Barton Goldsmith, Ph.D., MFT, CADC-I

Psychotherapist/Licensed Marriage & Family Therapist, Certified Substance Abuse Counselor
32129 Lindero Canyon Blvd. Suite 210, Westlake Village, California
Phone: 818-879-9996 Fax: 818-879-6502 www.BartonGoldsmith.com

PATIENT EMAIL CONSENT FORM

To Address the Risks of Using Email

Patient Name: _____ Patient Email: _____

1. Risk of Using Email
   Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:
   a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   b) Email senders can easily misaddress an email.
   c) Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
   d) Employers and online services have a right to inspect email transmitted through their systems.
   e) Email can be intercepted, altered, forwarded, or used without authorization or detection.
   f) Email can be used to introduce viruses into computer systems.
   g) Email can be used as evidence in court.
   h) Email may not be secure, and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions For the Use of Email
   Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:
   a) **Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email will be read and responded to within any particular period of time.**
   b) Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.
   c) **All email will usually be printed and filed in the patient's medical record.**
   d) Office staff may receive and read your email messages.
   e) Provider will not forward patient identifiable emails to other healthcare providers without the patient's prior written consent, except as authorized or required by law.
   f) The patient should not use email for communication regarding sensitive information.
   g) Provider is not liable for breaches of confidentiality caused by the patient or any third party.
   h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. Instructions
   To communicate by email, the patient shall:
   a) Avoid use of his/her employer's computer.
   b) Put the patient's name in the body of the email.
   c) Key in the topic (e.g., medical question, billing question) in the subject line.
   d) Inform Provider of changes in his/her email address.
   e) Acknowledge any email received from the Provider.
   f) Take precautions to preserve the confidentiality of email.

4. Patient Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Provider and me, and consent to the conditions and instructions outlined. If I have any questions I may inquire with Dr. Barton Goldsmith or his staff.

_____
Signature of Patient or Responsible Party

_____
Date

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HIPAA NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act ("**HIPAA**") requires that we maintain the privacy of your medical information and provide you this notice in writing of our privacy practices.

We value the confidentiality of your personal health information ("PHI"). Your health information includes records that we create and obtain when we provide care to you, including records of your symptoms, examination and test results, diagnosis, treatments, and referral for further care, in addition to bills and payment information, and insurance claims that we maintain related to your care. This notice describes how physical and mental health information about you may be used and disclosed, your rights regarding this information, and how you may access this information. Please review it carefully. Any questions should be directed to our office.

Consistent with HIPAA and California law, we are required to:

- Maintain the privacy of protected health information as required by law.
- Give you this notice of our legal duties and privacy practices regarding your health information
- Follow the terms of the Notice currently in effect.

It is the policy of our office that a notice of privacy practices be provided to all subject individuals at the first patient encounter if possible, and that all uses and disclosures of protected health information be done in accord with this office's notice of privacy practices. In order to better serve our patients, office staff may receive and read email messages, and may also hear and transcribe voicemail messages from patients. Our office staff abides by HIPAA guidelines.

The following describes the way we may use and disclose your health information. Except for the following purposes, we will use and disclose your health information only with your written permission. You may revoke this permission at any time by writing to our office.

It is our policy of that for all routine and recurring uses and disclosures of PHI (except for uses or disclosures made 1) for treatment purposes, 2) to or as authorized by the patient or 3) as required by law for HIPAA compliance, such uses and disclosures of protected health information must be limited to the minimum amount of information needed to accomplish the purpose of the use or disclosure. It is also our policy that non-routine uses and disclosures will be handled pursuant to established criteria. It is also our policy that all requests for protected health information (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request.

We may use and disclose your physical and mental health information for your treatment and to provide you with treatment-related health care services. We may use and disclose your physical and mental health information to contact you and remind you of your appointment times, to advise you of treatment alternatives, health related benefits, or other services you could use. We will disclose your physical and mental health information when required to do so by international, federal, state or local law.

It is our policy to require an authorization for any use or disclosure of psychotherapy notes, as defined in the HIPAA regulations, except for treatment, payment or health care operations as follows:
A. Use by originator for treatment;
B. Use or disclosure in defense of a legal action brought by the individual whose records are in issue;

C. Use or disclosures as required by law, or as authorized by law to enable health oversight agencies to oversee the originator of the psychotherapy notes. In most cases, when we receive a request to disclose psychotherapy notes, it is our policy to provide copies of psychotherapy notes to the patient, along with the information of the entity requesting the notes, allowing the patient to provide the notes to the requesting entity.

You have the right to inspect and/or receive a copy of your physical and mental health information and billing records, except in very limited circumstances. You have the right to request an amendment to your records. You have the right to an accounting of disclosures of your PHI. All requests should be made in writing to this office.

