

TYLER C. RALSTON, PSYD

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Dear New Client,

Thank you for your interest in my therapy services.

Please read and complete the forms on the following 12 pages and bring them to our first meeting, at which time I will go over them with you to be sure you have an opportunity to ask any questions you may have, and to ensure that you understand the information before you sign.

If you have children, please arrange in advance for child care away from the office as there is no child care available at our office while we meet. This will help to ensure we have a focused and uninterrupted meeting during which you receive the most benefit from the limited time we have.

A scheduled session means that time is reserved specifically and only for you. Once a session is scheduled, you will be expected to pay for the full session unless you provide at least 24 hours advance notice of cancellation. To avoid this charge, please call at least 24 hours in advance of your scheduled session if you plan to miss or cancel.

Please arrive on time for your appointment.

Location: 3599 Waialae Avenue, 3rd Floor
Honolulu Hawaii 96816

Please Bring: Completed initial forms (found on the following 12 pages)
Insurance card
Photo identification such as a driver's license or state ID
Cash or check if your plan has a deductible, copay, or coinsurance

I look forward to our first appointment.

Sincerely,
Tyler C. Ralston, PsyD

THERAPIST - CLIENT CONTRACT

Welcome to my psychotherapy practice. This document contains important information about my professional services and business policies. Please read it carefully and write down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you bring forward. There are many different methods I may use to help you with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. Therapy will be most beneficial to you when you work on things we talk about both during our sessions and between sessions.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, it is likely that you will experience uncomfortable thoughts and feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. A benefit of psychotherapy is that it has been shown to often help people who go through it. In other words, therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Up to our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. It is in your best interest to evaluate this information along with your own opinions of whether you are comfortable working with me. Therapy involves a large commitment of time, money, and energy, so it is in your best interest to be very careful about the therapist you select. If you have questions about my procedures, please let me know as they arise so that we can discuss them. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

I provide psychotherapy. I generally do not provide services, evaluations, or paperwork related to workers compensation, occupational fitness for duty/work, vocational rehabilitation, Social Security disability, disability insurance, Veterans Affairs claims, child custody, court evaluations, or other legal proceedings.

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SESSIONS

I normally conduct an evaluation that will last from 1 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45 to 50-minute or one 75 to 80 minute session (one appointment hour of 45 to 50 or 75 to 80 minutes duration) per week at a time we agree on, although some sessions may be more frequent.

CANCELLED/MISSED SESSIONS

A scheduled session means that time is reserved specifically and only for you. If you cancel within 24 hours of your scheduled session or miss your session, I am left with an empty hour in my schedule that cannot be filled by another client. If you were to make an appointment and then not keep it, it takes away an hour that another client who needs the services could have been seen.

Once a session hour is scheduled, you will be expected to pay for the full session unless you provide at least 24 hours advance notice of cancellation. If your appointment is scheduled for Monday, you are expected to contact me by 6:00 p.m. the previous Friday. For missed sessions, or sessions cancelled less than 24 hours before the scheduled session start time, you will be billed directly according to the scheduled fee or according to the rules of your health plan/insurance. If your health plan/insurance does not cover payment for missed sessions, you will be required to pay the full session fee.

If there are special circumstances where you think you may regularly miss appointments, please discuss this with me. I will do my best to work with you to make your treatment program work for you. If you would like phone or email reminders the day before, I will be happy to do so. However, I cannot guarantee you will always get the reminder, and it is still your responsibility to come to your scheduled appointment.

