Elizabeth Shouse, Psy.D. (PSY27796)
1151 El Centro St., Ste B.
South Pasadena, CA 91030

Patient's Name: _____

Today's Date:_____ Date of Birth: _____

Age: _____ Gender:_____ Ethnicity:_____

Address: _____

City, State, ZIP: _____

Referred by: _____

How did you learn about Dr. Shouse's practice? (circle all that apply)

Google search	Good Therapy.org	A Psychiatrist
Yahoo search	Family Doctor	Another Therapist/Psychologist
Psychology Today	School	Other_____

Occupation (if applicable): _____

Highest Education Completed:_____

Home Phone: _____

Cell Phone: _____

Email:_____

What phone number/method is best for communication with you?

Home ____ Work ____ Cell Phone ____ Email ____

Is it okay to leave a message for you at your preferred number? Yes____ No_____

Is it okay to email you about scheduling concerns? Yes____ No_____

Emergency Contact:

Name: _____

Relationship: _____

Cellular #_____ Home # _____

Who Is Financially Responsible for this account? Who is the insured?

Name: _____

Relationship to Patient: _____

Date of Birth of Policy Holder: _____

Driver's License# _____

Address (if different than patient):

_____

City, State, Zip:

_____

Employer: _____

Occupation: _____

Authorization and Release:

- I authorize the release of necessary information to third party payers/insurance companies and/or other health practitioners.
- I authorize the release of necessary information to Verdant Oak Behavioral Health, Inc., administrator.
- I am informed of HIPAA guidelines and regulations related to confidentiality of medical records.
- I agree to be responsible for payment of all services rendered on my behalf or for my dependents.
- I agree to notify your office more than 24 business hours in advance if I need to reschedule or cancel an appointment.

X_____

Signature and Printed Name of Responsible Party **Date**

Elizabeth Shouse, Psy.D.
1151 El Centro Street
Suite B
South Pasadena, CA 91030
Lic. #: PSY27796

AGREEMENT, INFORMED CONSENT, OFFICE POLICIES AND GENERAL INFORMATION

This form provides you (patient) with information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPAA pre-emptive analysis.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. Below is a non-exhaustive list of circumstances when disclosure is, or, may be, required by law. The list is not exhaustive because the laws in this area change from time. However, the list is designed to give you an idea of some of the circumstances where disclosure may be required.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled or when client's family members communicate to Dr. Shouse that the client presents a danger to others.

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Dr. Shouse. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Dr. Shouse will use her clinical judgment when revealing such information. Dr. Shouse will not release records to any outside party unless she is authorized to do so by all adult family members who were part of the treatment.

Emergencies: If there is an emergency during our work together or in the future, after termination, where Dr. Shouse becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, she will do whatever she can, within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, she may also contact the person whose name you have provided on the biographical sheet.

Health Insurance & confidentiality of records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Verdant Oak Behavioral Health, Inc. is an administrative agent of Dr. Shouse for the

purposes of processing claims information and will have limited access to that information needed to process any health insurance claims. Dr. Shouse has no control or knowledge over what insurance companies do with the information she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future ability to obtain insurance, other benefits or even a job. The risk stems from, among other things, the fact that mental health information is likely to be entered into insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database always carries some risk because computers are inherently vulnerable to break-ins and unauthorized access. Medical data has also been reported to be legally accessed by enforcement and other agencies, which also puts you in a vulnerable position.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc..), neither you (client's) nor your attorney's, nor anyone else acting on your behalf, will call on Dr. Shouse to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

Consultation: Dr. Shouse consults regularly with other professionals regarding the treatment and well-being of her clients; however, client's identity remains completely anonymous, and confidentiality is fully maintained.

E - Mails, Cell phones, Computers and Faxes: It is very important to be aware that computers and e-mail and cell phone communication can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, Dr. Shouse's e-mails are not encrypted. Faxes can easily be sent erroneously to the wrong address. Dr. Shouse's computers are equipped with a firewall, virus protection and a password, and she also backs up all confidential information from her computers onto an external drive on a regular basis. The drive is stored securely off-site. Please notify Dr. Shouse if you decide to avoid or limit in any way the use of any or all communication devices, such as e-mail, cell-phone or faxes. If you communicate confidential or highly private information via e-mail, Dr. Shouse will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and she will honor your desire to communicate on such matters via e-mail. Please do not use e-mail or faxes for emergencies.

