CAROL UMMEL LINDQUIST, PH.D., FACLINP
CLINICAL PSYCHOLOGIST

THE PSYCHOLOGY CENTER
380 GLENNEYRE SUITE D
LAGUNA BEACH, CA 92651

Dear New Client--

Welcome. I am looking forward to meeting with you for your first appointment. I love my work as a psychologist and look forward to helping you with whatever challenges you would like to explore and resolve. Directions to my office are located on my website: www.cullagunabeach.com .

There are some policies, procedures and disclosures that I may not fully review with you initially because I am most interested in understanding you and your concerns. To ensure you are fully informed, I felt writing them down would save time and avoid confusion. As a result, this document will act as an agreement between you and me. Please retain a copy of this agreement and please feel free to discuss any questions or concerns you have about these policies or any other matter at any time. I will gladly discuss any of these with you. As a potential consumer of psychological services, you are entitled to be fully informed. Of course, I will also bring up matters with you which seem to directly affect your particular concerns.

My view of psychotherapy is that you, as a client, are hiring me, as the therapist, to consult with you regarding growth issues or problems that significantly impact your life. Some of my clients view our relationship as coaching them to achieve their goals. One aspect of my practice is executive coaching for healthy people who wish to enhance their performance and communication in their profession or lives.

The goals of therapy and coaching are best set by both client and therapist together, so that our agendas in working together can be clear and most effective. With these goals in mind, a treatment plan will be developed using the latest psychological information available for helping you.

Legal & Ethical Statements

The following disclosure statements are to provide you with information concerning therapy, as well as the legal and ethical issues related to services provided by licensed psychologists in California, and any federal rules and regulations concerning you.

TYPE OF THERAPY: Many different kinds of psychotherapy are available to the consumer today. Although it is difficult to present a comprehensive statement of my therapy style and theory within the confines of this disclosure, I want to share some fundamental ideas with you. We can discuss these any time you wish.

Therapy is essentially a relationship between the client and the therapist. The client may be an individual, a couple or a family. The initial focus of the therapy is on understanding thoughts, emotions and life situations that concern the client. Therapy then offers the support, skills and directions that facilitate the client's desired changes.

As a client you have the ability to understand and implement change; you are responsible for deciding the ultimate course of action. Through a sequence of self-explorations, which include an investigation of your family history and a commitment to change personal behaviors, you learn more about yourself and the external factors that affect the quality of your life. You may find improved skills in the areas of communication, decision making, personal effectiveness, self-control and self-understanding. Formal and informal assessments, readings, structured experiences, journal writing, and "homework" are sometimes used to augment the therapy experience. You are in full control of what you want to accomplish in therapy, and we decide together what methods to use. It is most helpful, I find, if you are as open and honest as possible about what you choose to share.

If I feel you can best be helped by a therapeutic method different from my own scope of practice, I will discuss a referral with you.

My background statement and a more detailed therapy orientation are available on my website. I hope our work together will add significantly to your experience of wellbeing and achieving your goals.

RISKS AND BENEFITS OF THERAPY AND COACHING: The desired benefits are your improved ability to identify problematic areas, evaluate reasonable options and take action in an honest manner. A good therapy or coaching experience also offers opportunities to learn important things about one's self, to acquire helpful life management skills and to integrate both past and present learning toward higher functioning. The risks include the awareness of negative feelings and situations, some of which may not be changed to your satisfaction. Some awareness may cause emotional disability or disruption to your current life. The possible realization that therapy is helpful and desired, but beyond the limits of your financial resources is also a risk.

You may wonder if there are any guarantees in the light of the benefits and risks presented here. In short, while I expect that therapy will be helpful, there is no guarantee that therapy with me will be the best way to reach your desired goals. Because every therapeutic experience is unique, it varies from individual to individual. Therefore, it is vital that you feel free to discuss any concerns you have about the course of treatment with me at any time. As a client, you also have the right to seek a second opinion from another clinician. I encourage you to do so if you feel it may be beneficial.

