Doctor Diane, P.S.
1412 SW 43rd Street, Suite 240
Renton, Washington 98057
253-852-4699 phone 253-852-5589 fax

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 Adams, 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. Adams 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 Adams (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 ______________________ (You *must* complete this item).
   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. Adams and inform her of my status or authorize someone else to do so.

I understand that Dr. Adams 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. Adams may refer me to other mental health resources and may decide to terminate our treatment if she decides this appropriate.

Signature:____________________________________ Date:_____________

____ ____________________

Diane Adams, Ph.D. Date
Licensed Psychologist

Individual therapist's signature:____

Individual therapist's name:____

_____/_______/______
Date

Doctor Diane, P.S.

Diane M. Adams, Ph.D.
Licensed Psychologist PY2393

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CO-ORDINATED TREATMENT AGREEMENT

I ___________________________________ as a client of a psychotherapy group with Diane Adams, Ph.D., licensed psychologist, as my therapist, agree that I am required to maintain a therapeutic relationship with my individual therapist ___________________________________

I understand that I should follow the agreement I have with my individual therapist if I am in crisis. If for any reason, that therapeutic relationship ends, I agree to inform Dr. Adams as soon as possible. I understand that I am responsible for obtaining a new individual therapist within one to two weeks unless otherwise decided between us. I understand that Dr. Adams may decide to terminate my participation in group therapy if I am not effectively participating in ongoing, regularly scheduled individual therapy appointments as I would not be receiving the level of therapeutic contact necessary for participation in this group. I further understand that Dr. Adams may terminate my group therapy for other reasons such as if she decides that participation in group therapy is either not therapeutically appropriate for me or for other members of the group.

I understand that I will be asked to provide regular written authorization for Dr. Adams to release and obtain information with my individual therapist and that I must comply with all aspects of any treatment contract I hold with my individual therapist as a condition of participating in group therapy with Dr. Adams.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

____
Name (Please Print)

___________________________________ _______________
Signature Date

I ___________________________________ as the above named client's individual therapist or psychiatrist agree to be responsible for the above client's crisis contact needs and will immediately inform Dr. Adams if the above named client terminates therapy.

_____/_____/_____ Therapist's signature: ___________________________________
Date

___________________________________ _______________
Diane M. Adams, Ph.D., Licensed Psychologist Date

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GROUP PSYCHOTHERAPY FEE AGREEMENT

Adult(s) responsible for fees ____
(Please print)
Phone #: ______________________ Alt. Phone #: ______________________

Dr. Adams and I agree that the fee for group sessions paid at the time of the session will be $50 per session If I or some other entity must be billed, the fee is $90. I understand that I am paying for a space in the group and will be charged regardless of whether I am able to attend. In an effort to provide some relief to group members for sessions they may not be able to attend the following missed appointment fee schedule will occur: This first missed group I will be charged $10, the second $30, and the third or beyond will be the regular $50 rate. I agree that I will give the group one month 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. Adams does related to any legal issue, individual sessions, or telephone contacts (brief or infrequent telephone contacts are typically free).

Signature:____________________________________ Date:_____________

____
Diane M. Adams, Ph.D.
Licensed Psychologist #2393

_____/_______/______
Date