Robert B. Bannister, M.A., M.F.T.

LMFT27664

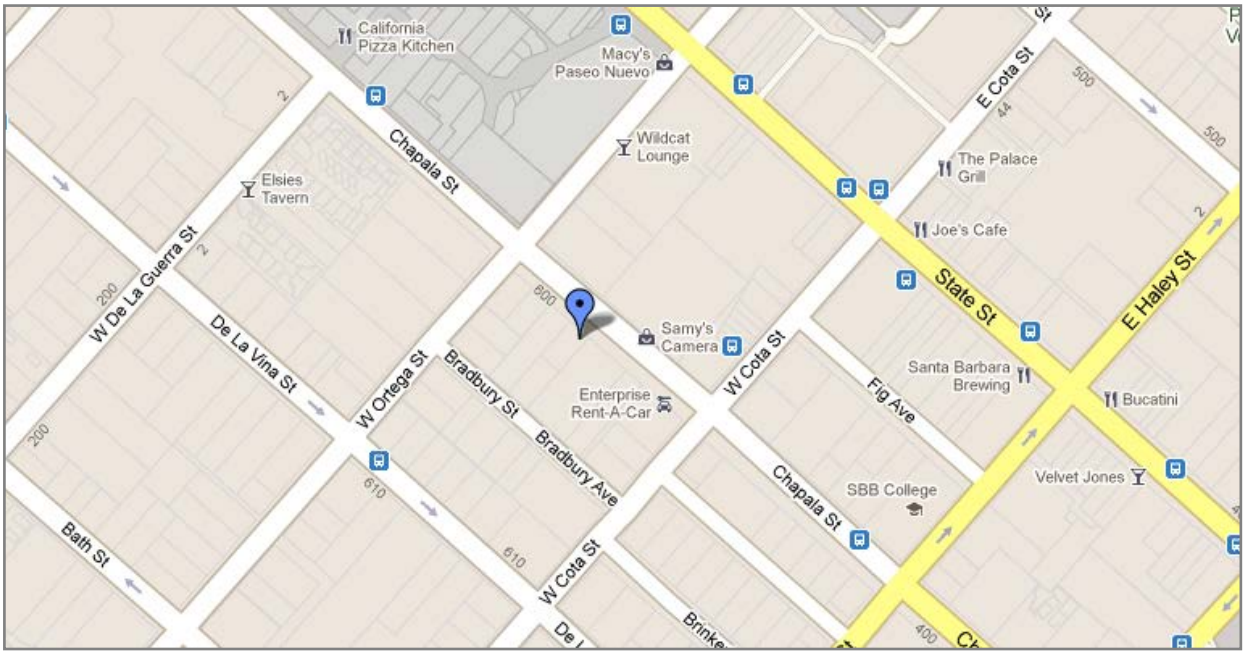
Psychotherapy for couples, families and individuals · Marriage & Family Therapist

Introductory Comments and Needed Documents

Though we may have already covered some of this information during a preliminary phone call, it's possible we didn't, so these comments will provide information to those who have not had appointments with me in the past.

Location

My office is located at 621 Chapala Street, on the second floor of the Dudek Engineering building, the first right hand door, Suite C. The Suite C door *intentionally* has no other identification.



Parking

Unfortunately, the front parking lot is entirely reserved. The good news is that there is 75 free minutes of on-street parking. (NOTE: If your appointment is on Saturday, the Dudek staff is not here, so parking in the front lot is permitted on Saturday only.)

Please – Contact your insurance company prior to our first appointment to find out what your copayment is. Because copayments vary based on employer, insurance company, plan and group, beginning January 1, 2016, I will charge a *DEFAULT* copayment of $35.00 unless you have contacted your insurance company and have been informed that it is different.

621 Chapala Street ~ Suite C Santa Barbara, CA 93101

Office: 805-705-3987 FAX: 866-294-0916 rob@robbannistermft.com www.robbannistermft.com

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New Patient Information

Name (Last, First, MI)_____ Today's Date _____

DOB _____ SS# _____ Phone #1 _____

Phone #2_____ Email_____

Street Address _____City_____Zip_____

Marital Status_____ Employer/School_____

Emergency Contact_____ Phone#_____

Primary Insurance _____Policy # _____ Group#_____

Plan Name:_____ Member ID#_____

Subscriber Name _____ Subscriber's Address _____

Subscriber DOB: _____ Subscriber's Phone _____ Physician _____

Previous Treatment _____

Medications _____

_____

Copayment Amount $_____

(Because copayments vary based on employer, insurance company, plan etc., it is not feasible for me to determine your copayment. The insurance company – phone number is listed on the back of your insurance card – will tell you what your copayment is. Otherwise, I charge a $35.00 copayment which will be adjusted we received an "Explanation of Benefits" – usually within ten weeks of claim submission.)