RIGHTS OF CLIENTS: My practice is guided by the Ethical Code of the American Psychological Association. A copy of that code, as well as a discussion of clients' rights, is available online, see https://www.apa.org/ethics/code see also https://www.apa.org/topics/ethics/potential-violations. Sexual intimacy between client and therapist is never appropriate whether during or following a therapeutic relationship and here is the California Board of Behavioral Sciences pamphlet link on the issue: https://www.dca.ca.gov/publications/proftherapy.pdf. The State Board of Psychologists in Sacramento investigates reports of such behavior.

INDEPENDENT PRACTICE: While I am housed with The Psychology Center and enjoy the benefits and the stimulation of interaction with my very skilled peers, each practice, including mine, is completely independent. We are each separately responsible for our own policies and practices.

Therapeutic Policies

TREATMENT SESSIONS: Therapy sessions are usually held once a week for fifty minutes. Sessions are scheduled on a weekly basis until you and I mutually agree that a different time schedule is appropriate. If we decide EMDR therapy for trauma is an appropriate therapy for you, sessions are scheduled differently. After initial orientation session, EMDR therapy is usually scheduled for 90-minute sessions per week or every other week. Sometimes sessions are separated by a non-EMDR session to process changes that are occurring. Goals for therapy are determined within the first few sessions. These are periodically reviewed and refined. Termination occurs when both of us mutually agree that the goals have been satisfactorily addressed or there is some other reason to terminate. You have the right to terminate at any time; I ask that you discuss your concerns with me for at least one session or by telephone before you leave therapy.

THERAPY AND PHYSICAL SYMPTOMS: Physical symptoms are often the result of emotional stress. They can be reduced and even eliminated under certain therapy conditions. It is important, however, that an appropriate medical specialist review your current situation to ascertain the degree to which any symptoms have a physical basis. A physical exam is therefore required when any physical symptoms are a primary concern. If there is a physical problem that affects your therapy, I will work closely with your medical specialist (with your consent) to coordinate treatments and services. It is important for you to let me know if you have a persistent physical discomfort. I will discuss a referral to another specialist with you.

MEDICATIONS IN PSYCHOLOGICAL THERAPY: Depending on symptoms and problems, medications may or may not be appropriate. As a psychologist I am not licensed to prescribe medication. In the event a consideration for possible medications for psychological distress seems necessary, then I will refer you and assist you in obtaining a medical evaluation. It is your responsibility to inform me of any and all prescribed medications and changes in medications as they may significantly affect your mental status and therapy. It is also important that you are compliant with the course of treatment as prescribed by your physician. For some conditions however, therapy has been shown to be more effective than medications. I will inform you if I feel medications will affect or enhance your treatment.

LIMITATIONS AS A THERAPIST: Because I have family responsibilities, I do not do hospital work or severe substance abuse cases. If we feel you require these special services, I will refer you to another therapist, or to a program I trust that specializes in these areas. I will maintain contact with you and support you during that time as permitted by the new treatment professional.

CONFIDENTIALITY: The information presented in therapy is personal and confidential. Information is also legally protected. The only circumstances when information could be shared without your prior written and verbal permission are when there is a clear intention to do harm to yourself or to someone else. I also have a legal and ethical responsibility to notify appropriate social agencies of any suspicion of emotional, physical or sexual abuse or neglect of a child, a dependent disabled adult or an elderly person. Please note that if you initiate (or otherwise become involved in) a lawsuit, your mental status and all your records may become subject to court scrutiny. I will release information when your insurance company asks for routine

information if you have previously authorized it and when I receive a valid court subpoena. Even when I receive previously signed written authorizations for insurance purposes or regarding legal matters, I will contact you to discuss whether I feel releasing all or some of the information is in your best interest. It is my general policy to forward all information to you, for you to release to your Insurance Company or lawyer as you see fit. As required, I will respond to any subpoena directly, even if you receive a copy.

PROFESSIONAL WILL. In the unlikely event of my sudden inability to conduct my therapy practice, I have a professional will. The provisions will be carried out by one of a set of highly competent and trusted professional colleagues. They will use my secure database of clients to contact anyone who has seen me in a professional capacity in the previous 7 years. You will be given a chance to talk about what has happened and will be offered one or more referrals if you desire. By signing this agreement, you are agreeing to have your name released to a trusted professional psychologist for this purpose.

