LA CBT DBT

dr. jenny taitz

CLINICAL PSYCHOLOGIST

LA CBT DBT Psychological Services
Jennifer L. Taitz, Psy.D., ABPP
License 25222, NPI 1396058335

PERSONAL INFORMATION QUESTIONNAIRE

Name:	Date:	
Address:		
Date of Birth:		
Contact information	May we contact you here/ leave a message	
Mobile phone:	Yes	No
Home phone:	Yes	No
Email address:	Yes	No
Emergency contact -- name, number, and relationship to you:		
Relationship status: Single In a relationship Cohabitating Married Separated Divorced Widowed		
Children (names and ages):		
Education:		
Occupation:		
Religious Denomination:		

How do you identify yourself ethnically or culturally?
Do you speak any other languages at home besides English?
What is your sexual orientation?
How did you hear about LA CBT DBT?
Insurance information (Please note: I do not accept insurance and am not a Medicare provider)
Do you have insurance coverage?
Carrier and percentage of coverage per session:
Do you have Medicare?
Psychiatric and Medical History
Are you currently seeing another therapist or a psychiatrist?
If so, please list the therapist or psychiatrist's name and contact information:
May I reach out to your other treatment provider to collaborate?
Names and dates of previous therapists:
Name: Start Date: End Date:
Name: Start Date: End Date:
Are you currently taking medication? Please list the names, dosage, and dates of each medication:

Please list any psychiatric diagnoses that describe your current experience:
When was the last time you had a physical exam and what was the outcome?
Physician Name:
Please describe any medical problems:
Goals and Psychological History
What are your hopes for therapy?
If therapy proves remarkably effective, what would we accomplish?
What qualities do you find most helpful in a therapist?

Please highlight any problems you would like help with:			
Anxiety	Suicidality	Anger	Decision Making
Depression	Assertion	Aggression	Violence
Fear	Loneliness	Hopelessness	Problem solving
Work	Shyness	Meeting people	Insomnia
Overeating	Under eating	Alcohol	Substance use
Obsessing	Sexual	Panic	Procrastination
Self-criticism	Self-harm	Hopelessness	Relationships
Pain/medical	Legal	Attention span	Fatigue
Other:			
If you've ever faced a trauma or loss, can you describe?			
Do you avoid situations because of anxiety? If yes, please list what you avoid:			
How many hours do you sleep?			
What type of exercise do you do and how often?			
Do you have a history of struggling with eating disorders?			

What substances do you use and how often?
Have you had a problem with substances?
Have you ever had a period of mania?
Have you ever engaged in self-harm behaviors?
Do you feel suicidal or have you ever wanted to die or attempted to end your life?
What do you do like to do in your free time?
Family Background
Please list the names, ages, and occupations of your parents and siblings. If anyone in your family struggles with a psychiatric problem, please provide details.

LA CBT DBT Psychological Services

CONSENT FOR TREATMENT

Mission

Welcome to LA CBT DBT, I am a clinical psychologist and aim to provide evidence-based therapy in a compassionate setting. My hope is for us to work collaboratively toward building/enhancing a life that's meaningful to you. To best accomplish this, we'll try to understand what might be getting in the way and practice tools (based on researched therapies including CBT, DBT, and ACT) to face challenges effectively. It takes courage to seek services and I feel honored to have the opportunity to meet you. I value your time and believe that change is possible. In working with you, I value your input and look forward to hearing what feels helpful and what might not be working.

To start, we'll meet for an initial consultation to get a better sense of whether we might be a good team and to ensure that my experience meets your therapy goals. If we decide that it makes most sense to pursue another approach, I will provide you with referral recommendations.

Before we begin, I want to give you logistical information on what to expect as a patient. These forms are meant to address potential questions, though I am happy to discuss any concerns you have now or in the future.

Therapy Time

Once you start therapy, you can reserve a consistent time with me. If you need to cancel or reschedule your appointment please do so 48 hours in advance or you will be billed the full amount of the session. If you are sick and do not want to come to session, you may use your scheduled time for a phone session. Unfortunately, if you are late, that time will be lost from that session to prevent interfering with time set aside for other clients.

