INNOVATION
Behavioral Health Solutions, LLC
The Offices of Dr. Sandra Gray, Ph.D.

Licensed Clinical Psychologist
6655 W. Sahara Ave., Suite B200, Las Vegas, NV 89146 • (702) 900-2784

PLEASE FILL OUT THIS INFORMATION SHEET, READ THE ATTACHED PAGE, AND SIGN IN THE APPROPRIATE PLACES.

Today's Date: _____

PATIENT INFORMATION:

Name: _____ Age: _____ Birth Date: _____

Home Address:_____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____Home Phone: _____ Cell Phone:_____

School/Place of Employment: _____ Occupation: _____

Business Address: _____ Work Phone: _____

Emergency Contact: _____Phone: _____

SPOUSE/PARENTS (IF MINOR) INFORMATION:

Name(s): _____ Age: _____

_____ Age: _____

For Minors: If parents are separated/divorced please describe custody arrangement: _____

_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____Home Phone: _____ Cell Phone: _____

Place of Employment: _____ Occupation:_____

Business Address: _____ Work Phone: _____

Religious Preference: _____

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EDUCATION (Please circle the highest level attended):
☐Elementary ☐High School ☐College ☐Graduate School

If currently in school, grade level: _____

Relevant Medical Conditions:
_____

_____

What Has Brought You in Today?
_____
_____

Have You Received Psychological Services in The Past? Yes _____ No _____

If Yes, When? _____

What Services Did You Receive? _____

Who Was Your Provider? _____

Your appointment time has been set aside for you. If you cannot attend your appointment, it is important that you give your therapist a 24-hour cancellation notice. If you do not cancel within 24 hours, you will be responsible to pay the fee for service.

Insurance companies cannot be billed for appointments you do not attend.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION REGARDING CANCELLATION OF APPOINTMENTS.

_____ _____
Signature **Date**

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INSURANCE INFORMATION

☐ Check if Not Applicable

PRIMARY INSURANCE
Insurance Company: _____
Person Insured: _____ Insured's Date of Birth: _____
Insured's Social Security #: _____ Insured's Phone: _____
Insurance Company Address: _____
_____
Policy Number: _____ Group Number: _____

Secondary Insurance
Insurance Company: _____
Person Insured: _____ Insured's Date of Birth: _____
Insured's Social Security #: _____ Insured's Phone: _____
Insurance Company Address: _____
_____
Policy Number: _____ Group Number: _____

ASSIGNMENT OF BENEFITS

I authorize the release of any medical or other information necessary to process this claim. I understand that if my insurance company requires pre-authorization for treatment, a treatment report or other summary of progress may also be released to the insurance company. I also request payment of government benefits or other medical benefits to be paid to Sandra Gray, Ph. D.

_____ _____
Signature **Date**

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CONSENT TO TREATMENT

Thank you for selecting me to help facilitate the achievement of your goals. I cannot stress too heavily that there are no magic cures for what is bothering you. I am not a physician, so I cannot prescribe medications for you. I am not a mystic or magician, so I cannot control your thoughts or behavior, nor will I accept responsibility for what you ultimately decide to do with your life. What I *can* do as a psychologist is listen and understand. I may offer suggestions regarding alternative solutions to your problem or new behaviors for you to try. I *can* help you to examine aspects of your problem that you may not have thought of before. At times, I may introduce specific therapeutic intervention techniques to help you make the changes that you desire. Additionally, I may confront you from time to time with the reality of your behavior. In short, I can help facilitate the process of identification, realization, and change. The success of this process is largely predicated on three factors: adequate goal identification, your own level of motivation to remain committed to the process of change, and how hard you are willing to work at it.

Therapy sessions are usually held once a week for 50 minutes. The goals of your therapy will be determined or clarified within the first few sessions. Therapy usually ends when you and I mutually agree that your goals have been satisfactorily met. You have the right to end therapy at any time, but I request that we discuss this prior to the termination of treatment.

CONFIDENTIALITY

The information you share with me is held in absolute confidence. I will be keeping records of our sessions together. Should you wish any information or records regarding your sessions be released to anyone, you will have to sign a consent form specifying which part of the information may be shared and with whom. Confidentiality must be broken under specific rules of law, which are:

1. Child or Elder Abuse.
2. If you are a danger to yourself or others.
3. Under Court Order.

FEE FOR SERVICES

The fee for services is the amount you pay for each 45-minutes session. Payment is due in full at the time of the session unless alternative arrangements are made with our office. We will bill your insurance company for you, but you are responsible for the bill, including any co-payments or deductible amounts your insurance company may require.