PRIVACY AND VISIBILITY: Laguna Beach is a small town which can present some challenges to maintaining privacy for those receiving professional services. While unlikely, it is possible that you will recognize someone or be recognized by someone in the waiting room of the office. If you know someone who sees me and you don't want to cross paths, please let me or my staff know. I ask all my clients to maintain their privacy and the privacy of others in and out of the office. Of course, I will maintain the confidentiality of all parties at all times. I also live in Laguna Beach, and you may encounter me accidentally or in a planned or expected manner in the community. Unless you tell me otherwise, I will neither acknowledge you in the community first, nor will I acknowledge working with you without your permission. If I act like I don't see you, I probably don't. Please remember I am practically blind at a short distance. Please feel free to discuss any concerns you might have about this with me.

ORIENTATION AND CONFIDENTIALITY IN COUPLE, AND/OR FAMILY THERAPY: My orientation to family and marriage therapy is that children and individuals do better when the family remains intact except in cases of domestic violence or child abuse. When I treat you whether as part of a couple or family group, no information is released to outside parties without the written consent of <u>all</u> parties present. Minor children (when appropriate) will also be asked for their consent. When we meet in individual sessions in the context of family therapy, no information is shared with other members of the family unless that individual (even a minor child) shares it himself/herself or indicates a willingness for me to share. It will not be shared unless their disclosure suggests they are putting themselves or others in grave danger. Even then I will discuss any disclosure prior to making it, if possible. Again, you are agreeing to this procedure when you sign this agreement.

REQUESTS FOR INFORMATION: Insurance companies (including health maintenance organizations and preferred provider organizations) sometimes require extensive documentation of your diagnosis, treatment plans and progress. While I am happy to comply with such requests, I must charge for my preparation time and routine costs if lengthy reports are required. Fees for report preparation will be billable at $250 per hour and, when litigation is involved, are not included in testimony or preparation charges. I will provide you with separate documentation of those fees should the need arise.

These organizations are not always obligated to maintain any legal privilege or to preserve confidentiality

and may have no ethical guidelines. It is my policy to contact you directly when I receive written requests even when the request includes written authorizations to release information. I do this so we can discuss exactly what you wish released and how I might accomplish this. You should be aware that by using any third-party payment (such as health insurance), either the releases you sign or the processing procedures followed might compromise your legal protections of privilege and confidentiality. I find many of my clients are unaware of the existence of the Medical Information Bureau that has over 750 insurance companies as members. They share with other health, life and mortgage insurers, as long as you sign a general or specific release. For these reasons and because of the HIPAA regulations discussed elsewhere, when I am asked by you to release information I mail or give you both the original in a sealed envelope and a copy for you so that you may forward it as you choose. Often, I send you a rough draft by email first if you request it. In the case of a court subpoena, however, I must mail it directly from my office.

LEGAL MATTERS: Some situations involve legal matters. If you are involved in a legal matter of any kind, you agree to sign the retainer agreement at the beginning of therapy (or at any other time when a legal matter might arise). This is for your protection and mine. See the retainer agreement (Retainer and Expert Fees) under forms if this applies to you.

RECORDS: I regularly keep written records of our sessions. These records include date of meeting, who was present, how long we met and brief notes regarding the issues we discussed. I also record quotes and specific details if issues of homicide, suicide, or abuse or neglect or other legal matters are discussed. I document calls to and from other care providers. These records are maintained seven years after age of majority and seven years after the last session ("discharge date") for an adult per California laws and guidelines. Fees for report preparation and review of records for any purpose will be billable at $250 per hour and, when litigation is involved, are not included in testimony or preparation charges.

CONSULTATION WITH PEERS: I routinely consult with my therapist peers regarding cases. This is to ensure my objectivity and that I do not overlook possible avenues to help you. I do not use my clients' names and try to omit all identifying information unless I have a specific signed consent and you wish me to contact my peers. Confidential records of these contacts are kept with your records and I inform you of the discussion if I feel it is helpful to you. If you have any questions or discomfort about this, please do not hesitate to discuss this with me.

VACATION/OUT OF OFFICE POLICY: I will always inform you about my plans to be away from the office on the days we usually meet. When I am not available at times other than our scheduled times, I will usually inform you in advance. In any case, my office will be available to inform you who will be "on call". Your signature on this form provides me with permission to share some minimal information about your case with the on-call therapist covering for me. For each vacation, I will inform you what information, if any, I feel it necessary to share and with whom.

