Thomas D. Carver, MA LMFT
The Sespe Counseling Center and Gallery
Licensed Marriage and Family Therapist MFC#41948
155 Granada Street, Suite O, Camarillo, CA 93010
PH (805) 794-7800 FX (805) 830-1560
www.thomascarver.com

INTAKE INFORMATION

Please be sure to legibly fill out the Intake Information page completely including your address, date of birth and social security number, home and cell phone numbers, e-mail, and signature(s). It is important that I know if you are on any medications and who the prescribing physician(s) are.

Date ____/____/____ *Therapist's Name* ____________________

CLIENT ____________________ Birth date ____/____/____

Address ____________________ Gender: ☐ Female ☐ Male

____________________ Soc. Sec # ____________________

____________________ Relationship Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Other ____________

Home Phone ____________________

Client's Occupation ____________________

Employer or School ____________________ Work Phone ____________ Ext. ______

Address ____________________ Cell Phone ____________________

Who referred you? ____________________ E-Mail ____________________

Physician ____________________ Physician Phone ____________________

Date if Last Physical ____/____/____ Major Illness ____________________

Current Medications ____

Previous Psychotherapy? Yes No

If yes, when? ____________________, with whom? ____________________

____

OTHER FAMILY MEMBERS:

Name	*Birth date*	*Relationship*	*Living at home*
____________	____/____/____	____________	yes / no
____________	____/____/____	____________	yes / no
____________	____/____/____	____________	yes / no
____________	____/____/____	____________	yes / no
____________	____/____/____	____________	yes / no
____________	____/____/____	____________	yes / no

PERSON RESPONSIBLE FOR THE ACCOUNT ____________________

Address *(If different from above)* ____________________

Signature ____________________ Date ____/____/____

Signature ____________________ Date ____/____/____

I AUTHORIZE TREATMENT FOR THE MINOR CHILD(REN) UNDER MY CARE.

Signature ____________________ Date ____/____/____

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Signature ______________________________ Date ___/___/___

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INSURED/INSURANCE INFORMATION

(Please present insurance card)

PRIMARY INSURANCE: ______________________________

Insured ______________________________ Gender: ❑ Female ❑ Male

Address ______________________________

____

Authorization No. ______________________________

Relationship to client: ❑ Self ❑ Spouse ❑Other ______________________________

Insured Date of Birth ______________

Contact number to receive benefit information: (____) ______________

SECONDARY INSURANCE: ______________________________

Insured ______________________________ Gender: ❑ Female ❑ Male

Address ______________________________

____

Authorization No. ______________________________

Relationship to client: ❑ Self ❑ Spouse ❑Other ______________________________

Insured Date of Birth ______________

Please Note: It is the client's responsibility to confirm their own benefits. Information regarding benefits/reimbursement conveyed by our office to you is subject to change dependant on your specific policy.

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature ______________________________ Date ___/___/___

I authorize payment of medical benefits to the undersigned physician or supplier for services described on claims.

Signature ______________________________ Date ___/___/___

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EXCEPTIONS TO CONFIDENTIALITY

Confidentiality is the cornerstone of therapy. What you say to me is held in the utmost confidence. It is my job not only legally, but ethically to protect your privacy. If someone was to contact me and ask if I am seeing you, I will clearly state that I cannot discuss any case with a third party and that I cannot avow or disavow that I even know you. Also, if I see you in public, I will not initiate contact.

However, under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:

a. Revealing to me active child abuse or neglect if a perpetrator is in contact with minors and there is a reasonable suspicion that he/she may still be abusing minors. Also if active physical abuse of a dependent adult or an elder is taking place. I am required to report any suspected child or elder abuse (either current or past) to local child protective or law enforcement officials within 24 hours. Abuse is defined as the willful cruelty to or the unjustifiable punishment of a child or elder person or endangering the life or health or either one (Section 11161.5 – Cal. Penal Code). This includes sexual molestation, the willful infliction of physical pain or injury, willfully causing or permitting unjustifiable mental suffering, or the willful failure to provide necessary food, clothing, shelter and medical attention. If any therapist fails to report, he or she may be both civilly and criminally liable (Section 273a – Cal Penal Code).

