Jodi Klugman-Rabb, PsyD, LMFT, LPC
Psychotherapy

Disclosure Statement and Nature of the Professional Therapeutic Relationship

Welcome to my practice. I have prepared this document so that you can be fully informed. Please read it carefully. Although it deals with difficult, anxiety-provoking subjects, it is important that you consider it carefully. If you have any questions or concerns, please do not hesitate to raise them in the future.

Our first few sessions will involve an evaluation of your needs, my assessment of my abilities to meet those needs, as well as an opportunity for you to experience working with me. Therapy can involve a large commitment of time, money, and energy, so it is wise to be very careful about the therapist you select. If you have questions about my procedures, training, or experience, we can discuss them whenever they arise throughout the course of therapy.

Since the length of treatment for different problems vary widely among individuals, I cannot give you exact information about the length of your treatment. However, I will be happy to discuss your progress and its implications for treatment length at any time during the course of therapy.

Confidentiality Policy

Confidentiality is the cornerstone of the therapeutic relationship. Nothing will be discussed outside of our sessions except for the following if applicable:

1. If I have reason to believe that a child under the age of 18 or an adult over the age of 65 or a dependent adult is suffering serious physical, sexual, or emotional injury as a result of abuse or neglect. A mandatory exception to the confidentiality agreement states I must file a report with the appropriate governmental agency;
2. If I believe that you are threatening immediate harm to yourself, and you are unwilling or unable to follow my treatment recommendations. A permitted exception to the confidentiality agreement allows me to seek your involuntary admission to an appropriate hospital, or contact a family member or other person who can help protect you;
3. Thirdly, if you threaten physical violence against another person or their property. A mandatory exception (California Civil Code Section 43.92) to the confidentiality agreement states I take reasonable action to protect that person or their property. This can include notifying the potential victim, notifying the police, or seeking involuntary hospital admission;
4. If my records are court-ordered I must surrender them.

OFFICE
21 Tamal Vista Blvd
Suite 194
Corte Madera, Ca. 94925

1303 Jefferson Street
Suite 600A
Napa, Ca. 94559

PHONE
415-652-7644

EMAIL
jodikrabb@gmail.com

WEB
jkrabb.com

In the rare event that these circumstances arise, although I am not required to inform you or seek your permission, it is my practice to discuss these matters as fully as possible with clients.

In the event we see each other outside the office, my policy is not to acknowledge you to preserve the confidential nature of the relationship. However, I do welcome you saying hello if you choose to.

I use Square for online scheduling and to process credit card services. Payments can also be made with Venmo or PayPal (neither is confidential) in addition to cash or check. My name along with my title will appear on your financial statements should you use these forms of payment. Please understand that may impact confidentiality if others in your life have access to your financial records or settings are not set to *private*.

Confidentiality can also be affected by using electronic communication between sessions for business issues such as rescheduling appointments, etc. I welcome the use of text and email messaging for this purpose and caution you to be aware that those messages may become intercepted electronically or read by others, breaking confidentiality.

Payment, Attendance, and Cancellation Policies

All payments are to be paid at the time of service. For your convenience, I can accept credit card payments through a mobile Square, Inc. terminal. I suggest that clients work directly with their own health plans to receive reimbursement for "out-of-network providers". Any missed sessions or late cancelations will be billed directly to you. I require a credit card on file for guarantee of payment in the case of missed sessions or late cancelations only. Collections may be pursued if balances go unpaid for longer than 6 months.

My base fee is $200.00 for each 50-minute session or $280 for 80-minute sessions. Additional services such as record requests, and requested professional consultations (legal, medical, hospital) via telephone, email, or in person are charged at $200/hour including travel time; telehealth sessions are billed at the base rate.

Fees are updated 10% annually on January 1st reflecting the cost of living increases, etc. You will be notified in writing 30 days in advance of any such fee change. This document fulfills The No Surprises Act of 2022 requiring a statement of good faith estimates.

In order to avoid paying the full fee for a canceled session, **I require notification within 48 hours** in the form of voice mail, text, or email messages. Appointments are not considered canceled unless you have direct confirmation from me. Please take your financial responsibility seriously.

I will consider two (2) missed sessions without adequate notice to be a termination of services and will note it in the record and with the appropriate referral sources. Outstanding balances will be sent to collections if not paid.

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Contacting Me

If I am unable to answer your contact, I will make every effort to return your message within 1 business day, unless it is an emergency. If you are difficult to reach, please leave some times when you will be available.
If I will be out of town or otherwise unavailable for an extended period of time, I will provide you with the name and number of a colleague whom you can contact for support if necessary. In the event of an emergency please consider the following numbers:
Crisis Unit at Marin: 415-499-6666; Marin 24-hour Suicide Hotline: 415-499-1193; Napa Psychiatric Emergency Response 707-253-4711 or 911.

In signing this document, I state that I understand and accept the obligations, which Jodi Klugman-Rabb must adhere to under the law as a licensed psychotherapist in the state of California. By signing this document, it indicates that I have read the information in this document and agree to abide by its terms during our professional relationship and that I have received a copy.

_____ _____

Client's Signature Date Client's Signature Date

Jodi Klugman-Rabb, PsyDc, LMFT, LPC

_____

Therapist's Signature Date

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Suite 194
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NOTICE TO CLIENTS
The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Jodi Klugman-Rabb, PsyD, LMFT, LPC

Marin & Napa Counties & Telehealth

Intake Information Sheet

Name: _____ Date: _____

Physical Address: _____ Mailing: _____

_____ _____

Email Address: _____@_____

Home Telephone: _____ Cell: _____
Can a confidential message be left at these numbers?