VOICE MAIL SERVICE: My office has a Voice Messaging Service when you call 949-494-5432. If you do not receive a call back within 12 hours of when you leave a message, please call again because I may not have gotten the message. If your call is urgent or is about an appointment in the next 24 hours, please leave a message then press the # then wait to be prompted to press the number 4, listen for menu then press # (that is, press #, then 4, then #) and I will be paged. If it is a life-threatening emergency and I can't be

reached, call 911.

TELEPHONE CALLS, TEXTS AND E-MAILS: Routine calls for the purpose of scheduling or billing information are an expected part of my service and not billed. Telephone calls, emails or texts occurring on week-ends that are primarily therapeutic in nature, occur frequently, or require more than ten minutes will be prorated and billed at the usual rate. Please do not use texts to communicate therapeutic information. Texts, email correspondence and cellular phone calls cannot be considered completely confidential or secure. Moreover, texts and email can easily be misdirected (sent to the wrong person) or forwarded which can compromise the confidentiality of the communications. You will want to be cautious with their use. In addition, any emails I receive from you and any responses that I send to you become a part of your legal record.

Consent to receive emails and text. You are agreeing to receive periodic text messages as a means of communication with you. Msg &Data Rates May Apply. You may decide you would prefer to use other means at any time and discontinue the use of texting at any time by notifying us.

I cannot guarantee a timely response on emails so schedule changes and cancellations should always be handled by phone. Also, we do typically respond to calls regarding schedule issues, texts or emails during business hours of Tuesday, Wednesday & Thursday. Please do not text me or my staff outside of our normal business hours regarding schedule changes.

TELE-HEALTH: TeleHealth is the term applied to the provision of therapy remotely, rather than in person. It can occur by telephone, video conference or other various other telecommunication devices. I do provide therapy by telephone and by video conferencing where it is appropriate to my client's goals and treatment.

As a reminder, as with email and text, there are some elements of TeleHealth that you should keep in mind. Again, they are not entirely secure. Communications outside an office session may not be entirely private and can be overheard or otherwise compromised (that is, not confidential). In addition, no technology is perfect and can be subject to interruption, or the voices may be unintelligible or misunderstood.

Consent to TeleHealth. In signing this agreement, while recognizing the risks, you are agreeing that the use of telephone, video conferencing or other remote services where we are not meeting in person (that is, TeleHealth), is as an acceptable mode of receiving these therapy services.

SOCIAL MEDIA AND INTERNET: As a therapist, my concern is to protect your safety, privacy and confidentiality. For these reasons, I do not follow or accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Twitter, Instagram, and so on). I do not use search engines or social networking sites (such as Google or Facebook) to obtain information about current clients except in extremely rare crisis situations where I am concerned about your well-being or when you want to show me something about yourself.

You may find my practice listed on business review sites such as Yelp, Healthgrades, Bing, Google and so on. These listings are generated by the search sites and business review sites independently from me and without my knowledge. Please know that this listing is NOT a request for a testimonial, rating, or

endorsement from you as my client. Of course, you have a right to express yourself on any site you wish but I would urge caution when sharing personally identifying information in a public forum. Due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I ask you to take your own privacy as seriously as I take my commitment of confidentiality to you.

FEES FOR SERVICES: The current fee for service is $250 for a 50-minute session. It is best to pay in advance when you arrive for your session as we may discuss challenging material and you may be more comfortable leaving directly when the session is over. Payment can be made with cash, credit card or a personal check. I do not accept any insurance. However, if you have insurance coverage, we will be glad to provide you with a receipt or statement satisfactory for filing your insurance claim at the end of each month. Therapy is a significant personal and financial commitment. Please do not hesitate to discuss financial matters with me.

MEDICARE INSURANCE: I do not accept Medicare. If you are over the age of 65 and have Medicare, please inform us so we can have you complete and sign the Medicare Opt-Out (Private Contract) Form. It is also available on the website for your convenience.

MISSED APPOINTMENTS AND CANCELLATIONS: Sometimes emergencies come up. If I need to cancel or change an appointment time, I will give you 24-hour notice, as I know you will have reserved the time for the appointment. If for any reason I cannot give you 24-hour notice, I will provide our next session free of charge to you. Likewise, I expect that you will give me 24-hour notice if you must cancel the appointment. If, for any reason, you cannot let me know 24 hours in advance you will be charged the regular fee for the time reserved.

