Stephanie Washington Kuffel, Ph.D., P.S.
Licensed Clinical Psychologist
628 S. Maple St., Suite 101
Spokane, WA 99204
(509) 456-7888

_____

_____

_____

_____

Dear

This letter is to confirm your appointment with me on _____ at _____. My office is located at 628 S. Maple St., Suite 101 in Spokane.

Part of your evaluation and treatment involves gathering a great deal of information. Your evaluation will move more rapidly if you (and your partner, if applicable) complete the enclosed forms at home and bring them with you on your first visit. Included are basic questions about your medical history, recent mood, and stressful life events. If you object to some questions, you do not have to answer them, although I appreciate a response where possible. Your answers are completely confidential. Also enclosed are forms regarding my practice information, privacy policies, and financial agreements.

Unless prior arrangements have been made, you will be expected to pay for services at the time they are provided. I encourage you to contact your insurance company with any questions regarding coverage before you come in.

My office is located in a bright yellow historic house on the lower South Hill in Spokane on the corner of 7th and Maple. You may park for free on any of the side streets near the building. If you are traveling westbound on I-90, take Exit #280/Maple St and get in the far left lane. You will reach a traffic light at the bottom of the exit. Proceed straight through the traffic light on 4th Ave. and head toward the next traffic light at Maple. Take a left at the light onto Maple. As you are heading up the hill, get in the far right lane (but NOT onto the freeway on-ramp) and travel about 2-3 blocks. The house will be on your right. You can turn right onto 7th and park there. If you are traveling eastbound on I-90, take Exit #280/Maple St. Stay in the right lane, following the signs to head south. Turn right onto Maple at the traffic light. Travel up the hill about 2 blocks, and the house will be on your right. You can turn right onto 7th and park there. Please enter the building using the door that faces Maple and walk straight into the waiting room through a wooden door that is labeled “Reception.” Please seat yourself in the waiting area (there is no receptionist), and I will greet you at your appointment time.

Please do not hesitate to contact me if you have any questions about this information. I look forward to meeting with you!

Sincerely,

Stephanie Washington Kuffel, Ph.D.
Licensed Clinical Psychologist

ENCLOSED DOCUMENTS

There are 6 documents to review/sign:

1. **Agreement for Psychological Services** – This document provides information about Dr. Kuffel's practice. Please review and sign/date the last page. Return the signature page to Dr. Kuffel. The informational document is yours to keep.

2. **Client Information** – This document will provide Dr. Kuffel with pertinent information about you and your medical/psychological history. Please complete and return to Dr. Kuffel. If you will be coming as a couple, enclosed is a separate Partner Information packet for your partner to complete and return to Dr. Kuffel.

3. **Notice of Privacy Practices (Brief Version)** – This document is a brief version of the privacy policy implemented in April 2003. This is your copy to take.

4. **Notice of Privacy Practices Acknowledgement** – This is your acknowledgment of your receipt and understanding of the privacy policies. Please sign, date, and return to Dr. Kuffel.

5. **Guarantee of Payments** – This document is acknowledgement of your agreement to pay for services or other fees due to Dr. Kuffel. Please sign, date, and return to Dr. Kuffel.

6. **Contact Sheet** – This form will help me contact you when needed and will inform me of your contact preferences.

Stephanie Washington Kuffel, Ph.D., P.S.
Licensed Clinical Psychologist
628 S. Maple St., Suite 101
Spokane, WA 99204
(509) 456-7888

Agreement for Psychological Services

Welcome to my practice. In order to provide you the best care, I want you to have as much pertinent information as possible. If you have any questions or concerns, please feel free to discuss them with me. This document contains important information about my professional services and business policies. It also contains references to the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations (TPO). You will be provided with separate documents specifically addressing HIPAA. When you sign this document, it will represent an agreement between us. You may revoke this contract in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it, if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy

Psychotherapy involves a mutual commitment to work toward a better understanding and resolution of the issues or problems in your life. The overall goal of therapy is to facilitate positive change, which can then lead to greater happiness and satisfaction, less stress, a better ability to cope with problems, improved relationships, and deeper meaning and balance in your life. Each person's experience in therapy is different, depending on why and when a person enters therapy, what is explored, their level of commitment, and what is happening in their life. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will need to work on things we talk about both during and outside of our sessions.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life and may increase your awareness of your feelings, you may experience increased distress before you feel better. Making changes in your beliefs or behaviors can be scary and sometimes disruptive to the relationships you already have. On the other hand, psychotherapy also has been shown to have benefits for people who participate in it. Therapy often leads ultimately to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees about what you will experience.

