# Uram Family Therapy

**Michael Uram, MA, LMFT, LPCC**
Licensed Marriage and Family Therapist, MFC45428
Licensed Professional Clinical Counselor, LPC1984

**(949) 777-6694** **michael@michaeluram.com**
1000 Quail St., Suite 155 Newport Beach, CA 92660
145 W Main St., Suite 240, Tustin, CA 92780

Thank you for scheduling an appointment with Michael Uram, MA, LMFT, LPCC, practicing as Uram Family Therapy.

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I ask that you complete the three following forms before our first appointment:

**1. Intake Form**
**2. Informed Consent**
**3. Authorization for Use, Exchange and Disclosure of Protected Health Information (PHI)**

For the **intake form**, please fill it out to the best of your ability. If you feel uncomfortable answering any of the questions, please feel free to leave them blank.

The **Informed Consent** outlines the legal disclosures and confidentiality practices regarding psychotherapy. Please feel free to ask me any questions.

The **Authorization for Use, Exchange and Disclosure of Protected Health Information (PHI)** form is necessary if you would like for me to contact your insurance company for reimbursement, communicate with a parent, a family member or consult with another treating professional or school.

If you have any questions or concerns about the form, please leave the section blank and we can discuss it in person.

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## Uram Family Therapy Adult Individual Intake Form

| | Client | May We Contact you by this means? |
|---|---|---|
| Name: | | |
| Phone: | | **Voicemail?** ☐ Yes ☐ No **Text?** ☐ Yes ☐ No |
| Email: | | ☐ Yes ☐ No **Newsletter?** ☐ Yes ☐ No |
| Address: | | ☐ Yes ☐ No |

(Please note that texting or email is not considered to be a HIPAA compliant means of communication)

Please use a secure messaging platform, such as OfficeAlly or Simple Practice ☐ Yes ☐ No

Insurance Company: ______________________________Insurance ID#:_________________________

Group Number: _____________________Employer:________________ DOB:___________________

Primary Insured's Name: ________________________________ DOB:________________________

Referred by (If Applicable):______________________________________________________________

What is your Primary Concern/ Presenting Problem?__________________________________________

What is your previous diagnosis, if any?____________________________________________________

What medications are you prescribed and/or currently taking?_________________________________

_____________________________________________________________________________________

Please describe previous behavioral health providers and outcomes?___________________________

_____________________________________________________________________________________

Are you presently in danger of hurting themselves or others? _________________________________

Please describe any relevant medical conditions/ history: _________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

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## Authorization for Use, Exchange and Disclosure of Protected Health Information (PHI)

1. **Client's name**: ______________________________________________

2. **Date of Birth**: __ _/__ _/_ __

3. **Date authorization initiated**: __ _/__ _/_ __

4. **Authorization initiated by**: ☐ CLIENT ☐ PROVIDER

5. **Information to be Released**:

☐ **Psychotherapy Notes** and Dates of service, Diagnosis, Treatment Goals, Prognosis, Summary and Relevant Background Information
☐ Authorization for Dates of Service, Diagnosis, Treatment Goals, Prognosis, Summary and Relevant Background Information
☐ Authorization for **Psychotherapy Notes** ONLY
☐ Other: ______________________________________________

6. **Purpose of Disclosure**: The reason I am authorizing release is: ☐ My request

☐ Other (describe): ______________________________________________

7. **Person(s) Authorized to Make/ Receive the Disclosure**: Michael Uram, MA, LMFT, LPCC

8. **Person(s) Authorized to Make/ Receive the Disclosure**:______________________________________________

9. **Insurance Company Authorized to Make/ Receive the Disclosure**: ☐ Aetna ☐ Blue Shield ☐ Kaiser

10. **This Authorization will expire one year from today's date or on ___/___/___ or upon the happening of the following event**: ______________________________________________

**Authorization and Signature**: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

**Signature of the Patient**: ______________________________________________**Date**: _______________

**Signature of Personal Representative:** ______________________________________________**Date**: _______________

**Relationship to Patient if Personal Representative (E.G. CAREGIVER or PARENT)**: _________________________

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## PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("***HIPAA***").

