West County Psychological Associates

1215 Fern Ridge Parkway
Suite 110, St. Louis, MO 63141

(314) 275-8599

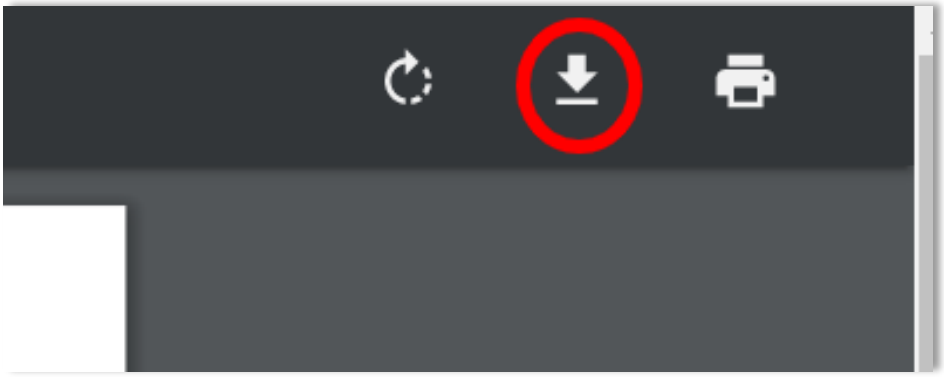
wcpastl.com

Instructions

Download the Form

You must view this form in Acrobat to successfully save your data. Please download this document as shown below (upper right-hand corner)

Then complete the form and save to your computer. For security purposes, completed forms must be uploaded to www.wcpastl.com/upload. Please do not send forms to any of our email addresses.



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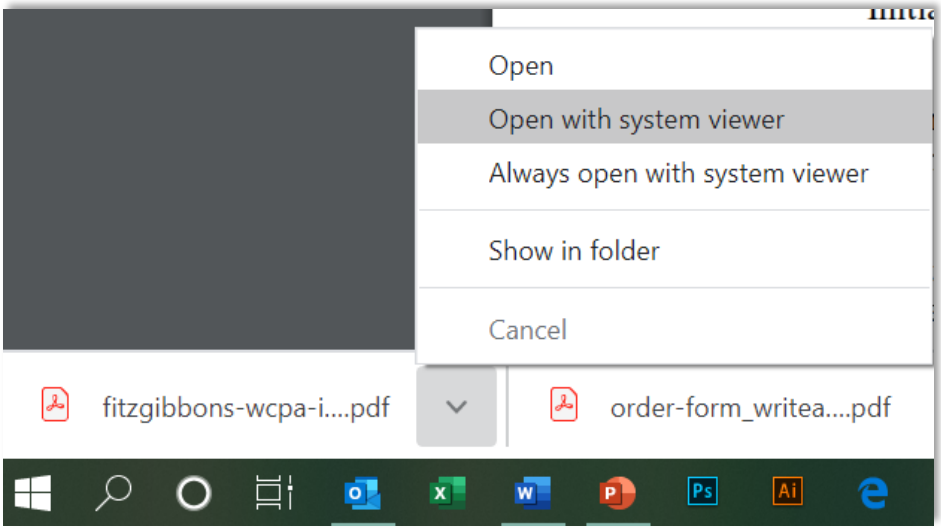

WEST COUNTY PSYCHOLOGICAL ASSOCIATES
1215 Fern Ridge Parkway, Suite 110
St. Louis, Missouri 63141
314-275-8599

Fee Agreement for
Georgean Rustemeyer, MSW, LCSW

Giving you the best possible service with consideration for your well-being is of utmost importance to us. The following is some information concerning fee schedules and payment procedures.

Individual session (50 minutes)	$145.00

Payment is due at completion of the session.
A Mastercard or Visa credit card account number and expiration date is required to guarantee payment. *The credit card will not be charged as long as there is no balance on the account.* If the balance has not been addressed, we will notify you that your credit card will be charged. Please fill in your credit card information on the Billing Information sheet.

Also, we offer Mastercard/Visa services to our clients. If you are interested in charging your visits to either your Mastercard or Visa Account, please fill in the space provided on the Billing Information sheet.

If the fees are covered by insurance, we will be happy to furnish you with an itemized statement for you to submit to your insurance company for reimbursement. If Medicare payments are not approved, client will be responsible for payment.

If an appointment must be cancelled for some reason, we require 24 hours notice. **Appointments not cancelled 24 hours in advance will be charged to your account.** If you need to cancel an appointment after 4:00 p.m. or on weekends, we do have an answering service available to take your calls. You can reach them by dialing our daytime number at 275-8599.

