Larisa Traga, LCSW, MAC, CCDS
(805) 266-3231 (phone) (805) 262-6275 (Fax)
330 James Way #180, Pismo Beach, CA 93449
526 E Mill St, Santa Maria, CA 93454

Patients Bill of Rights

The Association of American Physicians and Surgeons adopted a list of patient freedoms in 1990, which was modified and adopted as a 'patients' bill of rights' in 1995: *All patients should be guaranteed the following freedoms:*

- *To seek consultation with the physician(s) of their choice;*
- *To contract with their physician(s) on mutually agreeable terms;*
- *To be treated confidentially, with access to their records limited to those involved in their care or designated by the patient;*
- *To use their own resources to purchase the care of their choice;*
- *To refuse medical treatment even if it is recommended by their physician(s);*
- *To be informed about their medical condition, the risks and benefits of treatment and appropriate alternatives;*
- *To refuse third-party interference in their medical care, and to be confident that their actions in seeking or declining medical care will not result in third-party-imposed penalties for patients or physicians;*
- *To receive full disclosure of their insurance plan in plain language, including:*

  CONTRACTS: A copy of the contract between the physician and health care plan, and between the patient or employer and the plan;
  INCENTIVES: Whether participating physicians are offered financial incentives to reduce treatment or ration care;
  COST: The full cost of the plan, including copayments, coinsurance, and deductibles;

  COVERAGE: Benefits covered and excluded, including availability and location of 24-hour emergency care;
  QUALIFICATIONS: A roster and qualifications of participating physicians;

  APPROVAL PROCEDURES: Authorization procedures for services, whether doctors need approval of a committee or any other individual, and who decides what is medically necessary;
  REFERRALS: Procedures for consulting a specialist, and who must authorize the referral;
  APPEALS: Grievance procedures for claim or treatment denials;
  GAG RULE: Whether physicians are subject to a gag rule, preventing criticism of the plan.

I have read and understand these patient's rights listed above.

SIGNATURE_____ **DATE** _____

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Name ________________________________ **Today's Date:** _________________

Please list all medications you are currently taking:

MEDICATION NAME HOW OFTEN (DAILY) WHO PRESCRIBED IT

MEDICATION NAME HOW OFTEN (DAILY) WHO PRESCRIBED IT

MEDICATION NAME HOW OFTEN (DAILY) WHO PRESCRIBED IT

MEDICATION NAME HOW OFTEN (DAILY) WHO PRESCRIBED IT

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MEDICATION NAME HOW OFTEN (DAILY) WHO PRESCRIBED IT

MEDICATION NAME HOW OFTEN (DAILY) WHO PRESCRIBED IT

Please list all OVER THE COUNTER DRUGS you are currently taking:

(ALCOHOL, CIGARETTES, ASPIRINS, OVER COUNTER DRUGS, NARCOTICS, ETC)

DRUG NAME HOW OFTEN

DRUG NAME HOW OFTEN

Do you have ALLERGIC problems?

Yes No (Please Explain)

____

____

____

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CONSENT TO TREATMENT

Dear Client,

It is important in beginning our professional relationship to understand both the nature and limitations of the relationship. Please review the following policies to understand these areas:

CONFIDENTIALITY. The therapy relationship is both a professional and confidential relationship protected by professional and ethical standards, to the extent that, with a few important exceptions, what you disclose is confidential and cannot be released without your written consent. However, there are certain circumstances under which we are ethically and/or legally required to disclose information. These include the following:

1. If there is a reasonable belief that child, elder or dependent adult abuse has occurred.
2. If you make a threat to harm a third party and/or you pose a risk to yourself or others.

You should also be aware your confidentiality can be waived if you tender your mental condition in civil or criminal limitation. Thus, the decision of whether to tender your mental condition is an issue you should consult your attorney on.

APPOINTMENTS. Once an appointment is made that time has been reserved solely for you. If you find you are unable to keep your appointment, it is your responsibility to notify us and cancel your appointment at least 24 hours in advance (48 hours is greatly appreciated). Failure to cancel 24 hours in advance will result in a $85 charge.