SIGNATURES: By signing below, you agree as follows:

- *You have read the materials presented in this disclosure statement and agreement.*
- *Your signature indicates that you understand the information and agree with the conditions of therapy as described here, and you commit yourself to compliance with them.*
- *You understand that once therapy begins, you retain the right to withdraw consent to participate in therapy at any time that seems appropriate.*
- *You will make every effort to discuss your concerns about the progress of therapy with me before you terminate.*

x _____ _____
Client's Signature Date

x _____ _____
Client's Signature Date

x _____ _____
Carol Ummel Lindquist, Ph.D. ABPP Date

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380 GLENNEYRE SUITE D
LAGUNA BEACH, CA 92651

Client/Coaching Client Information

Full Name: _____
first middle last

Address: _____
street city state zip

Cell Phone:( )_____Work Phone: ( )_____ Home Phone: ( )_____

Reminders: As a courtesy, we remind you of next day's appointment. Please check preferred notice ☐Text ☐Email
Please check here if you do not want to be reminded: ☐

Birthdate: _____ Age: _____ Social Security #:XXX-XX-( )

Occupation/Job Title: _____ Employer: _____

Employment Address: _____

Length of time on job: _____ Email Address:_____

Spouse/Partner Information

Name:_____ Time Together: _____

Birthdate: _____ Age: _____ Email Address: _____

Occupation/Job Title:_____ Employer: _____

Name of Referral_____

(May we contact them to thank them?) ☐ Yes ☐ No If yes, Phone #: _____

Person to Notify in Case of Emergency (Other Than Spouse/Partner)

Name:_____ Relationship to You: _____

Address: _____ Phone: ( )_____

Current Symptoms/Problem and Background Information

Briefly describe reason for seeking help: _____

_____

_____

Approximate date these problems/symptoms first appeared: _____

Have you ever had these problems/symptoms before? ☐ Yes ☐ No If yes, when? _____

Approximate date of last physical examination/visit to your physician? _____

Physician Name _____ For what reason(s)? _____

List any current health problems: _____

_____

List names and telephone numbers of physicians concurrently treating you and indicate if we may contact them should the need arise: _____

_____

_____

_____

Have you seen a Chiropractor, Physical Therapist, or Alternative Healer? ☐ Yes ☐ No

Name & how recently seen_____

List the members of your family and all others <u>living with you</u> at this time:

Name	Age	Relationship	Occupation

List parents, step-parents, siblings and any children of yours or your spouse who <u>do not live with you</u>:

Name	Age	Relationship	Occupation

Prior History of Psychological/Psychiatric Treatment or Treatment for Alcohol or Drug Problems

Problem Dates Response Name of MD/Therapist (Phone if known)

_____

_____

_____

_____

If you drink alcoholic beverages, please indicate which kind and how often:

_____

If you use drugs of any kind, including prescription medications or street drugs, please indicate which kind, for what purpose, the dosage/amount and frequency:

Drugs (prescription, marijuana, cocaine, Ecstasy) Purpose Dosage/Frequency

_____

_____

Names and relationship to you of family members with whom there has been a drinking or drug problem (include grandparents, aunts or uncles):

_____

_____

_____

Have you or has anyone in your family had an eating problem (e.g. overeating, anorexia, bulimia)?

☐ Yes ☐ No If yes, who?

_____

Have you been a victim of physical, sexual or emotional abuse, neglect or other trauma? ☐ Yes ☐ No
If yes, by whom and in what situation or relationship?

_____

_____

Are you currently involved in any legal matters? ☐ Yes ☐ No If yes, please describe:

_____

_____

_____

Symptom Checklist

Please circle any of the following problems that apply to you:
Number the most important in order (1 is first priority)

Nervousness	Depression	Fears	Shyness
Sexual Problems	Suicidal Thoughts	Separation	Divorce
Finances	Drug Use	Alcohol Use	Friends
Anger	Self Control	Unhappiness	Sleep
Stress	Work	Relaxation	Headaches
Tiredness	Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions	Loneliness
Concentration	Health Problems	School	Career Choices
Marriage Problems	Temper	Nightmares	Appetite
Stomach Trouble	Bowel Troubles	Being a Parent	My thoughts
Children	Inferiority Feelings	My Parents	Education
Self Confidence	Anxiety	Aging	Guilt
Menopause Issues			

Considering your issues, what is the goal you would like to most achieve first in therapy?