MY EXPERIENCE AND APPROACH

My Experience

I am a licensed clinical psychologist in the State of Washington, which means that I have attended an accredited training program and have passed the national written examination and the oral examination given by the Washington State Examining Board of Psychology. I obtained a doctoral (Ph.D.) degree in Clinical Psychology from Washington State University in 2002. I completed a two-year postdoctoral fellowship at the University of Washington Reproductive and Sexual Medicine Clinic where I specialized in the treatment of sexual dysfunction and couples issues. In addition to my private practice, I am Clinical Assistant Professor with the University of Washington Department of Psychiatry part-time where I teach and provide supervision to fellows and residents in general psychotherapy skills as well as in the area of sexual dysfunction. I strive to adhere to the highest possible professional standards of competence and ethics. Whenever you have concerns about the treatment you are receiving, I hope that you will talk with me about them. If you feel that I have behaved unprofessionally or unethically, you may contact the Department of Health, Examining Board of Psychology, P.O. Box 47868, Olympia, WA, 98504-7869, (360) 236-4700.

My Approach

My therapeutic orientation is best described as integrative, drawing strongly from psychodynamic, cognitive-behavioral, and humanistic therapy modalities. This means that I use a broad range of techniques in therapy, applying those techniques that I believe are most suitable to your particular needs at a particular time. If appropriate, I may make changes in your treatment over time and/or make referrals to other providers, and your input into these decisions is crucial for the success of our work.

Our first few (1-3) sessions will involve an evaluation of your goals and needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow. Part of our work will involve identifying your patterns of thinking, behaving, and relating that may impede your goals. The length of treatment will depend on the type and extent of difficulties you are experiencing. Our first few sessions also will be an opportunity for you to evaluate whether you feel comfortable working with me. If it feels like I am not a good match for you, I would be happy to provide referrals to other mental health professionals. Therapy involves a large commitment of time, money, and energy, so it is important that you feel comfortable with the therapist you are working with. If you have questions about my procedures, we should discuss them whenever they arise. You have the right to refuse service at any time.

MEETINGS

Individual psychotherapy

The first appointment typically lasts about 75 minutes, during which I will obtain detailed information about your present concerns and the factors that may be contributing to them. I will also obtain information about your history as appropriate. After the first session, I typically schedule one 60-minute session per week at a mutually agreed upon time.

Couples psychotherapy

The first appointment typically lasts about 75-90 minutes, and both members of the couple are expected to be present. I will obtain detailed information from both of you about your present concerns and the factors that may be contributing to them. After the first session, I typically schedule one individual session with each member of the couple to obtain information about your individual history and present concerns. That will be the only time that we will meet on an individual basis if you are participating in couples therapy. Both members of the couple will be expected to be present for all following therapy sessions. Following the initial couples appointment and individual assessment sessions, we will schedule a couples session during which I will provide feedback about the problems you are experiencing and ways in which we can address them. I prefer to work collaboratively as a team, so I will encourage your input during this session as we develop our treatment plan. After the evaluation process and feedback session, I typically schedule one 60-minute session per week at a mutually agreed upon time.

MISSED APPOINTMENTS

Once an appointment hour is scheduled, you will be expected to pay a $100 fee for missed appointments unless you provide advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If you miss an appointment, I am happy to find another time to reschedule it.

PROFESSIONAL FEES

My fee for the initial consultation meeting is $250. The session fee thereafter is $200 for a 60-minute individual therapy session, $200 for a 60-minute couples therapy session, or $150 for a 45-minute session. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include scoring and interpreting test data, report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings or consulting with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty and disruption of legal involvement, I charge $300 per hour for preparation and attendance at any legal proceeding.