PROFESSIONAL FEES

My fees are dependent on the service provided and are as follows:

Diagnostic Interview	50 minutes	CPT code 90801	\$200.00
Psychotherapy	20-30 minutes	CPT code 90804	\$100.00
Psychotherapy	45-50 minutes	CPT code 90806	\$200.00
Psychotherapy	75-80 minutes	CPT code 90808	\$250.00

Tax will be added accordingly to fees above. In addition to weekly appointments, my hourly fee for other professional services you may need is \$200.00 plus tax. I will break down the hourly cost if I work for periods of less than one hour. Other services include telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records

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or treatment summaries, and the time spent performing certain other services you may request of me. I will not willingly participate in any legal matters on your behalf. However, if you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$600.00 per hour plus tax for preparation and or attendance at any legal proceeding.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. A portion of my fees are covered by most insurance plans. Copayment is required at the time of each visit. Payment schedules for other professional services will be agreed to when they are requested. Cash or check made payable to Tyler Ralston, PsyD is acceptable. A return check fee of \$15.00 will be charged to your account for insufficient funds.

If your account has not been paid for more than 30 days after the date of service and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out, and understand, exactly what mental health services your insurance policy covers.

Carefully read the section in your insurance coverage booklet, or online, that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have become increasingly more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed

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Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, you may want more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

Please be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. 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 possession. 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.

It is important to remember that you always have the right to pay cash for my services to avoid the insurance-related situations described above.

CONTACTING ME AND COMMUNICATION

I am often not immediately available by telephone as I may be with a client in session. When I am unavailable, my telephone is answered by voice mail, that I monitor frequently. I will make every effort to return your call on the same day you make it. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and believe that you can’t wait for me to return your call, contact your family physician, call 911, or go to the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, such as on vacation, I will provide you with the name of a colleague to contact, if necessary. Part of my ability to provide the best treatment possible for you depends on your willingness, effort, and ability to communicate with me in a timely manner. Therefore, when I leave a phone message for you to call me, your care from me will be enhanced when you call me back as soon as you can, and by the end of the day at the latest.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are

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professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. You will be charged an appropriate fee for any professional time spent in responding to information requests.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission. However, there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if s/he determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about your treatment. For example, if I believe that a child, elderly person, or a person with a disability is being abused, I may be required to file a report with the appropriate state agency.

If I believe that you are threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for you. If you threaten to harm yourself, I may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I believe that it is important to our work together.

I deposit client copayments and coinsurance checks at the bank. Bank personnel can therefore see a client's name on a check written to me or my psychology practice. If you do not want bank personnel to see a check from you to me or my business, I encourage you to pay copayments and/or coinsurance with cash.

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While this written summary of exceptions to confidentiality may prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signature below indicates that you have read, understand, and been given the opportunity to ask questions for clarification about the information in this document and you agree to abide by its terms during your professional relationship with Tyler C. Ralston, PsyD.

Client Print Name _____

Client Signature _____ Date _____

APA Revised 9911

Revised 0908

NOTICE OF PRIVACY POLICIES AND PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA) requires that I provide you with this Notice of my privacy policies and practices, and that I obtain your signature acknowledging that you have received this Notice. If you do not understand any part of this notice, please ask for further explanation.

1. Uses and Disclosures for Treatment, Payment and Health Care Operations

Protected health information (PHI) is information in your records that could identify you. I am required by law to maintain the privacy of PHI. Your PHI may be used or disclosed for routine *treatment, payment, and health care operations* purposes with your written, advance *consent*, which is provided by your signature of the Therapist - Client Contract.

2. Uses and Disclosures Requiring Authorization

You may give written *authorization* for the use or disclosure of PHI for purposes other than treatment, payment, or health care operations. Written *authorization* is also needed for the release of *Psychotherapy Notes*, which are notes made during psychotherapy sessions, and which are kept separate from the rest of your clinical record. All authorizations may be revoked, in writing, at any time, except to the extent that prior disclosure of information has already taken place.

3. Uses and Disclosures with Neither Consent or Authorization

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

Health Oversight Activities - If a government agency such as the Hawaii Board of Psychology requests information for health oversight activities, I must release the necessary information.

Judicial and Administrative Proceedings - If you are involved in a court proceeding and a request is made for information about the psychological services provided to you and/or the records thereof, such information is privileged under Hawaii law. I shall release such information only with written authorization by you or your legally appointed representative, or at the direction of a court order.