_____

_____

_____

_____

Thank you for your time and attention in completing this information form.

Carol Ummel Lindquist, Ph.D.
Clinical Psychologist

380 Glenneyre Street, Suite D
Laguna Beach, CA 92651
949-494-5432
949-497-0913 fax
carol@carolummellindquist.com

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Psychotherapy Notes. We do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your written Authorization. Note that to guard against the potential harm to clients we do not release psychotherapy notes to clients unless ordered to do so by a court of law.

In addition, information could be shared without your prior written or verbal permission when there is a clear intention to do harm to yourself or to someone else. Psychologists also have a legal and ethical responsibility to notify appropriate social agencies of any suspicion of emotional, physical or sexual abuse or neglect of a child, a dependent disabled adult or an elderly person.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: 1 May 2020

This Notice of Privacy Practices applies to the following organizations.

Carol Ummel Lindquist, Ph.D., Clinical Psychologist

CAROL UMMEL LINDQUIST, PH.D., FACLINP
CLINICAL PSYCHOLOGIST

THE PSYCHOLOGY CENTER
380 GLENNEYRE SUITE D
LAGUNA BEACH, CA 92651

Acknowledgment of Receipt of Notice of Privacy Practices

Client _____

This psychology practice adheres to the requirements outlined by the Health Insurance Portability and Accountability Act ("HIPAA"), which ensures the security and privacy of an individual's medical records and promotes privacy and trust between patients and their healthcare providers. As provided under HIPAA, medical and mental health practitioners are required by law to provide their patients with a Notice of Privacy Practices. Even before these new federal laws went into effect, my practice and those of other psychologists have been dedicated to protecting the privacy of their clients and the confidentiality of psychotherapy information and records.

I acknowledge that I have received a copy of the Notice of Privacy Practices provided by this office.

Signature:_____ Date:_____

CAROL UMMEL LINDQUIST, PH.D., FACLINP
CLINICAL PSYCHOLOGIST

THE PSYCHOLOGY CENTER
380 GLENNEYRE SUITE D
LAGUNA BEACH, CA 92651

Pre-Authorized Credit Card Form

Client Name _____

I authorize Carol Ummel Lindquist, Ph.D. to keep my signature on file and to charge my credit card from time to time for my treatments.

I understand that payment is due at the time of treatment and that my credit card may be charged at any time after my appointments.

Credit Card Information
☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Name on Credit Card _____

Credit Card #: ____ ____ ____ ____--____ ____ ____ ____--____ ____ ____ ____--____ ____ ____ ____

Expiration Date (MM/YY) _____/_____ Security Code (CVV)_____

Billing Address_____

City _____ State_____ Billing Zip_____

Telephone _____ Email address _____

X_____
Cardholder Signature **Date**

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Permission to Release to, or Obtain Records from, Third Parties

To _____
(name of person or entity who has, or requires information)

Address _____
(their address, city, state zip)

Phone _____
(their phone)

Re: _____
(your name, your child's name or both)

Permission is granted to Carol Ummel Lindquist, Ph.D., to obtain (or release) any information from (or to) the above-named person or entity regarding

_____
(your name, your child's name or both)

Any limitations _____

_____
(Things you do not want Dr. Lindquist to discuss or obtain)

x_____ _____
Printed Name

_____ _____
Date Expiration date (if none, write none)

Dr. Lindquist routinely gathers information from other professionals who have worked with you unless you would prefer that she does not. If you have someone you have previously seen in therapy, or another professional such as a physician that you would like Dr. Lindquist to communicate with or from whom you would like her to obtain records, please sign this form and return to her office. If you want to her to talk to them before her first session, you may fax this form at the fax number above. Otherwise, bring this form with you and you and she can discuss whether there is anyone else additional it would be helpful to contact. You may make extra copies of this form or obtain them from Dr. Lindquist.

