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Charleston, SC 29407
843-571-4005
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From North Charleston

Take I-26 east (toward Charleston).

Take 7 South (Cosgrove) across the Ashley River. When you cross the river, you're 1.4 miles from Southgate. By the time you get to the Exxon Station, be in the left lane. Stay left on 171 when 7 and 171 split. Take a left at the T-Bonz onto Southgate Drive. After you turn, there is a row of businesses converted from condos on your immediate right. The Southgate Center has a sign in the yard.

From Folly Beach / James Island

Take Folly Road to the Connector (Road 30) toward downtown. On the bridge, take 61 north. When 61 and 171 split, take 171 north (the right fork). Soon after Charlestowne Landing, take a right at the T-Bonz onto Southgate Drive. After you turn, there is a row of businesses converted from condos on your immediate right. The Southgate Center has a sign in the yard.

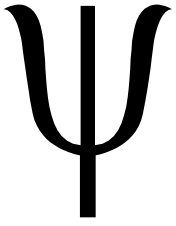
From West Ashley:

Take 7 (Sam Rittenberg) toward I-26. Take a right at Charlestowne Drive; if you get to Bi-Lo, you've gone too far. Take a left at the light on 171. Begin looking for the T-Bonz immediately. Take a right at the T-Bonz onto Southgate Drive. After you turn, there is a row of businesses converted from condos on your immediate right. The Southgate Center has a sign in the yard.

From Mt. Pleasant:

Take 17 South across the Cooper River, across the peninsula, and across the Ashley River. Immediately after the Ashley, bear right on Highway 61. When 61 and 171 split, take 171 north (the right fork). Soon after Charlestowne Landing, take a right at the T-Bonz onto Southgate Drive. After you turn, there is a row of businesses converted from condos on your immediate right. The Southgate Center has a sign in the yard.

www.bonniecleveland.com



Bonnie Cleaveland, PhD, ABPP
Board Certified Clinical Psychologist
National Register of Health Service
Providers in Psychology

I prefer that you pay by credit card – that way, I can simply take care of the payment at the end of our session. Please complete this form. Talk to Dr. Cleaveland if you'd like to use another method of payment. Checks and cash are also accepted.

Please charge my session fees, unpaid balances, and no-show/late cancellation fees as described in my contract to:

Card #

Expiration Date _____

Signature

Date

Visa MasterCard American Express

Patient Name _____

Mailing Address: _____

City, State, Zip _____

Physical Address (if different):

City, State, Zip _____

Phone numbers:

Home: _____

Work: _____

Mobile: _____

Pager: _____

E-mail: _____

Date of Birth: _____

Gender: Male Female

Employer: _____

Emergency contact: _____

Emergency contact's phone: _____

Who referred you? _____

May I thank him or her? _____

Signature/ date: _____

Who is responsible for the bill? (If different)

Full Name _____

Mailing Address: _____

City, State, Zip: _____

Physical address _____

City, State, Zip _____

Phone numbers:

Home: _____

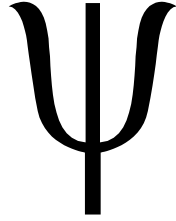
Work: _____

Mobile: _____

OPTIONAL

All reasonable requests to receive communication of your health information by alternative means will be granted. Please describe the alternative means (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

All reasonable requests to receive communication of your health information at alternative locations will be granted. Please complete the following section only if you want communications regarding your health care information sent to an alternate address (other than your residence).



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PSYCHOLOGIST-PATIENT SERVICES AGREEMENT

- This is a legal document. Please read it carefully.
- You may revoke this Agreement in writing at any time, which invalidates it only from that point forward.

PSYCHOLOGICAL SERVICES

- The success of psychotherapy depends primarily on **your** efforts during and between sessions.
- Psychotherapy can be difficult, so you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness.
- Psychotherapy frequently has benefits, but there are no guarantees of what you will experience.
- We will spend 2-3 sessions in an evaluation. Treatment will not begin until the evaluation is complete, so do not expect immediate results. I may, for various reasons, choose not to work with you in therapy. Of course, you may also choose not to work with me.
- If you have any problems or difficulties with therapy, please discuss them with me immediately.

MEETINGS

- Meetings are 45 minutes, with about 5 more minutes for administrative tasks such as payment and scheduling.
- I am usually quite punctual. If you arrive late, you will miss part of your therapy time.
- **You will be responsible for the session fee once it's scheduled unless you cancel within 24 hours of the appointment time.**
- Insurance companies do not provide reimbursement for cancelled sessions.

PROFESSIONAL FEES

- The initial evaluation is \$160.
- Subsequent 45 minute sessions are \$140 per session.
- I charge \$140 per hour for other professional services such as report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, 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 at \$200/hour, including preparation and transportation costs, **even if I am called to testify by another party.**

CONTACTING ME

- We use voicemail; you will rarely reach me live. Please leave a voicemail with times I can reach you. Let me know if I can leave a detailed message, or if I can email you.

