Client Information Is Treated With Professional Confidentiality

Today's Date: ________________________

◆CLIENT INFORMATION Referred By:___________________________________

Client Name: ____
Last First MI

Address: ____
Street City Zip

Sex: M / F Client Date of Birth: ______________________ Age: _____ Social Security #: ____________________

Home Phone: ______________________________ Cell / Work Phone: __________________________________

Is it OK to leave a voicemail at any of these numbers? Yes / No Preference please circle: Home Work Cell

Please send me a message reminder of my upcoming appointment: Yes / No

Email____Cell phone:____________________________________

Confidential Email Address: ____
(If client is under 18, use parental email)

Employer/School Name: ______________________________________ Occupation: __________________

Relationship Status (please circle): Single / Married / Domestic Partner / Separated / Divorced / Widowed

◆IF CLIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Caregiver Name: (If client is under age 18): ____
First Middle Last

Relationship to Client:____

Address (if different from above): ____

Caregiver Social Security #: ______________________________ Date of Birth: ______________________

◆CLIENT MEDICAL INFORMATION:

Are you currently receiving other psychological treatment? YES / NO

If yes, from whom: ____ Phone: _________________________

Client's Physician:____ Phone:_____________________

Current Medications (for what conditions with dosage and frequency):___________________________________

____

Allergies: ____

Emergency Contact Person: ____ Relationship: _______________________

Phone number of emergency contact: ____

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PLEASE FILL OUT COMPLETELY & PRESENT YOUR INSURANCE CARD TO YOUR THERAPIST

◆INSURANCE INFORMATION

Insured's Name: ____ Date of Birth: ________________________

SSN of Insured _______________________________ Employer/Company Name:_____________________________

Insurance Company Name: _______________________________________Phone: ____________________________

Group Number: __________________________ Policy or Identification Number: ______________________________

Authorization Number/Code:________________________ Other Insurance Info: _______________________________

____

Relationship of insured to the client: Child / Spouse / Domestic Partner / Parent

On a scale of 1 to 5; Five being very urgent, what is the urgency of your issue? 1 2 3 4 5

Please briefly state reasons for seeking treatment:

____

____

◆IMPORTANT TREATMENT INFORMATION

Treatment risks: Participation in psychotherapy can result in a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek treatment. Psychotherapy does involve some risks, including possible experience of intense feelings such as sadness, anger, fear, or guilt. Please remember that these experiences are natural and normal and an important part of the psychotherapy process. Sometimes in psychotherapy, clients choose to make major life decisions including decisions about family, relationships, employment, and lifestyles. Decisions made during the psychotherapy process may result from calling into question old beliefs and values that may bring about changes not originally intended. Your therapist cannot guarantee the ultimate outcome to psychotherapy.

Fees and insurance: The individual provider sets treatment fees. If you are using insurance coverage to pay for your therapy, you may still have a co-payment or co-insurance charge due. As a service, your therapist can bill your insurance company directly provided you authorize the insurance payment be made directly to your therapist. You are responsible to know the limits and specifics, including co-payment amounts and deductibles, of your insurance coverage. Oftentimes this information can be found in your employer's benefits summary booklet. your therapist can help you clarify your benefits information and coverage.

Regardless of your insurance coverage, you are solely responsible for any charges incurred. With most insurance companies, there are procedures you can use to appeal denied charges. IF YOUR INSURANCE COMPANY DENIES PAYMENT FOR SERVICES, YOU ARE RESPONSIBLE FOR THE CHARGES INCURRED.

Returned Check Policy: If your banking institution returns a check for any reason there will be a $25 service charge. This payment must be made by cash or credit card.

Clients who are dependents: As the parent or guardian, you have a right and responsibility to question and understand what occurs in therapy with your child, but please remember that it is also important that your child be able to trust the therapy process. As such, your therapist will use clinical discretion as to what is appropriate disclosure of information. In particular, you can expect that the therapist will disclose information to you that is important to your child's progress and your participation in the treatment. If you are the custodial parent in a divorced relationship with your child's other parent, please provide your therapist with a copy of your court custodial order.

