Louisa Storen, LISW, LMFT
757 Johnnie Dodds Blvd., Ste# 100
Mount Pleasant, SC 29464
Ph. 843.416.1103 ~ Fax 843.416.1153

WELCOME!

I know it seems like you've been handed a lot of paperwork to fill out and read – actually you have been – and we apologize for that. However in order to better serve you, and to meet the standards of our profession and the legal requirements of the state and federal government we do request that you read everything and complete all the forms as thoroughly to the best of your knowledge and ability.

If you have any questions or need any help at all, please see the person who gave you this material, he or she will be glad to help.

INSTRUCTIONS

1.) Fill out the Personal Data Form completely
    Note: If you are here with a spouse or partner you each need to fill out a separate form, however for those areas that pertain to both of you as a couple, such as, information about children, only one of you needs to complete that section.

2.) Read the office policy and procedures agreement "Professional Disclosure & Policy Statement" (you may keep it)

3.) Read the "Privacy & HIPAA Statement" (you may keep it)

4.) Sign the "Acknowledgement & Authorization Page"
    Note: If you are here with a spouse or partner, both of you must sign this page.

5.) Bring the completed forms and signed pages to the Business Office. The other material you may keep.

Louisa Storen, LISW, LMFT

PERSONAL DATA FORM - PAGE 1

TODAYS DATE _____

NAME: Last_____ First _____ MI _____

NAME YOU WOULD LIKE US TO USE TO ADDRESS YOU? _____

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** Male ____ Female ____

HOME ADDRESS: Street _____ Unit _____

City _____ State _____ Zip Ccode _____ - _____

PHONE #s (WITH **AREA CODE):** Place check after number if its ok to leave a message at that number

Home _____ Voice Mail ____ Person Who Answers ____ NO Messages ____

Work _____ Voice Mail ____ Person Who Answers ____ NO Messages ____

Cell _____ Voice Mail ____ Person Who Answers ____ NO Messages ____

EMAIL (Your Email is Protected) _____

WHAT IS BEST WAY TO COMMUNICATE AND/OR LEAVE APPOINTMENT REMINDERS (Check ALL that apply)

Home Ph ____ Work Ph ____ Cell Ph Voice ____ Cell Text ____ Email ____ Comment _____

EMPLOYMENT: Company Name/Location _____

Position _____ How Long _____

HOW DID YOU FIND OUT ABOUT LOUISA? _____

PREVIOUS PROFESSIONAL HELP? WHO/WHERE_____ **LAST SEEN** _____

RELATIONSHIP STATUS (Check): Married ____ Separated ____ Divorced ____ Dating ____ Live Together ____

CHILDREN (Name, Age & Sex) _____

PRIMARY CARE PHYSICIAN _____ LOCATION or PH#_____

LIST ALL MEDICAITONS (if spouse/partner are together) _____ _____

_____ _____ _____

SPOUSE/PARTNER

NAME: Last_____ First _____ MI _____

NAME YOU WOULD LIKE US TO USE TO ADDRESS YOU? _____

DATE OF BIRTH _____ **AGE** _____ **SEX (Check)** Male ____ Female ____

HOME ADDRESS: Street _____ Unit _____

City _____ State _____ Zip Ccode _____ - _____

PHONE #s (WITH **AREA CODE):** Place check after number if its ok to leave a message at that number

Home _____ Voice Mail ____ Person Who Answers ____ NO Messages ____

Work _____ Voice Mail ____ Person Who Answers ____ NO Messages ____

Cell _____ Voice Mail ____ Person Who Answers ____ NO Messages ____

EMAIL (Your Email is Protected) _____

WHAT IS BEST WAY TO COMMUNICATE AND/OR LEAVE APPOINTMENT REMINDERS (Check ALL that apply)

Home Ph ____ Work Ph ____ Cell Ph Voice ____ Cell Text ____ Email ____ Comment _____