We may change this notice and make it effective for medical information we already have in addition to new information we may obtain from you. You have a right to request a paper copy of the current notice at any visit or by written request to this office.

If you have any questions or complaints regarding your privacy rights, please contact this office at the address above. If you believe your privacy rights have been violated, you may file a complaint with Dr. Barton Goldsmith. To file a complaint with the Secretary of the Department of Health and Human Services contact the: Department of Health and Human Services, Office of Civil Rights, South United Nations Plaza, Room 322, San Francisco, CA 94102, PHONE (415) 437-8310. (FAX) (415) 437-8329, (TDD) (415) 437-8311. *You will not be penalized for filing a complaint*.

Patient Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices of Barton Goldsmith, Ph.D.

_____ _____

Patient Name Date

For office use only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:

- **The patient refused to sign**
- **Communication barriers**
- **Emergency Situation**
- **Other**

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Informed Consent

Welcome. This patient information form will answer most of your questions about therapy services at my office. Please feel free to ask for clarification or additional information at your initial visit.

What is therapy and how does it work? Therapy is the process of solving emotional problems by talking with a person professionally trained to help people achieve a more fulfilling individual life, marital relationship, or family relationships. The process of change will, in many ways, be unique to your particular situation. Who you are as a person will help to determine the ways in which you go about changing your life. The process of change begins by first clearly defining the problem, and then discussing your thoughts and feelings, understanding the origin of the difficulty and developing new skills and healthy attitudes about yourself and others. As the patient, you have the right to ask your therapist questions about his/her qualifications, background and orientation. The most important factor in the success of therapy is good communication between therapist and patient. In some instances, talking about your difficulties may exacerbate your symptoms, however over time you should see an improvement. In addition, not all individuals benefit from therapy or working with a particular therapist. If at any time during the therapy you have questions about whether or not the treatment is effective, feelings about something I have said or suggested or need clarification of our goals, do not hesitate to bring this up in our session.

Confidentiality: By law and professional ethics, your sessions are strictly confidential. Generally, no information will be shared with anyone without your written permission. If you are seeing another therapist or health professional it may be necessary for me to contact that person so that we can coordinate our efforts. If this is necessary I will ask for your permission. In addition, some insurance companies require periodic updates. I will only provide this information with your permission.

Regarding couples counseling: I employ a "no secrets" policy when counseling couples. Your signature at the bottom of this document states that you understand that if you are seeing me with your partner and information arises through an individual conservation, that information is not bound by the standard confidentiality agreement. This process is therapeutically correct as it does not let either party covertly control the therapy.

The following are additional exceptions to this confidentiality policy.

- If I am ordered by the court to testify or release records.
- If you are a victim or perpetrator of child abuse I am required by law to report this to the authorities responsible for investigating child abuse.
- If you are a victim or perpetrator of elder or dependent adult abuse I am required by law to report this to Adult Protective Services or other appropriate authorities.
- If you threaten harm to yourself, someone else or the property of others, I may be required to call the police and warn the potential victim, or take other reasonable steps to prevent the threatened harm.

Fees: My current fee is $195.00 for a fifty-minute hour. **You are expected to pay for the counseling at each session unless other arrangements have been made.** Fees may be increased with reasonable notice. If at any time you have financial concerns do not hesitate to discuss them with me. In most cases, financial concerns can be resolved. Please have your check made out to Dr. Goldsmith before your session so we can use our time together in the wisest ways.

Unpaid balances: Delinquent bills will be turned over to a collection agency. The patient is responsible for the original bill, service charges, collection fees, as well as any legal costs that are incurred as a result of the collection process.

Insurance: I do not bill insurance companies directly. I will give you a statement at the end of the month marked "PAID" which you may submit to your insurance company for reimbursement directly to you.

When insurance is utilized for psychotherapy services, patients should be aware of the limits of confidentiality. Typically, insurance companies only require the following information: length of illness, psychiatric diagnosis, dates of service, and the names of persons being treated. Recently managed care companies have been requiring additional information such as family abuse history, alcohol and drug history, treatment goals/interventions, the details of the treatment sessions, and on some occasions, treatment notes. In addition, providers are now required to sign waivers that allow the payers to audit client records. What this means is, if you utilize your insurance benefits for psychotherapy services, you may not have the extent of confidentiality you would otherwise expect.

Cancellations: **You will be charged for all missed appointments**. You may call my answering service 24 hours a day, seven days a week to cancel an appointment. Frequent cancellations may result in your losing your regular appointment time and having to schedule our meetings based on my availability each week. If you have the type of schedule that makes consistent weekly appointments impossible, we may be able to work out a schedule that meets both of our needs. Periodically I will have to cancel sessions due to mandatory court appearances or medical emergencies. If this occurs I will notify you promptly so that we can reschedule our session. You will not be charged for these cancelled appointments.