Insurance and rates

I do not accept insurance though will provide you with a receipt you may submit to your provider for potential reimbursement. It is up to you to clarify if your insurance will cover treatment. My fee is $350/45 minutes or $466/60 minutes. You may pay by check, credit card (Visa or MasterCard), or cash, at the time of session or your card on file will be charged. In the unlikely event that bills are not paid within 60 days, past dues are placed in collections. Fees may be changed with at least 4 weeks advance notice. The rate for DBT group is $120/group.

Expectations for Communication
If there is an emergency and you need help urgently, please call 911 or go to your nearest emergency room. If you need to reach me between sessions for a non-urgent matter, I will generally try my best to get back to you within 1-2 business days.

Email, voicemail, and text messaging
There are security risks associated with email and voicemail messages (e.g. delivery to a mistaken email or phone number, electronic communication may not be received, unintended broadcasting of information may occur). While LA CBT DBT Psychological Services/Jennifer L. Taitz, Psy.D., ABPP, will use reasonable measures to protect the security of your information, LA CBT DBT/Jennifer L. Taitz, Psy.D., ABPP, cannot completely guarantee the security of your information. LA CBT DBT/Jennifer L. Taitz, Psy.D., ABPP, will not assume liability for information that is disclosed that is not caused by intentional misconduct. You can check off if you will allow electronic communication of your personal information in the personal information questionnaire. I do not use text messaging as a form of contact with prospective, current, or former clients. I only use email for scheduling. If you need help between sessions, please call by phone so we can talk.

Consulting/letter writing fee
In the event that you need me to write letters on your behalf (e.g. academic accommodations or custody considerations) or connect with outside professionals (e.g. academic counselors or attorneys), if these efforts take more than 15 minutes, you may be billed on a prorated basis for this time.

Ending therapy
You may end therapy at any time, though if you choose to end therapy, I hope we might be able to talk through your decision so I might be able to offer recommendations. If you want to end therapy and I believe that in doing so you are at risk, I will provide you with recommendations or referrals to continue your care. If you want to restart therapy with me, you're welcome to reach out and I will try my best to accommodate you. If I believe I cannot help you, your balance is significantly overdue, or it is in your best interest for our work to end, I will recommend alternative options.

Your rights
You have every right to ask me about my training experiences and credentials. Given how important this time is, you have the right to know what the goals of therapy are and how those will be measured. At any time, you can suggest changes in goals and in your treatment plan. I am open to negative and positive feedback about our work.

LA CBT DBT Psychological Services

HIPAA/PRIVACY PRACTICES

Confidentiality: This describes how medical information about you may be used and disclosed. Please review if carefully and contact me with any questions.

I am required by federal and state law to maintain the privacy of your health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) also requires that I give you this notice about my legal duties, my privacy practice, and your rights concerning your health information. I am required to follow the privacy practices in this notice while it is in effect.

I may use or disclose your protected health information (PHI), information that could identify you*,* for *treatment, payment, and health care operations*. To define these terms, *treatment* includes coordinating with another treatment provider (e.g. physician or another psychologist). *Payment* is when I obtain reimbursement for your health care or to determine eligibility or coverage. *Health care operations* relate to the performance and operation of my practice, such as quality assessment and improvement activities, business matters like audits and administrative services, and case management and care coordination.
Use applies only to activities within my practice, such as sharing, examining and analyzing information that applies to you. *Disclosure* applies to activities outside of my practice, such as releasing, transferring, or providing information about you to other parties.

Uses and disclosures requiring authorization: I may use or disclose PHI for purposes outside of treatment, payment and health care operations when your authorization is obtained. An *authorization* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization, or release of information form, from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes.
Psychotherapy notes are notes I have about our conversations during a private, group, joint, or family counseling session, which I have kept separate from the rest of your chart. These notes are given a greater degree of protection than PHI. It is my policy not to keep separate psychotherapy notes. All documentation we keep is a part of your clinical chart.

I will also obtain an authorization from you before using or disclosing PHI in a way that has not been described in this notice.

I will not use your PHI for marketing or sales purposes under any conditions.