Workers' Compensation and Personal Injury Claims - If you have filed a Workers' Compensation, No Fault, or other personal injury claim, I may be required to disclose PHI about any services I have provided to you that are relevant to the claimed injury.

Complaints and Lawsuits - If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

In some situations, I am legally obligated to take actions that I believe are necessary to attempt to protect a patient or others from harm. The following situations may require the disclosure of PHI:

Child Abuse - If I have reason to believe that child abuse or neglect has occurred or that there is a substantial risk that child abuse or neglect may occur in the reasonably foreseeable future, I must immediately report the matter to the appropriate authority.

Adult and Domestic Abuse - If I have reason to believe that a dependent adult has been abused or is threatened with imminent abuse, I must promptly report the matter to the appropriate authority.

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Serious Threat to Health or Safety - In situations in which there is clear and imminent danger to you, to another individual or to society, it is my duty to take action to minimize the danger. This may involve the disclosure of PHI to appropriate professional workers, to public authorities, or to the individual at risk. If you are at risk, I may also contact family members or others who could assist in providing protection.

4. Patients' Rights

Right to Request Restrictions - You have the right to request restrictions on uses and disclosures of PHI. I will attempt to accommodate reasonable requests, but I am not required to agree to a restriction.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications by alternative means and at alternative locations. (For example, you may request that bills or other correspondence be sent to another address.)

Right to Inspect and Copy - You have the right to inspect and obtain a copy of PHI in my clinical and billing records 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. A fee may be charged for copies.

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 have the right to receive an accounting of disclosures of PHI. 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.

5. 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, please inform me at once. You may also send a written complaint to the Secretary of the U.S. Dept. of Health and Human Services.

6. Effective date and Changes to Privacy Policy

This notice will go into effect on 04/14/2003. I reserve the right to revise the policies and practices described in this Notice, in which case I will notify you in person or by mail.

I hereby acknowledge that I have received a copy of this "Notice of Privacy Policies and Practices" as required by the Health Insurance Portability and Accountability Act (HIPAA).

Client/Recipient Print Name

Client/Recipient Signature

Date

Revised 0908

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CLIENT INFORMATION AND INSURANCE AUTHORIZATION

Name _____
First MI Last

Home Address _____
Street City State Zip

Billing Address (if different than home address) _____
Street City State Zip

Home Phone # _____ Business Phone # _____ Mobile Phone # _____
(Please check box for preferred phone where you can be reached)

Social Security Number: _____ Birth Date _____ Sex: M F

How did you learn about my services or who referred you? _____

Employer (if employed) _____ Occupation _____

Emergency Contact: _____ Relationship to you? _____ Phone _____

INSURANCE INFORMATION:

Primary Insurance Carrier _____	Secondary Insurance Carrier _____
Subscriber's Name _____	Subscriber's Name _____
Subscriber # _____	Subscriber # _____
Group # _____	Group # _____
Subscriber's Birth Date _____ Sex M F	Subscriber's Birth Date _____ Sex M F
Relationship to Client _____	Relationship to Client _____
Client's Insurance Number (if different than subscriber) _____	Client's Insurance Number (if different than subscriber) _____

Insurance Authorization - Please Read and Sign

I hereby authorize Tyler Ralston, PsyD to furnish information to insurance carriers or governmental agencies concerning my psychological difficulties and treatment and I hereby assign to him all payments for medical or psychological services rendered to me. I understand I am responsible for any amount not covered by insurance. A copy of this signature is as valid as the original. If I am covered by Medicare, I authorize any holder of medical or psychological information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I am expected to pay my portion of the bill at the time of service, unless my health plan requires otherwise. For my portion of the bill not paid at the time of service, I understand that I am expected to pay within 30 days after the date of service. Cash or check made payable to Tyler Ralston, PsyD is acceptable. If any problems with your payment are anticipated, please discuss them with Dr. Ralston at this time.