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Retainer Agreement for Professional Services (Court/Hearing/Mediation/Deposition)

Client name _____

Witness Fees. Dr. Lindquist charges expert witness fees for appearances in court (or other proceedings such as arbitration or mediation). The fees are $1,500 per half day or part thereof; $2,500 for a full day or part thereof plus preparation time. (A half day is either from start of the day to lunch break, or from coming to order after lunch until adjournment for the day). The preparation of any reports in anticipation of any appearances is not included in these fees.

Once Dr. Lindquist is committed to appear, she will consider herself "on-call" for that appearance, for which an advance retainer of $2,000 is required. The retainer must be received at least 10 days prior to the "on call" date, in the form of good funds (such as credit card, cashier's check, electronic transfer including wire transfer). The retainer is in consideration of Dr. Lindquist making herself available for the day on call. In the event that Dr. Lindquist does make an appearance, the retainer fee will be credited against the witness fees.

Depositions. There is a fee of $250 per hour or part thereof (with a minimum of 2 hours) for depositions. Travel time is subject to the same fees. Depositions must be scheduled at least 10 days in advance. A retainer of $250 is required at the time of scheduling.

Preparation and preparation of reports. Preparation (including the preparation of any reports, whether in anticipation of any proceedings or otherwise) is charged at $250 per hour or part thereof. There is a minimum preparation time of 2 hours for any trial or other appearance, a minimum 1 hour for depositions and for reports.

Client request. Client requests that Dr. Lindquist appear in a court or other proceedings on the following dates _____ for ☐ Half day ☐ Whole day ☐ Deposition.

Client understands client will be obligated to pay for all the fees involved in this request. Client understands that Dr. Lindquist is not committed to be "on call" or to appear unless and until Client has paid the required retainer fee.

x_____ _____
Client's Signature Date

x_____ _____
Carol Ummel Lindquist, Ph.D. Date

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PARENT OR THIRD-PARTY AGREEMENT TO ASSUME RESPONSIBILITY FOR PAYMENT OF PSYCHOTHERAPY SERVICES

I _____ agree to pay for the psychotherapy services
(Print name of person assuming responsibility)

for: (Client) _____
(Print name of client receiving psychotherapy services)

I understand the following terms apply to this agreement.

1. Payment will be made ***at the time that service is provided by cash, check or credit card on file.***

2. The current fee for psychotherapy, psychological testing and interpretation, consultation letter or report writing is $250.00 per hour unless otherwise specified.

3. Services will be terminated if payment is not made as agreed to by this agreement.

4. Agreement to assume financial responsibility for these services does not entitle the third party payer to any interview or phone contact with the therapist or access to any confidential information that is shared within the therapeutic relationship unless agreed to by client and therapist in advance.

5. In case of an adolescent or child a parent has a right to know whether the client attends and participates but not the content of the sessions unless the minor chooses to reveal this information. Exceptions will be discussed in advance with the minor. In any case, where there is danger to self or others the therapist is obligated share this information with appropriate parties.

6. <u>The office does not accept or bill insurance</u>. However, a bill will be provided suitable for presenting to your insurance carrier for possible reimbursement.

X _____
Signature of Client Date

X _____
Signature of Person Assuming Responsibility Date

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Informed Consent for Eye Movement Desensitization and Reprocessing (EMDR) Therapy

Client name _____

Eye Movement Desensitization and Reprocessing (EMDR) therapy is supported by more than 30 years of research showing that EMDR has produced promising results in reducing anxiety and in reducing post-traumatic stress symptoms, such as intrusive thoughts, nightmares and flashbacks. The World Health Organization (WHO), American Psychiatric Association, the US Department of Veterans Affairs and the Department of Defense recognize and recommend it as an effective treatment for trauma. It has also produced promising results treating anxiety, depression and substance abuse, although the research is not as extensive.

However, <u>you should be aware</u> of these aspects of EMDR

- Distressing, unresolved memories may surface through the use of the EMDR procedure
- Some clients have experienced reactions during the treatment sessions that neither they nor the administrating clinician may have anticipated, including a high level of emotional or physical sensations
- Subsequent to the treatment session, the processing of incidents or material may continue and other dreams, memories, flashbacks or feelings may surface
- If you are involved in any legal action, the "relief" obtained through the EMDR procedures may reduce your ability to recall the details of your trauma, which may be necessary to testify clearly or convincingly

<u>Your acknowledgment and understanding</u>.