b. If you seriously threaten harm or death to another person. I am required to warn the intended victim and notify the appropriate law enforcement agencies.

c. If I believe that you truly intent to harm to yourself, he/she will make every effort to insure your safety. If he/she is unable to do this, he/she must (by law) notify the police.

d. If you are in therapy or are being evaluated by order of the court. The results of that treatment or tests must be revealed to that court. I am required to create documents (i.e. Co-Parenting Plans, Reunifications Plans, Progress Reports, etc.).

e. If you are using your insurance to pay some or all of your therapy costs, it is important for you to know that your therapist may be required to make regular reports to the insurance company regarding your diagnoses and course of treatment. I may also use electronic methods (FAX) to communicate with your insurance company. While we make every effort in our office to protect your privacy by having your FAX machine in a separate room and using cover sheets on all FAXed material, we are not responsible for any problems that occur once information has left our office. If this creates issues for you, please discuss alternatives with your therapist.

Client's Signature ______________________ Date ________

Parent's Signature (if Client is under 18 years of age) ______________________ Date ________

Family Member's Signature ______________________ Date ________

Family Member's Signature ______________________ Date ________

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OFFICE POLICIES HIGHLIGHTS PAGE

Session Rates:

Please pay at the beginnings of each session.

The initial intake/assessment session fee is $125.00 per hour. The following sessions are charged at a standard rate of $120.00 per hour. For court-involved cases the hourly rate is $140.00 and a credit card authorization contract must be on file or a $5000 retainer can be held.

Insurance Payments/Reimbursement:

Clients either have HMO in-network benefits or they have PPO out-of-network benefits. It is important that you fax or e-mail me (before the first session) a copy of the front and back of your insurance card and write on the sheet the name of anybody who is going to be in therapy and their date(s) of birth and a phone number that my billing service can call you back with an estimate of your benefits. Please provide information for any secondary insurance as well. You must have an authorization number before the first session or you will be financially responsible for it. We will attempt to verify your benefits. If you have a PPO and I am not a provider for that insurance company, but you have out-of-network benefits, we can find out what your reimbursement rate is and will tell you before your first appointment.

Cancellations:

If you need to cancel a session, please remember I require **24 hour notice**. You can leave a message on my voice mail 24 hours a day, 7 days a week <(805) 794-7800> or by e-mail <thomas@thomascarver.com>. Please do not text message me with cancellations. Otherwise, you will be charged for your missed session (charged to you, not your insurance company for the full fee <$120>). If we have set reoccurring appointments you will be charged for the duration of two more schedule appointments without contact to cancel those appointments (see Termination section).

Telephone/e-mails:

Telephone/e-mail time is limited to 10 minutes, beyond which I will bill you at my standard rate rounded to the next half hour. Payment will be expected at the next regularly scheduled appointment, or sooner by mail.

Treatment of minors:

Children under the age of 18 years must have the consent of all parents/guardians who hold "legal custody." I will not treat children without this written consent. I prefer to involve all parents/guardians as much as is therapeutically appropriate. I will be glad to discuss how, when, and if this can be accomplished in your case. Additionally, in court referred cases, I need copies of all court documentation

Limits to Confidentiality:

Review thoroughly in the attached Therapeutic Contract/Informed Consent for Treatment the section called Limits to Confidentiality.

Court involved cases:

Please provide me with a copy of all court documentation (i.e. Divorce Decrees, Restraining Orders, etc.).

All charges are your responsibility. It is your responsibility to maintain insurance coverage, update therapist upon any changes, verify benefits as well as keep information as to deductibles or charges in co-payment and for ensuring reimbursement if you have PPO out-of-network benefits.

I have read the attached **Therapeutic Contract/Informed Consent for Treatment** and fully understand this Office Policies Highlights Page.

