**Dr. Petra S. Blum, PhD, LPC**

12813 Flushing Meadows Rd, Suite 140

St. Louis, MO 63131

Phone: 314-503-3001, Fax: 314-394-1404

**CLIENT INFORMATION**

**Child’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date** \_\_\_\_/\_\_\_\_/\_\_\_\_ **M / F**

**Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Full Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone:** \_\_\_\_\_\_\_\_\_\_\_\_**Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications currently taking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Phone # for Emergency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT FOR TREATMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission to Dr. Petra Blum, PhD, LPC, to provide counseling to me or my child who is a minor in my legal custody.

As a client, it is your right to have the content of your therapy sessions held in confidence with these exceptions in which Dr. Blum is mandated by law to report: 1) if you sign a release form for me to divulge any or all information, 2) if you intend suicide, or if you intend to do serious harm to yourself, 3) if you intend homicide, and 4) if a child, elderly person, or disabled person is being abused or has been abused.

In some cases, the Missouri courts have held that if an individual intends to take harmful or dangerous action against another person, it is the counselor’s duty to warn the person and/or the family of the person who is likely to suffer the results of harmful behavior. Every effort will be made to resolve these issues before such a violation of confidentiality takes place. Every effort will be made to prevent an attempted suicide or a dangerous action against another person.

By signing below, I affirm that the information given on this form is true and complete.

I have read and agree to the above policies, procedures, and statements.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Printed Name of Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Printed Name of Client Date

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**PAYMENT POLICY AND MISSED APPOINTMENTS**

Please take a few minutes to acquaint yourself with my policies.

**PAYMENT FOR SERVICES:** Counseling sessions usually run 50 minutes. **The standard hourly fee is $150.00**; additional time is billed to the quarter hour. My practice is to ask clients to pay as we proceed. Please present payment at the beginning or immediately following your session.**Online payment methods include Venmo, Apple Pay, Zelle, or Square (a card on file with Square would incur a $5 transaction fee).** Where insurance is applicable, I will receipt you personally with a diagnostic receipt that you may file with your insurance company who will reimburse you. Please note that: a) some companies do not reimburse for counseling services and, b) insurance coverage policies are often changing. This means you are responsible for insurance questions. I may be able to help where you direct me, but you are ultimately responsible to ascertain coverage and initiate filing diagnostic receipts. Such receipts are given upon request.

**MISSED APPOINTMENTS:** Your cooperation in keeping scheduled appointments is expected. To cancel an appointment, you are required to notify me 24 hours in advance. ***If you cancel or do not keep an appointment without appropriate (24 hours) advance notice, you will be charged the full hourly fee for the time you reserved for an appointment. Insurance does not pay charges for reserved time; you will personally be responsible for any such charges.***

If you have any questions at all, please feel free to ask me.

**I/WE HAVE READ AND AGREE TO THE ABOVE POLICIES.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date

**Acknowledgment of Receipt of Notice of Privacy Practices &**

**Request for Confidential Communication**

*Please initial the following:*

\_\_\_\_\_\_\_ I have received a copy of the Notice of Privacy Policies for Dr. Petra Blum. Furthermore, I have read the privacy policies and I consent to the use of my PHI or my child’s PHI for the purpose of healthcare operations, treatment, and payment activities.

\_\_\_\_\_\_\_ I grant permission for my therapist to leave a message for me at the following phone number(s):

* + - home
		- cell

You may also opt in for email, text messaging communication, and online counseling. Every effort will be made to maintain your privacy. **However, the security of these forms of communication cannot be guaranteed.** *Please read and initial the following statements if you agree.*

\_\_\_\_\_\_\_ I recognize that e­mail & text communication are not a secure means to transmit data.

\_\_\_\_\_\_\_ I consent to the use of text messaging communication.

\_\_\_\_\_\_\_ I consent to the use of email communication.

\_\_\_\_\_\_ I consent to the use of online counseling, including Zoom, FaceTime, etc.

**I voluntarily waive my rights provided by federal and state laws regarding confidentiality in order to send and receive communications (and/or invoices) from Dr. Petra Blum via email or text**. I voluntarily give my permission and will not hold Dr. Petra Blum, PhD and Associates legally responsible for the transmission of this data.