I fully understand and agree to the above stated terms.

Please print name here

Signature Date

WEST COUNTY PSYCHOLOGICAL ASSOCIATES

BILLING INFORMATION

Name of Client(s): _____

_____

Person responsible for payment of services:
*Please only include phone numbers where you prefer to be contacted and where we may leave a message.
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Telephone: _____ Cell Phone: _____
E-mail Address: _____

Employer: _____
Telephone: _____
Social Security Number: _____

Spouse's Name: _____
Spouse's Employer: _____
Spouse's Telephone: _____ Cell Phone: _____
Spouse's Social Security Number: _____
E-mail Address: _____

Referred by: _____

West County Psychological Associates will provide you with an invoice after each visit which you may mail to your insurance company if you are planning to file.

I accept financial responsibility for expenses incurred at West County Psychological Associates by the above named client(s).

☐ Please charge my credit card for each visit
☐ I will pay by check or cash at the time of my visit

_____ _____
Signature of Responsible Party Date

***Required Information**
Mastercard/Visa Account # _____ Expiration Date: _____
Security Code: _____

INITIAL INFORMATION FORM

Instructions: Please answer the following questions about the client(s).
Note: If you are completing this for a child or adolescent client, please answer each question in regard to the child, not to yourself. Thank you.

I. Identifying Information

Client's Name:_____ Today's Date:_____

Date of Birth:_____ Age:_____

Marital Status:_____ Occupation:_____

Please note phone numbers and email addresses where we may contact you and leave a message:

Home Phone #:_____ Cell #: _____

E-mail Address: _____

Home address & zip code: _____

Person completing this form:_____

Please check one of the following to let us know how you learned of our office:

☐ Attended a presentation given by WCPA therapist

☐ Referred by former/current client

☐ Referred by friend or family member

☐ I was referred by a school. School name:_____

Person at school who referred me:_____

☐ I was referred by a Physician. Physician's name:_____

☐ I was referred by an attorney. Attorney's name:_____

☐ Other – Please specify_____

☐ Website

☐ Facebook

☐ Email Articles

II. Reason for coming to therapy at this time:

_____

_____

_____

_____

III. Current Concerns: (please mark any you are experiencing)

Mood:

- ☐ Depressed/Irritable Mood
- ☐ Changes in Sleep
- ☐ Changes in Appetite
- ☐ Crying Spells
- ☐ Fatigue
- ☐ Problems Concentration
- ☐ Suicidal Thoughts/Attempts
- ☐ Elevated Moods
- ☐ Feeling Restless/Irritable
- ☐ Impulsive Behavior
- ☐ Grandiose Thinking
- ☐ Agitation
- ☐ Rapid Speech
- ☐ Racing Thoughts

Anxiety:

- ☐ Feeling Nervous/Worried
- ☐ Unrealistic Fears
- ☐ Feelings of Panic
- ☐ Social Anxiety/Extreme Shyness
- ☐ Obsessions/Compulsions
- ☐ Nightmares
- ☐ Hair Pulling/Skin Picking

Attention and/or Impulsivity:

- ☐ Difficulty Paying Attention
- ☐ Often Loses Things
- ☐ Doesn't Follow Instructions
- ☐ Difficulty Organizing
- ☐ Easily Distracted
- ☐ Often Forgetful
- ☐ Fidgets
- ☐ Squirms in / Leaves Seat
- ☐ Talks Excessively
- ☐ Runs/Climbs Excessively
- ☐ Difficulty in Playing Quietly
- ☐ Difficulty Awaiting Turn

Eating:

- ☐ Fear of Gaining Weight
- ☐ Recurrent Binge Eating
- ☐ Self Induced Vomiting
- ☐ Excessive Exercise
- ☐ Loss of Menstrual Periods
- ☐ Unrealistic Body Image

Behaviors:

- ☐ Aggressive Toward People
- ☐ Aggressive Toward Animals
- ☐ Destructive Toward Property
- ☐ Fire Setting
- ☐ Sexual Aggression
- ☐ Cutting or Harming Oneself
- ☐ Social Skill Difficulties
- ☐ Unusual/Odd Behaviors
- ☐ Bed Wetting or Soiling
- ☐ Stealing
- ☐ Alcohol or Drug Abuse
- ☐ Internet/Technology Problems
- ☐ Often Loses Temper
- ☐ Argumentative
- ☐ Breaks Rules
- ☐ Deliberately Annoys Others
- ☐ Seems Angry and Resentful
- ☐ Easily Annoyed / "Touchy"