1. Tell your counselor if you don't understand this authorization, and the counselor will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.***

HIPAA provides special protections to certain medical records known as "Psychotherapy Notes."
All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition is the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

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## Client Informed Consent Form

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

I understand that I will be receiving psychotherapy services with **Michael Uram, Licensed Marriage and Family Therapist, MFC #45428, Licensed Professional Clinical Counselor, LPC #1984** doing business as **Uram Family Therapy, Professional Corporation.**

**Fees:** Current fees are **$150 per each 50-minute individual, family or intake session**. I am aware that I am responsible for payment, even if my insurance company does not reimburse Michael for our session. If I have to cancel, I will give at least **24 hours of notice of the cancellation** of my scheduled appointment. Otherwise, I will be responsible for a **$150** missed appointment fee, **even if I am usually covered through my insurance plan or pay a reduced fee. Each client is given one fee waiver for a missed appointment per 12-month cycle. Payment is always due before each session. Payment can be made by Cash, Check or Credit Card through Paypal or Square.** There is a sliding scale of fee of $95 per session if your family makes less than $75,000 per year. Other fees are listed on Michael Uram's Fee for Services, which is available by request

**Therapist Availability/ Emergencies:** Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions. Calls longer than 15 minutes will be billed at the therapist's rate of $150 per hour. You may leave a message for your therapist at any time on his voicemail at (949) 777-6694. If you wish for your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls and emails are returned during normal workdays (Monday through Friday, 9 AM – 6PM within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail. In the event of an emergency, especially a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 or the police to request emergency assistance.

**Risks:** I understand that there are inherent risks to psychotherapy and that there are no guarantees. I understand that there may be alternative treatment methods and that I can discuss these alternatives with my therapist at any time. I understand that my participation in therapy is on a voluntary basis and I may choose to stop treatment at any time.

**Information about your therapist:** Michael Uram has a Master's Degree in Clinical Psychology with an Emphasis in Marriage and Family Therapy. He graduated from Pepperdine's Graduate School of Education and Psychology in 2005. He was initially licensed by the California Board of Behavioral Sciences in February 2008 after receiving 3000 hours of clinical experience and supervision and passing two exams. He was additionally licensed as a Licensed Professional Clinical Counselor in April 2015. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

**Session Length:** Each session is **approximately 50 minutes** in length. If additional time is requested, you will be billed for another session at the rate of **$150 per unit**. A 110-minute long session is $250.00.

**Confidentiality:** All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples' therapy.** This means that if you participate in family, and/or marital/couple's therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your

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family. Please feel free to ask your therapist about his or her "no secrets" policy and how it may apply to you. There are exceptions to confidentiality. For example, **therapists are required to report instances of suspected child, dependent adult or elder abuse**. This includes physical abuse, sexual abuse and neglect. Therapists are permitted to report emotional abuse. **Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. A court may order the therapist to turn over your records, even if you specifically request that they not be released.** In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers, and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

**Web- Based Services:** Michael Uram uses several different web-based providers to facilitate treatment. These may change without notice. Currently, these are the providers that Michael utilizes:
Voicemail: Google Voice, no Business Associate Agreement, not HIPAA Compliant
Email: Google, Google for Business with Business Associate Agreement
Fax: Faxage, with Business Associate Agreement
Video Chat: Simple Practice, Microsoft Teams, Skype for Business, Business Associate Agreement
Insurance Billing/ Practice Management: OfficeAlly, PracticeMate, ReminderMate
**These Web based services do not guarantee confidentiality**. Michael agrees to maintain best practices to protect your information. Unfortunately, unauthorized access may still occur. I will inform my clients if I do believe that their information has been accessed and possibly used. I strongly discourage contacting me through social networks or any type of group discussion or forum online for any of my clients to protect your privacy as well as to avoid a dual relationship with my clients.

