



THErapy FOR AUTO RELATED TRAUMA ▣ REGAIN YOURSELF

SOMA TRAUMA THERAPY, LLC

833 S.W. 11th Ave. Suite 320
Portland, OR 97205
503.227.5692

www.somatraumatherapy.com
connect@somatraumatheapy.com

ABOUT SOMA

SOMA Trauma Therapy is a therapeutic service specializing in helping people recover from motor vehicle accident (MVA) related trauma. Treatment is provided by licensed therapists and clinicians experienced with healing the impact of trauma on mind and body. We treat children, adolescents, and adults in a safe, relaxed, and comfortable setting.

WHAT TO EXPECT

SOMA uses Short-Term Trauma therapy to assist clients in regaining functioning and confidence after a motor vehicle accident. Treatment typically averages 10-15 sessions usually scheduled weekly. Clients often experience positive changes. However, we encourage you to discuss any questions, doubts, or preferences regarding the treatment at any time.

CONFIDENTIALITY

Counseling works best when people talk freely about the issues that are important. To make talking easier, information shared during therapy is kept confidential. It is important to establish trust that your personal information will not be shared without your written permission. A signed consent for release of information is necessary prior to contact with another party such as your attorney or doctor.

State law stipulates that information cannot be kept confidential when it involves keeping people safe. For instance, information cannot be kept private if someone discloses child abuse, abuse of an elderly person, or plans to kill another person or themselves. If someone commits a crime against the therapist the police may be called. Non-custodial parents generally have the right to learn about their child's treatment. Finally, if we are given a subpoena, the court can order the disclosure of information shared in counseling.

CONSENT FOR TREATMENT

I authorize SOMA to provide assessment and appropriate psychotherapeutic treatment for my motor vehicle accident related trauma. I understand that this may include but is not limited to: Psychotherapy, EMDR (Eye Movement Desensitization and Reprocessing), EFT (Emotional Freedom Technique), TAT (Tapas Acupressure Technique), SE (Somatic Experiencing), Guided Imagery,

Relaxation Exercises, and other recommended mind-body approaches. Some therapeutic approaches involve gentle touching of the head to assist with relaxation and visualization to promote healing. A separate release is necessary for these hands-on techniques after discussing their potential benefit with your SOMA provider.

I consent to receive treatment for myself and/or dependent(s).

I give permission for my SOMA provider to use consultation with other staff to plan treatment services for myself and/or my dependent(s).

Client Signature

Date

Parent/Legal Guardian

Date

SOMA Provider

Date



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CANCELLATION POLICY

Please be aware that PIP does not reimburse for missed appointments. Therefore, in such cases, the responsibility for payment rests with you. If you need to cancel, please contact us a minimum of 24 hours prior to your appointment. Otherwise you will be charged a \$75.00 fee for the missed appointment. The fee will be waived for sickness, emergencies, and extenuating circumstances.

BILLING

SOMA will bill your Personal Injury Protection (PIP) benefit under your auto insurance policy. Should your PIP benefit be exhausted, or if SOMA treatment exceeds the one-year PIP limit, a lien may be placed on your MVA settlement. We may contact your attorney to assist with this process.

RELEASE OF INFORMATION FOR PAYMENT

I give permission to my SOMA practitioner to release clinical information about me/my dependent(s) to my insurance company in order to obtain payment for treatment provided.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment to SOMA for all motor vehicle accident related treatment services provided by my SOMA practitioner billed under my PIP insurance.

STATEMENT OF UNDERSTANDING

I certify that I have read, fully understand, and consent to the terms set forth in this document. I also certify that I understand my rights to privacy of my personal health information as defined within the notice of privacy practices.

Client Name _____
(Please Print)

Parent/Legal Guardian Signature

Client Signature _____

Date _____



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IRREVOCABLE DOCTOR'S LIEN AND ASSIGNMENT OF RIGHT TO RECOVERY

In consideration and exchange for not having to pay immediately the debt owed and in consideration for receiving future care at or by the clinic and providers whose letterhead this document is printed (hereinafter 'SOMA'). I, the undersigned, hereby grant, sell, bargain, assign, and convey to SOMA a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of that certain accident or trauma-producing event which occurred on or about the _____ day of _____, 20____ to the full extent of the cost of treatment provided or to be provided to me by SOMA.