BILLING AND PAYMENTS
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed upon when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature and dates of services provided, and the amount due.

INSURANCE REIMBURSEMENT
In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it may provide some coverage for mental health treatment, although ***many insurance companies will not cover couples therapy or treatment for sexual dysfunction.*** I will assist in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

Due to the rising costs of health care, insurance benefits increasingly have become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy if this is in your best interest.

You should also be aware that most health insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and may be stored on a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their possession. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by contract.

CONTACTING ME
You may contact me at my office phone: (509) 456-7888. Please keep in mind that I am only in my office on a part-time basis (Tuesday mornings and Wed-Fri) and am often not immediately available by telephone. When I am unavailable, my telephone is answered by confidential voice mail that I monitor frequently when I am in the office. I will make every effort to return your call as soon as possible.

If you need more rapid attention for your own or someone else's safety, do not delay while waiting for a return call from me, call Spokane Mental Health crisis services at (877) 266-1818, call 911, or report the nearest hospital emergency room.

E-MAIL

I recognize that email can be a convenient way to communicate as needed, and I have found that it is best to limit email communications to topics such as scheduling, referral resources, insurance information, etc. Please note that I will not engage in detailed therapeutic conversations in email. Also, please be advised that, although I will take reasonable steps to protect the confidentiality and security of any email communications between us, they cannot always have the assurance of complete security, which is acknowledged as understood by you as part of this agreement. Therefore, if you choose to communicate with me by email, you acknowledge that security and confidentiality may be at risk.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information (PHI) about your treatment in your clinical record. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging or cause danger to the life or safety of you or another. In this case, at my professional discretion, I may provide you with a treatment summary at your written request. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. However, this is not true in legal evaluations or evaluations requested by a third party. In these cases, you will not be allowed access to the records without the consent and authorization of the party requiring the evaluation. With limited exception, you do have the right to inspect and obtain a copy of your PHI as it pertains to relevant medical and billing records maintained by me. Patients will be charged an appropriate fee for any professional time spent responding to information requests. I may withhold your record until the fees are paid. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by state law and/or HIPAA.

There are some situations where I am permitted or required to disclose information without either your consent or authorization. Please refer to the Notice of Privacy Practices for more information on limits of confidentiality:

- If I believe that a child has suffered abuse or neglect, the law requires that I file a report with the appropriate state agency, usually the Department of Social and Health Services.
- If I believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, the law requires that I file a report with the appropriate state agency, usually the Department of Social and Health Services.
- If believe that there is an imminent danger to the health or safety of the patient or any other individual, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can provide protection.
- If the patient has disclosed to me the unethical or unprofessional conduct of another licensed health provider, I may be obligated to report this information to the Washington State Department of Health.

Should one of these situations arise, I will make every effort to discuss it with you before taking action.

Special Case for Couples: It is my policy generally not to keep secrets about one member of the couple from the other member of the couple. Therefore, if I have any individual contact with one member of the couple or obtain

information from one member of the couple, I will assume that it is okay to discuss the contact/information during our couples sessions. If, for some reason, you have information that you would like to share with me but are not comfortable discussing it with your partner, please alert me before disclosing the information to me so that we can discuss how best to handle the situation. In addition, if at any point, you are requesting any portion of your medical record to be released to you or any other identified party (including any individual notes, conjoint therapy notes, forms signed, etc.), I will require consent in writing from both you and your partner.

PROFESSIONAL CONSULTATIONS

I may occasionally find it helpful to consult with other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patients. The consultant is also legally bound to keep the information confidential. Unless you request otherwise, I will not tell you about these consultations unless I feel that it is important to our work together.

ADDITIONAL PATIENT RIGHTS AND RESPONSIBILITIES

You are responsible for choosing the provider and treatment that best suits your needs. You have the right to be informed about your treatment plan, have input into it, and request changes in it. I prefer to work collaboratively with clients, and periodically I will check in with you about how therapy is proceeding and whether we would like to modify the work we are doing in any way. You have the right to privacy in our communication except as explained elsewhere in this document.