EMPLOYMENT: Company Name/Location _____

Position _____ How Long _____

PREVIOUS PROFESSIONAL HELP? WHO/WHERE_____ **LAST SEEN** _____

PRIMARY CARE PHYSICIAN _____ LOCATION or PH#_____

LIST ALL MEDICAITONS (if spouse/partner are together) _____ _____

_____ _____ _____

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PROFESSIONAL DISCLOSURE & POLICY STATEMENT
(This version is effective as of 6/23/17)

Introduction: This document is intended to provide important information to you regarding your treatment, and about myself & practice. This document also fulfils our requirements to provide you with this information under state and federal law. *Please feel free to discuss any questions or concerns you may have about this document at any time.*

You may request a copy of this document to keep and take with you. We will always have the most recent version available for you to review. It can change periodically so please ask us for the latest version at any of your visits.

Contact & Hours Information: Our appointment business hours are Monday – Friday, 9am – 5pm (first appointment is 9am and the last is generally 5pm – in special circumstances a 6pm appointment can be arranged).

Office Ph.: 843-416-1103, Fax: 843-416-1153.

Note: If no one answers the phone we are either out of the office or on the phone with another patient. Please feel free to leave a voice mail. Our system is secure and confidential.

Email: louisa@louisastoren.com
Website: www.louisastoren.com

Professional Qualifications:

- ☞ South Carolina Licensed Independent Social Worker, License No: 86
- ☞ South Carolina Licensed Marriage and Family Therapist, License No: 1390
- ☞ Clinical Member American Association for Marriage and Family Therapist
- ☞ Accredited Member National Association of Social Workers
- ☞ Over 32 years' experience in private practice

Counseling Relationship: The Board of Examiners for the Licensure of Professional Counselors, Marriage and Family Therapist and Psychoeducational Specialist requires that all clients be informed that forms of dual relationships such as business ventures and sexual intimacy are prohibited. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Ms. Storen is not available 24 hours a day.

Ms. Storen is not a physician and cannot prescribe medications. If you require medication Ms. Storen can refer you to someone who is qualified to prescribe them.

Ethics: Louisa Storen follows the Code of Ethics of the following organizations:

- The South Carolina Boards of Examiners of Licensure of Social Workers, Professional Counselors, Marriage and Family Therapists, and Psycho-educational Specialists
- The American Association for Marriage and Family Therapy
- The National Association of Social Workers

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Therapy Process: Psychotherapy is a process in which we will discuss a myriad of issues, events, experiences and memories. It is a joint effort between us. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. While I do expect benefits to result from counseling, I cannot guarantee any specific results. Treatment is not always successful and may open unexpected emotionally sensitive areas.

Collaboration with Other Professionals: In order to provide quality services, I often need to collaborate with other professionals, such as your physician, psychiatrist, past therapists, and/or other mental health professionals. You will be asked to complete a Release Of Information form authorizing these exchanges **prior to** any collaboration with other professionals. No information will be released, or communicated, until you authorize such in writing on a separate Release Of Information form.

Appointment Scheduling & Cancellation Policies: Appointments may be made in person, over the phone, or via email (this is the least recommended option however due to a little longer response time with email). 50 minutes is considered a one hour appointment (25 minutes a half hour). Appointments generally are made for one hour on the hour from 9am – 5pm (5pm being the last appointment), unless a special arrangement is made.

If an appointment is missed, or canceled with less than 24 hours' notice, you (not your insurance company) may be charged the full fee for that missed session. Exceptions may be made if you are sick or have an unavoidable emergency.

Payment Policy: We are committed to providing you with the best possible care. The fee for service is $140.00 per 50 minute session ($70.00 for 25 minute session). Fees are due at the end of the session and can be paid by check, cash and debit or credit card (we accept Visa, Master Card & Discover – we do not accept American Express). Our policy on returned checks includes an additional $25 office charge to be paid before your next appointment by cash, credit card or money order.

A "no show" (a missed appointment where you failed to contact us within 24 hours of your appointment) fee equivalent to your normal session fee will be charged (eg. if your normal session fee for 1 hour is $140, then you be charged and billed $140). Only in the case of an emergency will negotiating this fee be considered.

Any accounts 90 days past due will assessed 1.5% interest per month and may be turned over to a collection agency. You will be required to pay the amount due plus any collection and/or attorney fees.