I Am: ***Separated*** ***Divorced*** ***Widowed*** ***Exclusive/Living Together*** ***Married***

Single ***Polyamorous/Lifestyle***

Name and # of Emergency Contact: _____

Your SSN: _____ DOB: _____

Your Occupation: _____

Psychotropic Medications, Reason & Dosage: _____ _____

_____ _____ _____

I Was Referred By: _____

Have you been in therapy before? _____

Insurance Plan	ID #	Telephone	Mat#/Authorization

Jodi Klugman-Rabb, PsyD, LMFT, LPC
Psychotherapy

Treatment Goals

Circle all that apply - Identify the top 3

Reduce a fear:		Learn effective parenting skills
Have more pleasurable activities		Improve my sleep
Improve communications with my:		Reduce sensitivity to criticism
1.)	3.)	Talk out a pending decision
2.)	4.)	Problem solving techniques
Reduce uncomfortable thoughts		Reduce panic attacks
Express myself more assertively		Increase self-esteem
Learn how to relax		Reduce family difficulties
Manage my health better		Reduce job difficulties
Tolerate my mistakes better		Better manage my temper
Tolerate other's mistakes better		Take initiative more often
Feel less guilty		Learn assertiveness skills
Feel less depressed		Decrease procrastination
Better accepting loss/death		Better manage my time
Increase my conversational skills		Derease perfectionism
Learn how I come across to others		Reduce emotionality
Not take disappointments so hard		Allow myself to express feelings more
Doubt myself less		Worry less
Think more positively		Feel more self-confidence
Improve my sexual relationship		Discuss thoughts of self-harm
Control my eating or weight		Discuss thoughts of harming others
Control my alcohol use		Improve self-awareness
Change a habit		Adjust better to past/recent issues
Control my drug use		Use EMDR to address trauma
Better manage my pain		Learn how to manage ADHD
Learn how to improve relationships		Learn how to cope with partner’s ADHD
Be more positive		Resolve identity crisis

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Credit Card Form

In order to guarantee payment and book sessions, a credit card on file is required in the case of missed sessions or late cancelations only, in which case the card will be charged automatically.

	expiration date	session fee $
credit card number		
name on card	security code	
		zip code
Signature	Date	

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Psychotherapy

CONSENT TO USE TELETHERAPY OR TELEPHONE SESSIONS

There are many types of telehealth platforms. I use the HIPAA-compliant Zoom platform for teletherapy for its security, video clarity, and reliability. Telephone sessions are possible but not preferable. Please initial the following and sign below.

_____There are concerns about telehealth platforms. The primary concerns of telehealth sessions are confidentiality and privacy, HIPAA compliance, dropped calls, and other potential interruption(s) of communication due to technology issues. At the present time, there is no definitive evidence that telehealth meets HIPAA security requirements and BAA (Business Associate Agreement) is required. Although most telehealth programs are HIPAA compliant, using these platforms is a risk due to security breaches and this release informs you of that risk as well as releases TCTI from any associated liability.

_____The HITECH Act of 2011 added more ways to enforce HIPPA and added more regulations and penalties. These new regulations have added importance to the BAA. Several experts have cited HITECH Act to raise a concern that telehealth programs don't always provide a protocol for trail audits or breach notification. Trail audits are a means of logging information to keep records. Breach notification relates to whenever data was accessed by unauthorized people or even an attempt to gain access to the session. Interactive technology platforms are supposed to notify the government when a breach or breach attempt occurs. However, not all platforms have or use the mechanism.

_____During a telehealth session, both locations (client and clinician) are considered a treatment room. Both parties need appropriate audio and visual equipment and privacy. Both parties will take precautions to maintain privacy and permission is required for either party to record the session. All HIPPA requirements apply to the session except when client consent (such as this consent) has been granted for a possible confidentiality breach or HIPPA violation: any platforms other than Zoom are considered not secure or HIPAA compliant, including Skype and FaceTime. I will disclose my physical location at the start of every telehealth session so that the clinician may meet my safety needs.

My initials above and signature below indicate that I have read the above description regarding the use of teletherapy. After reading the above, I agree to receive telehealth counseling and I understand the risks associated. I give my informed consent for the use of telehealth and I take FULL responsibility in the event of a breach of confidentiality or other telehealth-related concerns. I fully release Jodi Klugman-Rabb, PsyDc, LMFT from any liability associated with the use of teletherapy.

Client Name (Printed): _____

Client Signature: _____ Date: _____

Clinician Signature: *Jodi Klugman-Rabb* Date: _____

Jodi Klugman-Rabb, PsyDc, LMFT, LPC
Psychotherapy

HIPAA NOTICE OF PRIVACY PRACTICE

(Health Insurance Portability and Accountability Act)

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

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I WILL USE AND DISCLOSE YOUR PHI

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/ him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to

my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
4. **If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations**, such as the Privacy Rule that requires this Notice.
5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by the California Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.
8. **If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/ imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of

national security, such as protecting the President of the United States or assisting with intelligence operations.

13. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
14. **For Workers' Compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.
15. **Appointment reminders and health related benefits or services.** Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer**.**
16. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. **I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other heath-related benefits and services that may be of interest to you.**
18. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
19. **If disclosure is otherwise specifically required by law.**

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email. You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you**.**

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at:

Jodi Klugman-Rabb, MFT
21 Tamal Vista Blvd #194
Corte Madera, CA. 94925
415-652-7644

VII. EFFECTIVE DATE OF THIS NOTICE: April 14, 2003

I acknowledge receipt of the HIPAA Notice of Privacy Practice:

Patient Name: _____

Patient Signature: _____ Date: _____

Patient #2 Name: _____

Patient Signature: _____ Date: _____

Patient #3 Name: _____

Patient Signature: _____ Date: _____