After Hours Emergencies: **I am not available after my usual business hours for emergencies** I do check my messages during weekdays between 9:00 AM and 8:00 PM and I am usually available to speak with you on the telephone (or schedule a time we can talk). There will be a charge for all telephones calls other than brief calls concerning rescheduling appointments, confirming appointments, etc. Leave a message on my voicemail (**818-879-9996**) and I will call you back as soon as I retrieve the message. For after-hours emergencies or if you need immediate assistance call 911, your medical group, or your primary care physician.

Vacations: I will give you reasonable notice before I go on vacation. If I am going to be out of town or unavailable, a colleague will be on call for emergencies. The name and phone number of this individual will be on my answering machine. If you feel that you will need continuing treatment during this time, I will help you make arrangements ahead of time with another therapist.

Terminating Treatment: You have the right to terminate or take a break from your treatment at any time without my permission or agreement. However, if you do decide to exercise this option, I encourage you to talk with me about the reason for your decision in a counseling session so that we can bring sufficient closure to our work together. In our final session we can discuss your progress thus far and explore ways in which you can continue to utilize the skills and knowledge that you have gained through your therapy. We can also discuss any referrals that you may require at that time.

Psychotherapists are ethically required to continue therapeutic relationships only so long as it is reasonably clear that patients are benefiting from the relationship. Therefore, if I believe that you need additional treatment, or if I believe that I can no longer help you with your problems I will discuss this with you and make an appropriate referral.

HIPPA Privacy Act: Your signature below acknowledges that you have received a copy of the HIPPA Privacy Act.

Legal Issues: Should any legal issues/disputes arise between the client and the therapist, the client agrees to settle said issues/disputes through mediation and binding arbitration rather than the court system. By signing this document you are waving your rights to have this matter determined and resolved through any civil or court proceeding.

Initials:_____ _____

Please initial this form above and sign below and keep a copy for yourself for future reference.

I/we have read, understand and agree to the information and policies described in this form.

_____	_____	_____
Client Name (print)	Client Signature	Date
_____	_____	_____
Client Name (print)	Client Signature	Date

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General Information

(All Information is strictly CONFIDENTIAL)

Client: _____ Age: _____ Birth Date: _____

Social Security #: _____ Insurance: _____ Group #: _____

Subscriber # _____ E-mail: _____

Home Phone: (____) _____ Other Phone: (____) _____

Address: _____ City: _____ Zip: _____

Business Phone: (____) _____ Occupation/Company: _____

Person to Notify in Case of Emergency: _____

Phone: (____) _____ Relationship: _____

Medical Dr.: _____ Phone: (____) _____

Who recommended Dr. Goldsmith to you: _____

Credit Card # _____ Exp._____ I.D.# _____

Welcome to Dr. Barton Goldsmith's office. Please read the following guidelines carefully. If you have any questions, please speak with Dr. Goldsmith before signing this agreement.

Fees: The customary fee is $195 per session, unless other arrangements have been made with Dr. Goldsmith. Payments for services are required at the end of the session, unless prior arrangements have been made with Dr. Goldsmith. Each session is 50 minutes long. The minimum fee to prepare any reports, case summaries, court appearances, or any other services rendered on the client's behalf is $325.

Telephone Consultation: Telephone and electronic communication involves Dr. Goldsmith's time, expertise, and the documentation of the medical management provided. By utilizing these convenient options, these services *may replace or prevent the need for an office visit.* Therefore, telephone and electronic care are recognized as patient care by the American Medical Association and *some* insurance providers. Telephone and electronic communication are considered a professional service and charges may be submitted to you when appropriate. Telephone conversations up to 10 minutes are free of charge. Telephone conversations over 10 minutes are considered patient sessions and will be charged as such.

Insurance: If you have insurance, you will be provided with an insurance statement to submit to your insurance company. I am not a contracted provider with insurance companies. Services are not rendered on the basis that your insurance company will reimburse you.

Cancellation: **A minimum of 48 hours notice is required for rescheduling or canceling appointments.** The full fee will be charged for missed sessions or cancellation of less than 48 hours before the appointment. Dr. Goldsmith has my permission to charge my credit card for services rendered or un-cancelled/missed appointments.

Confidentiality: All information disclosed within sessions is confidential and will not be revealed to anyone without written permission. No information you disclose will ever be divulged - except where disclosure is required by law. For insurance purposes Dr. Goldsmith may need to e-mail/fax or speak to your insurance company. Please sign below to grant your permission and to acknowledge that you have received the HIPPA Privacy Notification.

