



PATRICIA BRUNNER, Ph.D.

Clinical Psychologist
PSY 9737

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Patient Information:

Today's Date: _____

Patient Name: (First) _____ (Middle Initial) _____ (Last) _____

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

Email: _____ *Permission to contact* () Yes () No

Address: _____ City: _____

State: _____ Zip: _____ D.O.B.: _____ Age: _____ () Male () Female

Work Status: () FT Employed () PT Employed () FT Student () PT Student () Homemaker () Retired () Other

Employer's Name / Address: _____

Occupation/Job Title: _____ Work/Shift Hours: _____

Referred By: _____ Phone: _____

Address: _____

May I contact them to thank them for your referral? : () Yes () No

Emergency Contact:

In case of an emergency you have my permission to contact: _____

Address/Phone #: _____ *Your Initials:* _____

Health History:

Please list any current or recurring health problems: _____

Are you presently taking *any* medications? () Yes () No If yes, please list *name, use, and dosage:* _____

Have you had previous mental health treatment? () Yes () No Are you in current mental health treatment? () Yes () No

Have you had any psychiatric hospitalizations? () Yes () No If yes, please indicate with whom, dates you attended and /or hospitals: _____

Reasons for seeking counseling:

Please state briefly why you are seeking assistance now and what you would like to achieve: _____

Symptom Checklist

These symptoms may or may not be related to the problem(s) that bring you in to see us. However, they may help in planning your treatment. Please check the "C" for current symptoms or "P" past symptoms.

	C	P			C	P	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	trouble going to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	allergy problem? specify _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	restless sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	waking up very early and being unable to go back to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	menstrual irregularity or distress
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling guilty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	asthma attack
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	depressive feelings that are regularly worse in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	irritable bowels, constipation, diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	thoughts about suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tics
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	have made suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heart disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fatigue or loss of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	eating disturbance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor concentration and memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	frequent flu or colds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	decreased sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	significant feelings of restlessness, agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	grinding teeth, jaw tension/pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loss of pleasure in usual activities; have lost your zest for life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	endocrine dysfunction, e.g. thyroid problems, hypoglycemia, diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	appetite loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	kidney problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling worthless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	head injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weight loss/how much in how long? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	smoking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weight gain/how much in how long? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	over eating
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feelings of sadness, depression, hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	over spending
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	withdrawing from others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	gambling problem
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	use alcohol/drugs. If you do, how frequently _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	palpitations, rapid heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	how much _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	light headedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other health issue _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sense of dread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling lonely even when with others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscle tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling shy or uneasy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chest pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	wanting to be alone often
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling bored with others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	arguing with others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling critical of others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling people dislike you
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cold, clammy hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel that people are out to harm you
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	afraid of losing control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other relationship problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	avoiding certain situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel others do not understand you
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	difficulty communicating what you really think or feel
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tense or anxious all day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel others are not meeting your needs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	very anxious in social situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel others are inferior to you
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	recurring troubling thoughts, images, impulses you can't get out of your mind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feeling inadequate, less than others
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	repetitive behaviors such as excessive hand washing, etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	have phobias (fears); of what? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	decreased need for sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	increased sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel that you can read people's minds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	greatly increased energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	have homicidal thoughts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	described by friends as hyper or excitable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	see visions/hear voices
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	have special powers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel that people can read your mind
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel that people control your actions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nausea, upset stomach, indigestion, ulcers, vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anything else you would like me to know? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hot or cold spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness or tingling in parts of your body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Childhood and Family History

Current Living Situation:

Spouse/Significant Other's Name: _____

Age: _____ Spouse/Significant Other's Occupation: _____

Children's Names and Ages:

Name	Age	Name	Age	Name	Age
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Who currently lives in your household? _____

Background Information:

What is your ethnic, cultural and religious background? _____

List your brothers and sisters from oldest to youngest and their ages. Indicate (B) biological, (S) step or (H) half sibling please:

Name	Age	Name	Age	Name	Age
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Did your parents live together throughout your childhood? Yes No If not, what happened and how old were you? _____

Number of times moved and at what age: _____ Grew up in _____

Special problems in the family: Disabled child Parents fought Death in the family Hospitalizations Alcohol/drugs
 Serious medical illness Parent unemployment Parent changed jobs a lot Legal problems Other _____

What were you like as a child? Had problems learning in school Got into trouble in school Had problems with the law
Other (please explain): _____

Did you have any of these problems with your family? Physically abused Sexually abused Fought with parents
 Felt like you did not belong Had too much responsibility Isolated yourself from the family Emotionally abused
 Other _____

Take these few lines to describe your childhood and your relationship with your parents:



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CONSENT TO TREATMENT AND CONFIDENTIALITY

CONSENT TO TREATMENT

Psychotherapy may involve change, or the possibility of change, which may feel threatening and cause anxiety not only to you but also to those people close to you. The prospect of giving up old habits, no matter how destructive or painful, can often make you feel quite vulnerable. At the same time, discovering tools and techniques that are used to improve the quality of your life and your relationships can be very helpful. Most people find the benefits of therapy outweigh any risks. In fact, sometimes there can be more risks associated with *not* participating in therapy.

- **My Credentials:** I am a **licensed clinical psychologist** and an **independent private practitioner**. I provide individual, couples and family therapy to adults, adolescents and children.
- **Session Duration:** Unless otherwise agreed, the session is **45-50 minutes** in length. Weekly appointments are the usual pattern when beginning psychotherapy. Other arrangements may be made depending on your individual circumstances and clinical needs.
- **Fees:** My fees are \$200 for the initial evaluation, \$180 for individual psychotherapy, and \$200 for couples or family therapy. The fee for forensic services (depositions, court appearances, etc.) is \$500/hour, including travel time, with a half-day minimum. ***Fees are paid at the time of the appointment.***
- **Insurance Reimbursement:** Your health insurance may provide some reimbursement for mental health treatment. I can provide you a monthly statement for you to submit directly to your insurance company.
- **Missed or Canceled Appointments:** ***No-show or canceled appointments may incur the full charge of the session unless a twenty-four hour notice is given,*** except for unforeseen emergencies or crises which requires your immediate attention. Please call and let me know as soon as possible if you will not be able to come to your appointment. You may leave a voicemail message at **(916) 678-0798**, which is available **24 hours a day**, 7 days a week.
- **General Availability and Telephone Calls:** I am available in the office for appointments and telephone calls on **Tuesday, Wednesday, and Thursday**. During evenings and

other days of the week, (Friday, Saturday, Sunday and Monday), a message can be left on my voicemail at any time. **If it is urgent you reach me during these hours, leave your message and indicate that it is urgent that you speak to me.** I will return your call as soon as I am able. Please remember to leave your telephone number(s), including cell #s. ***If your call is not returned within two days, please call again. Errors can occur in telephone numbers or voicemail clarity.***

- **Email or Text Messages:** I use email or texting only to schedule appointments or for other administrative matters. Please do not email/text me content related to your therapy sessions, as **email and texts are not completely secure or confidential.** If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send you become part of your psychotherapy record.
- **Emergencies:** ***If you are dealing with an imminent or life-threatening emergency please phone 911 immediately. If you are experiencing a psychiatric emergency, please call Sutter Center for Psychiatry at (800) 801-3077.***
- **Professional Records:** The laws and standards of my profession require that I keep information about you in your Clinical Record. Except in unusual circumstances where I believe that access is reasonably likely to cause substantial harm, you may request a copy of your Clinical Record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents.
- **Treatment of Minors:** In most cases, when the patient is a minor, the law allows parents to examine their child's treatment records. However, because privacy is crucial to successful progress for many children and adolescents, it is usually my policy to request an agreement between patient and their parents about access to information. This agreement provides that during treatment, I will give only general information about progress and the patient's attendance at scheduled sessions. If a patient discloses something which affects their safety, I will either assist the patient in discussing this with their parents or notify their parents of my concerns. In the rare case where disclosure of this information to the parent would put the patient at risk, I will notify the appropriate agencies to ensure the patient's safety.
- **Termination:** As the patient, you have the right to terminate treatment at any time. As the therapist, I can terminate treatment at anytime and facilitate a referral. If I determine you are not sufficiently benefiting from treatment, it is my ethical duty to refer you to alternative care.

CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you provide written Authorization. But, there are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- I may find it helpful to consult other health and mental health professionals about a case without revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential.
- You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis and sometimes additional clinical information. I will make every effort to release only the minimum information about you that is necessary for the purpose requested. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.
- If you are involved in a court proceeding and a request is made for records, I cannot provide any information without your written authorization, a court order, or other legal action compelling me to release the information. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities pursuant to their legal authority, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I must, upon appropriate request, disclose information relevant to the claimant's condition, to the worker's compensation insurer.
- If a patient's account is seriously past due, I may disclose necessary information to a collection agency.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I reasonably suspect that a child under 18 has been the victim of child abuse or neglect, the law requires that I file a report with the appropriate governmental agency. I also may make a report if I reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way. Once such a report is filed, I may be required to provide additional information.
- If I observe or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, the law requires that I report to the appropriate government agency. Once such a report is filed, I may be required to provide additional information.

- If a patient communicates a serious threat of physical violence against an identifiable victim, I must take protective actions, including notifying the potential victim and contacting the police. I may also seek hospitalization of the patient, or contact others who can assist in protecting the victim.
- If I have reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to him or herself, I may be obligated to take protective action, including seeking hospitalization or contacting family members or others who can help provide protection.

If such a situation arises, I will make every effort to fully discuss it with you and I will limit my disclosure to what is necessary.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTOOD THIS AGREEMENT AND THAT YOU VOLUNTARILY AGREE TO PARTICIPATE IN TREATMENT. If the person receiving care is a minor, a parent or legal guardian acknowledges having read and understood this document and voluntarily agrees to the minor's participation in treatment.

SIGN HERE

Patient's/Guardian's Signature

Date

Printed Name

NOTICE OF PRIVACY PRACTICES OF PATRICIA BRUNNER, PHD

Policies and Practices to Protect the Privacy of Your Health Information

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Disclosures for Treatment, Payment, and Health Care Operations

As your psychologist, I may use or disclose your *protected health information (PHI)*, for certain *treatment, payment, and health care operations* purposes without your *authorization*. In certain circumstances I can only do so when the person or business requesting your PHI gives a written request that includes certain promises regarding protecting the confidentiality of your PHI. To help clarify these terms, here are some definitions:

- “Use” applies only to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.
- “PHI” refers to information in your health record that could identify you.
- “Treatment” is when I provide diagnosis or therapy for you. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist, regarding your treatment.
- “Payment” is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- “Health Care Operations” is when I disclose your PHI to your health care service plan (for example your health insurer), or to your other health care providers contracting with your plan, for administering the plan, such as case management and care coordination.
- “Authorization” means written permission for specific uses or disclosures.

II. Uses and Disclosures Requiring Authorization

Under certain circumstances, I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances, I will obtain an authorization from you before releasing this information. You may revoke or modify this authorization at any time; however, the revocation or modification is not effective until received. I will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this Notice.

III. Uses and Disclosures with Neither Consent nor Authorization

I may also use or disclose PHI *without your consent* or authorization in the following circumstances:

Child Abuse: Whenever I, in my professional capacity, have knowledge of or observe a child I know or reasonably suspect, has been the victim of child abuse or neglect, I must immediately report such to a police department or sheriff’s department, county probation department, or county welfare department. Also, if I have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other, I may report such to the above agencies.

Adult and Domestic Abuse: If I, in my professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these or if I reasonably suspect such, I must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency.