**Billing:** Michael utilizes his own employees, Simple Practice and Office Ally to process claims. Information disclosed to Uram Family Therapy employees and Office Ally will be limited to the purpose of payment and billing. If there is an outstanding balance, a collection agency or other outside agency may be used to settle the debt. In this case, only information related to billing, including patient name, location and dates of service, cost of service, and total bill will be disclosed.

**Consultation:** Michael Uram may consult with other mental health professionals in regards to my treatment, taking as much effort as is reasonable to protect client's identity, so they are not reasonably identifiable. If he feels as if he needs to disclose my identifiable information, he will obtain my written consent. If insurance reimbursement is requested, a Protected Health Information (HIPAA) disclosure form will be included in the materials that your therapist will provide to you, to release at your discretion.

**Additional Confidentiality for Minors:** Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his/her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist. As a client, I understand that Michael Uram periodically updates this informed consent. Updated forms are available on michaeluram.com. If I have any concerns about the updated informed consent, I will contact Michael Uram.

**Patient Acknowledgement**

I, the Patient or Responsible Party, have read Michael Uram's informed consent notification, understand it and agree to its conditions.

Name: ______________________________ Signature: ________________________________ Date: ______

Name: ______________________________ Signature: ________________________________ Date: ______

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## Credit Card Authorization

The undersigned authorizes **Michael Uram, MA, LMFT, LPCC** to make the following charges to their credit card for payment of psychotherapy services and/or associated expenses.

**This card can be placed on file with a PCI Compliant online credit card processor, currently Square and Stripe.**

By signing below, you confirm that you fully understand that health insurance policies and reimbursement issues are between you and your health insurance company, not Uram Family Therapy. You understand that all services rendered to you or your child are charged directly to you. You understand that you are personally responsible for payment to Uram Family Therapy, Michael Uram, MA, LMFT, LPCC and that this responsibility is not related to potential health insurance coverage or reimbursement. We request that you notify our office as soon as possible if any of this information changes. This agreement will remain in effect, and your card may be charged, until this agreement is cancelled in writing.

Signature: ________________________________________ Date: _____________

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## Service Menu Pricing 2020

| **Assessment** | Total Sessions | Cost |
|---|---|---|
| Reasoning Skill Assessment, facilitated by Collaborative Problem Solving (All Ages) | 2, Assessment and Family Interview | $300 |
| ADHD Assessment (Under 18 YOA) | 2 Assessment and Clinical Interview | $300 |
| Asperger's Assessment (All Ages) | 2, Assessment and Clinical Interview | $300 |
| Gottman Relationship Checkup for Couples | 2, Assessment and Report Review | $300 plus $30 Administration Fee |
| Prepare/ Enrich Premarital Assessment | 2, Assessment and Report Review | $300 plus $35 Administration Fee |
| Barkley Sluggish Cognitive Tempo Assessment (Under 18 YOA) | 1, Assessment and Review | $150 |
| Barkley Executive Functioning Assessment | 1, Assessment and Review | $150 |

| **Treatment** | Session Length | Cost |
|---|---|---|
| Individual Psychotherapy | 50 minutes | $150 |
| Individual Psychotherapy | 110 minutes | $250 |
| Couples Psychotherapy | 50 minutes | $150 |
| Family Therapy | 50 minutes | $150 |
| Skype Session/ Phone Session | 50 minutes | $150 |
| COGMED Program | 5 weeks, 3X Week 30-45 minute sessions, approximately 15 sessions total with weekly 30 minute progress review meetings | $1500 total |
| VR Assisted Therapy for Phobias | 50 minutes | $150 |

**For all services rendered by Michael Uram, MA, LMFT, LPCC**
**Alternative pricing sheets available for Rajiv Joshi, MA, LMFT,**
**And Cristina Deneve, MA, AMFT**