Uses and disclosures with neither consent nor authorization: I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse***:** If in my professional capacity, I have reasonable cause to believe that a minor child is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk or harm to the child's health or welfare (including sexual abuse), or from neglect, including malnutrition, I must immediately report such a condition to the Department of Children and Families.
- *Adult and Domestic Abuse***:** If I have reasonable cause to believe that an elderly person (age 60 or older) is suffering or has died as a result of abuse, I must immediately make a report to the Department of Elder Affairs.
- *Health Oversight***:** The Board of Registration that applies to my particular license to practice has the power, when necessary, to subpoena relevant records should I be the focus of an inquiry.
- *Judicial or Administrative Proceedings***:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release information without written authorization from you or your legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the court evaluation is court ordered. I will inform you if this is the case.
- *Serious Threat to Health or Safety***:** If you communicate to me an explicit threat to kill or inflict serious bodily injury upon an identified person and you have the apparent intent and ability to carry out the threat, I must take reasonable precautions. Reasonable precautions may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. I must also do so if I know you to have a history of physical violence and I believe there is a clear and present danger that you will attempt to kill or inflict bodily injury upon an identified person. Furthermore, if you present a clear and present danger to yourself and refuse to accept further appropriate treatment and I have a reasonable basis to believe that you can be committed to a hospital, I must seek said commitment and may contact members of your family or other individuals if it would assist in protecting you.
- *Workers Compensation***:** If you file a worker's compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division or Worker's Compensation.

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 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 the decision reviewed. On your request, I will discuss with you the details of the amendment 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 or 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.

Psychologist'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 the 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

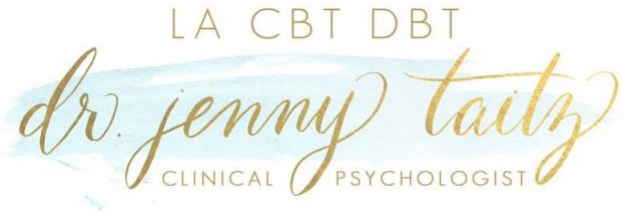
procedures, I will notify current clients and post the new policies in the waiting area.

Questions and 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 at 310-270-5401. You may also send a written complaint to my office. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

Effective Date and Changes to Privacy Policy:

This notice will go into effect on November 1, 2017. I reserve the right to change the terms of the notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by either distributing it to you in the office or mailing it to your home address.



LA CBT DBT Psychological Services

CREDIT CARD AUTHORIZATION

All clients are required to have a current credit card on file. Payment is due at the time of service. In the event you are unable to attend an appointment, please cancel 48 hours in advance. If you miss an appointment and don't cancel 48 hours prior, a "no show" fee will apply.

Please indicate how you would like to render payment:

☐ I would like to use my card on file to regularly pay for my session. Sessions will be billed the week of your scheduled appointment.

☐ I prefer to pay by cash or check for scheduled payments. I understand I will be charged for sessions if I don't furnish payment at the time of service.

Name on credit card: _____

Relationship to cardholder: _____

Credit card billing address: _____

Email: _____

Credit card number: _____

Security code: _____

Expiration: _____

By signing or electronically signing below, I authorize LA CBT DBT Psychological Services/ Jennifer L.Taitz, PsyD., ABPP to charge the above credit card for services provided and in accordance with the terms of the cancellation and fee policies agreement.

Name Signature Date

LA CBT DBT

dr. jenny taitz

CLINICAL PSYCHOLOGIST

LA CBT DBT Psychological Services

PLEASE REVIEW AND SIGN

Acknowledgement and agreement for consent for treatment.

I have read and understand this consent for treatment form. In the event I type my name in the spaces provided, I agree that my electronic signature is the legally binding equivalent to my handwritten signature.

_____

Name Signature Date

Acknowledgement of receipt of notice of privacy practices:

_____

Name Signature Date

Good Faith Estimate & Financial Policies

** indicates a required field*

LA CBT DBT/ Dr. Jenny Taitz
Phone: (310)270-5401
Tax ID: 82-4599947
NPI: 1396058335

Good Faith Estimate of Services and Fees:

The first appointment at LA CBT DBT/ Dr. Jenny Taitz will be a diagnostic intake session (90791), which will allow us to determine the appropriate course of treatment for you. If it feels like a good fit, we will create an individualized treatment plan to best meet your needs. If it does not feel like a good fit, you will be provided with a more appropriate referral. Below is a list of CPT codes and fees.