- Dr. Lindquist has explained to you the reasons why the use of EMDR therapy is recommended for you or for your child.
- You understand that there are other options available to you or your child should you decide not to use EMDR therapy.
- Dr. Lindquist has provided you with an explanation of the nature of EMDR and your questions about EMDR have been answered to your satisfaction.
- You may always discontinue EMDR at any time.
- Before commencing EMDR therapy, you have considered all the above and have obtained any additional information or professional advice you consider necessary to make an informed decision regarding EMDR for yourself or your child.
- Your signature on this consent form is free from pressure or influence from any person or entity.

By signing, you consent to participating in EMDR treatment for yourself or your child.

x_____ _____

Client's Signature (or parent, if client is under 18) Date

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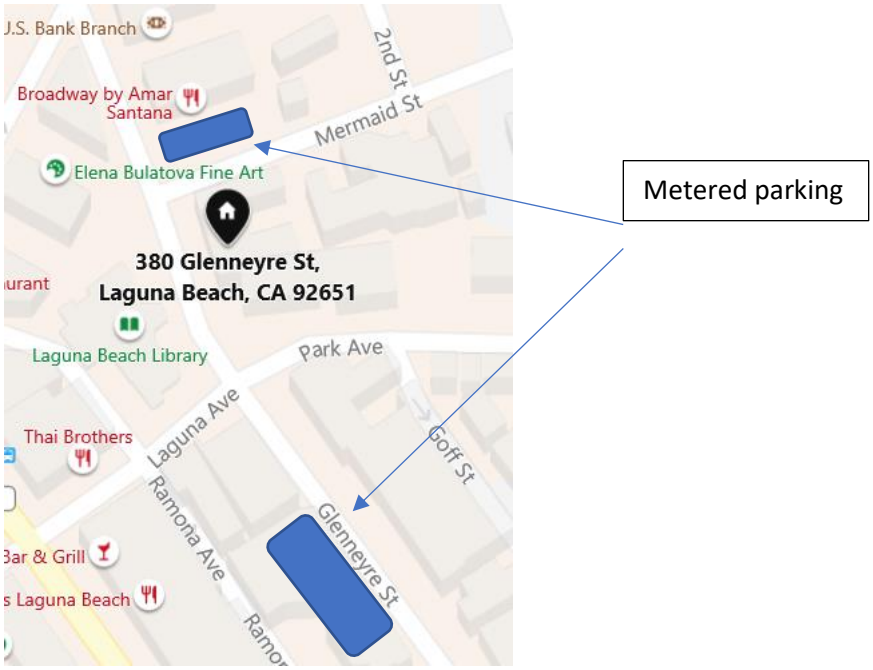
Directions to the Psychology Center

From San Diego Freeway (I-405) or Santa Ana Freeway (I-5). Take Highway 133 South (Laguna Canyon Road). Follow Laguna Canyon Road through Laguna Canyon. After passing the Festival of Arts grounds (on your right) the next signal is Forest Avenue. Turn Left on Forest Avenue. Follow Forest Avenue two blocks (past Ocean Avenue) to the stop sign. Turn Right onto the continuation of Forest Avenue. Follow two blocks to stop sign at Glenneyre Street. Turn Left. The Psychology Center is at 380 Glenneyre Street, just past Mermaid Street. Turn left through the breezeway into the parking lot. Suite D is upstairs.

From Pacific Coast Highway. From Pacific Coast Highway (actually called Coast Highway), turn Inland onto Forest Avenue. Coming from the south (from Dana Point) that will be a right turn. From the north (from Newport Beach) that will be a left turn. Follow Forest Avenue one block to the stop sign at Glenneyre Street. Turn right onto Glenneyre Street. The Psychology Center is at 380 Glenneyre Street, just past Mermaid Street. Turn left through the breezeway into the parking lot. Suite D is upstairs.

Parking. You may park in any of the last three spaces on the left (toward the back) marked "the Psychology Center". If full, there is metered parking at the corner of Mermaid and Glenneyre Street. There is also a large metered two-story parking structure just south on Glenneyre Street past Park Avenue on the right (if there are no spaces in the lower lot, you need to exit then drive up the hill to the upper lot).



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