MISSED APPOINTMENTS & CANCELLATIONS

If you must cancel, please do so at least 24 hours in advance. We cannot bill your insurance company for sessions not attended. You are personally responsible for payment of late cancellations and/or no shows.

PHONE CALLS BETWEEN SESSIONS

I will do everything I can to return phone calls as soon as possible. However, I have a diverse practice and at times am not able to return calls within the same day. Should your call be an emergency, call 911 or go to the nearest emergency room.

I have read the materials presented in this disclosure statement. My signature indicates that I understand the information, agree with the conditions of therapy that are either stated or implied, and commit myself to compliance with them.

_____ _____
Patient's Signature Date

_____ _____
Psychologist Signature Date

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BEHAVIOR AND SYMPTOM IDENTIFICATION SCALE

Name: _____ Date: _____

Recorded by: _____

INSTRUCTIONS: Below is a list of problems and areas of life functioning in which some people experience difficulties. Using the scale given below, fill in the box with the answer that best describes the degree of difficulty you have been experiencing in each area during the PAST WEEK.

Please respond to each item. Do not leave any blank. If there is an area that you consider to be inapplicable, indicate that it is *"No Difficulty".*

For each question, please fill in one and only one response scale number in the box.

0 = No difficulty
1 = A little difficulty
2 = Moderate difficulty
3 = Quite a bit of difficulty
4 = Extreme difficulty

To what extent are you experiencing difficulty in the area of:

1.	Managing Day-to-Day Life. (For example, getting places on time, handling money, making everyday decisions)……..	1
2.	Household Responsibilities. (For example, shopping, cooking, laundry, cleaning, other chores) ……	2
3.	Work. (For example, completing tasks, performance level, finding/keeping a job) …….....	3
4.	School. (For example, academic performance, completing assignments, attendance) ……	4
5.	Leisure time or recreational activities ……	5
6.	Adjusting to major life stresses. (For example, separation, divorce, moving, new job, new school, a death) ……	6
7.	Relationship with family members……..	7
8.	Getting along with people outside of the family …….	8
9.	Isolation or feelings of loneliness ……	9
10.	Being able to feel close to others ……	10
11.	Being realistic about yourself or others ……..	11
12.	Recognizing and expressing emotions appropriately……..	12

PLEASE TURN PAGE TO CONTINUE

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0 = No difficulty 1 = A little difficulty 2 = Moderate difficulty 3 = Quite a bit of difficulty 4 = Extreme difficulty

13.	Developing independence, autonomy ……..	13
14.	Goals or direction in life ……..	14
15.	Lack of self-confidence, feeling bad about yourself ……	15
16.	Apathy, lack of interest in things …….	16
17.	Depression, hopelessness……..	17
18.	Suicidal feelings or behavior ……	18
19.	Physical symptoms. (For example, headache, aches and pains, sleep disturbance, stomach aches, dizziness) ……	19
20.	Fear, anxiety or panic ……...	20
21.	Confusion, concentration, memory ……..	21
22.	Disturbing or unreal thoughts or beliefs …….	22
23.	Hearing voices, seeing things ……...	23
24.	Manic, bizarre behavior ……	24
25.	Mood swings, unstable moods …….	25
26.	Uncontrollable, compulsive behavior. (For example, eating disorder, hand-washing, hurting yourself) ……...	26
27.	Sexual activity or preoccupation…….	27
28.	Drinking alcoholic beverages ……...	28
29.	Taking illegal drugs, misusing drugs ……	29
30.	Controlling temper, outbursts of anger, violence …….	30
31.	Impulsive, illegal or reckless behavior …….	31
32.	Feeling satisfaction with your life ……..	32

Sum For Total Score …… 33

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HIPPA Privacy Policy

The offices of Sandra Gray, Ph.D. are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain federal and state regulations to implement policies and procedures to safeguard the privacy of your health information.

Individually identifiable information about you, care given to you or payment for treatment or services is considered *protected health information.* This policy explains how, when and why we may use or disclose your protected health information and explains your rights and our obligations. Except in specified circumstances, we will use or disclose only the minimum necessary protected health information to accomplish the intended purpose of use or disclosure of such information.

We have a limited right to use and disclose your health information for the purpose of treatment and payment. For other purposes, you must give us your written authorization to release protected health information, unless the law permits or requires us to use or disclose information without your authorization. Sandra Gray, Ph.D., reserves the right to change the privacy practices and to make the new provisions effective for all protected health information it maintains. Any revisions made will be posted and made available.

