MARY BETH THOMPSON, LMFT
Best Self Therapy, LLC
1001 West 31st Street
Cheyenne, WY 82001

For office use only:
DX: _____

PATIENT INFORMATION SHEET

*Patient Name: _____ *Date of Birth: _____

*Street: _____

*City: _____ *State: _____ *Zip:_____

*Home Phone: _____*Work Phone: _____*Cell phone:_____

*Sex: Male [ ] Female [ ] *Social Security No. (Last Four):_____

*Patient Relationship to the Responsible Party (Circle one): Self Spouse Child Other

*E-mail address: _____

*Primary Care Physician: _____

*Emergency Contact: _____ *Phone: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

*Responsible Party Name: _____ *Date of Birth: _____

*Street: _____

*City: _____ *State: _____ *Zip: _____

*Home Phone: _____ *Social Security No. (Last Four): _____

INSURANCE INFORMATION *attach copy of card(s) for commercial payers

***Primary Insurance**: _____*Phone: _____

*Claims Mailing Address: _____

*Name of Subscriber: _____ *Subscriber's Date of Birth: _____

*Policy ID: _____ *Group No.: _____

*Patient Relationship to Subscriber (Circle one): Self Spouse Child Other

***Secondary Insurance**: _____ *Phone: _____

*Claims Mailing Address: _____

*Name of Subscriber: _____ *Subscriber's Date of Birth: _____

*Policy ID: _____ *Group No.: _____

*Patient Relationship to Subscriber (Circle one): Self Spouse Child Other

I authorize Mary Beth Thompson, LMFT to furnish my insurance carrier with all information to process my claim for services rendered. I understand that if my insurance should deny payment, I am responsible for the full charges. If my plan requires pre-authorization or referrals, I understand that it is my responsibility to request referrals from my primary care provider in advance and to be aware of the terms of my plan benefits. I have read and agree to the above information:

Signature: _____ Date: _____

BEST SELF THERAPY, LLC
With Fleming Associates
Mary Beth Thompson, MS, LMFT
1001 W 31st St
Cheyenne, WY 82001
Phone (307) 634-6883
Fax (307) 634-9462

DISCLOSURE STATEMENT AND CONSENT TO TREATMENT

This disclosure statement is required by the Wyoming Mental Health Professions Licensing Act of 1997 in which responsibilities and ethics are established and published. The agency regulating the practice of psychotherapy in Wyoming is the Wyoming Mental Health Professions Licensing Board, 2001 Capitol Ave., Room 104, Cheyenne, WY, 82002, telephone (307) 777-3628, email wyomhplb@wyo.gov.

I will adhere to the Code of Ethics of the American Association of Marriage and Family Therapy, Wyoming Statutes, and standards of confidentiality.

MY QUALIFICATIONS

I have completed the requirements of the State of Wyoming to be a Licensed Marriage and Family Therapist, LMFT-206. I received a Master of Science degree from Colorado State University in Human Development and Family Studies, with a specialty in Marriage and Family Therapy. My Bachelor of Science degree is from Brigham Young University in Geography, with a Minor in Child Development and Family Relations. I have received additional specialized training in grief and loss, addictions, play therapy, trauma-informed therapy and attachment.

CONFIDENTIALITY

You have the right to expect the maintenance of confidentiality of all written or verbal communication between client and therapist. No personal information will be released without your written permission. As of March 1, 1999, Wyoming has implemented a privileged communication statute, W.S. 33-38-113. This law states that, when involved in legal proceedings (civil, criminal or juvenile) clients retain the right to privacy, unless these specific circumstances exist:

a) Abuse or harmful neglect of children, the elderly or disabled or incompetent individuals is known or reasonably suspected,
b) The validity of a will of a former client is contested,
c) Information related to therapy is necessary to defend against a malpractice action brought by a client,
d) An immediate threat of physical violence against a readily identifiable victim is disclosed to the therapist,
e) In the context of civil commitment proceedings, where an immediate threat of self-inflicted harm is disclosed to the therapist,
f) The client alleges mental or emotional damages in civil litigation or his/her mental or emotional state becomes an issue in any court proceeding concerning child custody or visitation,
g) The patient or client is examined pursuant to a court order, and
h) In the context of investigations and hearings brought by the client and conducted by the board, where violations of this act are at issue.

When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. Therefore, I may disclose to law enforcement information about my concerns. By signing this and agreeing to receive treatment from me, you consent to this practice should it become necessary.

Under circumstances where safety is concerned, inadequate level of care, or out-of-scope practice develops, I will provide specialty referrals or assure access to ancillary and/or inpatient facilities including Cheyenne Regional Medical Center Behavioral Health Services.

The standard of practice for most psychotherapists is to receive consultation/supervision from their colleagues and/or supervisors in order to maintain the highest quality of services. I participate in several consultation/supervision groups on a regular basis. The members include the therapists at Fleming Associates and other local and/or regional therapists. In these groups, we avoid giving identifying information and the therapists are bound by strict confidentiality laws. If you are interested, I will provide you a list of names of the therapists who participate in the groups. If you know any of these therapists personally, professionally, or otherwise, I will not be discussing your case with them in any manner.

E-mail: We may communicate by email for the purposes of reminders, assignments, or setting appointments only. Please

do not provide any confidential information over email as e-mail is not considered a secure means of communication. I include a confidentiality notice within each of my e-mails, but I cannot guarantee that your e-mails will remain confidential. By signing this disclosure, you assume the risks of e-mailing me should you choose to do so.

CLIENT RIGHTS AND GRIEVANCE PROCEDURE

As a client in therapy, you have the following rights:

1) You have the right to be treated with dignity and respect.
2) You are entitled to information about any procedures, methods of therapy, techniques, fees and the possible duration of therapy.
3) You have the right to terminate therapy at any time without any moral, legal, or financial obligations other than those you have already accrued.
4) You have the right to receive a second opinion from another therapist or to change therapists at any time. If you wish, I will provide the names of at least three other qualified professionals whose services you may prefer.
5) You have the right to review and/or receive a summary of your records at any time.
6) In a professional relationship, sexual intimacy between a therapist and client is never appropriate. If sexual intimacy of any kind occurs, it should be immediately reported to the State Grievance Board.
7) You have a right to expect confidentiality within the limits described above. If you request it, in writing, any part of your records can be released to any person or agency you designate.
8) You have the right not to be discriminated against due to race or ethnicity, sex or gender, age, religion, education, ability, sexual orientation, or socioeconomic status.
9) You have the right to be informed of your rights in a way that you understand.
10) You have a right to make a complaint or grievance at any time without retaliation. If you have complaints or concerns about the way that you have been treated, you may speak directly with me and/or file a grievance with the State Grievance Board.

In order to keep our relationship professional, I do not accept any gifts, however small. Sexual intimacy with a client is never appropriate.

I have a "no secrets policy "with couples and families. I will work with you to help you tell a secret that could be a problem for therapeutic progress and not encourage you to keep the secret, as long as safety is not an issue.

FEES AND CANCELLATIONS

Payment is due in full at the time of service, unless other arrangements have been agreed upon. I accept cash, checks, and credit cards.

My standard charge is $200.00 for an initial clinical assessment and $180.00 per session; however, I do bill insurance for payments. You may be responsible for copayments and/or co-insurance. I do not discriminate in the provision of services to an individual because the individual is unable to pay; or because payment for services is made under Medicare, Medicaid or the Children's Health Insurance Program (CHIP).

If you elect to self-pay, the rate is $90 per session out-of-pocket.

Please give at least 24 hours notice when canceling an appointment or you may be charged $25.00 for the session. Exceptions for late cancellations may be made in emergency situations. If you are late to session, your time may be shortened or rescheduled.

I understand that, if necessary, any outstanding balances will be submitted to:

American Collection Systems
407 S 21st Street
Laramie, WY 82070

COURT TESTIMONY

On occasion, clients will request that I testify in court proceedings. My court fees are $250 per hour and include any preparation, travel, documentation, supplies, and fees, and wait/appearance time. If you are involved in divorce or custody litigation, my role as a therapist is <u>not</u> to make recommendations to the court concerning custody or parenting issues. The court can appoint professionals, who have no prior relationship with family members, to conduct an investigation or

evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children.

Please be aware that having me testify in court puts any testimony regarding confidential therapeutic content into the public record. It also produces a risk of the entire therapeutic file being ordered into the public record. If you or your attorney subpoena me for testimony, you are responsible for assuming these risks.

THE THERAPEUTIC PROCESS

Change has many costs and benefits, all of which cannot be foreseen. Some possible benefits that may be gained from participating in therapy include more positive relationships, a greater sense of self, a stronger sense of happiness and empowerment, and for children, improved behavior at home and school. In working to achieve these benefits, however, people may experience significant discomfort. Remembering and working through unpleasant events or attempting to change negative behaviors can bring up feelings of anger, fear, depression, frustration, and confusion. As a result, you or your child may have the experience of things getting worse before they get better. While our goal is to improve the quality of life for you or your child, there can be no guarantee of a "cure" in the practice of psychotherapy.