Insurance Policy & Reimbursement: As fairly typical, Insurance filing is a courtesy extended to you and not a requirement for Ms. Storen. All session fees and account balances are the sole responsibility of the patient. We have limited our participation in managed care insurance plans because we have found that the extraordinary amount time and resources required for paperwork, telephone time, email traffic, meeting government regulations, etc. takes us away from out main objective of providing you with the best patient care. We are also quite concerned by possible intrusions into issues of confidentiality for our clients.

However, if you have medical insurance and it provides for mental health counseling, we support your receiving the maximum allowable benefits. To assist you in that effort on a case by case basis we can file a claim for you with your insurance carrier. You will need to contact your insurance company yourself beforehand to see if you need pre-qualification or if they will cover Ms Storen, and to what extent. There are so many different plans by so many different companies it would be almost impossible for us to keep up with the specifics of each plan.

In summary, you would pay us directly at the time of your session and then we would generate the required form and mail in to your insurance carrier for direct reimbursement to you. We will need to make a copy of your insurance ID card to keep on file in order to submit a claim for you. You will also need to sign a separate form allowing us to release information to your insurance carrier (please see "psychotherapy notes" in our Privacy and HIPPA Policy – we do *not* submit psychotherapy notes for an insurance claim, so the intimate details you discuss in session are *not* shared with any insurance company).

Termination of Therapy: If you have not scheduled an appointment within 60 days of your last appointment or made a plan for extended follow-up as part of my treatment, you understand that your case will be considered closed and your professional relationship with Ms. Storen will be ended. Your case could be re-opened at a later time if you should wish to return.

In order to provide a safe, respectful, and pleasant experience for all of our clients and guests, there may be times where we need to discharge a client from out practice. Although this is something we rarely do, here are some of the reasons (list is not meant to be all inclusive) we might have to do this:

- ♦ Threatening, rude, or loud behavior by you or those accompanying you.
- ♦ Three no-shows and/or cancelled appointments.
- ♦ Failure to pay your bill in a timely manner.
- ♦ Failure to follow the recommendations of Ms. Storen.
- ♦ A breakdown of communication with you and/or family resulting in a lack of trust that makes it impossible for Ms. Storen to treat you.

Records and Record Keeping: Ms. Storen may take notes during session (legally called "psychotherapy notes"), and will also produce other notes and records regarding your treatment. These notes constitute her clinical and business records, which by law, she is required to maintain and are the sole property of Ms. Storen. Please see "Privacy & HIPAA Statement" for information on accessing your records.

Social Media (other than Email & Texting – see separate heading): I do not accept "friend", contact requests, respond to, or communicate in any manner with current or former clients on any social networking sites (ie. Facebook, Linkedin, Twitter, Pinterest, etc.). I believe that this could compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Email & Internet Based Communications and Texting: Our practice considers email and text messages as the same type of communication as the telephone and thus are used the same way. If you so authorize by filing out our Initial Intake Form we can communicate with you regarding

appointments, reminders, or other important information related to your sessions or therapy, by email or text. All communication in this manner, as with the phone, is strictly for professional or administrative related matters.

Our email, and other forms of internet based communications (ie. Skype), are secure and password protected, but as in any communication via the internet there is always the possibility of data breaches. We take all necessary steps to keep your messages secure but ultimately we cannot be responsible for data breaches using these methods of communication.

Licensing Authorities: Ms. Storen is licensed through the SC Board of Examiners for The Licensure of Professional Counselors, Marriage and Family Therapists, and Psycho-educational Specialists; this Board is located in the Synergy Center (Kingstree Building) in Columbia, SC. Phone #: 803-896-4652. Mailing address: P.O. Box 11329, Columbia, SC 29211-1329.

She is also licensed through the SC Dept. of Labor, Licensing and Regulation Board of Social Work Examiners. The Board's address is Suite 101, 3600 Forest Dr., Columbia, SC 29211-1329. Phone #: 803-895-4665.