Experiences:

- ☐ History of Physical Abuse
- ☐ History of Trauma
- ☐ School Difficulties
- ☐ Grief /Loss
- ☐ Bullying/Harassment
- ☐ History of Sexual Abuse
- ☐ Seizures
- ☐ Lead Exposure
- ☐ Life Transition
- ☐ Sexual Concerns
- ☐ Chronic Pain
- ☐ Parent/Child Relationship Concerns
- ☐ Partner Relationship Concerns
- ☐ Divorce/Remarriage Concerns
- ☐ Child Custody Concerns

Other Current Concerns: _____

IV. Client's Family History

Spouse's Name: _____ Age: _____
Occupation: _____ Health: _____
Quality of relationship: _____
If Deceased: Cause of Death: _____
Age at Death _____ *Client's Age at the Death* _____

Mother's Name _____ Age: _____
Occupation: _____ Health: _____
Quality of relationship: _____

If Deceased: Cause of Death:

Age at Death *Client's Age at the Death*

Father's Name: Age:
Occupation: Health:
Quality of relationship:
If Deceased: Cause of Death:
Age at Death *Client's Age at the Death*

Client's parents are (or were, If Deceased):
☐ Married ☐ Divorced ☐ Never Married ☐ Living Together ☐ Separated

Please list step-parents and other parental figures:

If not always raised by parents, who provided care and when?

Names and ages of client's siblings:

Names and ages of client's children:

Family history of emotional or behavioral concerns:

Other family information:

If Client is still in school, please complete the following:

School:
School's phone number:
Name of school contact person:
Current grade or level:

Recent grades/performance

Special services received at school:

Behavior problems at school:

Extra-curricular involvement:

VI. If client is an adult and no longer in school, please complete the following:

Educational level obtained:

Current employer and position:

Length of current employment:

Satisfaction level (circle number): **(Low)** ① ② ③ ④ ⑤ **(High)**

VI Client's Medical History

Major illnesses and physical disabilities:

Date of last physical exam:

Has the client previously seen a profession for counseling / therapy? ☐ yes ☐ no

If yes, please provide the name of the professional and approximate dates of treatment:

Is substance abuse, alcohol use, or medication a concern? ☐ yes ☐ no

Please list any previously diagnosed mental health conditions:

Current medications:

West County Psychological Associates

Informed Consent for Therapy Services

Welcome to our practice. This document contains important information about our professional services and business policies. Please read it carefully. When you sign this document, it will represent an agreement with West County Psychological Associates (WCPA).

Therapy Services

Therapy is a collaborative process between you and a professional therapist to work on areas of dissatisfaction in your life and assist you in creating change. For therapy to be most effective, it is important that you take an active role in the process. Therapy is not an identical process for everyone. There are many different methods your therapist may use to address the problems that you identify together. The type and extent of services that you receive will be determined following an initial assessment and through ongoing discussion between you and your therapist. If you have any questions about therapy procedures, you are always free to discuss them with your therapist.

Benefits and Risks

Therapy has benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, or anger. Each person's experience and outcomes are unique to their own circumstances.

Fees for Additional Services

If you request that your therapist provide non-therapy services, such as attending meetings with school officials or other professionals, charges for those services will normally be higher than the usual rate for in-office therapy services.

If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for their professional time even if they are called to testify by another party. Because of the difficulty of legal involvement, charges for such services are higher than those for regular therapy services. These services include but may not be limited to responding to subpoenas, document preparation, depositions, meetings with other attorneys and court testimony.

Therapists, at their discretion, may charge for excessive time spent on phone calls between therapy sessions. This includes calls you make to your therapist as well as calls the therapist makes to others at your request, such as to your child's school or to your attorney.

Contacts and Emergencies

You may contact your therapist through the WCPA office phone number, (314) 275-8599. In case of an emergency, please call 911 or go to your nearest emergency room. Your therapist is not on-call at all times, and may be unreachable. You may leave an emergency message on his or her office voicemail, and your therapist will return your emergency call when they are able.

Confidentiality and Professional Records

The privacy of all records and communications between a patient and a therapist is protected by law. In general, we can only release your information with your written permission. But there are a few exceptions:

- When a valid court order is issued for records and/or testimony on the part of the therapist, the therapist is bound by law to comply with such an order.
- When there is risk of imminent harm to you or to another person, the therapist is ethically bound to take necessary steps to prevent such harm. This notification may include notifying an intended target of violence, notifying the police, informing a family member about the situation, or seeking appropriate hospitalization.
- When there is suspicion that a child has been sexually, physically or mentally abused or neglected, the therapist is legally required to inform the proper authorities.
- Ethical therapists consult with professional colleagues about their cases, in order to provide clients the best possible services. If your therapist consults with a colleague, your therapist will not share your name or identifying information.

