

Diane Adams Nakamura, Ph.D., P.S.
19203 99th Place South
Renton, Washington 98055
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Authorization for Release of Information Form

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I _____ authorize psychologist, Diane Nakamura, Ph.D., to
release obtain release and obtain (circle one option) the following:
Case consultation, assessment results, diagnoses and any other clinical information needed within limits listed below.

This information should only be released to and from my individual therapist identified by the following:

(Provide name/function), institutional affiliation and address) Name: _____.

address _____:

telephone: _____ fax: _____.

I am requesting my psychologist to release this information for the following reasons, and subject to the following limitations: Only information necessary to assist Dr. Nakamura and individual therapist in providing services to Client.

This Authorization shall remain in effect until N/A (date) or until Client named above completes treatment with Dr Nakamura (event). However, I understand that this Authorization does not permit disclosure of my future health care given more than 90 days from the date of this Authorization (unless this is for disclosures to insurance companies). If this Authorization does not contain an expiration date, the Authorization expires 90 days from the date of my signature.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my psychologist's office address. However, my authorization will not be effective to the extent that the psychologist has taken action in reliance on my authorization, or if this authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient

Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

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CRISIS PLAN AGREEMENT WITH OTHER INDIVIDUAL THERAPIST

I, _____, agree to take the following actions to obtain assistance should I be in crisis.

Immediate Risk: If I am at *immediate risk* for harming myself or someone else, I will ^{call 911} explain my risk and provide identification and location information.

If I am in crisis, I will:

1) Follow the crisis plan my individual therapist and I have agreed upon.

If for some reason, I have tried to follow that plan and have not been able to do so I will

2) Call my physician or my physician's after hours number and explain my crisis.

My doctor's name is _____

and the after hours number is _____.

Or

3) Call The King County Crisis line at (206) 431-3222 and explain my crisis. To ensure my safety I agree to give my full name and whereabouts if asked for that information.

Or

4) Have someone take me to a hospital emergency room.

And

5) As soon as I am able, I will call Dr. Nakamura and inform her of my status or authorize someone else to do so.

You must complete this item or if you do not have a physician, you must obtain one with 24 hour crisis coverage.

I understand that Dr. Nakamura is not a physician and does not have admitting privileges at any hospitals. Therefore, should I require hospitalization, my doctor or the King County Crisis team may need to be informed. I further understand that if I am unable to follow this crisis plan agreement, Dr. Nakamura may refer me to other mental health resources and may decide to terminate our treatment if she decides this appropriate.

Signature: _____ Date: _____

Diane Nakamura, Ph.D.
Licensed Psychologist

Date

Individual therapist's signature: _____

Individual therapist's name: _____

Date

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GROUP PSYCHOTHERAPY FEE AGREEMENT

Adult(s) responsible for fees _____

(Please print)

Phone #: _____ Alt. Phone #: _____

Dr. Nakamura, the group and I agree that the fee for group sessions paid at the time of the session will be _____ per session (between \$10 and \$50 per session). If I or some other entity must be billed, the fee is \$50-65 depending on the length of the group. I understand that I am paying for a space in the group and will be charged regardless of whether I am able to attend. I understand that the fee I write in above will be my missed appointment fee, as missed appointments cannot be billed to third party payers. I understand that Dr. Nakamura will donate fees collected from group members to charity or earmark these funds toward a scholarship for clients in other full-fee groups who may need financial assistance from time to time. I agree that I will give the group two months termination notice to allow the group members and myself enough time to properly terminate. It is my responsibility to let the group know if my ability to pay changes for the better or worse so we may discuss adjustment of fees or other options. I understand that this fee does not apply to work Dr. Nakamura does related to any legal issue, individual sessions, or telephone contacts (brief or infrequent telephone contacts are typically free).

I understand that we will revisit this fee agreement approximately every 4 months.

Signature: _____ Date: _____

Diane Nakamura, Ph.D.
Licensed Psychologist #2393

_____/_____/_____
Date