Finally, for the purposes of confidentiality and the integrity of the therapeutic relationship, please be aware that **I do not interact with clients using social media platforms**. Thank you for your understanding.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian (if client is a minor) Date

### HIPAA Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Protecting your confidential health information is important to us.

# As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations we are required to ensure you are aware of our privacy policies and legal duties and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration of our operation and must be followed by our office. This notice will be in effect until it is replaced; it became effective 01/01/06.

This Notice describes your rights as our client or your child’s rights as our client and our obligations regarding the use and disclosure of your Protected Health Information (PHI) and your child’s PHI. We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all PHI that we maintain, including PHI we created or received before the changes were made. Changing this notice will precede all significant modifications. Copies of this notice are available at your request. We will post a copy of the current notice in the waiting area.

Each time you visit Dr. Petra S. Blum, PhD, LPC, a record of your visit is made. This record typically contains information regarding symptoms, observations, assessments (including test results and diagnoses), plans for future treatment, and billing information.

**We will use and communicate your PHI for the following purposes only:**

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

# Information regarding your protected health information (PHI) may be used and disclosed for the purpose of treatment, payment, and other health care options. Examples cited below further explain the use and disclosure process.

**Treatment:** We may use and disclose your PHI or your child’s PHI to provide you with the best treatment and services possible. This may include administrative and clinical office procedures within our office and in coordination with other service providers, such as in clinical supervision or in case consultation with law enforcement and child protective services.

**Obtaining Payment:** We may use and disclose your PHI or your child’s PHI so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company, or another party.

**Health Care Operations:** We may use and disclose your protected healthcare information in relations with our health care process. These processes include quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management, supervision and care coordination. We may use your PHI to assist you with appointment reminders in the form of voicemail messages or letters.

## II. Uses and Disclosures Requiring Authorization

At any time you may provide in writing, your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization it will not affect any use or disclosure prior to the revocation. You may not revoke an authorization to the extent that (1) Dr. Petra S. Blum, PhD, LPC, has 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.

Each of the uses and disclosures listed immediately below requires your *written* permission.

a. **Payment***.* We will ask for your *written* permission to use and disclose information regarding the services provided to you in order to bill and collect payment from you. For example, if your account becomes delinquent, we may need to report your account information to our collection agency for them to pursue payment.

b. **Other Uses and Disclosures.** In addition to the above, we will require your *written* permission for us to use or disclose your medical information:

* If Dr. Petra S. Blum, PhD, LPC, refers you to another health care provider (such as a physician). We will ask you to authorize our sending your health information to them so that they have the information needed to diagnose or treat you.
* If you ask Dr. Petra S. Blum, PhD, LPC, to disclose your health information to *anyone*, including other health care or educational professionals.
* To friends or family members who are involved in your care. If your written permission is not obtained and you are not present and able to agree or object, such communications shall be made only by authorized healthcare providers when, in their professional judgment, such disclosure is in your best interest.

*Any uses or disclosures* of your medical information that are not specifically covered by this Notice of Privacy Practices or by the laws that apply to us will be made only with your *written* permission. Your protected health care information may be used and disclosed to you, as described in the patient rights section of this notice.

# III. Uses and Disclosures Requiring Neither Consent nor Authorization

Dr. Petra S. Blum, PhD, LPC, may use or disclose PHI without your consent or authorization in the following circumstances:

**Child Abuse** – If Dr. Petra S. Blum, PhD, LPC, has reasonable cause to suspect that a child has been or may be subjected to abuse or neglect, or if Dr. Petra S. Blum, PhD, LPC, observes a child being subjected to conditions that would reasonably result in abuse or neglect, Dr. Petra S. Blum, PhD, LPC must immediately report such information to the Missouri Children’s Division. Dr. Petra S. Blum, PhD, LPC, must also report suspected sexual abuse or molestation of a child under 18 years of age to the Children’s Division. Dr. Petra S. Blum, PhD, LPC, may also report child abuse or neglect to a law enforcement agency or juvenile office.