Minors

While the law provides parents the right to examine a minor child's treatment records, parents are encouraged to speak to their child's therapist about the risks and benefits of exercising that right. Therapists at WCPA regularly include parents in the therapeutic process with their children. WCPA therapists will notify parents if they believe the minor client is at risk for harm. WCPA therapists do not see minors under age 18 for in-office therapy without parental consent.

In the case of separated or divorced parents, WCPA requires a copy of the legal parenting plan. Unless otherwise stated in the legal parenting plan, both parents must provide signed consent for their minor child to receive therapy services and both parents have the right to exchange information with the therapist about the minor child's therapy.

Electronic Transmissions

WCPA cannot ensure the confidentiality of any form of communication through electronic media. You are advised that any text, email, or internet-enabled communication between you and your therapist involves greater risk to confidentiality than does traditional in-person communication. WCPA strongly discourages any electronic communication between clients and their therapists.

Termination

At any time, you have the right to seek a second opinion with another qualified mental health professional. You also have the right to terminate therapy at any time. If you choose to do so, your therapist may offer to provide you with names of other professionals whose services you might prefer.

Informed Consent for Therapy Services

Consent to Treatment

I voluntarily consent to receive, and/or for my minor child(ren) to receive, mental health assessment, care, and treatment. I authorize my therapist through WCPA to provide such professional services. I understand and agree that I will participate in the planning of my treatment and that I may stop these services at any time. By signing below, I acknowledge that I have both read and understood the information in West County Psychological Associates' *Informed Consent for Therapy Services* document and agree to its terms. This consent ends when I notify my therapist that I am terminating therapy or one year following my last therapy session.

Name of Adult Client(s): _____

Signature of Adult Client(s):

_____ **Date:** _____

_____ **Date:** _____

In the case of a minor client, the signature of a parent is required.

If parents are divorced or legally separated, the signatures of both parents are required unless otherwise stated in the legal parenting plan.

Name /Age of Minor Client(s): _____

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

West County Psychological Associates

Informed Consent for Telephone or Online Counseling Services

I _____ (name of adult client or child's legal guardian) hereby consent to engage in online and/or telephone therapy services for myself/my child through West County Psychological Associates (WCPA). I understand that online counseling/teletherapy may include consultation, therapy, assessment, diagnosis, transfer of medical data, telephone conversations, and education using interactive audio, video, or data communications. I understand that online counseling/teletherapy also involves the communication of my medical/mental health information, or that of my child, both verbally and visually.

I understand that I have the following rights with respect to online counseling/teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to online counseling/ teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are limits and exceptions to confidentiality with teletherapy, just as there are with in-person therapy. These include, but are not limited to, reporting child, elder, and dependent adult abuse and expressed threats of harm.

3. I understand that there are risks and consequences from online counseling/teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of WCPA that: the transmission of my information could be disrupted or distorted by technical failures, the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

4. In addition, I understand that online counseling/teletherapy based services and care may not be as complete as face-to-face services. My therapist cannot see me, my body language, or my non-verbal reactions to what we are discussing. My therapist may not hear all of what I am saying and may need to ask me to repeat and clarify more often than during face-to-face sessions. Confidentiality is not as assured as it may be during face-to-face services.

5. I understand that I may benefit from online counseling/teletherapy, but that results cannot be guaranteed.

6. I accept that online counseling/teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help, or call my primary care physician or psychiatrist. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) or text 741741 for free, 24 hour hotline support.

7. I understand that I am responsible for providing the necessary telephone or internet-connected devices and internet access for my online counseling/teletherapy sessions and arranging a location with sufficient privacy that is free from distractions or intrusions for my online counseling/teletherapy session.

8. I understand that telehealth services through WCPA will only be conducted through telephone and/or online video services. Therapy will not be provided through email or text. Email and text communications with my therapist may only be used for setting appointments.

8. I understand that I have additional rights and responsibilities, which are outlined in the document *West County Psychological Associates Informed Consent for Therapy Services*, which I have also been provided.

By signing below, I acknowledge that I have both read and understood the information in this document and in *West County Psychological Associates Informed Consent for Therapy Services*, and agree to the terms of both documents. This consent ends when I notify my therapist that I am terminating telephone and/or online-based therapy or one year following my last therapy session.