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Intake Information

Please answer the following questions; it will allow us to use the scheduled time more effectively.

History: (Briefly, explain the events in the last six months leading to your decision to make an appointment.)

Previous psychiatric history: including names and initial dates of treatment (roughly).

Family psychiatric history:

Trauma history:

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Medical history:

Current/previous medications: (in the past 6 months)

Substance use: (past 6 months and current)

Social history: (Friends, church affiliation, recreational)

Legal history:

Education/Occupation:

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License # LMFT27664

INFORMED CONSENT

[I'm required by my malpractice carrier to provide this long legal recitation document – I apologize]

Introduction

This Agreement is intended to provide

_____ (Please print your name)

(herein "Patient") with important information regarding the practices, polices and procedures of Robert Bannister, MA, LMFT (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Risks and Benefits of Therapy

Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Patient's perceptions and assumptions, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient. During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

Professional Consultation

Professional Consultation is an important component of a competent psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Patient.

Initials

621 Chapala Street Santa Barbara, CA 93101 Suite C

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Records and Record Keeping

Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient. Should Patient request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested by Patient, provide a copy of the record to another treating health care provider. Therapist will maintain Patient's records for ten years following termination of therapy. However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

Confidentiality

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another. [*Tarasoff v. Regents of the University of California]*

Patient Litigation

Therapist will, at Patient's request, participate in litigation, or custody dispute in which Patient and another individual, or entity, are parties. Therapist will generally not provide records or testimony unless compelled to do so or requested by Patient. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of $165.00.

Psychotherapist-Patient Privilege

The information disclosed by Patient to Therapist, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist generally will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by Patient or Patient's representative. Patient should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

Initials

Fee and Fee Arrangements

- **Because of differing insurance companies with differing plans and different employers, it is no longer practical for me to determine the copayment for a given patient. The insurance company will not tell me – but they will tell you what the copayment is. I strongly suggest you call the insurance company prior to our first appointment and ask what the copayment is for you. Beginning January 1st 2016, the *DEFAULT* copayment is $35.00 – unless your insurance company has informed you otherwise.**

- The *usual and customary fee* for service is $165.00 per 50-minute session. Sessions longer than 50-minutes are sur-charged, *pro rata*. Therapist reserves the right to periodically adjust this fee. Patient will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with Therapist. Therapist does not bill "secondary insurance". If you have dual insurance, I will provide a "super bill" (accepted by all insurance companies) you may then submit the super-bill to your secondary insurance company to be reimbursed.
- Patient agrees that if Therapist is contracted with Patient's insurance company, that Therapist will bill the insurance company, but if the insurance company does not pay Therapist within 30 business days of claim submission, the patient will be responsible for all fees for provided services. If requested, Therapist will provide a statement of services rendered with sufficient information to allow Patient to submit the claims themselves. Patient further agrees that by signing this agreement that they will pay contracted co-payments established by the insurance company at the time of service. In order for Therapist to bill the insurance company, the patient hereby permits the release of necessary information to the insurance company to allow for payment of services (assignment of payment). Patient is responsible for payment of the agreed upon fee (on a *pro rata* basis) for any telephone calls longer than ten minutes. Patients are expected to pay for services at the time services are rendered. Therapist accepts cash, credit cards or checks.
- From time-to-time, Therapist may engage in telephone contact with Patient for purposes other than scheduling sessions. Patient is responsible for payment of the agreed upon fee (on a *pro rata* basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at Patient's request and with Patient's advance written authorization.

Cancellation Policy

Patient is responsible for payment of the agreed upon fee ($165.00 per session) for any missed session(s). Missed appointments are not covered by insurance. You are responsible for the full fee if an appointment is missed. Patient is also responsible for payment of Therapists normal and customary fee for any session(s) for which Patient failed to give Therapist at least 24 hours advance notice of cancellation. Cancellation notice should be left on Therapist's voice mail at 805-705-3987 or email: rob@robbannistermft.com, or by text message.

Initials

Therapist Availability

- Therapist's office is equipped with a confidential voice mail system that allows Patient to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately.
- If Patient sends email to Therapist, it shall be understood that Therapist takes precautions to protect the patient's confidentiality but electronic communications are inherently vulnerable to security compromise. No assurance is given that Therapist will receive all emails sent. Therapist does not practice psychotherapy via email. Therapist normally does not reply to email messages sent but will review them with Patient during the next scheduled appointment.
  Therapist's email address is rob@robbannistermft.com I use HIPAA compliant encrypted email when corresponding if there is identifying and personal information.