Emergencies: When emergencies arise, you may call Dr. Goldsmith on his cell phone at (818) 521-2922. For non-emergency communications, please contact the office at (818) 879-9996.

If you do not understand any part of this agreement, please discuss your questions with Dr. Goldsmith before signing this form.

Signature below permits use of credit card.

I have read and understand this agreement. My signature acknowledges my agreement to all conditions stated above.

Signature: _____ Date: _____

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MEDICAL HISTORY

Patient Name:_____Date:_____

MEDICAL HISTORY (If yes, check box & write past or present)

□ Headache _____ □ Hepatitis _____ □ Arthritis _____
□ Head injury _____ □ Appetite/Weight Change_____ □ Cancer _____
□ Loss of Consciousness_____ □ Thyroid Problems_____ □ Skin problems _____
□ Asthma _____ □ Diabetes _____ □ Vision problems _____
□ Shortness of breath_____ □ Kidney Disease _____ □ Hearing problems_____
□ Allergies/Hay fever_____ □ Urinary Problems _____ □ Polio _____
□ Heart problems _____ □ Seizures _____ □ Abnormal Lab Tests _____
□ High Blood Pressure_____ □ Withdrawal Seizures_____ □ Sexual Problems_____
□ GI disorder _____ □ Frequent Infections _____ □ Other _____
□ Constipation_____ □ Anemia _____ □ Other _____
□ Diarrhea_____ □ Allergies to medications- names and reactions: _____
_____

WOMEN ONLY

Currently Pregnant? □ Yes □ No Planning pregnancy? □ Yes_____ □ No _____
Regular Menstrual Cycles? □ Yes □ No Date of Last PAP? _____

MEN ONLY

It's common for men to occasionally experience erection difficulties. Is this something that happens to you? □ Yes □ No
How often does this occur? □ Frequently □ Sometimes □ Rarely

HABITS

□ Smoke: Packs Daily_____ □ Coffee: Cups daily: _____ □ Sleep: Difficulty falling asleep _____
How long? _____ Other caffeine _____ Difficulty staying asleep _____
Tried stopping?_____ □ Alcohol: Type: _____ Snoring _____
□ Exercise: What kind _____ Amount daily:_____ Early morning awakening _____
Minutes per day_____ Amount Weekly:_____ □ Special Diet: _____
Days per week_____

HOSPITALIZATION OR SURGERY

Reason(s):_____ Date: _____
Reason(s):_____ Date: _____

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A message to my patients about Arbitration:

The contract below is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the mental health services you receive is to be resolved in binding arbitration rather that a suit in court. I believe the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts. By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings. Of course, my goal is to provide mental health care in such a way as to avoid any such disputes. I know that most problems begin with communication. Therefore, if you have any questions about your care, please ask me.

PATIENT ARBITRATION AGREEMENT

By signing this agreement, the patient agrees with the provider that any dispute between you and Dr. Barton Goldsmith and any dispute relating to medical services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whomever made (including, to the full extent permitted by applicable law, third parties who are not signatories to this agreement) shall be resolved by binding arbitration. Any award of the arbitrator(s) may be entered as a judgment in any court having jurisdiction. In the event a court having jurisdiction finds any portion of this agreement unenforceable, that portion shall not be effective and the remainder of the agreement shall remain effective. This agreement shall be governed by and interpreted under the Federal Arbitration Act, 9 U.S.C. Sections 1-16.

This agreement binds all parties whose claims may arise out of or relate to treatment or service provided by Dr. Barton Goldsmith, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean both the mother and the mother’s expected child or children. This provision for arbitration may be revoked by written notice delivered to the physician within 30 days of signature.

If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:
Effective as of the date of first medical services: Patient/Responsible Party Initials: _____

The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the physician, cannot be brought as a lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as described in this section.

_____
Patient Name

_____
Date

Authorization to Release Confidential Information

I, [Name of Patient] _____

hereby authorize [Name of Provider] _____

to release confidential information obtained during the course of my treatment to [name and function of the person(s) or entities to which information is to be released] _____

_____

This Authorization permits the release of the following information:

____ Any and All Information Necessary

____ Diagnosis ____ Treatment Plan ____ Prognosis

____ Progress to Date ____ Clinical Test Results ____ Dates of Treatment

____ Patient Records ____ Summary of Treatment

____ Other _____

_____

I authorize the release of the information described above for the following purpose(s):

_____

_____

The recipient may use the information described above solely for the following purpose(s):

_____

_____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until: _____("Expiration Date")

By: _____ Date:_____

(Patient or Patient's Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative: