James H. Bramson, Psy.D., LCSW
Licensed Clinical Psychologist – (PSY-19459)
Psychological & Organizational Solutions, Inc.

10 Funston Avenue, San Francisco, CA 94129 Tel: 925-285-2429

89 Moraga Way, Suite B Tel: 925-285-2429
Orinda, CA 94563 Fax: 925-429-9259

Patient Information			
Name		Date	
Home Phone		Mobile Phone	
Work Phone May we contact you? (Please circle one) Yes or No May we leave a message? (Please circle one) Yes or No			
Fax Number			
Email Address			
Street Address			
City, State, Zip Code			
Birth date Age	Social Security	Sex M or F	
Ethnic Background			
Insurance Information			
Insurance Company		Insurance Company Phone:	
Name of Insured	Group No.	Authorization No.	
Date of Birth of Insured		SSN of Insured	
Employee Assistance Program Reference No.			
Total Sessions Pre-authorized		Co-payment	
Job Information			
Name of Company		Job Title	
How long have you worked there?			
Any job related concerns?			

What is the reason for your visit?

Family History
Marital Status: Single Married Separated Divorced Widowed Other_____
Partner's Name & Length and General Description of Relationship
Parent's Name
Sibling/s Name
Child or Children Name/s

Persons Living in Household			
Name	Sex	Birth Date	Relationship
Education and/or employment			
Military Service			

Emergency Contact's Name	Phone
Relationship	Address

Environmental Stressors	
Marriage	Divorce
Employment	Family
Illness	Legal
Other current stressful situations	

Drug & Alcohol Use	**Frequency/Amount**	**First Use/Last Use**

Mental Health History	
Therapy Dates	Hospitalization Dates
Therapist (License Type)	
Agency	
Contact Information	
Tests Given	
Therapy Dates	Hospitalization Dates
Therapist (License Type)	
Agency	
Contact Information	
Tests Given	

Medical History			
Prior medical hospitalization?		Yes	No
Dates	Doctor		
Dates	Doctor		
Dates	Doctor		
Currently being treated for a medical problem?		Yes	No
Doctor	Condition		

Doctor	Condition
Doctor	Condition

Current Medications		
Medication	Dosage/Frequency	Prescribed by

Past or Current Conditions Experienced by Patient or Blood Relatives *(Please write "S" for conditions you experience yourself and "F" for conditions experienced by family members)*			
Relationship problems	Pain	Headaches	Anxiety
Job problems	Substance abuse	Dizzy spells	Violence
Sleep disorders	Suicide	Memory loss	Legal problems
Depression	Eating disorders	Sexual problems	Head injuries
Huntington's	Parkinson's	Thyroid problems	Seizure disorders
Learning Disabilities/ADD/ADHD			
Other:			
Are you right or left handed?			
Date of last physical exam		Results	

Intake Form Signature Page:

_____ _____

Patient's Signature Date

_____ _____

Parent's Signature (If Patient is a Minor) Date

_____ _____

Witness Signature Date

Please bring any medical, mental health, school, work, or other supporting documents with you. Also, please enclose a copy of your insurance card. Thank you for completing this patient packet.

James H. Bramson, Psy.D., LCSW
Licensed Clinical Psychologist (PSY-19459/LCS-19040)
Contract for Psychological Services

Welcome

The following information is provided to help you make an informed decision about participating in therapy, as well as to answer any questions you may have about office policies and treatment. Please feel free to discuss any questions or concerns you may have after reviewing the enclosed information.

Licensure

I am licensed by the State of California as a Clinical Psychologist (PSY-19459) and Licensed Clinical Social Worker (LCS-19040). I have been licensed by the state of California since 1998, but have over 20 years of clinical experience with licensures in other states. I have a Doctoral degree in Counseling/Clinical Psychology & Master's in Social Work.

Confidentiality

All clients are assured of confidentiality. Only a release of information, signed by you, may authorize me to discuss any information with other individuals. There are, however, important exceptions in which I am required by law to reveal information about you without your permission.

1. The law requires that I notify the intended victim and the appropriate law enforcement agencies if I judge that a patient had an intention to cause serious bodily harm or death to another individual.

2. I am obliged by law to report any suspected child abuse, neglect, or molestation to protect the child/children involved.

3. I am obliged by law to report any suspected abuse, neglect, or molestation of an elderly person or dependent adult involved.

4. It I assess a client to be suicidal, I am required by law to notify the individuals or agencies necessary to prevent self-harm, including initiating hospitalization on an involuntary basis if necessary.

5. In cases of alleged criminal or civil liability, I may be court ordered to release treatment information and/or records.

6. Some confidentiality will be lost in the insurance billing process. Additionally, if you have a managed care policy, clinical information is generally required in order to authorize reimbursement for services rendered. I will explain the issues surrounding these procedures if you have any questions.

7. I may determine it clinically necessary to discuss some aspects of your psychotherapy with another qualified professional in order to further your treatment goals. If I seek such consultation, neither your name nor any identifying information will be communicated.

8. I may release your name for collections processing. However, not treatment related information will

accompany the disclosure.

Client's Rights

1. You have the right to decide to end our psychotherapy work at any time. If you would like, I will provide you with the names of other qualified psychotherapists.

2. You have the right to learn about alternative methods of treatment. If you would like, I will discuss these with you during our work together.

3. You have the right to refuse the use of any therapeutic technique. I will inform you if I intend to use any unusual procedures and explain any risks involved.

