Becoming A Better Me, LLC.

Psychotherapy is one of the most private endeavors in which one can engage. So it is our effort to make it most pleasurable and indeed a beneficial experience.

Together, we will address all 8 dimensions of wellness as needed (financial, social, environmental, spiritual, physical, emotional, intellectual, and occupational). We will also explore your intimate thoughts and feelings in a way that is different from all other relationships outside of therapy.

The success of this work, supported by the Clinical Code of Ethics, depends in part on the privacy of what we discuss awareness of our relationship while we work together, your commitment and willingness to **do the work,** all in an effort to **BECOME YOUR BEST VERSION OF YOU!**

Please print out the attached forms and take some time to look them over. We will go over them more in depth during your first session. Please feel free to ask questions about any of these forms and policies and to have anything you do not understand explained to you. (If you do not have access to a printer, please let us know, and plan to arrive 15 minutes before your scheduled appointment allowing time for completion. **If working by way of telecommunication, forms and/or questions should be submitted to **Becoming.ABetterMeTeam@yahoo.com***

The attached forms explain how we work, what you can expect, and ask for some basic information about you and your decision to engage in therapy at this time:

- **New Client Intake Form**
- **Becoming A Better Me, LLC Service Agreement**

If you are not planning to use insurance to pay for your treatment (or otherwise/as needed) please fill out:

- **Private pay Agreement**

The following forms discuss communication between sessions, emergency procedures, privacy, and confidentiality:

- **Notice of Privacy Practices**
- **Acknowledgment of Privacy Practices**
- **Emergency Procedures**

Thank you for allowing us to be a part of your journey of **Becoming A Better You!**

Becoming A Better Me, LLC.

Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Personal Information

First Name: _____ Last Name _____

DOB: _____ Age: _____ Gender: □ Male □ Female

Parent/Legal Guardian (if under 18): _____

Address: _____

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

Email: _____ May we leave a message? □ Yes □ No

Please note: Email correspondence is not considered to be a confidential medium of communication.

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Referred By (if any): _____

Whom may we contact in case of emergency? : _____

Relationship: _____ Phone: _____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No

If yes, please list:

_____

_____

Have you ever been prescribed psychiatric medication? □ Yes □ No

If yes, please list and provide dates:

_____

_____

General and Mental Health Information

1. How would you rate your current physical health? □Poor □Satisfactory □Good □ Very good

Please list any specific health problems you are currently experiencing: _____

_____

2. How would you rate your current sleeping habits? □Poor □Satisfactory □Good □ Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems: _____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ Yes □ No

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ Yes □ No

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ Yes □ No

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ Yes □ No

9. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Never

10. Are you currently in a romantic relationship? □ Yes □ No

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

_____

11. What significant life changes or stressful events have you experienced recently? _____

_____

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the Family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Difficulty	Yes / No	Family member
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

OCCUPATIONAL INFORMATION

1. Are you currently employed? □ No □ Yes If yes, what is your current employment situation? _____

_____

2. Do you enjoy your work? Is there anything stressful about your current work? _____

_____

RELIGIOUS/SPIRITUAL INFORMATION

1. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____

_____

ADDITIONAL INFORMATION

1. What do you consider to be some of your strengths? _____

_____

_____

2. What do you consider to be some of your weaknesses? _____

_____

_____

3. What would you like to accomplish out of your time in therapy? _____

_____

_____

Becoming A Better Me, LLC.

Service Agreement

***Please read carefully the following information regarding the psychotherapy practice of Becoming A Better Me LLC/Allashia Smith-Harris, LMHC.**

***Please initial each item to indicate that you have read, understand, and agree with the following items. Please ask for clarification if anything is unclear to you.**

____The session lasts for 50 minutes. (Due to new insurance regulations, insurance companies may restrict sessions to 45 minutes) I will let you know when you are near the end of the session so that you can share any closing thoughts or feelings.

____The standard fee is $150 per session, payable at the conclusion of the session. For your convenience, I take Visa, MasterCard, Discover, American Express and cash**. ****

_____Cancellation: 24-hour notice is required; otherwise, you will be charged the full fee for the session.

____In case of sickness: (I prefer that you do not keep your appointment if you are not feeling well). Notice of cancellation must be given at least 2 hours before the appointment time, (however I would appreciate notice as early as possible).

