

**Lynne Angela Santiago, LMHC**  
**PHONE CONSULTATION CLIENT REGISTRATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (please indicate which number is best to reach you at and leave a voice message)

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ SSN: \_\_\_\_\_

MARITAL STATUS:    S    M    D    W    NAME OF SPOUSE/PARTNER: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Name

Phone #

Relationship

How did you find out about me?

MD \_\_\_\_\_ Google Search      Yahoo Search      Friend      Therapist Website

Other Internet Search/Website \_\_\_\_\_ Other \_\_\_\_\_

**PHONE CONSULTATION SESSIONS & FINANCIAL AGREEMENT**

***Please initial indicating that you have read and understand:***

\_\_\_\_\_ I consent to receive consultation services over the phone from Lynne A. Santiago, LMHC

\_\_\_\_\_ I understand that phone sessions are to be booked in advance and require advanced payment through either credit card or electronic check.

\_\_\_\_\_ I understand that when I schedule a phone session I am reserving a period of time, therefore, I will be charged a \$50.00 fee if I do not cancel an appointment at least 48 hours in advance and I will be charged the full fee if I do not show for an appointment without giving notice.

\_\_\_\_\_ I understand that a collection agency may be utilized to recover unpaid debt and if this was necessary my private information would be disclosed to the collection agency.  
this action is necessary, I will receive a written notification of intent to release information to the collection agency with a time period to make alternate arrangements.

\_\_\_\_\_ I understand that my personal information may be transferred electronically (i.e. online billing, email, fax machine).

YES    NO      You can email me about upcoming workshops, seminars, appointment reminders.

My email address is: \_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Lynne A. Santiago, LMHC

\_\_\_\_\_  
Date

**Registration Information:**

What concerns or issues are you interested in discussing: *Please Circle:* Sex Addiction    Erectile Dysfunction  
Arousal/Desire    Premature Ejaculation    Delayed Ejaculation    Orgasm difficulties  
Other:

\_\_\_\_\_  
Have you tried to solve these problems yourself and how? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How has this affected your family and/or job: \_\_\_\_\_  
\_\_\_\_\_

How do you rate your physical health?:    excellent    good    fair    poor

Please circle if applicable:    Diabetes    Cardiac    Thyroid    High Blood Pressure    Depression/Anxiety

Are you having thoughts of suicide?    YES    NO

History of therapy, counseling and/or psychiatric treatment (please list date, doctor, therapist, hospital, outcomes)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications Currently Taking (include over the counter, herbal and/or diet supplements):

Drug	Dosage/Frequency	What is it for?	Side effects	Is it effective?

**Brief Sexual History/Problem Assessment:**

When did this problem first occur? \_\_\_\_\_

Has this problem occurred in other relationships?    YES    NO

Is there any history of childhood sexual abuse, physical abuse, or neglect?    YES    NO

How has your partner reacted to your problem? \_\_\_\_\_  
\_\_\_\_\_

Any thing else you want me to know before we have our first phone session? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Understanding Your Health Record

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The federal Standards for Privacy of Individually identifiable Health Information (HIPPA Privacy Rules 45 CFR Part 160-164) requires that, except for certain verifications for health plans and coverage facilities, an individual has a right to notice as to the uses and disclosures of protected information that may be made by the medical provider, is to be given information about his/her rights, and information regarding the medical providers legal duties with respect to protected information.

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please read carefully.

- 1) **Your Medical Record:** Each time you visit a hospital, physician, or other provider a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care of treatment. This information, often referred to as your health or medical record, serves as a:
  - Basis for planning your care and treatment.
  - Means of communicating among the many health professionals who contribute to your care.
  - Legal document describing the care you received
  - Means by which you or a third party payer can verify that service billed were actually provided.

Understanding what is in your record and how your health information is used helps you to:

- Ensure accuracy
- Better understand who, what, when, where and why others may access your health information.
- Make more informed decisions when authorizing disclosure to others.

- 2) **Your Health Information Rights:** Although your health record is physically the property of the healthcare practitioner or facility that compiled it, the information belongs to you.

**You have the right to:**

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
- Obtain a paper copy of the notice of information practices upon request.
- Inspect and copy your health record as provided by 45 CFR 164.524.
- Amend your health record as provided by 45 CFR 164.528.
- Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528.
- Request communications of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose your health information except to the extent that action has already taken place.

- 3) **Lynne Santiago's Responsibilities are to:**

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information I collect and maintain.
- Abide by the terms of this notice
- Notify you if I am unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.