4. You have the right to ask any questions about the procedures used in psychotherapy. If you would like, I will explain any usual methods of psychotherapy practice to you.

Emergency Coverage

You may leave messages for me 24 hours a day at (925) 285-2429. This information will be contained in my telephone message. Also, call the same number if there is an extreme emergency. In the event that I cannot respond quickly, you may call my covering therapist Howard Sattler (925) 215-5646.. He is another qualified therapist to cover any crisis that might arise, or direct you to a 24-hour crisis line. In the event that I (or the covering therapist) cannot respond quickly, you should call your psychiatrist, your family physician, the emergency room of a local hospital, 911, or the 24-hour crisis team at 1-800-479-3339 or 1-800-784-2433.

Psychotherapeutic Relationship

A therapy with a clinical social worker or any other professional psychotherapist has only one purpose—the client's emotional, psychological, and personal well-being. Because patients often disclose to their therapists many deeply felt personal thoughts and experiences, the relationship can become very close and important. Sometimes, patients come to want the relationship to become more than a therapeutic relationship. Although these feelings are understandable, it is necessary for all patients to recognize that I cannot at any time, during of after your source of treatment, be anything but your therapist. We may not now, or after your course of treatment, be friends or engage in any business endeavors. Should we meet by chance on the street or at a social gathering, I will keep our conversation to a minimum. While talking about sexual thoughts or feelings may be a part of therapy for many people, actual sexual relations between patients and their psychotherapist is not permitted. These boundaries are important for effective, ethical therapy.

Psychotherapy

Therapy is a joint effort, the results of which cannot be guaranteed. Progress depends upon multiple factors including motivation, effort devoted and other life circumstances. Helping you to reach your goals in therapy is the purpose of our work together. You can do your part by openly and honestly communicating your thoughts and feelings, even though this may be difficult. You may feel worse before you feel better. There is a risk of feeling anxious, depressed, frustrated or hopeless at times. These feelings are a normal part of the therapy process, and are usually temporary. We will work together to get through the difficult times. If you are ever concerned that our work together is not helping, please let me know so that we can discuss your concerns.

By signing below, I acknowledge that I have read this form and have had any questions I had answered to my satisfaction. I agree to work together in psychotherapy with Dr. James H. Bramson, Psy.D, LCSW.

_____	_____	_____
Print Name	Signature	Date
_____	_____	_____
James H. Bramson, Psy.D, LCSW	Signature	Date

James H. Bramson, Psy.D., (PSY-19459/LCS-19040)
Authorization to release information

I authorize Dr. James H. Bramson, Psy.D, LCSW and _____ to
(Provider/Insurance Company Name)
Disclose/exchange specific information/medical records for my or my _____'s
(Relationship to you)
Evaluation and/or treatment.

Specific information will include discussion of physical injuries, illnesses, or conditions, mental (psychological or psychiatric) conditions and alcohol and/or drug abuse. This information is required for treatment planning and follow-up.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance thereon. In any case, the authorization automatically expires in one year.

_____ _____
Patient Name (Print) Date of Birth

_____ _____
Patient or Legal Guardian Signature Date

_____ _____
Witness Date

James H. Bramson, Psy.D., LCSW
(PSY-19459/LCS-19040)
Financial Policy

1. You are responsible for full payment of all psychological services.

2. Fees are payable at the beginning of each session. For your convenience you can also pay on-line (pay pal) @ drbramson.com. A monthly billing summary can be provided upon request (call Linda Griebel/Biller @ 619-224-6343) that you can submit for insurance reimbursement after making your session payment.

3. The fee for a 45-minute individual therapy session is $195.00. The fee for a 60-minute session is $245.00. Each group session is $75.00. If group sessions are missed you are still responsible for the fee as long as you continue to be a group member (this holds your slot). New group members are required to commit to a minimum of 12-sesions and come in for a final termination session. There is a $30.00 charge for all checks returned by the bank. Fees are periodically reviewed and changed. You will be given a 60-day notice of any fee increase.

4. The time I have for seeing patients is valuable and limited; therefore, I must charge you for your appointments if missed or canceled less than 24 hours in advance. Most insurance companies do not reimburse for missed sessions. Cancellation Policy: If less than a 24-hour cancellation notice given (e.g. one business day -- call Friday for Monday cancellation) prior to your scheduled session you are responsible for the full fee.

5. It is your responsibility to contact your insurance company and discuss the specifics of your mental health benefits prior to your appointment. As courtesy for you, my billing office will bill your primary and secondary insurance carriers.

_____ _____

Signature: Date:

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

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH lNFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (if applicable). You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at (insert website address, if applicable).

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. **For treatment.** I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care.
2. **To obtain payment for treatment.** I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
3. **For health care operations.** I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I’m com-plying with applicable laws.
4. **Other disclosures.** I may also disclose your PHI to others with-out your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your

consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Uses and Disclosures Do Not Require Your Consent. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement**. For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. **For public health activities.** For example, I may have to report information about you to the county coroner.
3. **For health oversight activities.** For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
5. **To avoid harm.** In order to avoid a serious threat to the PHI to law enforcement personnel or persons able to prevent or lessen such harm.
6. **For specific government functions.** I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
7. **For workers' compensation purposes**. I may provide PHI in order to comply with workers' compensation laws.
8. **Appointment reminders and health related benefits or services.** I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

B. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures I Have Made.
You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of

disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any com-plaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: James Bramson PsyD, 89 Moraga Way Suite B, Orinda, CA. 94563 Phone: 925-285-2429 Email:drb@drbramson.com

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.