**Adult and Domestic Abuse** – If Dr. Petra S. Blum, PhD, LPC, has reasonable cause to suspect that an eligible adult (defined below) presents a likelihood of suffering physical harm or is in need of protective services, Dr. Petra S. Blum, PhD, LPC, must report such information to the Missouri Department of Social Services. “Eligible adult” *means any person 60 years of age or older, or an adult with a handicap (substantially limiting mental or physical impairment) between the ages of 18 and 59 who is unable to protect his or her own interests or adequately perform or obtain services which are necessary to meet his or her essential human needs.*

**Health Oversight Activities:**  The Missouri Attorney General’s Office may subpoena records from Dr. Petra S. Blum, PhD, LPC, relevant to disciplinary proceedings and investigations conducted by the Missouri State Committee of Psychologists.

**Law Enforcement:**  We may release PHI if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

**Judicial and Administrative Proceedings** – If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and Dr. Petra S. Blum, PhD, LPC, will not release information without written authorization from you or your personal or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. Dr. Petra S. Blum, PhD, LPC, will make all reasonable efforts to inform you in advance if this is the case.

**Serious Threat to Health or Safety** – When Dr. Petra S. Blum, PhD, LPC, judges that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted to you or your child or by you or your child on yourself or another person, Petra S. Blum, LPC, must disclose your relevant confidential information to the appropriate professional workers, public authorities, the potential victim, his or her family, or your family.

**Workers' Compensation** – If you file a worker’s compensation claim, Petra S. Blum, LPC, must permit your record to be copied by the Missouri Labor and Industrial Commission or the Division of Worker’s Compensation of the Missouri Department of Labor and Industrial Relations, your employer, you and any other party to the proceedings.

**Your Authorization:** Other than as stated above or where Federal, State or Local law requires us, we will not disclose your PHI other than with your written authorization. You may revoke this authorization in writing at any time.

IV. **Your rights regarding your PHI or your child’s PHI**

**Right to Request Restrictions**– You have the right to request restrictions on certain uses and disclosures of protected health information. However, Petra S. Blum, LPC, is 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 by Petra S. Blum, LPC. On your request, we will send your bills to another address.). You have the right to ask Petra S. Blum, LPC, to communicate with you in a certain way or at certain locations. We will accommodate all reasonable requests. Unless we are otherwise instructed, phone calls to you from Petra S. Blum, LPC, for purposes of scheduling or canceling sessions and mailings to you for purposes of billing will be directed to the home phone number(s) and home address that you provide us. Requests for alternative modes or locations of communication must be submitted in writing.

**Right to Inspect and Copy**– You have the right to read, review and copy your PHI such as treatment and billing records that we keep and use to make decisions about your care for as long as the PHI is maintained in the record. You must submit a written request to Petra S. Blum, LPC, in order to inspect and/or copy records of your PHI. We may deny your access to PHI under certain limited circumstances, but in some cases, you may have this decision reviewed. On your request, Petra S. Blum, LPC, will discuss with you the details of the request and denial process. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

**Right to Amend:** If you believe the PHI we have about you or your child is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To make this amendment you must submit your request in writing to Petra S. Blum, PhD, LPC. You must also provide a reason for the request. We may deny your request in certain cases.

**Right to an Accounting of Disclosures** – You have the right to receive an accounting of disclosures of PHI. This is a list of the disclosures we made of medical information about you to others except for purposes of treatment, payment and operations identified above, and a limited number of special circumstances involving national security, correctional institutions, and law enforcement. To obtain this list, you must submit your request in writing to Petra S. Blum, LPC. It must state a time period, which may not be longer than ten years and may not include dates before January 1, 2006. Your request should indicate in what form you want the list. The first list you request in a 12-month period will be free, but we may charge you for the costs of providing additional lists. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

We reserve the right to change this notice and to make the revised or changed notice effective for health information we already have about you or your child as well as any information we receive in the future. We will post the current notice in the office with its effective date. You are entitled to a copy of the notice currently in effect.

# V. Questions and Complaints

# If you have questions about this notice, disagree with a decision Petra S. Blum, PhD, LPC, makes about access to your records, or have other concerns about your privacy rights, you may contact the Missouri Department of Health, Bureau of Health Facility Regulation at 1-573-6302 and/or the State Attorney Generals Office, Consumer Hotline, 1-800-392-8222 for additional assistance. 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. Petra S. Blum, PhD, LPC, will not retaliate against you for exercising your right to file a complaint.