Confidentiality of information: You have the right to a confidential relationship with your therapist. Information revealed by you during the course of psychotherapy will be kept confidential and will not be released to any agency or other person without your written permission. There are important exceptions to confidentiality that are required by law and outlined herein:

1. If you threaten to harm someone else
2. If you threaten to harm yourself
3. Where there is any suspected incidence(s) of child abuse, neglect, or molestation
4. Where there is any suspected incidence(s) of physical abuse of an elderly or dependent adult
5. Therapists must release information subpoenaed by the court as appropriate

It is important to remember that confidentiality of session material cannot be guaranteed by your therapist in a family or couples therapy situation. Please understand that each family member participating in psychotherapy has the same responsibility to maintain confidentiality for the other participating members to ensure the best chance for success.

Appointments and cancellation policies: Services are by appointment only. The length of an appointment is 45-60 minutes. Please give your therapist at least 24-hours notice for any appointments you need to cancel. Because each appointment is reserved specifically for you, it is necessary to charge a late cancellation fee of $75 for appointments that are cancelled with less than 24-hours notice. Your therapist cannot bill your insurance for a missed appointment or late cancellation. You are responsible for missed appointment and late cancellation fees. *If you miss 2 appointments with no notice or less than 24 hours notice, we reserve the right to refer you to another therapeutic resource.*

Messages and emergency procedures: In the case of a life-threatening emergency, please call 9-1-1. If you have a psychiatric emergency, please go to the nearest hospital emergency room and ask for the psychiatrist on duty. If you have a primary care physician, this person may also be contacted to facilitate emergency psychiatric care. If you need to reach your therapist, leave a message for your therapist at his or her voice mail they have provided to you.

Termination of services: Termination of psychotherapy may occur at any time and may be initiated by either you or your therapist. Please contact your therapist if you decide to discontinue your psychotherapy so that you can schedule and meet for a final session. Termination itself can be a very constructive process and we encourage you to discuss any plans to end your treatment as soon as is necessary. If any referrals are warranted, your therapist will make them at that time.

Your rights: At any time, you may question and/or refuse therapeutic or diagnostic procedures or methods or request additional information regarding procedures. Please do not hesitate to discuss any concerns and/or complaints with your therapist so that we can work toward a resolution. Concerns can also be brought to the attention of the California Department of Consumer Affairs, the California Board of Psychology, and the California Board of Behavioral Sciences.

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Consent to Treat

Please complete and sign below:

I consent to participate in psychotherapy services with ___________________________________
Therapist's Name

(herein known as your therapist) and agree to the policies of this office as detailed in the above paragraphs. I have had the opportunity to ask questions and clarify my understanding of these policies and there are no misunderstandings or disagreements. I have read, understood, and agree to the "Notice of Privacy Practices" and have received a copy for my records or I can access the HIPAA notice online at www.abbeyfieldpsych.com .

Client Signature:____________________________________ Date:____________________

I authorize my insurance carrier to pay benefits associated with my care directly to MY THERAPIST and authorize the release of information necessary to coordinate benefits, treatment, and payment (including quality improvement efforts where applicable).

Client Signature:_____________________________________ Date: ___________________

Appointment and Cancellation Policies

Psychotherapy services are by appointment only. The length of the appointment is 45 minutes. Please give your therapist **24** hours notice for any appointment you will need to cancel (leaving a voice mail notification on your therapist's extension is acceptable).

Because each appointment time is reserved specifically for you, it is necessary to charge a **late cancellation fee of $75 for appointments that are cancelled with less than 24 hours notice. The same fee will apply if you fail to show for a scheduled appointment without calling to cancel.** If you are using insurance to pay for your psychotherapy services, please be aware that your insurance will not pay for a missed appointment or late cancel fee.

Understanding of Appointment and Cancellation Policies

I have read the above statement and understand that if I fail to notify my therapist within 24 hours that I will be canceling my scheduled appointment, or fail to show for an appointment, I will be personally responsible for the $75 late cancellation or no-show fee.

Client Signature: ______________________________________ Date: ____________________

Your Therapist:

I have reviewed the above policies and informed consent with the client and/or parent or guardian.

Therapist Signature: ______________________________________ Date:_________________

Therapist Printed Name____

Consent to Treat For Minor Clients:

I am the legal guardian or legal representative of the client and on the client's behalf legally authorize your therapist to deliver mental health care services to the client. I also understand that all policies described in this statement apply to the client I represent.

Signature of Both Parents (Legal Guardians) Required:

____ ____

_________________________________ _______________________________________

Relationship to Client **Relationship to Client**

Date: ___________________________ **Date:___________________________________**

Federal HIPAA Privacy Practices

I, ____, do hereby acknowledge receipt of a copy of the Notice of
(Print Client Name)

Privacy Practices, Policies, and Procedures.