I do not have to report such an incident if:

- I have been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect;
- I am not aware of any independent evidence that corroborates the statement that the abuse has occurred;
- the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and
- in the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

Health Oversight: If a complaint is filed against me with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is protected by psychologist-patient privilege law. I cannot provide any information without your (or your legally-appointed representative’s) written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where that party has given you proper notice (when required) has stated valid legal grounds for obtaining PHI, and I do not have grounds for objecting under state law (or you have instructed me not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

Serious Threat to Health or Safety: If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to

believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.

Worker's Compensation: If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of the your initial examination, and at subsequent intervals as may be required by the administrative director of the Worker's Compensation Commission in order to determine your eligibility for worker's compensation.

IV. Patient's Rights, Psychologist's Duties and Breach Notification

Patient's Rights:

Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket – You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

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

Dr. Brunner's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures and you are a current patient, I will attempt to notify you of the revisions on or after the effective date and you may request a written copy of the Revised Notice from this office.

Breach Notification:

When I become aware of, or suspect a breach in security of your PHI, I will conduct a Risk Assessment. I will keep a written record of this assessment and notify you if there is reasonable probability that your PHI has been compromised. I will also make changes in my privacy practices to prevent the re-occurrence of such breaches.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me and if you believe your concerns are not addressed, you may contact the Board of Psychology at the California Department of Consumer Affairs.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

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

This notice will go into effect on April 15, 2003. Updated September 1, 2013.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. You may request a copy of the revised notice on or after the effective date.

PATRICIA BRUNNER, PH.D.
Licensed Psychologist, PSY 9737
2412 Professional Drive, Roseville Ca 95661

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

This form serves to acknowledge that I have received the Notice of Privacy Practices of Patricia Brunner, Ph.D. The Notice of Privacy Practices describes my rights and the obligations of Patricia Brunner, Ph.D. to protect my health information including how my psychological and medical information may be used and disclosed as well as how I may access this information.

Patient Name: _____

Relationship to patient: Self _____ Other: _____

Date Notice Received: _____

By signing this form, I acknowledge that I have received the Notice of Privacy Practices of Patricia Brunner, Ph.D.

Patient/Guardian's Signature

Date



PATRICIA BRUNNER, PH.D.

Clinical Psychologist
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Teletherapy Informed Consent

During our work together, there may be times when it is clinically necessary to have sessions via Teletherapy. Teletherapy is broadly defined as the use of information technology to deliver therapy and information from one location to another. It includes the use of the telephone or internet for our therapy sessions. The benefit of this form of therapy is that it allows us to continue our work in situations that would otherwise require us to suspend therapy due to illness, transportation, community health precaution, etc.

If we chose to use information technology for some or all of your treatment, I will provide information to you about the options for accessing the Teletherapy sessions. Please review the following information before you consent to Teletherapy.

Consent

Your consent to Teletherapy sessions is not required if you would like to opt out of this form of therapy. In that case, we will have to discuss arranging face-to-face therapy when possible. If you do chose to participate, you retain the option to withhold or withdraw consent for Teletherapy at any time without affecting the right to future treatment.

Confidentiality

All existing confidentiality protections outlined in my *Consent to Treatment and Confidentiality* document are equally applicable to our Teletherapy sessions.

Potential Risks

It is possible that the Teletherapy session may be interrupted due to transmission technology issues. If this happens, all attempts will be made to reconnect. If this is unsuccessful, your session, or part session, will be rescheduled at a convenient time.

It is important for you to find a private place in which to participate in your Teletherapy session. If at anytime you or I are interrupted we will pause our session and resume at a time when privacy can be found.

Teletherapy-based services are not as complete as face-to-face services and may at times interfere with my ability to thoroughly assess or understand your communications. This is due to the limitations of not having you present in the same room with me which allows for greater access to nonverbal, emotional and more subtle communication cues. If this becomes an issue, we will form a plan for future sessions.