Signature ______________________________ Date__________

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Signature ______________________________ Date____________

Who were you referred by?: ______________________________

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Thomas Carver is focused on helping people explore their personal journey through life's challenging transitions. He assists individuals and couples in uncovering unconscious patterns, which keep them from realizing their full potential. His practice includes work that fosters discovery of innate strengths in relationships and new communication skills so that they can express their deepest needs to loved ones. He believes in the four keys to wellness: mind, heart, body and spirit and uses them to frame deep, introspective healing.

Thomas is certified in EMDR® (Levels I&II) and is an Ego State Therapist (Developmental Needs Meeting Strategy DNMS) used in the treatment of trauma (including family of origin dysfunction and survivor of physical, sexual and/or emotional abuse). He also specializes in Child and Adolescent Therapy as well as Co-Parenting/Divorce Dynamics and general psychotherapy. He uses a parent-child interactive model called Theraplay® for the treatment of children 5-14 years old and a solution focused, Child Centered/Two-Home Family Model for mediating divorcing couples' parenting issues. He is appointed by the Family Courts as a Reunification Therapist and for Supervised Therapeutic Visitation. Additionally, Mr. Carver uses a multi-modal approach including (primarily) the theories of Ego State, Family Systems, Psychodynamics, Solution Focused, and Cognitive Behavioral Therapies (CBT).

Please see his web page for additional specialties at www.thomascarver.com.

THERAPUTIC CONTRACT/INFORMED CONSENT FOR TREATMENT

The Therapy Process:

Participating in therapy can result in a number of benefits to you including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part and may result in your experiencing considerable discomfort/change that will sometimes by easy and swift, but more often it will be slow and frustrating. Remembering and resolving significant life events in therapy can bring on strong feelings or anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended, as part of my therapeutic process.

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Limits To Confidentiality:

Confidentiality is the cornerstone of therapy. What you say to me is held in the utmost confidence. It is my job not only legally, but ethically to protect your privacy. If someone was to contact me and ask if I am seeing you, I will clearly state that I cannot discuss any case with a third party and that I cannot avow or disavow that I even know you. Also, if I see you in public, I will not initiate contact.

However, under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:

f. Revealing to me active child abuse or neglect if a perpetrator is in contact with minors and there is a reasonable suspicion that he/she may still be abusing minors. Also if active physical abuse of a dependent adult or an elder is taking place. I am required to report any suspected child or elder abuse (either current or past) to local child protective or law enforcement officials within 24 hours. Abuse is defined as the willful cruelty to or the unjustifiable punishment of a child or elder person or endangering the life or health or either one (Section 11161.5 – Cal. Penal Code). This includes sexual molestation, the willful infliction of physical pain or injury, willfully causing or permitting unjustifiable mental suffering, or the willful failure to provide necessary food, clothing, shelter and medical attention. If any therapist fails to report, he or she may be both civilly and criminally liable (Section 273a – Cal Penal Code).

g. If you seriously threaten harm or death to another person. I am required to warn the intended victim and notify the appropriate law enforcement agencies.

h. If I believe that you truly intent to harm to yourself, he/she will make every effort to insure your safety. If he/she is unable to do this, he/she must (by law) notify the police.

i. If you are in therapy or are being evaluated by order of the court. The results of that treatment or tests must be revealed to that court. I am required to create documents (i.e. Co-Parenting Plans, Reunifications Plans, Progress Reports, etc.).

j. If you are using your insurance to pay some or all of your therapy costs, it is important for you to know that your therapist may be required to make regular reports to the insurance company regarding your diagnoses and course of treatment. I may also use electronic methods (FAX) to communicate with your insurance company. While we make every effort in our office to protect your privacy by having your FAX machine in a separate room and using cover sheets on all FAXed material, we are not responsible for any problems that occur once information has left our office. If this creates issues for you, please discuss alternatives with your therapist.

Releases of Information:

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If you want me to discuss any part or all of your treatment with anybody, I must have a Release of Information Contract to do so. These are used primarily for the purposed of consultation, case management and other collaborative efforts that I engage in for your benefit. I can only talk to someone else about your case with your permission considering the above limits to confidentiality. If you ask me, I can release any part of your records on file to any person you specify. I cannot give legal advice.

