

Stephanie R. Baron, Ph.D.  
Lic. #PSY 11972  
10436 Santa Monica Blvd, Suite #3030, Los Angeles, CA 90025

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

This is to acknowledge that I have received and reviewed a copy of the document entitled "Privacy Practices". I understand that this Acknowledgement of Receipt will be retained in my records for a period of six (6) years.

Please sign your name and print your name and date on this acknowledgement form and return your signed acknowledgement to Stephanie R. Baron, Ph.D.

\_\_\_\_\_  
Print Name: Patient (Parent/Guardian)

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Signature: Patient (Parent/Guardian)

\_\_\_\_\_  
Date:

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**CONFIDENTIALITY**

All information between therapist and patient is held strictly confidential unless:

1. The patient authorizes release of information with his/her signature.
2. The patient presents a physical danger to self.
3. The patient presents a physical danger to others.
4. Child/elder abuse/neglect is suspected.

In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken.

**FINANCIAL TERMS**

I do not accept insurance. I will provide a superbill for insurance. Payment is due at each session unless otherwise agreed between both Dr. Baron and the patient.

**CANCELED/MISSED APPOINTMENTS**

A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with less than 24 hours notice, the responsible party will be billed according to the scheduled fee.

**CONSENT FOR TREATMENT**

I further authorize and request that Dr. Stephanie R. Baron, Ph.D. carry out psychological examinations, treatments and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable.

**RELEASE OF INFORMATION**

I authorize the release of information in order to confer with other treatment providers. I understand and agree to all of the above information.

\_\_\_\_\_  
Print Name: Patient (Parent/Guardian)

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Signature: Patient (Parent/Guardian)

\_\_\_\_\_  
Date:

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First Date of Service \_\_\_\_\_

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ E-Mail \_\_\_\_\_

Marital Status: SINGLE \_\_\_ MARRIED \_\_\_ SEPARATED \_\_\_ DIVORCED \_\_\_ WIDOWED \_\_\_ LIVING TOGETHER

Medications: \_\_\_\_\_

Allergies to food or medication? \_\_\_\_\_

Previous therapy Yes \_\_\_ No \_\_\_ Dates \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Bank \_\_\_\_\_ Checking Account# \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

Date of Last Physical \_\_\_\_\_

OTHER TREATING PROVIDERS

Name \_\_\_\_\_ Address/Tel: \_\_\_\_\_

Name \_\_\_\_\_ Address/Tel: \_\_\_\_\_

Name \_\_\_\_\_ Address/Tel: \_\_\_\_\_

EMERGENCY CONTACT

Name \_\_\_\_\_ Home Tel \_\_\_\_\_

Relationship \_\_\_\_\_ Work Tel \_\_\_\_\_

REASON FOR SEEKING TREATMENT:

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I AM FULLY AWARE THAT I AM RESPONSIBLE FOR ALL PAYMENTS FOR PROFESSIONAL SERVICES RENDERED.

ALL APPOINTMENTS WILL BE BILLED AT THE FULL RATE WITHOUT 24 HOUR CANCELLATION.

\_\_\_\_\_  
Print Name: Patient (Parent/Guardian)

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Signature: Patient (Parent/Guardian)

\_\_\_\_\_  
Date:

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## **OUR PRIVACY PRACTICES**

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

**Uses and Disclosures of Your Health Information:** Dr. Baron uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other health care providers and facilities to which you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. Dr. Baron may use or disclose identifiable health information about you without your authorization for routine care and for legal reasons as described in the following pages, but beyond those situations, Dr. Baron will ask for your written authorization before using or disclosing any identifiable health information about you.

**Your rights:** In most cases, you have the right to look at or get a copy of health information about you. These requests must be in writing and Dr. Baron will charge you reasonable retrieval and photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that Dr. Baron made. If you believe that information in your record is incorrect, you have the right to request, in writing that Dr. Baron corrects the existing information.

**Complaints:** If you are concerned that Dr. Baron may have violated your privacy rights, or you disagree with a decision Dr. Baron made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

**Our legal duty:** Dr. Baron is required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before Dr. Baron makes a significant change in our policies, we will notify our then current patients of such change. For more information about our privacy practices, please contact the person listed below. If you have any questions or concerns, please contact Dr. Stephanie R. Baron at the above address.

## OUR PRIVACY PRACTICES

The following are examples of the types of uses and disclosures of your protected health information that Dr. Baron is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures.