Your Health Information Rights

Although your files are the physical property of Sandra Gray, Ph.D., the information belongs to you and you have the right to:

1. Inspect and receive a copy of your health record, such as your medical and billing records that we use to make a decision about your care and services, with some exceptions. In order to inspect or copy your health information, you must submit a written request to us using our *Request for Inspection/Copy of Protected Health Information Form.* We may charge you a reasonable fee for the paper, labor, and mailing costs involved. We will respond within thirty (30) days of receipt of your request. Should we deny your request to inspect/copy our health information we will provide you with written notice of our reasons and your rights for requesting a review of our denial. Sandra Gray, Ph.D., has the option of giving you a summary of psychotherapy notes. Raw psychological test data cannot be released.

2. You have the right to request that we limit how we use or disclose your protected health information for treatment, payment or other reasons. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or your payment for services, i.e. a family member. The office will review your request and may choose not to accept it. If your request is accepted, it will be included in your records. The request may not interfere with the legally defined uses and disclosures of your health information.

3. If you believe health information we have about you is incorrect or incomplete you have the right to request a correction/amendment to your health record as long as we maintain your record. We will respond within sixty (60) days of your written request. We may deny your request if: a) your request is not made in writing, b) your request does not contain a valid reason for your request, c) the information was not requested by us, unless the person or entity that created the information is no longer available to amend the record, d) it is not part of the information kept by our office, e) the information is already accurate and complete. If your request is denied, we will provide you with a written notification of the reason(s) and your rights to have the request, the denial, and any written response appended to your health record.

4. You may ask that we communicate with you at a location other than at your home or by a different means of communication. To request confidential communication, you must a) notify us in writing, b) indicate the information you wish to limit, c) indicate whether or not you wish to limit or restrict our use or disclosure of such information, 4) identify to whom the restrictions apply (which family members, etc.), and 5) by what means (i.e. fax, e-mail, etc).

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5. You have the right to receive a listing of disclosures made by Sandra Gray, Ph.D. This information is retained for six years or the life of the record, whichever is longer. We will respond to your request within sixty (60) days of written receipt of request.
6. You have the right to revoke written authorization to use or disclose health information. This does not apply to information already used or disclosed.
7. You have the right to obtain a copy of this notice.

Sandra Gray, Ph.D. is required by law to:

1. Maintain the privacy of your health information.
2. Inform you about our privacy practices.
3. Notify you if we are unable to agree to a requested restriction.
4. Accommodate reasonable requests you may have to communicate health information by alternative means or locations.
5. Honor the terms of this notice or any subsequent revisions.

Sandra Gray, Ph.D., may use or disclose your health information in the following circumstances:

1. To determine the course of your treatment with other health care providers
2. For payment purposes
3. Business associates, in order for them to perform their duties
4. Interpreters
5. Coroners or Medical Examiners to determine cause of death or to meet other legal duties
6. Workers Compensation claims as required by law
7. Public Health, as authorized by law or to report suspected abuse, neglect or other domestic violence, or knowledge of exposure of a communicable disease
8. Health Oversight Committees to determine compliance with state and federal regulations.
9. Compelling circumstances to law enforcement officials to identify or locate a suspect, fugitive, witness or missing person; present an imminent threat to the health and safety of a person; to report a crime; or other disclosures required by law including subpoenas
10. Our office may contact you by voicemail, letters, etc. to provide you with appointment reminders, or other office communications.

Sandra Gray, Ph.D., is not in violation of this Notice or the HIPPA Privacy Rule if any of its employees or Business Associates disclose protected health information under the following circumstances:

1. Disclosure by whistleblowers. If an employee believes in good faith that Sandra Gray, Ph.D. has engaged in unlawful or unethical conduct and discloses information to:
    a. Public Health oversight
    b. An attorney for the purpose of determining legal options regarding the suspected violation
2. Disclosure by an employee who is a victim of crime on or off the premises related to a suspect who is a patient of Sandra Gray, Ph.D.

To exercise your rights under this Notice, to ask for more information or report a problem contact:

HIPPA Compliance Officer
6655 W. Sahara Ave, Suite B200-124
Las Vegas, NV 89146
(702) 900-2784

If you believe your privacy rights have been violated, you may file a written complaint with:

Secretary of Health and Human Services
US Department of Health and Human Services
Washington, DC 20211

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HIPPA Privacy Policy
Acknowledgement of Receipt Form

I, _____, have received a HIPPA Privacy Policy on

_____ (date).

Signed: _____

Staff Member: _____

****

If Privacy Policy was not made available to patient on first visit, please state reason below.

Staff member: _____

Date: _____

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Notice of Privacy Practices (NPP)

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You May Get Access to This Information. Please review it carefully.

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Innovation Behavioral Health Solutions, LLC (IBHS, LLC) safeguards the protected health information of people who receive services from this agency.