Client's Rights Regarding Their File:

1. You have the right to ask questions about any of the procedures used in the course of your therapy.
2. You have the right to see the content of your records at any time and I have the right to provide you with a summary of their content and a complete copy of records if necessary. I can refuse to produce the file or its content if I assess that the information will cause harm (i.e. to a child).

Termination:

You have the right to terminate therapy with me at any time without any financial, legal, or moral obligations other then those you've already incurred. I have the right to terminate therapy with you under the following conditions:

a. When I believe that therapy is no longer beneficial to you.

b. When I believe that you will be better served by another professional.

c. When you have not paid for the last three sessions, unless special arrangements have been made with me.

d. Clients are assumed to be in my weekly/biweekly (etc.) schedule rotation. When clients do not show for three therapy sessions in a row without a 24-hour notice (by phone or e-mail: NOT by text message) they are considered terminated unless otherwise instructed. Clients maintaining contact with me indicates they are interested in remaining in my schedule rotation. Clients are financially responsible for No-Shows.

e. If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If I have written consent, I will provide that professional with information they request.

f. In all cases I will be happy to provide you with the resources and referrals as necessary.

Fees of Therapy and Services:

The standard fee of $120.00 for each session unless court appointed ($125.00/session) and the initial intake/assessment session is $125.00. Sessions are 50 minutes in duration. Clients that request letters of advocacy, letters to the courts or similar correspondence are charged $120 per hour (one hour minimum) for the generation of those documents. If I am requested to attend appearances such as court dates or Individualized Education Plans (IEPs), etc. my full hourly fee is charged from door to door (i.e. morning family court appearances are charged at an average of 6 hours).

Payments in cash or by check or by credit card are to be made at the beginning of the therapy appointment, unless we have made other arrangements. Please feel free to ask about credit card options such as an automated reoccurring charges option. Statements are sent out once a month. Clients are contracted only to pay for completed therapy sessions or session they miss without providing 24-hour notice, and telephone/e-mail time as outlined in this Therapeutic Contract/Informed Consent For Treatment.

A $25.00 late fee is added to overdue accounts for each month delinquent. Our office will bill you for three months before utilizing a collection agency.

Financial Reimbursement Policy:

1. Fees can be paid in the following manner:

    a. You pay in full each session; you may send my invoice to your insurance. Please request a billing invoice. We send you an invoice after the first session and then monthly after that. I also have an option for $4/month for us to submit the paperwork for you in order to be reimbursed by your insurance company.

    b. You pay your assigned co-payment by your insurance company or mental health benefits; I bill your insurance for balance. **You are responsible for balance due of what insurance does not pay.** My practice only is contracted with United Behavioral Health (UBH) & United States Behavioral Health Plan California (USBHPC) including Proctor and Gamble Paper Company Employee Assistance Program, as well as College Health Care Plan Employee Assistance Program, Point Magu Civilian Airbase Employee Assistance Program, and APS Healthcare.

2. A physical referral may be required by your insurance company for mental health benefits. If required, please obtain this promptly as you will be responsible for all charges until you do.

3. For clients using PPO out-of-network benefits, my billing service will submit all paperwork for you in order to be reimbursed. This is done for a charge of $4/month. However, All charges are your responsibility. It is your responsibility to maintain insurance coverage, update therapist upon any changes, verify benefits as well as keep information as to deductibles or charges in co-payment and for ensuring reimbursement if you have PPO out-of-network benefits.

Cancellation:

Since an appointment reserves time specifically for you, a minimum of 24-hours notice is required for rescheduling or cancellation of an appointment. The full fee will be charged for missed sessions without such notification. Insurance companies do not reimburse for sessions missed.

Telephone/E-mail time:

After 10 minutes of telephone time, you will be charged at your standard rate rounded to the next half hour.

After 10 minutes reading & responding to e-mails, you will be charged at my standard rate rounded to the next half hour.

I try to return all calls within 24 hours and leave an outgoing message when I am out of town and cannot call you back until I return.

Sessions Greater Than 50 Minutes:

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Sessions that go beyond fifty minutes will be prorated at my standard rate to the next half hour.

Emergency Procedures:

An emergency is an unexpected event that requires immediate attention and can be a threat to your health. If this happens leave me a message on my voice mail (805) 794-7800 and call 911. If an emergency situation arises, please state this when you leave your message and I will return your call as soon as possible.

Consent for Treatment

I herby authorize the request Thomas D. Carver. MA LMFT to carry out psychological examinations, diagnostic procedures and/or treatment, which now or during the course of my care as a patient are advisable.

I understand that the purpose of any procedure will be explained to me and be subject to my agreement.

I have read and fully understand this Therapeutic Contract/Informed Consent of Treatment.

Client's Signature .______________________________ Date ____________________

Client's Signature .______________________________ Date ____________________

Therapist Signature .______________________________ Date ____________________

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Acknowledgement

Federal law requires that all patients be given a copy of the California Notice Form. The Notice describes in detail how patient health information is used and shared with others. All reasonable efforts will be made to protect the privacy of patient health information, whether it is maintained on paper or electronically, regardless of how it is communicated.

I hereby acknowledge that I received the California Notice Form (Notice of Privacy Practices.)

Name (Print): ____________________

Signature: ____________________

Date: __________ Date of Birth: __________

Name (Print): ____________________

Signature: ____________________

Date: __________ Date of Birth: __________

When the patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Name (Print): ____________________

Signature: ____________________

Date: __________ Relationship to Patient: __________

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Name (Print): ______________________________

Signature: ______________________________

Date: ______________ Date of Birth: ______________

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SAMPLE NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. *(Please note that this particular provision must be set forth in your notice of privacy practices exactly as it is set forth here.)*

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (if applicable). You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at (insert website address, if applicable).

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

* A. **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.** I can use and disclose your PHI without your consent for the following reasons:

1. **For treatment.** I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care.
2. **To obtain payment for treatment.** I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

***It is the general policy of each New Beginnings therapist to obtain written consent before disclosing any patient information.**

3. **For health care operations.** I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws.
4. **Other disclosures.** I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. **Certain Uses and Disclosures Do Not Require Your Consent.** I can use and disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement.** For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. **For public health activities.** For example, I may have to report information about you to the county coroner.
3. **For health oversight activities.** For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
5. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, I may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
6. **For specific government functions.** I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
7. **For workers' compensation purposes.** I may provide PHI in order to comply with workers' compensation laws.
8. **Appointment reminders and health related benefits or services.** I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

C. **Certain Uses and Disclosures Require You to Have the Opportunity to Object.**

1. **Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The

opportunity to consent may be obtained retroactively in emergency situations.

D. **Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

B. **The Right to Choose How I Send PHI to You.** You have the right to ask that I send information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

C. **The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. **The Right to Get a List of the Disclosures I Have Made.** You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

E. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. **The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: [insert therapist's name, address, phone #, and e-mail].

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

Intake Form/Client Questionnaire

General

Client name(s) ______________________ Date ____________

Address ____

Home Phone ( ) ______________ Work Phone ( ) ______________

Cell Phone ( ) ______________ Fax ( ) ______________

E-mail address ____

Referred by ______________ DOB ____________ Age ______

Occupation ______________________ Education Level ____________

Gender : Female ___ Male ___

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___ Other ___

Counseling sought for: Individual ___ Couple ___ Family ___ Parent/child ___ Other(please specify) ________

Referral Source Name __________ Organization: __________ Phone ( ) ______________

V.C. Human Service Agency social (case/placement) worker ______________ Phone ( ) __________

Emergency Contact Information ____

Household and Family Members (Please put asterisk(*) by household members

Name	Age/Birth Date	Relation	Address (city/state)	Occupation/Employer or School Grade

Therapy Areas of Concern

What issues/concerns prompted you to seek therapy and why now? ______________________

____

____

What specific goals, if you have identified any, would you like to achieve through therapy? ______________