Crisis Service

Therapist is unable to provide 24-hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

Termination of Therapy

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to other providers.

Bariatric Evaluations

The fee for bariatric evaluation and a report to the surgeon is $185.00 and is often not a covered benefit by insurance companies. If a psychiatric diagnosis can be made, a portion of the fee may be covered by insurance. If you are to be seen for a pre-surgical clearance, please discuss this with me prior to the appointment.

Initials

Acknowledgement

By initialing the antecedent four pages and signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this five-page Agreement. Patient has discussed such terms and conditions with Therapist, and any questions with regard to its terms and conditions have been answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____

Patient Name (please print)

_____

Signature of Patient (or authorized representative)

_____

Date

_____

Robert B. Bannister, MA, LMFT (Therapist)

_____

Date

Revised: January 1, 2016

Robert Bannister, M.A, L.M.F.T.

621 Chapala Street Suite C Santa Barbara, CA 93101

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Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

I am required by law to maintain the privacy of your health information and provide you with a description of my privacy practices. This notice will also describe your rights and certain obligations I have regarding the use and disclosure of your health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

Your health information is personal. I am committed to protecting your health information. I create a record of the care and services you receive at this office. I need this record to provide you with quality care and comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office whether made by me or others.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

The following describes the different ways that your protected health information (PHI) may be used or disclosed by this office. "PHI" refers to information in your health record that could identify you. For clarification, I have included some examples. Not every possible use of disclosure is specifically mentioned. However, all of the ways I am committed to use and disclose your "PHI" will fit within one of these general categories:

- For Treatment. "*Treatment*" is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
- For Payment. "*Payment*" is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. I may also tell your health plan insurer about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover or continue to cover your treatment.
- For Healthcare Operations. "*Healthcare Operations*" are activities that related to the performance and operation of my practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. I may use and disclose health information to provide you with appointment information. This may be done with voice mail, messages, post cards, and other mailings.
- Use. "*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- Disclosure. "*Disclosure*" applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse. If we have reasonable cause to suspect child abuse or neglect, we must report this suspicion to the appropriate authorities as required by law.
- Adult and Domestic Abuse. If we have reasonable cause to suspect you have been criminally abused, we must report this suspicion to the appropriate authorities as required by law.
- Health Oversight Activities. If we receive a subpoena or other lawful request from the Department of Health or the California Board of Psychology or Board of Behavioral Science, we must disclose the relevant PHI pursuant to that subpoena or lawful request.
- Judicial and Administrative Proceedings. If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, I may use your PHI to defend the office or to respond to a court order
- Law Enforcement. I may release PHI about you if required by law when asked to do so by a law enforcement official.
- Serious Threat to Health or Safety. If you communicate to me a threat of physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out that threat in the foreseeable future, I may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If I believe that there is an imminent risk that you will inflict serious physical harm on yourself, I may disclose information in order to protect you.
- Worker's Compensation. I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and LMFT Duties

You have the following rights regarding the PHI that this office maintains about you.

- Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at our office. On your request, I will send your correspondence to another address.) To request confidential communications, you must complete my request form in writing and submit it to me, the Privacy Officer. I will accommodate all reasonable requests.
- Right to Inspect and Copy. You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. To inspect and/or obtain a copy of your PHI, you must complete my request form and submit it to me, the Privacy Officer. If you request copies, I will charge you $0.10 per page. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend. You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. To request an amendment, you must complete my request form and submit it in writing to the me the Privacy Officer. In addition, you must provide a reason that supports your request. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting. You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process. To request this accounting on disclosures, you must complete a request form and submit it in writing to me, the Privacy Officer. Your request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003.
- Right to a Paper Copy. You have the right to obtain a paper copy of the Notice from us upon request.

LMFT's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact the Privacy Officer at Psychological Consultants listed below.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to the me, the Privacy Officer. All complaints must be submitted in writing to:

Privacy Officer:
Robert Bannister, MA, LMFT
621 Chapala Street, Suite C
Santa Barbara, CA 93101
Office: 805.705.3987 Fax: 866.294.0916

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you or penalize you in any way for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If I revise my policies and procedures, I will post a copy of any revised Notice in this office.

Other uses and disclosures of your PHI not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide me such an authorization in writing to use or disclose PHI about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, I will no longer use or disclose PHI about you for the reasons covered by your written authorization. Be aware that I am unable to take back any disclosures we have already made with your permission, and we are required to retain our records of care that we provide to you.

ACKNOWLEDGMENT

By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices form.

_____ _____
Patient/Parent/Guardian Signature Date

Refusal to Sign Acknowledgment

_____ _____
Patient /Parent/Guardian Name Date