Records and Your Right to Review Them: Both the law and the standards of Dr. Shouse's profession require that she keeps appropriate treatment records for at least seven years. If you have concerns regarding the treatment records, please discuss them with Dr. Shouse. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Dr. Shouse assesses that releasing such information might be harmful in any way. In such a case, Dr. Shouse will provide the records

to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, upon your request, Dr. Shouse will release information to any agency/person you specify. When more than one client is involved in treatment, such as in cases of couple and family therapy, Dr. Shouse will release records only with the signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact Dr. Shouse between sessions, please leave a message at (323)345-1402, and your call will be returned as soon as possible. Dr. Shouse checks her messages a few times during the daytime only, unless she is out of town. If an emergency situation arises, indicate it clearly in your message, and if you need to talk to someone right away call Los Angeles Psychiatric Emergency Team: 800 854-7771, Las Encinas Hospital (800) 792-2345 or the Police: 911. Please do not use e-mail or faxes for emergencies. Dr. Shouse does not check her e-mail or faxes daily.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay their standard agreed upon fee to Verdant Oak Behavioral Health, Inc., administrative agent ("VOBH") for Dr. Shouse, at the end of each session unless other arrangements have been made. VOBH is the administrative agent for Dr. Shouse responsible for all billings and scheduling for Dr. Shouse. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify VOBH if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, VOBH will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose. As was indicated in the section *Health Insurance & Confidentiality of Records*, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, VOBH, as Dr. Shouse's agent, can use legal or other means (courts, collection agencies, etc.) to obtain payment. Dr. Shouse also reserves the right to suspend and/or terminate treatment if your account is overdue and no other arrangements are made.

MEDIATION & ARBITRATION: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Dr. Shouse and the client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Los Angeles County, CA. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Dr. Shouse or her agent can use legal means (court, collection agency, etc.) to obtain payment. The prevailing

party in arbitration or collection proceeding shall be entitled to recover a reasonable sum as and for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

VERDANT OAK BEHAVIORAL HEALTH, INC.: VOBH is an administrative agent for Dr. Shouse and its responsibilities are limited to scheduling sessions with Dr. Shouse, administration and any collections, billing or payment. VOBH is an assignee of Dr. Shouse's right to collect payments from you but Client understands that VOBH has no supervisory power over Dr. Shouse and, in fact, it is Dr. Shouse that has retained VOBH as her administrative agent. Client hereby acknowledges that VOBH has no actual or potential liability to Client on any actual or potential claim arising out of the treatment by Dr. Shouse of Client.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Dr. Shouse will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc, or experiencing anxiety, depression, insomnia, etc. Dr. Shouse may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, Dr. Shouse is likely to draw on various psychological approaches according, in part, to the problem that is being treated and her assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. Dr. Shouse provides neither custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within her scope of practice.

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, Dr. Shouse will discuss with you (client) her working understanding of the problem, treatment plan, therapeutic objectives and her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, Dr. Shouse's expertise in employing them, or about the treatment plan, please let Dr. Shouse know. You also have the right to ask about other

treatments for your condition and their risks and benefits and Dr. Shouse will use her best efforts to inform you of those treatments.

Termination: As set forth above, after the first couple of meetings, Dr. Shouse will assess if she can be of benefit to you. Dr. Shouse does not accept clients who, in her opinion, she cannot help. In such a case, she will give you a number of referrals whom you can contact. If at any point during psychotherapy Dr. Shouse assesses that she is not effective in helping you reach your therapeutic goals or that you are non-compliant, she will, upon discussion with you and, if appropriate, terminate treatment. In such a case, she would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, Dr. Shouse will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, Dr. Shouse will assist you with referrals, and, if she has your written consent, she will provide her or him with the essential information needed. You have the right to terminate therapy at any time; however, you will be responsible for any unpaid balance at that time. If you choose to terminate therapy, if appropriate, Dr. Shouse will offer to provide you with names of other qualified professionals.