**Treatment:** Dr. Baron may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. An example of treatment would be when The Shores Counseling Center consults with another health care provider, such as your family physician or another psychologist, regarding your treatment.

**Payment:** Your protected health information may be used, as needed, in activities related to obtaining payment for your health care services.

**Other:** Dr. Baron may use certain health information in the course of providing you directly with information about treatment alternatives within Dr. Baron's office or upcoming appointment reminders.

**Written Authorization:** Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. Authorization will also be obtained before releasing your psychotherapy notes. "**Psychotherapy notes**" are notes made during a private, group, joint, or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protection than your protected health information. You may revoke or modify all such authorizations of protected health information or psychotherapy notes at any time; however, the revocation or modification is not effective until it is verifiably received by Dr. Baron.

**Opportunity to Object:** Dr. Baron may use and disclose your protected health information in the following instances. You have the opportunity to object. If you are not present or able to object, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. **Emergencies:** In an emergency treatment situation, your provider shall try to provide you a Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

**Communication Barriers:** Dr. Baron may use and disclose your protected health information if your provider attempts to obtain acknowledgement from you of the Notice of Privacy Practices but is unable to do so due to substantial communication barriers and the provider determines, using professional judgment that you would agree.

## OUR PRIVACY PRACTICES

**Without Opportunity to Object Dr. Baron may use or disclose your protected health information in the following situations without your authorization or opportunity to object:**

**Child Abuse;** Whenever, in the professional capacity of, Dr. Baron has knowledge of or observes or reasonably suspects that a child known to Dr. Baron has been the victim of child abuse or neglect, Dr. Baron will immediately report such to a police department or sheriffs department, county probation department, or county welfare department. Also, if Dr. Baron has knowledge of or reasonably suspects that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, Dr. Baron will report such to the above agencies.

**Adult and Domestic Abuse:** If in the professional capacity of Dr. Baron, Dr. Baron has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if Dr. Baron is told by an elder or dependent adult that he or she has experienced any of these abuses and if Dr. Baron reasonably suspects such, Dr. Baron will report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency. Dr. Baron does not have to report such an incident if Dr. Baron has been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect and Dr. Baron is not aware of any independent evidence that corroborates the statement that the abuse has occurred; or the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; or in the exercise of clinical judgment, Dr. Baron reasonably believes that the abuse did not occur.

**Health Oversight:** If a complaint is filed against Dr. Baron with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information relevant to that complaint.

**Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services that Dr. Baron has provided you, Dr. Baron must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; or 3) a subpoena to produce records where the party seeking your records provides Dr. Baron with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified Dr. Baron that you are bringing a motion in the court to block or modify the subpoena. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. Dr. Baron will inform you in advance if this is the case.

**Serious Threat to Health or Safety:** If you communicate to Dr. Baron a serious threat of physical violence against an identifiable victim, Dr. Baron must make reasonable efforts to communicate that information to the potential victim and the police. If Dr. Baron has reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, Dr. Baron may release relevant information as necessary to prevent the threatened danger.

**Worker's Compensation:** If you file a worker's compensation claim. Dr. Baron must furnish a report to your employer, incorporating Dr. Baron's findings about your injury and treatment, within five working days from the date of the your initial examination, and at subsequent intervals as may be required by the administrative director of

the Worker's Compensation Commission in order to determine your eligibility for worker's compensation. In general, Dr. Baron may use or disclose your protected health information as required by law and limited to the relevant requirements of the law.

## **YOUR RIGHTS**

### **The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.**

You have the right to request to inspect and obtain a copy of your protected health information. All requests must be in writing and reasonable retrieval time and fees, along with reasonable copying fees will apply. Dr. Baron may refuse to provide access to certain psychotherapy notes or information for a civil or criminal proceeding. You have the right to request a restriction of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for treatment, payment or healthcare operations. You may also request that information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. Dr. Baron is not required to agree to a restriction that you may request, but if Dr. Baron does agree, then Dr. Baron must behave accordingly.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. Dr. Baron will accommodate reasonable requests. Dr. Baron may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Dr. Baron will not request an explanation from you as to the basis for the request.

You may have the right to have your provider amend your protected health information. You may request in writing an amendment of protected health information about you. If Dr. Baron denies your request for amendment, you have the right to file a statement of disagreement with us, and your medical record will note the disputed information.

You have the right to receive an accounting of certain disclosures Dr. Baron may have made. This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Effective Date: The effective date for the above Privacy Practices is October 20, 2022.