THE ALLIANCE FOR EATING DISORDERS AWARENESS
INTAKE CHECKLIST

- ❒ New Client Intake Form (Google Form)
- ❒ Authorization to Release / Obtain Records
- ❒ Notice to Mental Health Service Consumers
- ❒ Psychological Services Policies and Procedures
- ❒ Notice of Privacy Practices
- ❒ Financial Statement
- ❒ Consent for Audio / Video Recording & Demographic Data

THE ALLIANCE FOR EATING DISORDERS AWARENESS
Authorization to Release/Obtain Records

I,_____, authorize The Alliance for Eating Disorders to

_____
(Name of Individual or Agency)

And I,_____, authorize

_____
(Name of Individual or Agency)

To release to Alliance for Eating Disorders Awareness Psychological Services any case file or professional treatment data for the purpose of my continued psychotherapy.

_____
Date

_____ _____
Patient Signature Date of Birth

_____ _____
Witness Signature Date

THE ALLIANCE FOR EATING DISORDERS AWARENESS
NOTICE TO MENTAL HEALTH SERVICE CONSUMERS

We are advising you that your mental health services will be provided by an unlicensed Postdoctoral Fellow working under the supervision of Dr. Joann Hendelman, Clinical Director of The Alliance for Eating Disorders Awareness. Your protected health information (PHI) and any other confidential information are protected in accordance with applicable laws and guidelines, even though the psychology Postdoctoral Fellow is being supervised. All supervisors must agree to maintain patient confidentiality. The exceptions to this protection are the same as would apply if you were seeing a licensed mental health professional.

We may break confidentiality and either make reports to a protective agency or take steps to restrain you if:

- You report that you are dangerous to yourself or to someone else
- You appear unable to care for yourself
- You report that you or someone you know (by name) may be endangering children
- You report that you or someone you know (by name) may be endangering a dependent or elderly adult

We encourage you to discuss your treatment and other services you may receive with your therapist.

If you have an emergency, or if you cannot reach your therapist please call 911 or 211.

I_____acknowledge written and verbal receipt of this.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

THE ALLIANCE FOR EATING DISORDERS AWARENESS
PSYCHOLOGICAL SERVICES OFFICE POLICIES AND PROCEDURES

Thank you for seeking therapy with us. Before your first session, please review our office policies.

1. The relationship with your therapist is confidential. Records or information about your therapy will not be released without your permission. However, there are several legal limitations to confidentiality. If we believe that you pose a threat to your life, or to the life of another person, we are legally responsible for taking measures to prevent such action. This may include contacting appropriate authorities. In addition, if there is reason to believe that child and/or elder abuse/neglect is occurring, we are legally obligated to report this to the appropriate authorities. This is for your own protection, and that of your family.
2. Therapy sessions are 45 minutes in length. Longer sessions may be scheduled at your request.
3. Fees are payable before each session. The fee for your therapy session will be discussed with your therapist. Payment can be made by cash, debit card, or credit card.
4. There is no charge for appointments cancelled at least 24 hours in advance. However, if you cancel the same day, or fail to show up for an appointment, you will be expected to pay for the missed session except in cases of emergency. Our answering service will take messages evenings and weekends.
5. In case of emergency, your therapist is available by phone. If your therapist is unavailable, another therapist will provide assistance. Alternatively, or if unable to reach your therapist, you can call 911 or 211.
6. Your therapist is available for brief phone conversations between sessions. Calls, consultations, and/or correspondence longer than 10 minutes, will be billed at your therapy rate.
7. We do not believe it is beneficial to expect your therapist to testify in court. This interferes with the therapeutic process. All forensic work (e.g. depositions, testimony, court reports, research, correspondences, etc.) will be billed at the rate of 150% of your therapy fee.

Please sign below indicating you have read and that you understand and agree to the points above.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

THE ALLIANCE FOR EATING DISORDERS AWARENESS
NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can access this information. Please review this form carefully.

The Health Information Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by me in any form, whether electronically, on paper, or orally are kept confidential. As required by HIPAA, I have prepared this explanation of how I am required to maintain, use, and disclose your private health information in accordance with federal and state law.

My Legal Duty: I am required by applicable federal and state law to maintain the privacy of protected health information, and must inform you of my privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request. I am required to abide by the terms of the Notice of Privacy Practices that is most current. I reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that I maintain. You may request a copy of the revised Notice at any time. As Privacy Officer, I can answer your questions about my privacy practices and also will take your complaints and can give you information about how to file a complaint.

Use and Disclosure of Health Information: I use and disclose your protected health information for treatment, payment, and healthcare operations. First, I may use information in your record to provide treatment to you. I may disclose information in your record to help you get health care services from another provider, a hospital, etc.. Second, I may use or disclose information from your record to obtain payment for the services you receive. Third, I may use or disclose information from your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers.