Stephanie Washington Kuffel, Ph.D., P.S.
Licensed Clinical Psychologist
628 S. Maple St., Suite 101
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(509) 456-7888

Agreement for Psychological Services v.7

AGREEMENT

Your signature below indicates that you have read the information in the Agreement for Psychological Services and agree to abide by its terms.

Signature of patient or legal guardian Print Name Date

Signature of partner (if applicable) Print Name Date

Client Information

Name: _____ Age: _____ Birthdate: _____

Gender: _____ Pronouns: _____ Sexual Orientation: _____

Are you in a relationship with a partner/partners? □ No □ Yes, one partner □ Yes, multiple partners

- If yes, please indicate relationship status:
  □ Married/civil union □ Not married/Cohabiting (living together)
  □ Not married/Not living with partner(s) □ Separated

Length of present relationship(s): _____
Length of previous relationship(s): _____

Number of biological children: _____Step-children: _____Adopted children: _____ Foster Children:_____

Highest grade completed in school: _____ Are you in school now? _____

Racial/ethnic identity/identities: _____

Religious/spiritual affiliation: _____
Current religious activity: □ Regular □ Irregular □ Inactive

Are you presently employed? □ Yes □ No Occupation: _____
Employer: _____ □ Part-time □ Full-time

Household members:

Name	Relationship to you	Age	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How did you hear about my practice? _____
Who referred you to me? _____

Family physician	_____	Phone	_____	Last seen ____
Gynecologist	_____	Phone	_____	Last seen ____
Urologist	_____	Phone	_____	Last seen ____
Psychotherapist	_____	Phone	_____	Last seen ____
Other	_____	Phone	_____	Last seen ____

Medical History

Have you ever had any of the following? (check all that apply)

☐ Anemia	☐ Cancer	☐ Heart disease	☐ Meningitis	☐ UTIs
☐ Allergies	☐ Diabetes	☐ Head injury	☐ Nervous system disorder	☐ Vulvodynia
☐ Asthma	☐ Emphysema	☐ High blood pressure	☐ Radiation treatment	☐ Yeast infections
☐ Bladder disease	☐ Epilepsy	☐ Jaundice	☐ Sciatica	☐ Other _____
☐ Blood clotting problems	☐ Gall bladder disease	☐ Kidney disease	☐ Stroke	☐ Other _____
☐ Back injury	☐ Heart attack	☐ Lung disease	☐ Thyroid problems	

Please list all medications (including herbal supplements/vitamins) currently used:
Name of medication Dosage/Frequency used Start date

_____
_____
_____
_____
_____
_____
_____

Please list all medications, not included above, taken in the last year:

_____
_____
_____
_____

Family Medical History

Has a relative ever had:	Check if Yes	Relationship to you
Alcoholism		
Cancer		
Diabetes		
Drug abuse		
Heart attack		
High blood cholesterol/lipids		
High blood pressure		
Hormone problems		
Infertility		
Mental illness		
Sexual dysfunction		
Stroke		
Thyroid problems		

Surgery History			
Have you ever had:	Yes	Reason for surgery	Year(s)
Back surgery			
Bowel operation			
Breast augmentation			
Broken/cracked bones			
Gall bladder operation			
Heart surgery			
Hernia repair			
Ovary operation			
Penis surgery			
Prostate operation			
Rectal surgery			
Stomach operation			
Testicle operation			
Thyroid operation			
Urethral strictures			
Uterus operation			
Vaginal operation			
Vasectomy			
Other (specify)			

Drug Usage			
Have you ever used any of the following?	Yes	Frequency	Year(s)
Amphetamines			
Amyl nitrate (poppers)			
Cocaine or crack			
Dilaudid, Percodan, pain pills			
Glue or solvents			
Hashish			
Heroin or morphine			
LSD or hallucinogens			
Marijuana			
PCP			
Other (specify)			

