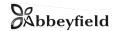


Client Information Is Treated With Professional Confidentiality

Today's Date:	<u> </u>		
◆CLIENT INFORMATION	Referred By:_		
Client Name:		First	MI
		First	MII
Address:Street	City		Zip
Sex: M / F Client Date of Birth:	Age:	Social Security	#:
Home Phone:	Cell / Work I	Phone:	
Is it OK to leave a voicemail at any of these numbers	bers? Yes/No Preferen	ce please circle: Ho	me Work C
Please send me a message reminder of my upcom	ning 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 / Mar.	ried / Domestic Partner /	Separated / Divorced	/ Widowed
◆IF CLIENT IS A MINOR, PLEASE COMPI	LETE THE FOLLOWIN	NG:	
Caregiver Name: (If client is under age 18):			
Caregiver Name: (If client is under age 18): Relationship to Client:	First	Middle Last	
Address (if different from above):			
Caregiver Social Security #:		Date of Birth:	
•CLIENT MEDICAL INFORMATION:			
Are you currently receiving other psychological t	reatment? YES / NO		
If yes, from whom:		Phone:	
Client's Physician:			
Current Medications (for what conditions with do			
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 / S	pouse / Domestic Partner / Parent		
On a scale of 1 to 5; Five being very urgent, w	what is the urgency of your issue? 1 2 3 4 5		
Please briefly state reasons for seeking trea	tment:		

◆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

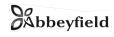
It is important to remember that confidentiality of session material cannot be guaranteed by your therapist in a family or couples therapy situation. Please understand that each family member participating in psychotherapy has the same responsibility to maintain confidentiality for the other participating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

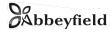
Termination of services: Termination of psychotherapy may occur at any time and may be initiated by either you or your therapist. Please contact your therapist if you decide to discontinue your psychotherapy so that you can schedule and meet for a final session. Termination itself can be a very constructive 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 ser	rvices with
(herein known as your therapist) and agree paragraphs. I have had the opportunity to a and there are no misunderstandings or disag	to the policies of this office as detailed in the above sk questions and clarify my understanding of these policies greements. I have read, understood, and agree to the "Notice opy for my records or I can access the HIPAA notice online at
Client Signature:	Date:
·	efits associated with my care directly to MY THERAPIST essary to coordinate benefits, treatment, and payment re applicable).
Client Signature:	Date:
Appointme	ent and Cancellation Policies
	length of the appointment is 45 minutes. Please give your therapist 24 cel (leaving a voice mail notification on your therapist's extension is
appointments that are cancelled with less than 24 l	by for you, it is necessary to charge a late cancellation fee of \$75 for nours notice. The same fee will apply if you fail to show for a f you are using insurance to pay for your psychotherapy services, please be pointment or late cancel fee.
Understanding of Appointment and Cancellation I	Policies
	nat if I fail to notify my therapist within 24 hours that I will be ow for an appointment, I will be personally responsible for the \$75 late
Client Signature:	Date:
Your Therapist:	
I have reviewed the above policies and informed co	onsent 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:	



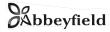
Federal HIPAA Privacy Practices

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





►Name:				
First	Middle Initial	Last		
► Name on card if differen	nt:			
First	Middle Initial	Last		
► I authorize your therapi	st to charge my credit ca	ard for professional ser	vices as follows:	
	Initial all that a	apply		
a. All visits in the next	12 months, beginning	<i>J</i> .		
b. Recurring charges f	for date(s) of service/_	/to/	/,	
\$ mon	thly, \$semi-monthl	у,		
\$week	ly, or \$per visit.			
c. To charge my card for the denial of p	or the balance of fees not page	aid for or covered by my ir	nsurance company v	within 180 days of
d. To charge my card fo	or the balance of fees not pa	aid 180 days from termina	tion of service(s).	
e. To charge my card f	or any missed appointment	s or appointments cancell	ed within 24 hours	for the fee of \$75.
f. To charge my card fo	or any copays not collected	at time of service.		
	\$3.00 convenience fee (pe		·	
	s not keep this fee and it is			•
► Type of card: □ Visa □ M				
➤ 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:				
Signatura		Data		



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

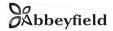
5479 E. Abbeyfield Street Suite 3 | Long Beach, CA 90815 Phone: 562-498-5900 | Fax: 562-498-5909 | abbeyfieldpm@gmail.com |

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 patie named above to the Kaiser Center located: (please circle)	25825 S. Vermont Ave Harbor City, CA 90710	
Kaiser Downey 9333 Imperial Hwy Downey, CA 90242	Kaiser Long Beach 3900 E PCH Long Beach, CA 90804 310-325-6542	
Kaiser Bellflower 9400 Rosecrans Ave Bellflower 90706 Kaiser Baldwin Park 1011 Baldwin Park Blvd. Baldwin Park 91706	Other	
Kaiser Lomita 2081 Palos Verdes Dr. N Lomita, CA 90717		
This request and authorization apply to coordination of care/treatment of understand I may revoke this authorization in writing submitted at a revoked it will stay in effect until termination of my enrollment in the	ny time to the clinician. If this authorization is not	
Client Signature:	Date signed:	
Authorized Person (if under 18):		
Printed Name:		
Relationship to		

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