____

____

Do you have any particular concerns/fears about therapy? ______________________

____

____

Psychological History

Have you received previous therapy? ______

When and for how long? ______

What was the focus of treatment? ______

______

Have you ever been subjected to one or more psychological tests? ______

If so, by whom? ______

Have you ever been hospitalized for mental or emotional problems? ______

When and for how long? ______

Why were you hospitalized? ______

______

What, if any, medications are you currently taking for a mental or emotional condition? ______

______

Since when? ______

Have you ever attempted suicide? ______

When? ______

Please describe the circumstances that led to that attempt. ______

______

______

Are you currently having any suicidal thoughts? If so, please describe. ______

______

______

Were you ever victim or perpetrator or witness of verbal, physical, emotional, sexual, and/or abuse? ______

Please identify which and identify by whom and to whom, identify when this occurred, and describe. ______

______

______

______

Please detail any history of violence and not whether you were the victim or perpetrator or witness. ______

______

______

______

Please detail history of traumatic events (deaths, divorces, suicide, assault, rape, violence, molest, neglect, etc.) ______

______

______

Do you have any history of arrests or convictions? How about your family members? Please define of who, by whom, when and for what the arrests and/or convictions occurred? ______

______

Have you experienced any changes in any of the following? Please circle each that apply and note when the change began and include a sentence or two describing the change for each:

Appetite/Eating Behavior ______________________________

Weight Gain or Loss ______________________________

Sleep/Dreaming ______________________________

Sexual Drive/Behavior ______________________________

Physical Energy/Behavior ______________________________

Sadness/Crying ______________________________

Mood Swings ______________________________

Current or history of Self-abuse ______________________________

Medical History

Physician name, address and phone number ______________________________

Date of last physical ______________________________

Name any medications you take or have taken, dates used, quantities taken, and purpose ______________________________

Any serious illnesses, dates and descriptions ______________________________

Do you have any medical conditions that may affect your therapy treatment? ______________________________

Please describe your overall heath today and rate it on a scale of 1 to 10 with 10 being best ______________________________

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional or stress-related condition? If yes, please describe. ______________________________

Have you ever been in a 12-step program? If yes, please describe. ______________________

____

____

Do you smoke? Yes ________ No ________

If yes, how many cigarettes a week? ________________ For how long have you smoked? ____________

Current alcohol consumption (type, frequency, quality, what you consumed, duration) ____________

____

____

History of alcohol consumption (type, frequency, quality, what you consumed, duration) ____________

____

____

Current drug use (both legal and illegal) (type, frequency, quality, what you consumed, duration) ____________

____

____

History of drug use (both legal and illegal) (type, frequency, quality, what you consumed, duration) ____________

____

____

Family history of alcohol drug use/abuse/treatment ______________________

____

____

History/current gambling or spending issues –self and/or family ______________________

____

____

History/current sexual issues (sex addiction, pornography, otherwise) – self and/or family ____________

____

____

History/current eating disorder issues (anorexia, bulimia, overeating, etc.) – self and/or family ____________

____

____

Rate the following on a scale of 1 to 10 with 1 being the lowest level and 10 being the highest level

- Daily level of worry and anxiety ______
  - Has it increased or decreased over the past year ___increased ___decreased
- Daily level of fear/panic ______
  - Has it increased or decreased over the past year ___increased ___decreased
- Daily level of anger/rage ______
  - Has it increased or decreased over the past year ___increased ___decreased
- Daily level of sadness/depression ______
  - Has it increased or decreased over the past year ___increased ___decreased
- Coping skills/strategies ______
  - Has it increased or decreased over the past year ___increased ___decreased

You and Your Family History

List history of marriages and primary relationships, duration and reason for relationship ending, if known. ____________

____

____

Parenting issues? ____

____

What do you consider to be your strengths and positive qualities? _____________________

____

How about your weaknesses and areas you would like to work on? ______________________

____

Current work satisfaction. ____

____

History of work. ____

____

Financial Support/Economic Challenges ____

____

Community/Group activities ____

____

Religious or Spiritual Support ____

____

Family Support ____

____

Friends/Close Relationships ____

____

Spouse/Significant Other if there is one ____

Domestic Violence? ____

____

Other Information

Please list any interests/hobbies. ____

____

____

____