Alcohol Use **1 drink = 1 oz. Hard liquor, 11 oz. Beer, or 4 oz. Glass of wine**

Please estimate the average number of drinks consumed per week currently: _____
Please estimate the average number of drinks consumed per week during the time of your heaviest drinking: _____ For how many years? _____ At what age? _____

General health, sexual issues, and habits

Type of contraception used (check all that apply):
□ None
□ Oral contraceptives □ IUD □ Condoms □ Tubal ligation □ Vasectomy
□ Other _____

Number of sexual partners in the last six months: _____
Number of sexual partners in lifetime: _____
Sexual partners have been: □ Men Only □ Women Only □ Both men and women

Have you ever been physically assaulted or beaten?
_____ No
_____ Yes, as a child
_____ Yes, as an adult

Have you ever been forced to have sexual contact with someone?
_____ No
_____ Yes, as a child
_____ Yes, as an adult

Rate the current stress in your life on a 1-10 scale (1 = the least stress ever, 10 = the most stress ever in your life): _____

Do you smoke currently? Yes _____ No _____
If yes, how many packs per day? _____ For how many years? _____

Do you drink caffeinated beverages? Yes _____ No _____
If yes, how many cups or glasses per day? _____

Number of hours spent exercising per week: _____

Women only – Menstruation and Pregnancy History

Age of first menstruation: _____
Previously pregnant? Yes _____ No _____
If Yes:
Number pregnancies _____
Number live births _____
Number induced abortions _____
Number miscarriages _____
Number still births _____
If applicable:
Age at which menopause began: _____ Age at which final period occurred: _____
Are you currently on any hormone replacement therapy? Yes _____ No _____

Mental Health History

Please check if you currently have any of the following concerns:

- ☐ Depression
- ☐ Anxiety
- ☐ Eating disorder
- ☐ Intrusive thoughts
- ☐ Suicidal thoughts
- ☐ Relationship concerns
- ☐ Physical illness(es)
- ☐ Pain

Please list any mental health concerns you have had in the past:

Diagnosis (if known) When did it start? When did it end?

_____
_____
_____
_____
_____

Have you ever been hospitalized for psychiatric reasons (e.g., suicide, depression)?

Yes _____ No _____

- If yes, how many times?_____ When? _____

What are you hoping to address in our work together?

_____
_____
_____
_____

Please indicate if there is anything else you believe would be pertinent for me to know that was not addressed on this form:

_____
_____
_____
_____

Thank you very much for taking the time to complete this information!

PATIENT REGISTRATION

Patient Name:_____ Age:_____
(First) (Middle) (Last)

Date of Birth:_____ Social Security #:_____

Address:_____
Street

_____
City State Zip Code

Employer/School:_____Occupation:_____

Partner's Name:_____ Home Phone #:_____

Partner's Employer:_____ Partner's Occupation: _____ Work Phone #:_____

PERSON TO NOTIFY IN AN EMERGENCY

Name: _____ Relationship: _____

Mailing Address: _____

Phone: Home_____Work_____Cell_____

PERSON RESPONSIBLE FOR PAYMENT *(NOT Insurance Company)*

☐ Check if patient is person responsible for payment

Name:_____Relationship:_____

Address:_____
Street

_____
City State Zip Code

Phone: Home_____Work_____Cell_____

Employer:_____Occupation:_____

INSURANCE INFORMATION

Primary Insurance:_____ID#_____

Subscriber Name:_____ Group #:_____

Secondary Insurance:_____ID#_____

Subscriber Name:_____ Group #:_____

Assignment of Benefits: I request that payment of authorized insurance benefits be made on my behalf to Dr. Stephanie Kuffel for any services furnished to me. I authorize any holder of protected health information about me to release to my insurance and it agents any information necessary to determine these benefits or the benefits payable for services.

_____
Signature of Patient Date

Partner Information

Name: _____ Age: _____ Birthdate: _____

Gender: _____ Pronouns: _____ Sexual Orientation: _____

Are you in a relationship with a partner/partners? □ No □ Yes, one partner □ Yes, multiple partners

- If yes, please indicate relationship status:
  □ Married/civil union □ Not married/Cohabiting (living together)
  □ Not married/Not living with partner □ Separated/Divorced

Length of present relationship(s): _____
Length of previous relationship(s): _____

Number of biological children: _____Step-children: _____Adopted children: _____ Foster Children:_____

Highest grade completed in school: _____ Are you in school now? _____

Racial/ethnic identity/identities: _____

Religious/spiritual affiliation: □ Buddhist □ Catholic □ Non-denominational Christian
□ Hindu □ Jewish □ Muslim □ Mormon □ Protestant □ Other (specify) _____
Current religious activity: □ Regular □ Irregular □ Inactive

Are you presently employed? □ Yes □ No Occupation: _____
Employer: _____ □ Part-time □ Full-time

Household members:

Name	Relationship to you	Age	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How did you hear about my practice? _____
Who referred you to me? _____

Family physician _____ Phone _____ Last seen ____
Gynecologist _____ Phone _____ Last seen ____
Urologist_____ Phone _____ Last seen ____
Psychotherapist_____ Phone _____ Last seen ____
Other _____ Phone _____ Last seen ____

Medical History

Have you ever had any of the following? (check all that apply)

☐ Anemia	☐ Cancer	☐ Heart disease	☐ Meningitis	☐ UTIs
☐ Allergies	☐ Diabetes	☐ Head injury	☐ Nervous system disorder	☐ Vulvodynia
☐ Asthma	☐ Emphysema	☐ High blood pressure	☐ Radiation treatment	☐ Yeast infections
☐ Bladder disease	☐ Epilepsy	☐ Jaundice	☐ Sciatica	☐ Other _____
☐ Blood clotting problems	☐ Gall bladder disease	☐ Kidney disease	☐ Stroke	☐ Other _____
☐ Back injury	☐ Heart attack	☐ Lung disease	☐ Thyroid problems	

Please list all medications (including herbal supplements/vitamins) currently used:

Name of medication Dosage/Frequency used Start date

_____
_____
_____
_____
_____
_____
_____

Please list all medications, not included above, taken in the last year:

_____
_____
_____
_____

Family Medical History

Has a relative ever had:	Check if Yes	Relationship to you
Alcoholism		
Cancer		
Diabetes		
Drug abuse		
Heart attack		
High blood cholesterol/lipids		
High blood pressure		
Hormone problems		
Infertility		
Mental illness		
Sexual dysfunction		
Stroke		
Thyroid problems		

Surgery History			
Have you ever had:	Yes	Reason for surgery	Year(s)
Back surgery			
Bowel operation			
Breast augmentation			
Broken/cracked bones			
Gall bladder operation			
Heart surgery			
Hernia repair			
Ovary operation			
Penis surgery			
Prostate operation			
Rectal surgery			
Stomach operation			
Testicle operation			
Thyroid operation			
Urethral strictures			
Uterus operation			
Vaginal operation			
Vasectomy			
Other (specify)			

Drug Usage			
Have you ever used any of the following?	Yes	Frequency	Year(s)
Amphetamines			
Amyl nitrate (poppers)			
Cocaine or crack			
Dilaudid, Percodan, pain pills			
Glue or solvents			
Hashish			
Heroin or morphine			
LSD or hallucinogens			
Marijuana			
PCP			
Other (specify)			

Alcohol Use **1 drink = 1 oz. Hard liquor, 11 oz. Beer, or 4 oz. Glass of wine**

Please estimate the average number of drinks consumed per week currently: _____
Please estimate the average number of drinks consumed per week during the time of your heaviest drinking: _____ For how many years? _____ At what age? _____

General health, sexual issues, and habits

Type of contraception used (check all that apply):
□ None
□ Oral contraceptives □ IUD □ Condoms □ Tubal ligation □ Vasectomy
□ Other _____

Number of sexual partners in the last six months: _____
Number of sexual partners in lifetime: _____
Sexual partners have been: □ Men Only □ Women Only □ Both men and women

Have you ever been physically assaulted or beaten?
_____ No
_____ Yes, as a child
_____ Yes, as an adult

Have you ever been forced to have sexual contact with someone?
_____ No
_____ Yes, as a child
_____ Yes, as an adult

Rate the current stress in your life on a 1-10 scale (1 = the least stress ever, 10 = the most stress ever in your life): _____

Do you smoke currently? Yes _____ No _____
If yes, how many packs per day? _____ For how many years? _____

Do you drink caffeinated beverages? Yes _____ No _____
If yes, how many cups or glasses per day? _____

Number of hours spent exercising per week: _____

Women only – Menstruation and Pregnancy History

Age of first menstruation: _____
Previously pregnant? Yes _____ No _____
If Yes:
Number pregnancies _____
Number live births _____
Number induced abortions _____
Number miscarriages _____
Number still births _____
If applicable:
Age at which menopause began: _____ Age at which final period occurred: _____
Are you currently on any hormone replacement therapy? Yes _____ No _____

Mental Health History

Please check if you currently have any of the following concerns:

- ☐ Depression
- ☐ Anxiety
- ☐ Eating disorder
- ☐ Intrusive thoughts
- ☐ Suicidal thoughts
- ☐ Relationship concerns
- ☐ Physical illness(es)
- ☐ Pain

Please list any mental health concerns you have had in the past:

Diagnosis (if known) When did it start? When did it end?

_____
_____
_____
_____
_____

Have you ever been hospitalized for psychiatric reasons (e.g., suicide, depression, bipolar disorder)?
Yes _____ No _____

- If yes, how many times?_____ When? _____

What are you hoping to address in our work together?

_____
_____
_____
_____

Please indicate if there is anything else you believe would be pertinent for me to know that was not addressed on this form:

_____
_____
_____
_____

Thank you very much for taking the time to complete this information!

PATIENT REGISTRATION

Patient Name:_____ Age:_____
(First) (Middle) (Last)

Date of Birth:_____ Social Security #:_____

Address:_____
Street

_____
City State Zip Code

Employer/School:_____Occupation:_____

Partner's Name:_____ Home Phone #:_____

Partner's Employer:_____ Partner's Occupation: _____ Work Phone #:_____

PERSON TO NOTIFY IN AN EMERGENCY

Name: _____ Relationship: _____

Mailing Address: _____

Phone: Home_____Work_____Cell_____

PERSON RESPONSIBLE FOR PAYMENT *(NOT Insurance Company)*

☐ Check if patient is person responsible for payment

Name:_____Relationship:_____

Address:_____
Street

_____
City State Zip Code

Phone: Home_____Work_____Cell_____

Employer:_____Occupation:_____

INSURANCE INFORMATION

Primary Insurance:_____ID#_____

Subscriber Name:_____ Group #:_____

Secondary Insurance:_____ID#_____

Subscriber Name:_____ Group #:_____

Assignment of Benefits: I request that payment of authorized insurance benefits be made on my behalf to Dr. Stephanie Kuffel for any services furnished to me. I authorize any holder of protected health information about me to release to my insurance and it agents any information necessary to determine these benefits or the benefits payable for services.

_____
Signature of Patient Date

Stephanie Washington Kuffel, Ph.D., P.S.
Licensed Clinical Psychologist
628 S. Maple St., Suite 101
Spokane, WA 99204
(509) 456-7888

NOTICE OF PRIVACY PRACTICES – BRIEF VERSION

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.

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I also am required by law to keep your information private. These laws are complicated, but I must give you this important information. This pamphlet is a shorter version of the full, legally required Notice of Privacy Practices (NPP), which I am happy to provide to you upon request. Please talk to me about any questions you may have.

I will use the information about your health, which I get from you or from others mainly to provide you with **treatment**, to arrange **payment** for my services, and for some other business activities that in the law are called health care **operations.** After you have read this NPP, I will ask you to sign a **Consent Form** to let me use and share your information. If you do not consent and sign this form, I cannot treat you.

If you or I want to use or disclose (send, share, release) your information for any other purposes, I will discuss this with you and ask you to sign an Authorization form to allow this.

Of course I will keep your health information private, but there are some times when the laws require me to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.

2. If I have reasonable cause to believe that a child or vulnerable adult has suffered abuse or neglect, I am required by law to report it to the proper law enforcement agency or the Washington Department of Social and Health Services.

3. Some lawsuits and legal or court proceedings.

4. For Workers Compensation and similar benefit programs.

There are some other situations like these that occur less often, and they are described in the longer version of the NPP, which I will provide to you upon request.

Your rights regarding your health information

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home instead of at work to schedule or cancel an appointment. I will try my best to do as you ask.

2. You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends. While I don't have to agree to your request, if I do agree, I will keep our agreement unless it is against the law, in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information I have about you such as your medical and billing records. You can even get a copy of these records, but I may charge you. In some very rare situations you cannot see all of what is in your records, for example, if I believe that seeing them would be emotionally damaging or cause danger to the life or safety of you or another. You also will not be allowed access to your records if your treatment was requested by a third party or part of a legal evaluation. Contact me about arranging to see your records.

4. If you believe the information in your records is incorrect or missing important information, you can ask me to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to me. You must tell me the reasons you want to make the changes.

5. You have the right to a copy of this notice. If I change this NPP, I will post the new version in my waiting area, and you can always get a copy of the NPP from me.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

If you have any questions regarding this notice or my health information privacy policies, please contact me at the address and phone number above.

The effective date of this notice is April 14, 2003.

Stephanie Washington Kuffel, Ph.D., P.S.
Licensed Clinical Psychologist
628 S. Maple St., Suite 101
Spokane, WA 99204
(509) 456-7888

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I keep a record of the health care services I provide you. You may ask to see and copy that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so. You may see your record or get more information about it by contacting Stephanie Washington Kuffel, Ph.D., 1500 W. 4th Ave., Suite 405, Spokane, WA 99201, (509) 456-7888.

My **Notice of Privacy Practices** (NPP) describes in more detail how your health information may be used and disclosed and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

_____

Patient or legally authorized individual signature Date

_____

Printed Name

_____

Patient's partner (if applicable) Date

_____

Stephanie Washington Kuffel, Ph.D., P.S.
Licensed Clinical Psychologist
628 S. Maple St., Suite 101
Spokane, WA 99204
(509) 456-7888

Guarantee of Payments

I, _____, by my signature below agree to make payment in full for any services or other fees that are due Stephanie Washington Kuffel, Ph.D., P.S. and am responsible for such payments independent from any efforts to obtain such payments from insurance or other financial providers. I hereby release Stephanie Washington Kuffel, Ph.D., P.S. and her agents or other persons acting in her behalf from all harm, and I hereby waive all rights to confidentiality in matters concerning collection of payments due. I accept full responsibility for any fees or other costs that may be incurred in the collection of payments due Stephanie Washington Kuffel, Ph.D., P.S.

Notice of Cancellation or Failure to Show for Appointment

It is my responsibility to give at least **24 hours notice** to cancel a session. By my signature below I understand that I will pay a fee of $50 for each occurrence of a missed session or late cancellation.

_____ Date: _____
Signature of Patient

_____ Date: _____

PLEASE HELP ME CONTACT YOU…

NAME: _____

PHONE: Home _____ Work _____ Cell _____

IS IT OKAY TO CALL YOU AT **HOME**? YES NO (CIRCLE ONE)

IS IT OKAY TO LEAVE A MESSAGE AT YOUR **HOME** NUMBER?
YES NO (CIRCLE ONE)

IS IT OKAY TO CALL YOU AT **WORK**? YES NO (CIRCLE ONE)

IS IT OKAY TO LEAVE A MESSAGE AT YOUR **WORK** NUMBER?
YES NO (CIRCLE ONE)

IS IT OKAY TO CALL YOU ON YOUR **CELL** PHONE?
YES NO (CIRCLE ONE)

IS IT OKAY TO LEAVE A MESSAGE ON YOUR **CELL** PHONE?
YES NO (CIRCLE ONE)

WHICH PHONE NUMBER DO YOU PREFER I USE TO REACH YOU?
(CHECK ONE)

□ HOME □ WORK □ CELL