Therapist Availability/Emergencies: You may leave a message for Ms. Storen at any time on her confidential voicemail at 843-416-1103. If you wish her to return your call, please be sure to leave your name, phone number(s) and a brief message concerning the nature of your call – please speak slowly and clear. Please understand that as a solo practitioner, Ms. Storen is unable to personally provide continuous 24-hour crisis services. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance, or go to the nearest emergency room. For other types of urgent situations, please follow any instructions that are provided on Ms. Storen's main voicemail at 843-416-1103 and leave your message there. The main voicemail is where she also provides on-call information in the event that she is on vacation or not available. Please do not use email for urgent situations.

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PRIVACY AND HIPPA STATEMENT
(This version is effective as of 3/25/15)

What is this document about? This document serves two purposes: one to explain how important your privacy is to us, and second to fulfill requirements by state and federal law regarding the privacy of your health information. The main guiding authority for this is a law passed by Congress in 1996 and since amended. The law is the Health Insurance Portability and Accountability Act, or more commonly called "HIPAA". The law covers in detail how your health information can be used and disclosed. It also details your individual privacy rights. All this is called "The Privacy Rule". We are also required to have a written privacy policy for you to read which explains our policy and the law to you.

The Privacy Rule applies, for all intents and purpose, to all health care providers or facilities whether medical or mental health. It also covers insurance companies and health plans. Even businesses associated with a health care provider can be covered by HIPAA.

All forms of media are covered: electronic (such as computer records, transmittals via the internet, etc), paper, and/or oral. Any record directly or indirectly related to your health information is covered (demographic information such name and address, notes taken in session, health insurance filings, etc.). Basically any, and all, of this information, is officially defined by the term **PHI (Protected Health information).** All the documents together that are PHI related are called your Designated Record Set

The federal law (HIPAA) is administered by the U.S. Dept. of Health and Human Services and within that department the Office for Civil Rights (OCR). OCR handles any complaint you might have about your privacy, our policy, and whether we are implementing it properly. They can be contacted at http://www.hhs.gov/ocr/hipaa.

The persons to contact regarding our policy, or if you have a complaint or concern regarding your privacy rights, are either Louisa Storen, or her practice manager located in the office area by the reception desk. You can file a written complaint by sending an email to joe@snowislandllc.com (Joe Boyd practice manager).

You may request a copy of this document to keep and take with you. We will always have the most recent version available for you to review. It can change periodically so please ask us for the latest version at any of your visits.

Permitted Uses & Disclosures of your PHI : We ***are*** permitted (but not required) to use and disclose your PHI, ***without*** **your authorization,** for the following purposes or situations. Otherwise your authorization is required. However in certain circumstances we do ask you to sign an authorization to release information even though we are not required to do so.
Note: There is one special category called "psychotherapy notes" that will be explained later that has its own special set of rules.

1.) To you the individual (see separate heading for a further explanation of this)

2.) Treatment, Payment, and Health Care Operations (also called TPO)
    1. *Treatment* is defined as the provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers regarding a patient and referral of a patient by one provider to another.
        i. Collaboration with Other Professionals: In order to provide quality services, I often need to collaborate with other professionals, such as your physician, psychiatrist, past therapists, and/or other mental health professionals. You will be asked to complete a Release Of Information authorizing these exchanges.
    2. *Payment* refers to anything dealing with payment of services, billing, and insurance filing.
    3. *Health Care Operations* encompasses business planning, development, general administrative activities, arranging for legal services, credentialing, etc.

3.) Opportunity to agree or object and informal permission
    1. Informal permission may be obtained by asking you outright or by circumstances that clearly give you the opportunity to agree, acquiesce, or object. Where you are incapacitated, or in an emergency situation, we may make such uses and disclosures if our professional judgment dictates that it's in your best interest.
    2. We may also rely on your informal permission to disclose to your family, and/or person or persons listed as emergency contacts on your intake form.

4.) Incidental Use and Disclosure
    1. The Privacy Rule does not require that every risk of an incidental use or disclosure of PHI be eliminated. A disclosure that occurs as a result of, or as "incident to", an otherwise permitted use is permitted as long as reasonable safeguards are in place.