PAYMENTS/FEES POLICY. Clients are expected to pay for services at the time they are rendered unless other arrangements have been made. Clients who carry insurance should remember professional services are rendered and charged to the patient and not to the insurance company. We will gladly provide you with a receipt, which you can submit to your insurance company for reimbursement and fill out any necessary forms. We accept cash or checks. There is a $40.00 charge for checks with insufficient funds.

COLLECTIONS POLICY. In the event you fail to make reasonable efforts to pay your bill, our office retains the right to pursue delinquent accounts. Our office will make every effort to work out a reasonable payment arrangement should you request that. However, patients who refuse to will have their accounts transferred to our collection agency. If it becomes necessary to transfer your account to our collection agency, your financial records will be released and your delinquent balance will be recorded with TRW. Please be aware we take this action only as a last resort.

TELEPHONE POLICY. Telephone calls are always welcome. Insurance benefits however, do not cover after hours phone calls. Therefore, any phone conversation more than a check-in (3 to 5 min) will be billed as a partial (25 min) or whole (50 min) session depending on the length of the call at $145 a session rate.

I have read the above policies and understand what it says. If I have any questions regarding these policies I will ask my therapist to clarify these policies.

_____ _____
(Client Signature) (Date)

_____ _____
(Therapist) (Date)

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Payment Responsibilities

Charges For Psychotherapy

Your insurance **co-payment is due at the time of service**. If you're insurance does not make a payment **you are responsible for the entire session fee** unless other arrangements are made. If necessary payment arrangements can be arranged that are suitable to both you and the therapist.

Billing For Psychotherapy

As a courtesy this practice will bill your insurance company for you and will notify you if there is a problem with your insurance. **You are responsible for payment of all psychotherapy services provided**. Please note **the Initial Assessment Evaluation may take an hour and a half.**

Insurance Billing

Please verify your insurance coverage before treatment
And obtain pre-authorization for the initial visit

Insurance Companies

Larisa Traga, LCSW is currently contracted with Holman, Victim Witness, SAVE EAP and SLO Mental Health. While she is accepting TriCare, Optim, Blue Cross/Blue Shield of California, Healthnet, Pacificare Behavioral Health, United Behavioral Health, Magellan and American Behavioral, Anthem, Cigna, Aetna, Humana, there is no guarentee these insurance carriers will make a payment. As mentioned above, as a courtesy we will bill your insurance company. **However, you are responsible for payment of all psychotherapy services provided** if the insurance company does not make a payment.

Delays For Your Session Time

At times, minor emergencies may occur or a patient may require additional care during the session before you and a delay may cause the start of your scheduled appointment to start a little late. We value your time and will attempt to remain on schedule. Be assured if the circumstances warrant, you too will receive the same careful attention.

Telephone Billing Policy

Telephone calls are always welcome. Insurance benefits however, do not cover phone calls during or after hours. Therefore, any phone conversation more than a check-in (5-10 min) will be billed as a partial (25 min) or whole (50 min) session depending on the length of the call at $145 a session rate.

Please sign below to indicate notification and agreement with these policies. We will provide you with a copy of this form if you wish.

_____ _____

Patient's signature or signature of guardian Date

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Patient Registration

Cell Phone: **Email:**

PATIENT DETAILS					
Legal Name : Last First Middle			☐ Male ☐ Female	☐ Married ☐ Single	Referred By
Street Appt #		City		Zip Code	
Home Telephone #	Social Security	Birth Date		Drivers Lic.#	Expire Yr.

EMPLOYER			
☐ Homemaker ☐ Retired ☐ Student	Employer Name	City & Zip Code	Telephone

INSURED AND/OR RESPONSIBLE PARTY				
Legal Name : Last First Middle		Relationship : ☐ Parent or Guardian ☐ Other _____ ☐ RESPONSIBLE PARTY		
Street Address Same As Patient ☐		☐ INSURED ☐ Insured same as above		
City & Zip Code	Telephone	Social Security	Birth Date	☐ Male ☐ Female
Employer Name		Occupation	Telephone	

IN CASE OF AN EMERGENCY			
Name	Relationship	Telephone	Work Telephone

PRIMARY INSURANCE COMPANY			SECONDARY INSURANCE COMPANY		
Insurance Company Name			Insurance Company Name		
Street Address			Street Address		
City	State	Zip Code	City	State	Zip Code
Policy ID #			Policy ID #		
Group #			Group #		
Plan / Program #			Plan / Program #		

Authorization to release information: I agree if the insurance denies or reduces the level of service received I will still be liable for the limiting rate established for treatment I received as submitted to insurance. I hereby authorize my therapist with the Coastal Wellness Center to furnish the insurance company or others authorized by law with full information regarding treatment rendered when so required. I hereby authorize my insurance company to pay directly to my therapist at the Coastal Wellness Center, Medical benefits otherwise payable to me and I will be responsible to my therapist at the Coastal Wellness Center for all expenses.