DUAL RELATIONSHIPS: A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person. Not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs Dr. Shouse's objectivity, clinical judgment or can be exploitative in nature. Dr. Shouse will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. South Pasadena, CA is a small community and many clients know each other and Dr. Shouse from the community. Consequently, you may encounter someone you know in the waiting room or Dr. Shouse in the community. Dr. Shouse will never acknowledge working with anyone without his/her written permission. Dr. Shouse will discuss with you, her client/s, the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it, and often it is impossible to know that ahead of time. It is your, the client's, responsibility to communicate to Dr. Shouse if the dual or multiple relationship becomes uncomfortable for you in any way. Dr. Shouse will always listen carefully and respond accordingly to your feedback and will discontinue the dual relationship if she finds it interfering with the effectiveness of the therapy or the welfare of the client, and of course, you can do the same at any time.

CANCELLATIONS: Therapy clients are typically scheduled on a weekly or bi-weekly basis. That time is specifically reserved for you. Consistent attendance optimizes your progress and can reduce the duration of treatment. While we recognize that unanticipated conflicts can arise, we encourage clients to reschedule missed appointments when possible.

When cancelling an appointment, please try to do so the week prior to the scheduled session. You are responsible for the full session fee (not your copay) for sessions cancelled less than 24 hours in advance and for sessions you do not attend without notice. A maximum of three (3) same-week cancellations will be allowed in one calendar year.

Subsequent same-week cancellations will be billed using the following scale:

Fourth same-week cancellation: $50
Additional same-week cancellations, late cancellations, and missed appointments: FULL FEE

NOTE: The above charges are your responsibility. Insurance companies DO NOT cover cancellation and/or missed appointment fees.

DURATION & PROMPTNESS:

Initial sessions take between 60 and 90 minutes. Subsequent therapy sessions are scheduled for between 45 and 50 minutes. If you are more than 20 minutes late for a session and have not notified us that you're coming, the doctor will assume you had to cancel your session and may not be in the office if you arrive for the appointment thereafter.

I have read the above Agreement, Informed Consent, Office Policies and General Information carefully, (5 pages) I understand them and agree to comply with them:

_____

Client name (print) Date Signature

Client name (print) Date Signature

Elizabeth Shouse, Psy.D. CA License # PSY27796

_____

Psychologist Date Signature

Elizabeth Shouse, Psy.D.
1151 El Centro Street
Suite B
South Pasadena, CA 91030
Lic. #: PSY27796

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization and its administrator, Verdant Oak Behavioral Health, Inc. originate and maintain health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means for Verdant Oak Behavioral Health, Inc. to bill for services rendered
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature_____

Date: _____

Witness_____

Date_____

Verdant Oak Behavioral Health, Inc.

1151 El Centro Street, Suite B
South Pasadena, CA 91030

Credit Card Authorization

Please make no marks nor add any comments to this page of the document. It is your consent to make payment for services rendered, and your treatment is conditional upon your signing of this consent form without modification. This form will be securely stored in your clinical file and may be updated at any time upon request.

You may opt out of leaving a credit card on file with us; however, you will then need to leave a cash or check deposit in the amount equivalent to full fee for two therapy sessions or in the amount of $450 for testing/assessment services.

In the event that you miss or fail to cancel an appointment within 24 business hours of the scheduled time, or if a check is returned unpaid, you will be charged the full session fee.

An additional $25 fee will be assessed for: 1) returned checks, and/or 2) inaccurately disputed charge-backs.

I, _____, hereby authorize Verdant Oak Behavioral Health, Inc. to bill my credit card at the usual fee for professional services including all of the following:

- Appointments and/or copayments that I elect to pay for by credit card
- Missed appointments
- Appointments that I have cancelled with less than 24 business hours notice
- Returned checks
- Fees not covered by insurance or insurance payments made to patient rather than provider

Credit Card Type (check one):

☐ Visa ☐MasterCard ☐Discover ☐ American Express

Card #_____ Expiration Date: _____

Verification/Security Code (3 or 4-digit code on back of card by signature line): _____

Name as Printed on Card: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

By signing below I am authorizing Verdant Oak Behavioral Health, Inc. to bill my credit card at the usual fee for professional services as described above.

Signature: _____ Date: _____