Protected health information includes descriptive information that can be used to identify a person and that relates to the physical or mental health or condition, the health care provided to the person or payment for the health care. The protected health information includes information from the past, present, or future. The right to privacy continues after death.

You have the right to expect that only those individuals, organizations and/or agencies that have a need to know will be granted permission to use your protected health information, unless otherwise allowed by law or by your written authorization.

This notice will explain your rights more completely.
1. Who we are: This notice describes the privacy practices of the IBHS, LLC, including case management services, crisis services, mental health services, rehabilitative mental health services and all of the people who work in these programs.
2. Our Privacy Obligations: We are required by law to keep your protected health information private, to tell you about these rules and to follow the rules.
3. Disclosing and Using Your Information with your consent: When you begin receiving services from us, we will ask that you (or your legally authorized representative) sign a consent form, which will permit us to release information about you in order to provide services to you, in order to be paid by your insurance company for the services provided to you, and to conduct our regular business activities. Your consent will permit us to share information with other parties who provide services to you. We will specifically ask your permission to share information related to psychiatric treatment, substance abuse or substance abuse treatment, and information pertaining to HIV testing and treatment.

We will share information with

- Providers in the community who provide services to you
- Your insurance company so your services will be paid for

We will also share information to resolve any complaints or grievances that you may have.

You may request to have the use or disclosure of your protected health information restricted. IBHS, LLC does not have to agree to the restriction you request. If we do agree, we must make a record of the restrictions and we must honor them.

If you wish to have information provided to other parties, you will be asked to sign an authorization. The authorization will allow us to provide information to others. We cannot provide information that was given to us by someone else. You may revoke this authorization at any time by providing a written dated notice.

4. Using Your Protected Health Information for Other Purposes
Generally, we may use your protected health information for other reasons only when we have a specific authorization signed by your or your legally authorized representative. We will use your protected health information when necessary to contact you about appointments and to provide you with information we think you may be interested in. You may provide us with another address or method to contact you and we will honor that request.

There are times when we may be unable to obtain your consent, or an authorization and we will still need to use your protected health information. We will use only what is absolutely necessary to accomplish the purpose. Examples of when we might use protected health information about you without consent or authorization include:

- If you need emergency treatment
- If you are incapacitated and we believe you would consent if you could
- If we find any of these situations, which we are legally required to report:
    - Cases of suspected abuse and neglect of children and incapacitated adults
    - Certain diseases to the public health authorities so they may stop the spread of disease
    - If we believe you represent a threat to the safety of someone in the community or yourself.

There are also times when we are required to provide information about you. For example,

- We are required to provide information about you to organizations that oversee the care we provide. Examples would be for licensing or certification.
- We may be required to provide information about you in response to a court order (including to certain law enforcement officials)
- We are required to report information to the coroner or medical examiner if requested.

5. Reviewing your Protected Health Information
You have the right to inspect and obtain a copy of protected health information maintained in IBHS, LLC files. You will be expected to make an appointment for this and you will be charged fees for copying. You may also request that your records be sent to a mental health professional for their review. If you choose to do this, you will be charged fees for copying. Some protected health information in our files, particularly if it was provided to IBHS, LLC by others, may not be reviewed or copied.

6. Amending your Protected Health Information
You have the right to amend your protected health information in IBHS, LLC files for as long as that protected health information is maintained in our files. You may not amend material that was not created by IBHS, LLC. You may add written material to your record to clarify information if you believe the information is false, inaccurate or incomplete. You may amend your records once annually at no cost with written request. If you amend your records more frequently, you will be charged fees for copying.

7. Disclosures
You have the right to request an accounting of all disclosures of your protected health information that IBHS, LLC may make if the disclosure was for something other than treatment, payment or IBHS, LLC business needs. You have the right to request an accounting of any disclosures you authorized.

Information and Complaints

If want more information about your Privacy Rights or our Privacy Practices, or are concerned that we have not followed our rules, you may contact us directly or you may also file a written complaint with the Director, Office for Civil Rights. Upon request, we will provide you with the address. We will not retaliate against you if you file a complaint of any kind.

Duration of this notice

This notice goes into effect upon receipt. We may change the terms of this notice at any time. If we do so, you may obtain any new notice from our office or we will provide you with a new one upon changes.

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Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information, according to federal and state law (often referred to as HIPAA). I encourage you to read it in full. In the future I may change how I use and share your information and so may change the Notice of Privacy Practices.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this acknowledgement, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on, but I may already have used or shared some of your information and cannot change that.

_____ _____
Signature of patient (parent/guardian if minor) Date

_____
Printed name & Relationship to the patient if applicable

_____
Sandra Gray, Ph.D., CPC-I
Licensed Psychologist (PY0815)