THE LENGTH OF THERAPY

Generally, therapy sessions will last 50-55 minutes. Typically, I schedule sessions on a weekly basis, but as therapy progresses, it may be helpful to schedule more or less frequently dependent upon the needs of you or your family. The length of therapy depends on several factors in your or your family's past and present experiences. Generally, the more distant or severe the issue, the longer the process will take. Your progress with be accelerated with your regular and timely attendance.

OFFICE HOURS AND EMERGENCIES

I am in the office and check messages on Monday through Thursday. I do not provide on-call emergency services outside of my business hours. When I am on vacation, my voicemail will have the contact information for another therapist who will cover my cases in the event of an emergency during business hours. If you have an unexpected mental health emergency after hours please call 911 or go to the nearest emergency room.

CONSENTS FOR TREATMENT

Health and Medical Care Consent: I give my consent to all mental health care services performed by Best Self Therapy, LLC and Mary Beth Thompson, LMFT to provide such medical care (including evaluation and diagnostic) as may be deemed necessary and appropriate.

Release of Information and Insurance Benefits: I authorize Best Self Therapy, LLC and Mary Beth Thompson, MS, LMFT to release my medical and/or financial records to individuals and entities as specified in the notice of privacy practices and/or by federal and state law. I understand that any revocation of consent will not be effective for disclosures necessary to effectuate any payments for health care that has been provided.

AGREEMENT: I have read and understand these disclosures and consents. I agree to the above stated policies and procedures.

_____	_____	_____
Client Name (**please print**)	Client Signature	Date
_____	_____	_____
Parent/Guardian Name (**please print**)	Signature (If needed)	Date
_____	_____	
Therapist: Mary Beth Thompson, MS, LMFT	Date	

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ADDITIONAL FAMILY AND COUPLE DISCLOSURES

a. Systems Approach. Couples and family therapy utilizes treatment modalities based upon the family or couple being the treatment unit and that neither the person nor his or her problems exists in a vacuum. Physical, social and emotional functioning of individuals is profoundly interdependent, meaning changes in one part of the system create changes in other parts.

b. "No secrets" policy. I have a "no secrets policy "in working with couples and families. You will be asked to sign releases of information so this therapist may talk freely with all members of family or couple and maintain an equal and balanced alliance with all family members. I will work with you to help you tell a secret that could be a problem for therapeutic progress and not encourage you to keep the secret, as long as safety is not an issue.

c. Documentation and billing. For billing purposes, records of family and couple's therapy will be maintained in the identified primary patient's chart. This will include a diagnostic classification for the individual, records of sessions and the therapist's observations and/or recommendations.

d. Access to Records. Should any member of the couple or family want or need records for the family or couple's treatment released to the patient or to a third party, the identified primary patient would need to sign the form to release that information; such records can be released with only that person's signature

e. Safety. Couples and family therapy can escalate emotions for all involved; an individual's sense of stability is important for family members to stay safe while participating in this type of therapy. In some instances, it may be appropriate for the therapist to discontinue couples and family therapy if the risks of safety become too high; in that case the therapist may recommend an individual seek individual therapy before resuming couples or family therapy

f. Attendance. The expectation is that all members of family or couple be present at every session unless a different arrangement is agreed upon ahead of time with the therapist. It is standard practice for therapist to sometimes meet with individuals or subgroups of a family or couple for one or more sessions in the service of couples or family therapy. If all members will not be able to attend, the therapist would request a phone call in advance informing them of this.

AGREEMENT: I have read and understand this disclosure and agree to the above stated policies and procedures.

_____	_____	_____
Client Name (**please print**)	Client Signature	Date
_____	_____	_____
Parent/Guardian (**please print**)	Signature (If needed)	Date
_____	_____	
Therapist: Mary Beth Thompson, MS, LMFT	Date	

GUARANTEE OF PAYMENT

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, co-payments, and service that are not covered by your insurance plan, and any service that your insurance company has determined not to be "medically necessary."

* *

I have read and understand this information. I understand that my insurance company may deny coverage and request that **Mary Beth Thompson, LMFT.** perform this medical service anyway. I agree to be personally and fully responsible for all charges.

I understand that if necessary any outstanding balances will be submitted to:
American Collection Systems
407 S 21st Street
Laramie, WY 82070

_____	_____	_____
Patient or Legal Representative	**Print Name**	**Date**

Fleming Associates

PRIVACY NOTICE – Effective Date: April 14, 2003
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.

1. PURPOSE: Fleming Associates and its professional staff and employees follow the privacy practices described in this Notice. Fleming Associates keeps your information in records that will be maintained and protected in a confidential manner, as required by law. Please note that in order to provide you with the best possible care and treatment, all professional staff involved in your treatment and employees involved in the health care operations of the agency may have access to your records.