- I make an effort to return all calls within 24 hours.
- You may email me, but please know that it is not confidential, and it is not for urgent matters. E-mail is likely to get lost, so if the issue is important, call. I usually do not return emails, but instead will address the issue in your next session.
- My mobile phone number is 843-224-0421 and should be used for emergencies.

ENDING THERAPY

If you decide to end your therapy before the two of us decide that your therapy is complete, please let me know that. If you simply drop out of therapy, it may take time to refund any overpayments. However, if you miss a session or do not reschedule and a month passes, your therapy will be considered legally terminated. I am not, at that point, responsible for your care. Most of the time, I am happy to restart therapy with past clients. But I always reserve the right to keep your case closed.

EMERGENCIES

- In emergencies, you can try me at my mobile number – 843-224-0421. Always also call my office phone to check for information about whether I'm available or not.
- If you are unable to reach me and feel that you can't wait for me to return your call, contact your physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.
- In the case of serious thoughts of suicide, go to the ER or call 911.
- If I will be unavailable for an extended time, another psychologist will cover for me.

LIMITS ON 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 HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided you, such information is protected by the psychologist-patient

privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I am required to provide it to them.
- I may disclose relevant information regarding a patient in order to defend or protect myself (for example, if a patient files a complaint or lawsuit against me).
- If I am treating a patient who files a workers' compensation claim, I will be required to provide otherwise confidential information to the patient's employer, the insurer, or the Workers' Compensation Commission.

There are some situations in which I am legally obligated to take actions which I believe are necessary to attempt to protect myself or others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I receive information that gives me reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect, or by acts or omissions that would be abuse or neglect if committed by a parent or other caretaker, the law requires that I file a report with the county Department of Social Services. If I believe that a child has been or may be abused or neglected by any other person, I must report that to the appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that a vulnerable adult has been or is likely to be abused, neglected, or exploited, the law requires that I file a report to the Adult Protective Services Program. Once such a report is filed, I may be required to provide additional information.
- If I believe that a patient presents a clear and substantial risk of imminent, serious harm to another, I may be required to take protective action, including notifying the potential victim, contacting the police, and/or seeking hospitalization for the patient.
- If a 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 help provide protection.
- If a patient reveals his or her intent to commit a crime, I may be required to take preventative action, such as calling the police.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I may keep Protected Health Information about you in two sets of professional records.

1. Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional

consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. You may examine and/or receive a copy of your Clinical Record if you request it in writing except in unusual circumstances. Examples include: danger to yourself and others, when others have supplied information to me confidentially by others, or when the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I charge a copying fee of \$.50 per page. If I refuse your request for access to your Clinical Record, you have a right of review (except for information supplied to me confidentially by others) which I will discuss with you upon request.

I keep patient records electronically, for five years after your last date of service, as required by SC law.

PATIENT RIGHTS

- You can request that I amend your record.
- You can request restrictions on what information from your Clinical Record is disclosed to others.
- You can request an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent.
- You can have any complaints you make about my policies and procedures recorded in your records.
- You have the right to a paper copy of this Agreement.
- You have a right to a paper copy of the notice form and my privacy policies and procedures.
- You can file a complaint with the SC Board of Examiners in Psychology PO Box 11329 Columbia, SC 29211-1329.

MINORS & PARENTS

The law allows parents of unemancipated patients under 17 to examine their child's clinical record unless I decide that such access is likely to injure the child, or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only, at the parent's request, with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. If requested in writing, I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

- Payment in full is due at the time of service unless we make other arrangements.
- After the first after-hours call during your course of treatment, I will charge \$50 for phone calls to my emergency number.

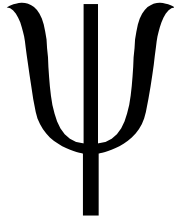
YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT (dated 09/17/10 pages 1-5) AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE BEEN OFFERED (ON THE WEBSITE AND IN THE OFFICE) THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Signature:

Name, printed:

Date:

Rev. 09/17/10



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Authorization Form

This form when completed and signed by you, authorizes me to release and receive protected information from your clinical record to the person you designate. Use this form if you would like me to communicate with your family physician, psychiatrist, or another doctor. **(OPTIONAL)**

I authorize my psychologist, Dr. Bonnie Cleaveland and/or her administrative and clinical staff to release and receive (Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible)

This information should only be exchanged with (name and address of person to whom the information is to be released)

I am requesting my psychologist to release and/or receive this information for the following reasons: (“at the request of the individual” is all that is required if you are my patient and you do not desire to state a specific purpose.)

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization to release records unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

 Signature of Patient

 Date