I hereby authorize and direct my attorney(s) to hold in trust, and to pay directly to SOMA such sums as may be due and owing SOMA for treatment and other professional services rendered me both by reason of this accident and by reason of any other bills that are due to SOMA and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately pay and protect SOMA. I hereby further give, grant, assign, and convey a legally enforceable interest and lien on my case to SOMA against any and all proceeds of any and all causes of action, settlements, judgments, or verdicts by which I may be paid to or through my attorney, or myself, as the result of the injuries or conditions for which I have been treated by SOMA.

I fully understand that I am directly and fully responsible to SOMA for all bills incurred for services rendered to me, and that this agreement is made solely for SOMA's additional protection and in consideration for SOMA waiting for payment. I further understand that payment for services rendered by SOMA is not contingent on any settlement, judgment, or verdict for which I may eventually recover. I am personally responsible for my bills regardless of the outcome of any legal claim or case.

I fully understand if my attorney(s) does/do not protect SOMA's interest, SOMA may require me to make payments on a current basis. SOMA may also bring a cause of action against my attorney(s) for failing to honor this binding and irrevocable agreement between SOMA and me.

I further understand and agree that SOMA is not responsible for paying any of my attorney's fees and SOMA does not agree to pay my attorney(s) or any attorney(s) fees for honoring this agreement between me and SOMA.

"I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY(S) TO PROTECT SOMA'S INTEREST AT THE TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHTS OVER TO SOMA. I ALSO KNOW THAT I MAY NOT REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM SOMA. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT, CONVEYANCE, AND LIEN."

Patient Name (Print)

Patient Signature

Date



THERAPY FOR AUTO RELATED TRAUMA ▣ REGAIN YOURSELF

SOMA Trauma Therapy, LLC Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how SOMA Trauma Therapy, LLC (hereinafter referred to as SOMA) may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

SOMA is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. SOMA is required to abide by the terms of this Notice of Privacy Practices. SOMA reserves the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that SOMA maintains at that time. SOMA will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on SOMA's website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. SOMA may disclose PHI to any other consultant only with your authorization.

For Payment. SOMA may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, SOMA will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. SOMA may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, SOMA may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided SOMA has a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. SOMA may use your PHI to remind you of appointments.

Required by Law. Under the law, SOMA must make disclosures of your PHI to you upon your request. In addition, SOMA must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with requirements of the Privacy Rule.

Abuse and Neglect reporting and investigation
Judicial and Administrative Proceedings
Deceased Persons
Emergencies (including immediate risk to self or others)
Family Involvement Care
Health Oversight
National Security

Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- . Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department.)
- . Required by Court Order
- . Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. SOMA may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI You have the following rights regarding PHI SOMA maintains about you. To exercise any of these rights, submit your request in writing to SOMA 833 S.W. 11th Ave. Suite 320 Portland, OR 97205.

1. **Right of Access to Inspect and Copy.** You have the right, which may be Restricted only in exceptional circumstances, to inspect and copy PHI that May be used to make decisions about your care. Your right to inspect and Copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. SOMA may charge a reasonable, cost-based fee for copies.
2. **Right to Amend.** If you feel that the PHI SOMA has about you is incorrect or Incomplete, you may ask SOMA to amend the information although SOMA is not required to agree to the amendment.
3. **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that SOMA makes of your PHI. SOMA may charge you a reasonable fee if you request more than one accounting in any 12-month period.
4. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. SOMA is not required to agree to your request.

5. **Right to Request Confidential Communication.** You have the right to request that SOMA communicate with you about medical matters in a certain way or at a certain location.
6. **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe SOMA has violated your privacy rights, you have the right to file a complaint in writing with SOMA 833 S.W. 11th Ave. Suite 320 Portland, OR 97205, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201, or by calling (202) 619-0257. **SOMA will not retaliate against you for filing a complaint.**

The effective date of this Notice is December 9, 2010.

**SOMA TRAUMA THERAPY, LLC
 Notice of Privacy Practices
 Receipt and Acknowledgment of Notice**

Client Name: _____
DOB: _____
SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of SOMA’s Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact SOMA at 833 S.W. 11th Ave., Suite 320, Portland, OR 97205.

 Signature of Client

 Date

Signature of Parent, Guardian or Personal representative
 If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual: (Power of attorney, healthcare surrogate, etc.).

Client Refuses to Acknowledge Receipt:

 Signature of Staff Member

 Date