5.) Public Interest and Benefit Activities: The Rule permits use and disclosure of PHI without your authorization or permission, for 12 national priority purposes. Although these disclosures are permitted, they not all are required by the Rule.
    1. Required by Law: We may disclose information as required by law, including by statute, regulation, or court orders.

    2. Public Health Activities: Rule allows disclosure to public health authorities for preventing injury or disability or reports of child abuse and neglect. Also information may be disclosed to employers if requested by employer for information concerning a work-related illness or injury, or workplace related medical surveillance, because such information is needed by the employer to comply with Occupational Safety and Health Administration (OHSA).

    3. Victims of Abuse, Neglect or Domestic Violence: In certain circumstances, we may have to disclose PHI to appropriate government authorities regarding victims of abuse, neglect, or domestic violence.

4. Health Oversight Activities: We may have to disclose PHI to purposes of government oversight activities such as audits or investigations of health care system and government benefits programs.

5. Judicial & Administrative Proceedings: We may disclose information if so ordered by a court or administrative tribunal. PHI may also be disclosed in response to a subpoena or other lawful process.

6. Law Enforcement Purposes: We may disclose PHI to law enforcement official under the following circumstances.
    i. As required by law (court orders, warrants, subpoenas, etc.).
    ii. To identify or locate a suspect, fugitive, material witness, or missing person.
    iii. In response to law enforcement's request for information about a victim or someone suspected of a crime.
    iv. To alert law enforcement of a person's death if it is thought that criminal activity caused the death.
    v. If it believed PHI is evidence of a crime that occurred on our premises.
    vi. Medical emergency not occurring on our premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or victims, and the perpetrator of the crime.

7. Research: PHI can be used for research purposes provided all regulations and laws governing medical research are followed.

8. Serious Threat to Health or Safety: PHI may be disclosed if we believe it is necessary to prevent or lessen a serious and imminent threat to a person or the public.

9. Essential Government Functions: including conducting intelligence and national security activities authorized by law, or determining eligibility for or conducting enrollment in certain government benefit programs.

10. Worker's Compensation: may disclose PHI as authorized by, and to comply with, worker's compensation laws.

Disclosure Accounting: You have the right to an accounting of the disclosures of your PHI (who has received your information), except for the following:

1.) For treatment, payment, or health care operations.
2.) To your personal representative.
3.) For notification of or to persons involved in your health care or payment.
4.) Pursuant to an authorization.
5.) For national security or intelligence purposes.
6.) To law enforcement officials as stipulated by law.
7.) Incident to otherwise permitted or required uses or disclosures.

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Authorizing Use and Disclosure of PHI: For any disclosure or use of PHI, except as already detailed in this document, a specific written authorization is required to be signed by you. We will have you sign our form for these purposes. It will list to whom the information can be released to, and what that information is. You have right to revoke the authorization any time you wish by providing a written request.

Psychotherapy Notes: This is a very ***special category!*** Psychotherapy notes are basically the written or typed notes that Ms. Storen takes during your session. They document or analyze your conversations. It is recognized here, and under law, that this type of very personal information needs to be protected more than other PHI. In fact these notes need to be kept separate from other PHI.

We have to obtain your individual written authorization to use or disclose these notes, ***except***, in the following circumstances – exception meaning we can do the following without your authorization:

- We may of course use them for treatment
- For our own training
- To defend ourselves in court
- For US Health & Human Services, and other health oversight agency investigations regarding adherence to HIPAA
- To avert a serious and imminent threat to public health or safety
- For health oversight agencies
- In South Carolina these notes can be subpoenaed through a court order signed by a judge

Duty To Warn Mandate: Ms. Storen is mandated by state and federal regulations – through duties to warn – to breach confidentiality if she discovers any of the following:

1. You are threatening self-harm or suicide.
2. You are threatening to harm another or homicide.
3. A child has been or is being abused or neglected.
4. A vulnerable adult has been or is being abused or neglected.