By signing below you are acknowledging and agree to the above service agreement.

Print: _____ Signature: _____

Date: _____

***Does not apply to clients with a sliding fee*

Becoming A Better Me, LLC.

Service Agreement-Sliding Fee

***Please read carefully the following information regarding the psychotherapy practice of Becoming A Better Me LLC/Allashia Smith-Harris, LMHC.**

***Please initial each item to indicate that you have read, understand, and agree with the following items. Please ask for clarification if anything is unclear to you.**

____The session lasts for 50 minutes. (Due to new insurance regulations, insurance companies may restrict sessions to 45 minutes) I will let you know when you are near the end of the session so that you can share any closing thoughts or feelings.

____ The standard fee agreed upon will be _____ per session, payable at the conclusion of the session. For your convenience, I take Visa, MasterCard, Discover, American Express and cash.

____ Sliding fees will be re-evaluated with clients on a six-month basis.

_____Cancellation: 24-hour notice is required; otherwise, you will be charged the full fee for the session.

____In case of sickness: (I prefer that you do not keep your appointment if you are not feeling well). Notice of cancellation must be given at least 2 hours before the appointment time, (however I would appreciate notice as early as possible).

By signing below you are acknowledging and agree to the above service agreement.

Print: _____ Signature: _____

Date: _____

Becoming A Better Me, LLC.

Private Payment Agreement

The following agreement outlines the terms of payment arranged for clients who prefer not to utilize their insurance coverage with Becoming a Better Me LLC/Allashia Smith-Harris, LMHC.

***Please initial each item to indicate that you have read, understand, and agree with the following items:**

_____ I am choosing not to use any Health Insurance Coverage to pay for psychotherapy services with Becoming a Better Me LLC/Allashia Smith-Harris, LMHC at this time.

_____ I understand that Becoming a Better Me LLC/Allashia Smith-Harris, LMHC, LMHC will not bill any third party or insurance companies for any services or fee's incurred while I am in treatment.

_____ I understand I am solely responsible for any fee's incurred while in treatment with Becoming a Better Me LLC/Allashia Smith-Harris, LMHC.

_____ I am aware of the fee per session for psychotherapy treatment with Becoming a Better Me LLC/Allashia Smith-Harris, LMHC

_____ I understand that if I decide to use my insurance coverage I will alert Becoming a Better Me LLC/Allashia Smith-Harris, LMHC in writing, and that any treatment provided before that date will not be billed to my insurance.

_____ I understand that Becoming a Better Me LLC/Allashia Smith-Harris, LMHC may not be a provider with my insurance company should I elect to have insurance billing in the future.

_____ I understand that this private pay agreement will be in effect for the duration of my treatment with Becoming a Better Me LLC/Allashia Smith-Harris, LMHC.

Please sign below to indicate that you have read, understand, and agree with the above initialed items.

Print Name: _____ Sign Name: _____

Date: _____

Notice of Privacy Practices

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

This Notice of Privacy Practices describes the legal obligations of Becoming A Better Me, LLC and your legal rights regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. HIPAA requires us to provide this Notice of Privacy Practices to you.

The HIPAA Privacy Rule protects certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

- Your past, present or future physical or mental health or condition;
- Providing health care to you; or
- Making past, present or future payments for providing health care to you.

If you have any questions about this notice or about our privacy practices, please contact Allashia Smith-Harris, LMHC, Founder and CEO at becoming.abetterme@yahoo.com.

Effective Date

This Notice is effective June 1st, 2018

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- notify you of any breach of unsecured protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

How We May Use and Disclose Your Protected Health Information

We may use or disclose your protected health information in certain situations without your permission.