____
Signature of Client Date

In the event this request is made by the individual's personal representative:

____
Signature of Personal Representative Date

____
Relationship for Personal Representative

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Credit Card Payment Consent Form

►**Name:**

____
First Middle Initial Last

►**Name on card if different:**

____
First Middle Initial Last

►**I authorize your therapist to charge my credit card for professional services as follows:**

Initial all that apply

_______a. All visits in the next 12 months, beginning ____/____/_____.

______ b. Recurring charges for date(s) of service ____/____/_____ to ____/____/_____ ,

$______ monthly, $_______semi-monthly,

$______weekly, or $_______per visit.

______c. To charge my card for the balance of fees not paid for or covered by my insurance company within 180 days of the denial of payment.

______d. To charge my card for the balance of fees not paid 180 days from termination of service(s).

_______e. To charge my card for any missed appointments or appointments cancelled within 24 hours for the fee of $75.

______ f. To charge my card for any copays not collected at time of service.

___X__ g. I understand that a $3.00 convenience fee (per transaction) will be added to any amount charged. My therapist does not keep this fee and it is paid to help maintain the credit card service.

► Type of card: □ Visa □ MasterCard □ AMEX Expiration date of card: ______/________

► Credit card number: ____ Security code: ____________

►Card holder's billing address for credit card receipts:

____
Street City State Zip

►Card holder's email address for credit card receipts: ____

► Cardholder's Signature:

____
Signature Date

Patty Berry, LCSW
Rosa Maria Kolts, MFT
Sue McWayne, LCSW
Jill Gravois, LCSW
Tamineca Lollis, LCSW
Hillary Marshall, LCSW
Evangelina Reina, LCSW
Geraldine Tinson, LCSW

Julia Cassidy, MS, RDN, CEDRD
Kimberely Beeli, LCSW
Kim Poehler, LMFT
Michael Silverman, LCSW
Ngina Tobias, LCSW
Lisa Heemer, LCSW
Richard Gotttschalk, LMFT

5479 E. Abbeyfield Street Suite 3 | Long Beach, CA 90815
Phone: 562-498-5900 | Fax: 562-498-5909 | abbeyfieldpm@gmail.com |

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ____ Date of Birth: __________________________

Medical Record Number: ___________________ Clinician Name: ______________________________________

I request and authorize to release healthcare information of the patient named above to the Kaiser Center located: (please circle)

Kaiser Lomita
2081 Palos Verdes Dr. N Lomita, CA 90717

Kaiser Downey 9333 Imperial Hwy Downey, CA 90242

Kaiser South Bay
25825 S. Vermont Ave Harbor City, CA 90710

Kaiser Bellflower 9400 Rosecrans Ave Bellflower 90706

Kaiser Long Beach
3900 E PCH Long Beach, CA 90804
310-325-6542

Kaiser Baldwin Park 1011 Baldwin Park Blvd. Baldwin Park 91706

This request and authorization apply to coordination of care/treatment & coordination/allocation of benefits

I understand I may revoke this authorization in writing submitted at any time to the clinician. If this authorization is not revoked it will stay in effect until termination of my enrollment in the health plan.

Client Signature: ____ Date signed: _________

Authorized Person (if under 18): ____ Date signed: _________

Printed Name: ____

Relationship to Client: ____

This disclosure is intended for the above named person(s); any further disclosure to those not named above is violation of Federal HIPPA laws.

5479 E. Abbeyfield Street Suite 3 | Long Beach, CA 90815
Phone: 562-498-5900 | Fax: 562-498-5909 | abbeyfieldpm@gmail.com |

Kaiser Behavioral Health Care Line 1-800-900-3277

Behavioral Health Clinic Information

Kaiser Downey
9333 Imperial Hwy Downey, CA 90242
562-807-6200

Kaiser Bellflower
9400 Rosecrans Ave Bellflower 90706
562-807-6200

Kaiser Baldwin Park
1011 Baldwin Park Blvd. Baldwin Park 91706
626-960-4844

Kaiser Lomita
2081 Palos Verdes Dr. N Lomita, CA 90717
310-325-6542

Kaiser South Bay
25825 S. Vermont Ave Harbor City, CA 90710
310-325-6542

Kaiser Long Beach
3900 E PCH Long Beach, CA 90804
310-325-6542

Kaiser Signal Hill
845 E. Williow St Signal Hill, CA 90755
310-325-6542