INTAKE INFORMATION

CLIENT INFORMATION

TODAY'S DATE: _____

NAME OF CLIENT:_____ M/F: ____ DATE OF BIRTH:_____

ADDRESS:_____

CITY/STATE/ZIP:_____

PHONE: Home:_____ OK to leave message?: ☐ Y ☐ N Cell:_____

Social Security No.:_____Driver License No.:_____

EMPLOYER:_____ PHONE:_____

EMPLOYER ADDRESS:_____

NAME of person financially responsible *if different from above:* _____

Social Security No.:_____Driver License No.:_____

ADDRESS:_____

PRIMARY INSURANCE INFORMATION Copy of both sides of insurance card required at intake

Policy Holder: _____ Policy Holder's Date of Birth:_____

Company:_____

Policy No.: _____

Group No.: _____ Phone: _____

EMPLOYEE ASSISTANCE PROGRAM (EAP) INFORMATION These are free sessions supplied to you by your employer

EAP Insurance Company:_____
This Company is usually different from your primary insurance carrier

Authorization No.:_____

Number of sessions authorized:_____

FINANCIAL RESPONSIBILITY

I authorize the treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges promptly upon presentation of statements unless other arrangements are agreed upon in writing. In the event legal action is necessary to collect unpaid balances, I agree to pay reasonable attorneys' fees and other such costs as the court determines proper. I agree to pay my copay at the time services are rendered. I hereby authorize the provider to release all information necessary to secure the payment of benefits to outside agencies.
IF UNABLE TO KEEP YOUR APPOINTMENT, KINDLY GIVE **24 HOURS** NOTICE. OTHERWISE A CHARGE WILL BE MADE FOR THE TIME RESERVED.

SIGNATURE _____ DATE:_____

PLEASE PRINT NAME:_____

☐ Michael McClary ☐ Deborah Bowser ☐ Bob Pobocik ☐ Megan Minnick

FAMILY & HEALTH INFORMATION

CLIENT INFORMATION

TODAY'S DATE: _____

NAME OF CLIENT:_____

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with someone

NAME OF SPOUSE/SIGNIFICANT OTHER: _____ DATE OF BIRTH: _____

CHILDREN:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

PROBLEM that brought you in today

_____

_____

_____

_____

COUNSELING HISTORY:

Therapist: _____ Dates: _____ to _____ Phone: _____

Initial reason: _____ Outcome: _____

Have you ever been hospitalized for psychiatric care? ☐ Y ☐ N If YES, please list dates and name of hospital:_____

_____

MEDICAL HISTORY (Specify: major problems, accidents, non-psychiatric hospitalization):_____

_____

_____ Continue on back if needed

MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING SUPPLIMENTS:_____

_____

_____

_____

PRIMARY CARE MEDICAL DOCTOR: _____

PHONE:_____ LAST EXAM:_____

HOW IS YOUR PHYSICAL HEALTH AT PRESENT? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

PLEASE LIST ANY PERSISTANT PHYSICAL SYMPTOMS OR HEALTH CONCERS (e.g. chronic pain, headaches, diabetes etc.)

AGREEMENT FOR PSYCHOTHERAPY SERVICES

OFFICE POLICIES & GENERAL INFORMATION

CANCELLATION: Since scheduling of an appointment involves the reservation of time specifically for you, a 24 hour (1 day) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee of $120 per 50 minute session at the end of each session or at the end of the month unless other arrangements have been made. Telephone Conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please notify your therapist if any problem arises during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance company. Unless agreed upon differently, your therapist will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose. Not all issues/conditions/problems, which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions areconfidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required By law.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled.

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your therapist. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Your therapist will use his/her clinical judgment when revealing such information. Your therapist will not release records to any outside party unless he is authorized to do so by all adult family members who were part of the treatment.

Emergencies: If there is an emergency during our work together, or in the future after termination where your therapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, he will do whatever he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, he may also contact the person whose name you have provided on the biographical sheet.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you instruct your therapist only the minimum necessary information will be communicated to the carrier. Your therapist has no control or knowledge over what insurance companies do with the information we submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance. The risk stems from the fact that mental health information is entered into big insurance companies' computers and soon will also be reported to, congress approved, National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank data base is always in question as computers are inherently vulnerable to break in's and unauthorized access. Medical data has been reported to be sold, stolen or accessed by enforcement agencies, which put you in a vulnerable position.

Confidentiality of E-Mail/Cell Phone/Fax Communications: It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Faxes can easily be sent erroneously to the wrong address. Please notify your therapist if you decide to avoid or limit in any way the use of any or all of the above mentioned communication devises.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client's) nor your attorney's, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Consultation: Your therapist consults regularly with other professionals regarding his/her clients; however, client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

continued

Your Right to Review Records: Both law and the standards of my profession require that I keep appropriate treatment records. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when your therapist assesses that releasing such information might be harmful in any way. In such a case your therapist will provide the records to an appropriate and legitimate mental health professional of your choice.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact your therapist between sessions, please leave a message on the answering service (909) 592-4431 and your call will be returned as soon as possible. Your therapist checks his/her messages a few times a day, unless he is out of town. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, you can call 1-800-784-2433, a 24-hour crisis line, the Police at 911, or the 24-hour Psych. Emergency line at 626-455-4706.

MEDIATION & ARBITRATION: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of therapist and client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Los Angeles County, in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed.

THE PROCESS OF THERAPY/EVALUATION: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits; however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Your therapist will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

TERMINATION: After the first couple of meetings, your therapist will assess if he/she can be of benefit to you. Your therapist does not accept clients who, in his/her opinion, he cannot help. In such a case, he/she will give you a number of referrals that you can contact. If at any point during psychotherapy your therapist assesses that he/she is not effective in helping you reach the therapeutic goals he/she is obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, he/she would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, your therapist will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, your therapist will assist you in finding someone qualified, and if he has your written consent, he will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, your therapist will offer to provide you with names of other qualified professionals whose services you might prefer.

I have read the above Agreement and Office Policies and General Information carefully, I understand them and agree to comply with them:

_____	_____	_____
Client name (print)	Signature	Date
_____	_____	_____
Client name (print)	Signature	Date
_____	_____	_____
Therapist name (print)	Signature	Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to that information.

PLEASE REVIEW THIS NOTICE CAREFULLY.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

CONSENT

1. The Practice may use and/or disclose your PHI provided that it first obtains a valid Consent signed by you. The Consent will allow the Practice to use and/or disclose your PHI for the purposes of:

(a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for lower back pain may need to know the results of your latest physician examination by this office.

(b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

NO CONSENT REQUIRED

1. The Practice may use and/or disclose your PHI, without a written Consent from you, in the following instances:

(a) De-identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative - To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

(i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

(ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(f) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(g) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(h) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(i) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(j) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(k) Specialized Government Functions - This refers to disclosures of PHI that relate primarily to military and veteran activity.

(l) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(m) National Security and Intelligence Activities - The Practice may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.

(n) Military and Veterans - If you are a member of the armed forces, the Practice may disclose your PHI as required by the military command authorities.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the Practice:

a) telephoning your home or cell phone and leaving message information on your messaging system.

b) e-mail.

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general con-

dition or death. However, in both cases, the following conditions will apply:

(a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

(b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

1. You have the right to:

(a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

(e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six (6) years and may not Include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

(h) Complain to the Practice or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(i) To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer, Michael McClary at Bonita Counseling Center

PRACTICE'S REQUIREMENTS

1. The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Is required to abide by the terms of this Privacy Notice.

(c) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(d Will distribute any revised Privacy Notice to you prior to implementation.

(e) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 01/01/10.