Adult Clients:

Name of Adult Client(s): _____

Signature of Adult Client(s):

_____ Date: _____

_____ Date: _____

Minor Clients:

In the case of a minor client, the signature of a parent is required.

NOTE: If parents are divorced or legally separated, the signatures of both parents are required unless otherwise stated in the legal parenting plan.

Name and Age of Minor Client(s): _____

Signature: _____ Date: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

The privacy of your personal information is important to West County Psychological Associates (WCPA). WCPA will maintain the privacy of your information and will not disclose your information to others unless you tell WCPA to do so, or unless the law authorizes or requires WCPA to do so.

A federal law commonly known as HIPAA requires that WCPA take additional steps to keep you informed about how WCPA may use information that is gathered in order to provide health care services to you. As part of this process, WCPA is required to provide you with the attached Notice of Privacy Practices and to request that you sign the written acknowledgement that you received a copy of the Notice. The Notice describes how WCPA may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding personal information WCPA maintains about you and a brief description of how you may exercise these rights.

If you have any questions about this Notice please contact WCPA's Director, Dr. Mary Fitzgibbons, at (314) 275-8599.

Notice of Privacy Practices

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.

WCPA is required by applicable federal and state law to maintain the privacy of your health information. It is also required to give you this Notice about privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). It must follow the privacy practices that are described in this Notice (which may be amended from time to time).

For more information about privacy practices, or for additional copies of this Notice, please contact WCPA using the information listed in Section II G of this notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

A. Permissible Uses and Disclosures without Your Written Authorization

WCPA may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. Treatment: WCPA may use and disclose PHI in order to provide treatment to you. For example, WCPA may use PHI to diagnose and provide counseling service to you. We may also disclose your information in order to remind you of appointment times. We may disclose your information to any family members or significant others that you voluntarily decide to bring to and include in a therapy session. We may disclose your PHI, with the exception of identifying information, during professional clinical supervision and/or consultation, in order to ethically provide you the highest quality services.

2. Payment: WCPA may use or disclose PHI so that services you receive are appropriately billed and payment is collected. By way of example, it may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

3. Health Care Operations: WCPA may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. Required or Permitted by Law: WCPA may use or disclose PHI when it is required or permitted to do so by law. For example, it may disclose PHI to appropriate authorities if it reasonably believes that you or a child are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition it may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law

enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

B. Uses and Disclosures Requiring Your Written Authorization

1. Psychotherapy Notes: Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

2. Marketing Communications: WCPA will not use your health information for marketing or fundraising communications without your written authorization. You have the right to opt out of any marketing or fundraising communications that you choose not to receive.

3. Other Uses and Disclosures: Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before WCPA can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical record and billing records maintained by WCPA in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, WCPA may deny access to your records. WCPA may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record may not be accessible to you, in accordance with state law. You have the right to an electronic communication of any records that WCPA keeps electronically.

B. Right to Alternative Communications. You may request, and WCPA will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. WCPA is not required to agree to any such restriction you may request. One exception is that, if you self-pay at WCPA, you may request that we not disclose these services to your health insurance company and WCPA is obligated to honor that request.

D. Right to Accounting of Disclosures or Breaches. Upon written request, you may obtain an accounting of disclosures of PHI made by WCPA after October 1, 2003. This right is subject to restrictions and limitations. You also have the right to be notified by WCPA if a privacy breach of your PHI has occurred. If such a breach occurred, you would be notified within a reasonable time.

E. Right to Request Amendment. You have the right to request that WCPA amend your health information. Your request must be in writing, and it must explain why the information should be amended. WCPA may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.

G. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that WCPA has violated your privacy rights, you may contact the **Privacy Officer,** Director Mary Fitzgibbons, Ph.D., at (314) 275-8599. You may also file written complaints with the

Director, Office for Civil Rights of the U.S. Department of Health and Human Services. WCPA will not retaliate against you if you file a complaint with the Director or the Privacy Officer.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on October 1, 2013.

B. Changes to this Notice. WCPA may change the terms of this Notice at any time. If WCPA changes this Notice, it may make the new notice terms effective for all PHI that it maintains, including any information created or received prior to issuing the new notice. If WCPA changes this Notice, it will post the revised notice in the waiting area of the office and on our website. You may also obtain any revised notice by contacting the Privacy Officer.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for West County Psychological Associates.

_____ _____

Signature of client (or personal representative) Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Name of Client: _____

Personal Representative's Name: _____

Relationship to Client: _____