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

• This contract cannot be entered into by myself, the Medicare beneficiary, or by my legal representative during a time when I, the Medicare beneficiary, require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with §3044.28 of the Medicare Carriers Manual)

• I the Medicare beneficiary or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract.

• I Dr. Lisa Strohman will retain the original contract (original signatures of both parties required) for the duration of the opt-out period.

• I Dr. Lisa Strohman will supply CMS with a copy of this contract upon request.

• I Dr. Lisa Strohman understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

_____	_____
Medicare Beneficiary Name (Printed)	Medicare ID Number (On Card)
_____	_____
Beneficiary Signature	Date Signed
_____	_____
Lisa Strohman JD, PhD	Date Signed

Lisa Strohman JD, PhD
8757 East Bell Roas
Scottsdale, AZ 85260
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Authorization Form

This form when completed and signed by you, authorizes me to obtain protected information from and / or release protected information to the person you designate.

I _____, authorize my psychologist, Dr. Lisa Strohman and her administrative staff to release/ obtain:

____ My entire record
____ A summary of my treatment
____ Information via verbal contact

This information should only be released to / obtained from:

_____

_____

_____

I am requesting my psychologist to release / obtain this information for the following reasons:

____ At my request
____ Other: _____

This authorization shall remain in effect until _____ or until termination of treatment with Dr. Strohman.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.
I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date

_____ _____
If Minor, Legal Guardian Date

Lisa Strohman JD, PhD

ARIZONA NOTICE FORM/Privacy Policy

Notice of Psychologist's 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 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.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or 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 or 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, law provides the insurer the right to contest the claim under the policy.

I will also obtain an authorization from you before using or disclosing:

- PHI in a way that is not described in this Notice.
- Psychotherapy notes

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* – I am required to report PHI to the appropriate authorities when I have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.
- *Incapacitated Adult Domestic Abuse* – If I have the responsibility for the care of an incapacitated or vulnerable adult, I am required to disclose PHI when I have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.
- *Health Oversight Activities* – If the Arizona Board of Psychological Examiners is conducting an investigation, then I am required to disclose PHI upon receipt of a subpoena from the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative 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* – If you communicate to me an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and I believe you have the intent and ability to carry out such a threat, I have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If I believe there is an imminent risk that you will inflict serious harm on yourself, I may disclose information in order to protect you.
- *Worker's Compensation* – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

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. 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. On 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. 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 this notice from me upon request, even if you have agreed to receive the notice electronically.
- Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

- Right to Be Notified if There is a Breach of Your Unsecured PHI. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

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 notify you 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 480.285.7011

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:

10149 N 92nd St, Suite 103
Scottsdale, AZ 85258-4557

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

This notice will go into effect on June 15th, 2003.

Lisa Strohman JD, PhD.
8757 East Bell Road
Scottsdale, AZ 85260
480.650.1720

Child, Adolescent, Adult Psychotherapy

Acknowledgement of Receipt of Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

I, _____ acknowledge that I have received a copy of Dr. Lisa Strohman Notice of Privacy Practices.

This Notice describes how Dr.Lisa Strohman may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
Signature of patient or representative Date

_____
Relationship to patient