



**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: \_\_\_\_\_

**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.

## 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](http://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 HIPPA 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



### 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.
- 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  
 Talese Fernbach, MASEP  
 Jill Gravois, LCSW  
 Tamineca Lollis, LCSW  
 Hillary Marshall, LCSW  
 Evangelina Reina, LCSW

Deborah Jaffe, LCSW  
 Julia Cassidy, MS, RDN, CEDRD  
 Kimbely Beeli, LCSW  
 Kim Poehler, LMFT  
 Michael Silverman, LCSW  
 Ngina Tobias, LCSW  
 Ektha Aggarwal, LCSW  
 Lisa Heemer, LCSW

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

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

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

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

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

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