Client Signature _____ Date _____
Rev 0908

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BACKGROUND INFORMATION

Name _____ Date _____

In your own words, what has been troubling you? _____

Since when (or date of first symptom?) Month _____ Day _____ Year _____

Have you been in therapy before Y N When _____

With what provider? _____ How many sessions? _____

For what kind of difficulty? _____

Was it helpful? Y N If yes, how so? _____ If no, why? _____

Describe how you think others "see" you. _____

Are you struggling with any of the following? (Circle all that apply)

Difficulty relaxing	Alcohol/Substances	Guilt	Stress
Family problems	Anger	Depression	Pain
Sleep	Work problems	Suicidal thoughts	Sexual issues
Other _____			

What do you tend to do when you find yourself struggling with any of the above?

What culture or ethnicity do you identify with? _____

Do you have a religious or spiritual practice? Y N If 'yes', what affiliation? _____

Who do you talk with when you have a problem? _____

Have you in the past, or do you currently, physically hurt yourself or others? _____
(e.g., hitting, cutting, suicide attempts, etc)

Do you have any current legal issues such as divorce, probation, parole, TRO, etc.? Y N

What is your source of income? _____

Any debt or worrisome issues related to money? _____

What do you do for fun and relaxation? _____

What are your individual strengths? _____

What are your family's strengths? _____

Please list the top 3 events that have changed your life:

- 1.
- 2.
- 3.

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MEDICAL

Significant medical history? (e.g., chronic illnesses, chronic pain, head injuries, hospitalizations, etc.)

Since when? _____

Current medications (include dosage) _____

Name of Primary Care Provider _____ Date of last physical? _____

Physical activity:

Kind _____

How often? _____ How long each time? _____

FAMILY:

Do you live with others? Y N If yes, who? _____

Do you have a significant other? Y N If yes, how long have you been in the relationship? _____

Are you married? Y N If yes, how long married? _____

Briefly describe your relationship with your significant other:

Do you have children? Y N If yes:

Name: _____ age: _____ Lives with you? Y N

Name: _____ age: _____ Lives with you? Y N

Name: _____ age: _____ Lives with you? Y N

Name: _____ age: _____ Lives with you? Y N

What is your relationship with your parent(s) like? _____

What is your relationship with your sibling(s)? _____

What family member do you consider yourself closest with? _____

Any losses/deaths of family members, including lost pregnancies? Y N

If yes, what was his/her relationship to you, and year of loss:

Please list any family members who have been diagnosed or treated for psychological problems:

If this was your last session, and you were satisfied with the outcome of therapy, how would your life be different?

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Substance Questionnaire

Name _____ Age _____ DOB _____ Date _____

Please complete the following table. Approximate information where necessary. Use the back of the page if you would like more room to answer.

	Age First Used?	Age Last Used?	How Often Use?	How Much Use Each Time?	Ever Had Treatment?	When?	Where? With Whom?	Was it Helpful?
Caffeinated Coffee					Y N			Y N
Caffeinated Tea					Y N			Y N
Caffeinated Soda					Y N			Y N
Cigarettes					Y N			Y N
Chewing Tobacco					Y N			Y N
Ecstasy (MDMA)					Y N			Y N
Amphetamines (Uppers)					Y N			Y N
Cocaine					Y N			Y N
Crack					Y N			Y N
Crank					Y N			Y N
Crystal Meth. (Ice)					Y N			Y N
Beer					Y N			Y N
Wine					Y N			Y N
Liquor					Y N			Y N
Marijuana					Y N			Y N
Barbiturates (Downers)					Y N			Y N
Opiates					Y N			Y N
Morphine					Y N			Y N
Heroin					Y N			Y N
Methadone					Y N			
LSD					Y N			Y N
Mushrooms					Y N			Y N
Peyote					Y N			Y N
Glue/Paint					Y N			Y N
Other Inhalants					Y N			Y N
Prescription Drugs					Y N			Y N
Other					Y N			Y N