SIGNATURE_____ **DATE** _____

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Dear Patient

Thank you for choosing Larisa Traga at The Coastal Wellness Center. To guarantee the best possible health care, please take time to review the following information and policies. It is very important to us to maintain our good relationship with you, therefore if you have any questions or comments please bring them to our attention.

Thank you!
From the Coastal Wellness Team

Appointment Policies

1. Please contact us at least ***24 hours in advance*** if you are unable to make your appointment. You will avoid a "no show" fee of eighty-dollars (**$80.00**) and we can give this time to another patient. If you have two no-shows our therapist-patient relationship will be terminated.

2. If you have a medical emergency, we will try to accommodate your urgent needs. ***Please do not abuse this*** service. If your medical needs are routine, be assured that we will Schedule you ***as*** soon as possible.

3. For emergencies if the office is closed, please contact our regular telephone number (598-0631) and leave a message.

4. Telephone calls are always welcome. Insurance benefits however, do not cover after hours phone calls. Anything more than a check-in phone call (3 to 5 minutes) will therefore be billed as a partial or whole therapeutic hour depending on the length of the call.

Medications

1. For your best care please bring a list of all your medications with you to the office.

Information

1. Please keep us informed of changes in your life - examples would include changes in the following :

- ☐ Address
- ☐ Telephone Number
- ☐ Name / Marital Status
- ☐ Insurance Company
- ☐ Employer
- ☐ Any other important information

This allows us to keep our records current so we can reach you quickly and if necessary and process insurance claims for you efficiently.

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Fees For Deposition, Court Services/Appearance and Court Reports

When served with a Subpoena Duces Tecum for my appearance in person, a Deposition Subpoena, a Subpoena or request for a Court Report, Progress Note or Treatment Summary or when my appearance is requested in any manner, the following fee policies will be in effect. This is the case unless you receive a signed written amendment from me.

My fee for a scheduled/requested appearance is $495 per hour paid in advance with a minimum fee of 4 hrs. The time begins when I leave my office and ends when I return back to my office. The requested appearance fee is required to be paid in advance for scheduling either a half day or the entire day and is paid whether or not I am actually called to the witness stand on that day. The fee for a scheduled appearance is due with the subpoena or upon request of my appearance. The fee is paid even if the appearance is cancelled by anyone other than myself for any reason at any time.

My fee for a requested Court Report, Progress Note or Treatment Summary is $200 per hour. I do not send, fax or copy my original clinical notes. The fee is due with the subpoena or upon request. If the fee for a scheduled appearance requested Court Report, Progress Note or Treatment Summary is not paid at the time services are requested, arrangements for payment are the duty of the party requesting the appearance or court report and must be made before delievery and/or on receipt of this communication. These fees are required any time I am requested to travel away from and return to my office. These are my usual and customary fee arrangements.

Further required attendance will be charged at the above hourly, half day and/or daily rates under the same circumstances and further requested Court Reports, Progress Notes or Treatment Summaries will be charged at the above hourly rate. These terms are not negotiable.

Sincerely,

Larisa Traga, LCSW, MAC, CCDS

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Digital Recording Release Form

I agree to participate in an audio, video, and/or digital recording for training purposes.

I understand and consent to the use and release of the recording by Larisa Traga. I understand that the information and recording is for training purposes only and that my name and image will not be used for any other purpose. I relinquish any rights to the recording and understand the recording may be duplicated and used by Larisa Traga, LCSW without further permission.

I understand that should a recording be an impediment to me or my career at any time, I can request in writing that the recording be removed from training materials.

I agree to immediately raise any concerns or feelings of discomfort with Larisa Traga, LCSW.

Your signature:_____

Date:_____

Please print your name: _____

Thank you!

We appreciate your participation.