Your Rights: You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, I do not have to agree to these restrictions. You have a right to receive confidential communications from me. For example, if you want to receive bills and other information at an alternative address, please notify me. You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing. If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing. You have the right to request an accounting of certain disclosures made by me. You have the right to complain to me about my privacy practices. You have the right to complain to the Secretary of the Department of Health and Human Services about my privacy practices. You will not face retaliation from me for

making complaints. Except as described in this Notice, I may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by me before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

Disclosure of Your Protected Health Information: I may use or disclose your protected health information when I am required to do so by federal and/or state law. For example, state law requires me to report suspected child abuse or neglect. I must disclose information to the Department of Health and Human Services, if requested, to prove that I am complying with regulations that safeguard your health information. Also, I must disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Communications between a psychotherapist and client in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, I may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others. There are certain situations where I am allowed to disclose information from your record without your permission. I may disclose information from your record to a law enforcement official if certain criteria are met. I may disclose information for specialized government purposes, such as the military, national security and intelligence, or protection of the President. I may contact you to provide appointment reminders as a courtesy.

Questions and Complaints: If you have any further questions and/or concerns about my privacy practices, please contact me. If you are concerned that I may have violated your privacy rights, or you disagree with a decision I made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have me communicate with you by alternative means or at alternative locations, you may complain to me. You also may submit a written complaint to the U.S. Department of Health and Human Services. I support your right to the privacy of your health information. I will not retaliate in any way if you choose to file a complaint with me or with the U.S. Department of Health and Human Services.

Alliance for Eating Disorders Awareness
1649 Forum Place, Suite 10
West Palm Beach, FL 33401
(561) 841-0900

U.S. Dept. of Health and Human Services
Office of Civil Rights
200 Independence Ave., SW
Washington, DC 20201
(877) 696-6775

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

THE ALLIANCE FOR EATING DISORDERS AWARENESS
FINANCIAL STATEMENT

1. What is your approximate household income? This should include the combined finances of any working individuals in your "taxable household" (i.e. if you are married, this should includeyour spouse + your income). Please do NOT include roommates. Please do your best to providean educated guess. You may check your previous IRS tax return for assistance.

   $_____

2. How many dependents do you have? _____

- Note: dependent is defined here as it is for taxes (2 types)
  - Qualifying Child:
    - Support test: Must provide more than half (50%) of the dependent's total support for the year
    - Age test: Under 19 at end of tax year and younger than taxpayer, or full-time student under age of 24 at end of tax year and younger than taxpayer
    - Relationship test: the dependent is the taxpayer's child, stepchild, foster child, adopted child or descendent (this includes taxpayer's grandchild or great-grandchild)
    - Citizen test: dependent must be a US citizen, a US resident, a resident of Mexico or Canada, or an adopted child who has lived with the taxpayer for the entire year
  - Qualifying Relative:
    - Can be any age
    - "Not a Qualifying Child Test": check first that not a qualifying child (see qualifications for this above)
    - Member of Household or Relationship test: person must live as member of taxpayer's household for the entire year or be related to the taxpayer
    - Gross income test: dependent's gross income less than threshold amount (changes every year, but for 2020 this is $4,300)
    - Support test: Taxpayer must provide more than half (50%) of the person's total support for the year

3. How do you file your taxes?

   □ Single

   □ Married

   □ Filing Jointly

   □ Married Filing Separately

   □ Head of Household

   □ Qualified Widower with Dependent Child

   □ Unknown

4. Do you have any roommates, if so how many? _____

   ● Note: roommate being defined here as living with someone else who files their taxes independently from the person filling out the intake form

5. Write out any extenuating finical circumstances you would like to let us know about. (ex. Someone sick in the family that has a lot of medical bills) (expected changes in income not present in your taxes)

6. Current health insurance Coverage?

Please select one option to the best of your ability. Even if your insurance coverage is unaffordable, there are no providers who accept your plan in your area, etc., please still indicateyour current coverage. Please only select "Other" if you have confirmed there is not a more applicable choice.

- □ Medicare / Medicare Advantage / Medicare Supplement
- □ Medicaid
- □ Medicare AND Medicaid / "Dual Eligible"
- □ Obamacare / Marketplace / Exchange / ACA
- □ Employer-provided insurance (i.e. group insurance through work)
- □ TriCare / Veteran's Affairs / VA
- □ I do not have ANY health insurance coverage
- □ Unsure (please only select if necessary)

7. What dollar amount are you able to pay for your therapy session?

$_____.00

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me from obtaining treatment at The Alliance for Eating Disorders Awareness.

_____ _____
Patient Name (Please Print) Date

_____ _____
Patient Signature Date

_____ _____
Therapist Signature Date

THE ALLIANCE FOR EATING DISORDERS AWARENESS
Consent for Audio/Video Recording

I,_____hereby give my consent and permission to The Alliance for Eating Disorders Awareness, and its Psychological Services program (together, the "Alliance") to audio and video record psychological testing and all therapeutic interactions in which I am involved. It is my understanding that the purpose of the recording is for evaluation and training purposes. I understand that the supervisors of the trainees will have access to the audio/video recordings at any time. The recordings will be maintained on a secure server accessible only to the Alliance staff. I also consent to the use of any evaluations, surveys, or forms I fill out to be released to the Alliance for any use, including but not limited to evaluating and promoting the Alliance's Psychological Services program, provided my identity is not revealed to any third parties. I agree to hold the Alliance and its agents and employees harmless of any liability in the proper and prudent use of the recordings and materials described herein.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date