2. HOW YOUR INFORMATION IS USED FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO):
   We will always limit the use(s), disclosure(s) and request(s) of your protected health information to that which is determined to be the minimum necessary to accomplish the intended purpose. Your treatment may include sharing information among mental health care professionals who are involved in your treatment. For example, if you are seeing both a physician (psychiatrist) and a psychologist, they may share information in the process of coordinating your care. Your insurance company or third party payer may request information that we are required to submit in order to provide and bill for your services. Anyone reviewing records must follow the same confidentiality laws and rules required of all health care providers. Treatment records may be reviewed as part of an on-going process directed toward assuring the quality of Agency operations. Staff members designed by Fleming Associates may access clinical records periodically to verify that Agency standards are met. Records are sometimes used for reasons other than client care. For example, records are periodically reviewed to evaluate the quality of care, or to be sure that Fleming Associates follows the rules of regulatory agencies for the efficient and effective utilization of care.

3. HOW YOUR PROTECTED HEALTH INFORMATION IS USED AND STORED:
   Your clinical record will be stored in locked file cabinets when not in use and retained by Fleming Associates for a minimum of six years after your last clinical contact with the agency. After that time has elapsed, the record will be shredded or otherwise destroyed in a way that protects your privacy, except where law requires it to be kept for a longer period of time.

In addition to those listed above in #2 (TPO), and until the records are destroyed, they may be used for the following purposes unless you ask for restrictions on a specific use or disclosure (instructions listed in #5 below):

- Appointment reminders;
- Notification when an appointment is cancelled or rescheduled;
- As may be required by law;
- For public health purposes such as reporting of child or elder abuse or neglect; reporting reactions to medications; infectious disease control; notifying authorities of suspected abuse, neglect, or domestic violence (if you agree or as required by law);
- Mental health oversight activities, e.g., audits, inspections or investigations of administration and management of Fleming Associates;
- Lawsuits and disputes (We will attempt to provide you advance notice of subpoena before disclosing information from your record.);
- Law enforcement (e.g., in response to a court order or other legal process) to identify or locate an individual being sought by authorities; about victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred on Fleming Associates property when emergency circumstances occur relating to a crime;
- To prevent a serious threat to health or safety;
- To carry out treatment and health care operations functions through medical transcription services;
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority;
- National security and intelligence activities;

- Protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.

4. YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES. Except as described previously, we will not use or disclose information from your record unless you authorize (permit) Fleming Associates to do so. You may revoke your permission in writing, which will be effective only after the date of your written revocation.

5. YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.
   You have the following rights regarding your health insurance.
   - Right to request restriction. You may request limitations on your mental health information we may disclose, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
   - Right to confidential communications. You may request communications in a certain way or at certain location, but you must specify how or where you wish to be contacted.
   - Right to inspect and copy. You have the right to inspect and copy your information regarding decisions about your care; however, psychotherapy notes may not be inspected and copied. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed mental health professional chosen by Fleming Associates.
   - Right to request to clarify record. If you believe that the information we have about you is incorrect or incomplete you may ask to add clarifying information. Fleming Associates is not required to accept the information that you propose.
   - Right to accounting of disclosures. You may request a list of the disclosures of your mental health information that have been made to persons or entities other than for treatment, payment or health care operations in the last six (6) years, but not prior to April 14, 2003.
   - Right to a copy of this Notice. You may request a paper or electronic copy of this Notice at any time.

6. REQUIREMENTS REGARDING THIS NOTICE.
   Fleming Associates is required to provide you with this Notice that governs our privacy practices. Fleming Associates may change its policies or procedures in regard to privacy practices. If and when changes occur, the changes will be effective for information we have about you as well as any information we receive in the future. Any time you come in to Fleming Associates for an appointment, you may ask for and receive a copy of the Privacy Notice that is in effect at the time. Fleming Associates will have the Notice posted.

7. COMPLAINTS.
   If you believe your privacy rights have been violated, you may file a complaint with Fleming Associates. You will not be penalized or retaliated against in any way for making a complaint.

   If you have a complaint, if you have any questions about this notice, if you wish to request an additional copy of this notice, or if you wish to request restrictions on uses and disclosure for health care treatment or operations, Contact:

   Fleming Associates
   1001 West 31st Street
   Cheyenne, WY 82001
   Phone: (307) 634-6883
   FAX: (307) 634-9462
   mail@flemingassociates.net

   Please acknowledge receipt of Fleming Associates Privacy Notice by signing below:

   _____
   Signature