CPT 90791(95)*: Diagnostic Evaluation (45 minutes, $350.00)
CPT 90834(95): Individual Therapy (45 minutes, $350.00)
CPT 90837(95): Individual Therapy (60 minutes, $466.00)
CPT 90846(95): Family Therapy without patient present (45 minutes, $350.00)
CPT 90847(95): Family Therapy with patient present (45 minutes, $350.00)
CPT 90846(95): Family Therapy without patient present (60 minutes, $466.00)
CPT 90847(95): Family Therapy with patient present (60 minutes, $466.00)

*95 is a modifier used for telehealth sessions

The fee structure detailed above is meant to serve as a GOOD FAITH ESTIMATE of the agreed rate for services reasonably expected to be provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.

As an example, sessions are typically 45 minutes (90834) once per week. Therefore, the Good Faith Estimate is based on weekly therapy sessions continuing through the end of the year, at $350 per session for a total of 50 weeks, accounting for vacations and holidays for an estimated total of [$350 x 50].

The Estimate is only an estimate - actual services or charges may differ. Because of individual differences in responses to therapy among patients, frequency and length of treatment may vary. Therefore, the total estimated cost might change over the course of treatment. The provider may also recommend additional services that are not in the Estimate. Treatment is voluntary and the Estimate does not obligate the client to obtain listed services.

The practice has the right to increase the session fee at any time by giving verbal and/or written notice at least 4 weeks in advance of the fee increase. Should you end treatment and elect to restart treatment at a later date, you will be billed at the then current billable rate.

Occasionally treatment may incorporate off-site consultation. Billing for this will be based on the same hourly rate as an individual therapy session.

Payment

Payment is due in full at the end of each session. If you fail to pay for two or more consecutive sessions, I have the right to stop treatment and refer you to another appropriate treatment provider.

Each patient is required to leave a credit card on file. Even if you choose to pay by cash or check, you agree to leave a debit or credit card on file. In the event of late payment for sessions by 10 or more days from the date of service, the card will be charged. In the event that a check is returned for insufficient funds, a $20 administrative fee will be incurred (in addition to any bank charges). In the event that a charge is denied, you will be notified immediately and asked to provide an alternative form of payment.

If you are delinquent in payment for services, I may refer your account to a collections agency. Information disclosed will comply with legal and ethical requirements. In the event you do not pay and collection is necessary, you are responsible for all costs including reasonable attorney's fees and interest on the debt.

Cancellation Policy

An appointment is a commitment to attend therapy. Once an appointment is scheduled it is your responsibility to call to cancel your appointment; cancellation may be subject to late cancellation fees as described below.

Attending your scheduled intake appointment is important, as it demonstrates your first commitment to treatment. You will be entitled to cancel or reschedule your intake appointment one time without penalty. If this happens, you will be asked to leave a credit card on file when you schedule a follow-up intake session. Should you cancel a rescheduled intake appointment in less than two business days (48 hours during the week; Friday cancellation for Monday appointment; holidays are treated like weekends) you will be charged the cost of the missed session.

For regularly scheduled therapy sessions, a full fee is charged for cancellation with notice that is less than two full business days. If you have to miss a session, you must notify your therapist 48 hours in advance in order to avoid incurring the full charge of your session fee.

* If you do not give 48 hours advanced notice, you understand that you will be charged in full for the appointment. Please be mindful that insurance companies generally do not provide reimbursement for fees related to cancelled or missed sessions.

Please check this box to confirm that you have read and understand the 48-hour cancellation policy

Insurance Reimbursement

LA CBT DBT, Dr. Jenny Taitz is an "out-of-network" treatment provider, which means therapists at the practice do not accept insurance. LA CBT DBT, Dr. Jenny Taitz also does not accept Medicare, Medical, Medicaid, Tricare, or any other governmental insurance plan. Please call your insurance company to find out what your "out of

network” benefits are. Payment is due directly to your therapist. At your request, your therapist will provide you with a statement that you can send to your insurance company for reimbursement. The best way to find out your coverage is to provide them with the codes of service (listed above).

* ☐ I acknowledge receiving the above information, and have had the opportunity to ask whatever questions necessary to fully understand this document and will abide by the information contained in this document.

By checking this, you are eSigning this form.

* Date: