ABOUT DR. ROSENAK AND YOUR COUNSELING EXPERIENCE

My Counseling Philosophy

As your therapist, I try to provide a calming influence, and hope for your life. You will leave feeling understood and with a belief that there are things you can learn and do to change your life situation. If changes can't be made, I can help you move through your feelings and your grief to facilitate moving forward.

I provide my clients a warm and understanding atmosphere, combined with an intelligent response to your situation. I listen and teach my clients about subtle issues they may not have considered before.

If you desire, I often recommend books to read and assignments such as journaling to do while you are not in the therapy office, so that you can continue your growth process outside of our sessions.

My spiritual perspective is based in the Christian Faith and I am comfortable talking with you about your spiritual concerns and about your relationship with God if you wish, whatever your faith experience may be.

Confidentiality

All information given to me is to be kept confidential and will not be released except in extreme circumstances, such as when your own or another's life is endangered. If you are under-aged, know that I will communicate with your parents using my best clinical judgment to protect your well-being. Also, please be advised that I am a mandated reporter and am obligated to report child and elder abuse. Consultation with staff members of CPS KC will be will be utilized as needed to enhance the services you receive. If you wish me to discuss your case with an outside party, I will require your signature.

Finances and Payment of Fees

If you are a fee for service client, your fee is due at the time of service. If you are an insurance client, your copay or coinsurance is due at time of service. If you wish to pay for your therapy with your credit card, our system will securely hold your information for future payments.

My Cancellation Policy

I request a 24-hour notice for a cancellation of an appointment. If you cancel your appointment in less than 24 hours, you will be charged a $30.00 "no show" fee. Cancellations due to inclement weather or other major emergencies will not incur a charge, but I will need you to communicate with me about this; a simple phone message is best. Insurance companies cannot be charged for missed appointments.

Phone Calls and Other Services

It is my preference for you to bring your concerns to a regularly scheduled session. However, phone support is available to you. It cannot be billed to insurance. I will charge you in ten minute increments, at the rate of $1.00 per minute. I assume you are agreeable to this unless you state otherwise. Some services are also out of pocket expenses such as report writing, testing, preparation of records, treatment summaries, school visits, and court appearances. These will be charged to you at your request or if legally required.

About Your Therapist

Dr. Rosenak is competent to treat the following areas: marriage and family issues, adolescent issues, depression, anxiety and phobias, substance and process addictions, eating disorders, ADHD (also evaluations), trauma and sexual abuse, and sexual dysfunctions.

Charlotte has 39 years of experience in helping individuals and families in their struggles. She has also been an adjunct professor at Avila College, UMKC, and Mid-America Nazarene University.

Licensed in Kansas as a Clinical Psychologist and Counseling Psychologist. Ph.D., Counseling Psychology, University of Kansas. M.A., Pastoral Care and Counseling, Lincoln Christian Seminary. C.P.E, Hospital Chaplain, United Methodist Medical Center. A.B., Missions and Linguistics from Lincoln Christian College.

Published national works in the areas of Psychological Type (MBTI), Research Design in Psychology, Violence and Terrorism as a Human Problem, Homosexuality, Forgiveness, and the Integration of Psychology and Christianity.

Charlotte has been married for 40 years and has 3 grown children. She enjoys pets, travel, family, teaching, reading about philosophy, quantum physics, astronomy, alternative science, and alternative medicine.

Necessary Information

Name (First)__________________(Middle)_________________(Last)____________________
Date of Birth______________________Address______________________________________
City/State/Zip____

	Okay to Leave Message (voice/text)		
Mobile Phone_(____)____________	Yes	No	
Home Phone_(____)____________	Yes	No	
Work Phone_(____)____________	Yes	No	
Preferred Phone (Circle One Please)	Mobile	Home	Work

Email Address (write clearly please) ____
Okay to receive email appointment reminders? Yes No

__________ I have read the information "About Dr. Rosenak and Your Counseling Experience," and I agree to her policies.

Check One

__________ I will not be using insurance and my agreed upon fee is __________.
__________ I want to use my insurance. (If you choose insurance, fill out below.)

Dr. Rosenak will need a copy of your driver's license (picture ID) & your insurance card.

1. Please be aware of your financial responsibility. Check with your insurance company to know your benefits. Fill in the following (if you know for sure) If you don't know, my staff will call for you.

   Copay______________ Soc Sec # (Tricare only)_______________________
   OR
   Co-insurance______________ Deductible_______________________________

2. Who is the primary insurance holder? (circle one)
   Me my spouse my mother my father other

   *If you are not primary on insurance, name and DOB of primary holder*________________
   ____
3. Other information (i. e., EAP?) (authorization number?)
   _____________________________ Date of expiration_________________________
4. Primary Insurance Company ____
   Secondary Insurance Company ____
5. I give Dr. Rosenak permission to file with this company, to use administrative staff to communicate with my company and to receive payments from my company.

____________________________ ________________________
Signature Date

Information to Help Me Help You

Name__________________ Date / /

Who referred you to Dr. Rosenak?____

____

Briefly describe the most important problem you want to work on in counseling:___________

____

____

Describe your spirituality:____

____

____

My religious affiliation is: ____

Previous counseling/therapy/hospitalization for emotional problems: When_______________

Where:_________________________ With Whom:________________________________

For what problem____

On a scale of 1 to 5, how hopeful are you that therapy will help you resolve problems?

1	2	3	4	5
not hopeful	only a little	unsure	somewhat hopeful	very hopeful

Check any of the following which apply to you:

_______ 1 My marriage needs help.
_______ 2 I am having problems getting along with members of my family.
_______ 3 A recent or current divorce is affecting my life.
_______ 4 I have an outside relationship that is interfering with my marriage.
_______ 5 My spouse has an outside relationship that is interfering with my marriage.

_______ 7 I am having sexual difficulties with my spouse.
_______ 8 Premarital sexual activity is one of my counseling concerns.
_______ 9 My husband/wife physically abuses me.
_______ 10 There is/has been child abuse in my home.
_______ 11 Child custody is a concern.
_______ 12 My child has behavior problems.
_______ 13 I believe I am depressed.
_______ 14 I have poor self-esteem.
_______ 15 I am awkward socially.
_______ 16 I need more intimate friends.
_______ 17 I am confused about what career to pursue.
_______ 18 I have made an attempt in the past to take my life.
_______ 19 I have been knocked unconscious on one or more occasions.
_______ 20 I have problems with alcohol/drugs. (Circle which one.)
_______ 21 At least one of my family members has misused alcohol or drugs.
_______ 22 I have a problem with stress.
_______ 23 I have problems with food.
_______ 24 I have recently experienced a trauma such as rape, assault, or something else.
_______ 25 I have irrational fears.
_______ 26 I have emotionally-caused physical illnesses.
_______ 27 I fear that my problems are very deep and relate to my personality.
_______ 28 I hear voices and see things that aren't real.
_______ 29 I have unusual sexual problems.
_______ 30 I am very angry at a situation or person but I am expressing my anger indirectly.
_______ 31 I can't seem to get over a recent loss I have experienced.
_______ 32 I often have suicidal thoughts
_______ 33 I am confused about my sexual identity
_______ 34 My religion causes me to feel very guilty.
_______ 35 I have a physical illness that affects my well-being:

____

_______ 36 I want to enhance my athletic capabilities and/or performance level in:

____

_______ 37 There are other important aspects to my problem, not listed above.

____

_______ 38 I am on the following medications:

____

What do you hope your therapist can to do to help you?

____

____

____

(file: HIPAA NOTICE REV 5/1/03, 1/27/2017)
Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

1. 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 we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we 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 our 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 case coordination.
- *"Use"* applies only to activities within our practice such as sharing, employing applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of our practice, 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. When we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes that have been made about our conversation during a private, group, joint, or family counseling session, which have been 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) we 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.

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 we have reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse, we must report the matter to the appropriate authorities as required by law.
- *Adult and Domestic Abuse* – If we have reasonable cause to believe that an adult is being or has been abused, neglected or exploited and needs protective services, we must report this belief to the appropriate authorities as required by law.
- *Health Oversight Activities* – We may disclose PHI to the Kansas Behavioral Sciences Regulatory Board if necessary for a proceeding before 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 we provided you and/or the records thereof, such information is privileged under state law, and we 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. I may disclose your confidential information if I am defending myself in a law suit from you.
- *Serious Threat to Health or Safety* - If we believe that there is a substantial likelihood that you have threatened an identifiable person and that you are likely to act on that threat in the foreseeable future, we may disclose information in order to protect that individual. If we believe that you present an imminent risk of serious physical harm or death to yourself, we may disclose information in order to initiate hospitalization or to family members or others who might be able 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.

IV. Patient Rights and Therapist 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, we are 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 alternate locations. (For example, you may not want a family member to know that you are being seen at CPS. On your request, we 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 our mental health and billing records used to make decisions about you as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You generally have the right to obtain a paper copy of any notice upon receipt, even if you have agreed to receive the notice electronically.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, we 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 upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of our 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 we notify you of such changes, however, we are required to abide by the terms currently in effect.
- In order to file your insurance, I have the duty to you and the authorization from you to provide your diagnosis.

V. Electing Not to File with Insurance

If I elect to not use my insurance, I DO NOT GIVE permission for my insurance company or to the government to have access to my records.

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

I may limit the access, use, or disclosures that we will make to the following "reviewable denials:" If, in the exercise of professional judgment, we determine that access to the record is "reasonably likely to endanger the life or physical safety" of you or another person. If the requested information makes reference to another person (other than another health care provider), and in the of exercise professional judgment, we determine that access is "reasonably likely to cause substantial harm" to this other person. If a personal representative for you has requested access to the record, and in the exercise of professional judgment, we determine that such access is "reasonably likely to cause substantial harm" to you or another person.

I may limit the access, use, or disclosures that we will make to the following "unreviewable denials:" When access to psychotherapy notes are requested, when information is complied in reasonable anticipation of, or for use, in a legal or administration action or proceeding. When someone other than a health care provider provides information about the patient under a promise of confidentiality, and the access to the requested information would be reasonably likely to reveal the source of the information. This notice will go into effect on 2/1/17. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. I will provide you with a revised notice in person or by mail if there are substantial changes.

I acknowledge that I have been provided access to the HIPAA NOTICE of policies and practices to protect the privacy of your health information maintained by Dr. Charlotte Rosenak, Ph.D., LLC. I am entitled to a paper copy upon request.

____
Date

______________________________	______________________________
Client's Name (please print)	Representative's Name (please print)
______________________________	______________________________
Client's Signature	Representative's Signature

CHRISTIAN PSYCHOLOGICAL SERVICES
Continuity and Coordination of Care
Authorization and Release of Information

Coordination of care between and among your behavioral health care providers and primary care physician is important. We request that you authorize and consent to the exchange of health information between your health care providers. *Please indicate your wishes below:*

My name printed ______________________________ **Date of birth** ______________

_____ **I want** Christian Psychological Services to notify my primary care physician that I have initiated counseling and *I am willing to provide contact information for my physician below.* This consent will last for one year from the date signed, and I understand that I may revoke my consent at any time.

____ **I do not want** Christian Psychological Services to notify my primary care physician that I have begun counseling. *Skip the rest of this form and sign below.*

_____ **I do not have** a primary care physician. *Skip the rest of this form and sign below.*

Physician Name ____

Address ____

Telephone ______________________ **Fax** ______________________

Clinical Information to be Released to Physician

Dear Dr. ________________

The above named client was initially seen in counseling on: ____________________

The following provisional diagnosis was assigned: ____________________

Coordination of care issues/Other significant information impacting medical or behavioral health care:

____

____

Printed name of Therapist	Date	Signature

Client signature	Date	Witness	Date

If requested, date mailed or faxed to provider ______________________________

Special Information Necessary for Children and Adolescents

Father's name ______________________ Date of Birth ______________________

Address, City, St., Zip ______________________

Cell Number ____________ Home Number ____________ Business Number ____________

Father's Employer ______________________ Occupation ______________________

Employer's Address ______________________ City, St., Zip ______________________

Mother's name ______________________ Date of Birth ______________________

Address, City, St., Zip ______________________

Cell Number ____________ Home Number ____________ Business Number ____________

Mother's Employer ______________________ Occupation ______________________

Employer's Address ______________________ City, St., Zip ______________________

If you claim decisions regarding the child are yours alone to make, please provide explanation or attach documentation to support your sole legal authority in your divorce, separation, or guardianship. Otherwise, I will assume both parents have equal and joint legal authority to make decisions regarding the child. I will also assume that if only one adult communicates or participates in the therapy process, that the parent or guardian has the implicit consent of the other parent or guardian, unless you expressly indicate in writing.

1. Confidentiality in psychotherapy is often crucial to successful progress, therefore parents and guardians will be provided only general information about the child's treatment, results of formal assessments, and attendance at sessions.

2. The therapist may request written consent from parents or guardians to obtain information from other significant individuals (e.g., teachers, pediatricians) that might be useful in diagnosis and treatment.

3. Parents and guardians are asked to share with the therapist their concerns and observations of the child and participate in the child's treatment as requested by the therapist. Information brought to the therapist's attention by either parent regarding the child's welfare will not be regarded as confidential, and will be shared with the other parent. Information that is brought to the therapist's attention that is irrelevant to the child's welfare will be kept in confidence.

4. In cases of parental separation for divorce, all parents and guardians are requested to affirm to the child that the therapist is the child's helper, and is not allied with either parent.

5. The caregivers are requested to affirm to the child that the therapist has their permission to maintain confidentiality in regard to the child with limits in the following circumstances: **a.** The therapist's written records of all therapy contacts are confidential unless a judge requires (through court order) that the records be shared with attorneys or the court. **b.** Both parents understand that the therapist is legally and ethically obligated to protect the safety and health of all parties by describing any and all such concerns to relevant authorities. This obligation requires that the therapist has no discretion to discern the validity of the concern, and must report suspicion of abuse or potential abuse to social services. Whenever possible, when this necessity arises, the therapist will advise all parties of the concern, and of his/her intention to notify only relevant authorities as mandated by state laws.

6. In cases of divorce or separation, the therapist will not provide recommendations regarding child custody. The therapist strongly recommends that issues of child custody be addressed in mediation, or through an objective custody evaluation conducted by other professionals.

Your signature below signifies that you have read the requisites described above, understand the importance of each, and agree to accept and abide by all points to enhance your child's psychotherapy.

______________________ ______ ______________________ ______
Printed name of parent Date Printed name of parent Date

______________________ ______ ______________________ ______
Signature of parent Date Signature of parent Date

A Special Note for Couples

When couples present for therapy, I ask that you each fill out Intake Information. At the beginning of our session, we will discuss how records will be kept on each of you and how insurance and billing will be handled.

Thank you.