Rights Regarding Access To Your Records: All PHI information, including psychotherapy notes, are solely the property of Louisa Storen. However, **e*xcept for psychotherapy notes***, you have a right to review and obtain a full, or partial copy (we can charge a small fee for this), of your PHI record set unless it is deemed by us that releasing this information would cause harm to your emotional or physical well-being, or emotional or physical well-being of another person who has given information about you. If access is denied to you by us to your PHI - ***excluding psychotherapy notes*** however - then you do have the option to have such denials reviewed by a licensed health care professional for a second opinion. This option does not pertain to psychotherapy notes; as stated earlier, psychotherapy notes have been setup as a special category by state and federal law.

You also have the right to request that your PHI be amended if you believe the information is inaccurate or not complete. Your request can be denied but if it is denied then we must provide you with a written denial and allow you to submit a statement of disagreement for inclusion in your record.

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ACKNOWLEDGEMENT & AUTHORIZATION

PERTAINS TO THE FOLLOWING :

1.) Professional Disclosure & Policy Statement (Form LISW-001) - the "Agreement"
2.) Privacy & HIPAA Statement (Form LISW-005)
3.) Consent for psychotherapy

Acknowledgement: By signing below, you acknowledge that you have reviewed and fully understand the terms and conditions of the agreement "Professional Disclosure & Policy Statement, and the "Privacy & HIPAA Statement". These two documents serve as our privacy statement and disclosure of informed consent as stipulated by law and psychotherapy standards. If you had any questions you stipulate that they were fully answered to your satisfaction.

You agree to abide by the terms and conditions of the Agreement and consent to participate in psychotherapy with Ms. Storen. Moreover, you agree to hold Ms. Storen free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

You further state you were given the opportunity to receive and keep a copy of both of these documents from our practice. Each person is entitled to a copy.

Couples, Families, or Groups:
If more than one individual (eg. spouse, partner or family member) is involved in therapy or counseling, each person please must sign below.

Patient Name (please print)	Signature of Patient (Or Authorized Representative)	Date
Patient Name (please print)	Signature of Patient (Or Authorized Representative)	Date
Patient Name (please print)	Signature of Patient (Or Authorized Representative)	Date
Patient Name (please print)	Signature of Patient (Or Authorized Representative)	Date

INSURANCE SUBMITTAL AUTHORIZATION

NOTE: Please read the section in our Professional Disclosure & Policy Statement (Form LISW-001) for a detailed explanation on our policy regarding insurance.

I hereby authorize the following insurance company to receive, process, and use as they deem necessary my Protected Health Information in order to determine eligibility, status, reimbursement, or direct payment for the services rendered by Louisa Storen. Louisa Storen and/or her office staff may release this information to this insurance company in a manner and means as they deem appropriate to facilitate processing of my insurance claim.

I understand signing this form does not supersede what is contained in our Professional Disclosure & Policy Statement regarding payment and acceptance of insurance. I understand I will still be required to pay the full fee amount at the time of the session. By filing insurance for you we do not guarantee any coverage, reimbursement or payment by your insurance company. Nor are we liable for any mistakes, incorrect filings, or delays in processing.

In addition to the below information we also **NEED TO MAKE A COPY OF YOUR INSURANCE CARD**. The information below and from the car are both needed to file a claim.

AUTHORIZATION EFFECTIVE DATE (Generally Today's Date) _____

NAME OF INSURANCE COMPANY _____

WHO'S NAME IS THE POLICY IN?_____ _____ ____
Last Name First Name MI

RELATIONSHIP OF POLICY HOLDER TO PATIENT _____

POLICY HOLDER'S DATE OF BIRTH _____

POLICY HOLDER'S ADDRESS (if different than yours) – Info is needed for insurance filing
Street Address: _____
City, State, Zip:_____
Phone Number w/Area Code _____
Email Address _____

HOW WAS INSURANCE OBTAINED
Name of Employer or Association: _____

IS THIS YOUR PRIMARY AND ONLY INSURANCE? _____ OR SECONCARY _____
Note: If you are covered by another policy, please fill out a separate form for that insurance.

_____ _____ _____
PATIENT Name (please print) Signature of Patient or Authorized Person Date

_____ _____ _____
INSURED Name (please print) Signature of Insured or Authorized Person Date