The main reasons for which we may use and may disclose your Protected Health Insurance are to evaluate and process any requests for coverage and claims for benefits. Your Protected Health Information (PHI) may be used:

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility or to coordinate coverage. For example, we may share your protected

health information with health care provider in connection with the payment of health claims or to another health plan to coordinate benefit payments.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

Special Situations

Although unlikely, it is also possible that we may use and disclose your protected health information in these situations:

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Required Disclosures

We are required to make disclosures of your protected health information in these situations:

Government Audits. We must disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. If you request, we must disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. If you request, we also must provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed due to your specific authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., if you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or
- treating such person as your personal representative could endanger you; and
- in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Authorizations. Other uses or disclosures of your protected health information, including but not limited to psychotherapy notes, will only be made with your written authorization. You may revoke written authorization at any time, but the revocation must be in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed before we received the revocation.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care. To inspect and copy your protected health information, you must submit your request in writing to the contact listed at the end of this notice. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept on file with becoming A Better Me, LLC. To request an amendment, your request must be made in writing and submitted to the contact listed at the end of this notice.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures

made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Contact listed at the end of this Notice.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. To request restrictions, you must make your request in writing to the contact listed at the end of this Notice.

Right to Request Confidential Communications. You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications that is different than what was originally indicated on your intake form, you must make your request in writing to the Contact listed at the end of this notice or with office staff. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the person listed at the end of this notice.

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Office for Civil Rights of the United States Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

We may change the terms of this Notice and make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any significant change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by mail within 60 days after the change.

Contact

Allashia Smith-Harris, LMHC
Founder and CEO
Becoming A Better Me, LLC
466 Main Street, Ste. 203
New Rochelle, NY 10801
Becoming.abetterme@yahoo.com

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

• Obtain payment from third-party payers.

• Conduct normal operations such as quality assessments and clinician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Becoming A Better Me, LLC has the right to change it Notice of Privacy practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name: _____
Relationship to Client: _____

Signature: _____

Date: _____

OFFICE USE ONLY:

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:

Emergency Notification Agreement

Please initial next to each item to indicate you have read and understand the information.

In case of a Mental Health emergency-specifically if I feel I may harm myself or someone else:

_____ I will call Allashia Smith-Harris, LMHC (914) 536-8100, then leave a voice message when prompted to do so.

_____ If I do not hear back from and/or if instructed by Allashia Smith-Harris, LMHC, I will immediately call 911, go to the nearest emergency room, or call the Crisis Prevention and Response Team (CPRT) at (914) 952-5959.

_____ In the event of an emergency you authorize your emergency contact person to be notified.

_____ I will place a follow up call to Allashia Smith-Harris, LMHC following said occurrence.

_____ I understand that if I flag a message urgent for reasons other than stated above I will be charged for psychotherapy services.

I _____, agree and understand the above emergency procedures.

Print Name: _____ Sign Name: _____

Date: _____

Becoming A Better Me, LLC.

Authorization for Disclosure and Release of Medical and Mental Health Information

Name: _____ D.O.B: ___-___-___ Phone: _____-_____-_____
(Print)
Address: _____

I hereby authorize Becoming A Better Me/Allashia Smith-Harris, LMHC to:

□ Release information to □ Receive information from □ Exchange information with

_____

(Person/facility, address, phone, fax which has medical and/or mental health information)

Type of disclosure: ☐ Verbal/Written/Electronic ☐ Copies of record ☐ Letter

Purpose of disclosure: ☐Ongoing treatment ☐ Support ☐ Other_____

By initialing below, you are authorizing the following information to be released:

_____ **All counseling/mental health information** (subject to HIPAA privacy Laws
(Initial) additionally, all information regarding Alcohol and/or Drug Abuse will be released unless restricted in limitations below).

_____ **All medication management services information medical information** (This may include but
(Initial) is not limited to drug/alcohol and mental health information).

Limitations, if any, upon disclosure: _____

Type(s) of information: ☐ Initial Assessment ☐ Treatment Summary ☐ Attendance

☐ Psychiatric evaluation/medication history □ Other_____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is _____ or 1 year from today's date, whichever is sooner.
- I understand that I may revoke this authorization at any time and it will be effective on the date notified except to the extent action has already been taken.
- I understand that if I have authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality law.
- I understand that a photocopy or fax of this form is as valid as the original.

Signature of Client: _____ Date: _____

Parent/Legal Guardian/Authorized Person: _____ Date: _____
(*Indicate relationship to client*)