THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment:

Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment:

We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations:

We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI

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with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law:

Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

- Abuse and Neglect Judicial and Administrative Proceedings
- Emergencies Law Enforcement
- National Security Public Safety (Duty to Warn)

Without Authorization:

Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission:

We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization:

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to your therapist.

- **Right of Access to Inspect and Copy.**
  You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.

- **Right to Amend.**
  If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.

- **Right to an Accounting of Disclosures.**
  You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.**
  You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

- **Right to Request Confidential Communication.**
  You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

- **Breach Notification.**
  If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

- **Right to a Copy of this Notice.**
  You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing the

Secretary of Health and Human Services
200 Independence Ave SW
Washington, D.C. 20201

Or, by calling: (202) 619-0257

We will not retaliate against you for filing a complaint.

Signature

I have read the above Notice Of Privacy Practice carefully (total 4 pages), I understand them and agree to comply with them.

	First Name	Middle Name	Last Name
Patient Name:			

Date:

Signature:

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Welcome!

Please read the following information regarding this clinic, our responsibilities to you, and your responsibilities and rights as a patient here. **Pacific Trauma Treatment Center (PTTC)** is an outpatient mental health practice striving to provide the highest level of care in the community. We are pleased you have chosen our services.

Treatment:

Initial visits are comprised of a thorough evaluation involving forms to be completed and an interview with a therapist. The initial interview typically lasts up to 90 minutes. Following this evaluation, we will recommend a course of therapy and any additional referrals we think you need to address your symptoms or that you may find helpful for your healing process.

Fee Schedule:

Fees for therapy are to be paid at the time of services and on a weekly basis. The fees for therapy are $150.00 for a one hour session and you are ultimately responsible for the cost of visits unless other arrangements are agreed upon at the onset of therapy. If you have insurance, you are responsible for paying your co-pay amount at the beginning of each session. PTTC will make reasonable efforts to bill your insurance provider for the remaining fee balance. If PTTC is not contracted with your insurance provider, you can provide us with a Super Bill to be filled out as an out of network provider. It is your responsibility to verify that your insurance policy is active and your visits in this clinic will be covered. If a situation arises in which your insurance provider does not pay, it is your responsibility to pay the outstanding balance. Any disputes about coverage and payment must be made between you and your insurance carrier. Outstanding balances must be paid within 30 days or a payment plan must be worked out and a referral to a low cost mental health clinic may be necessary. Balances older than 90 days may be sent to collections. You are also responsible for any fees or expenses incurred by your account having to be sent to a collections agency.

Standard hourly rates are billed the following:

Therapy services are billed at $150 per 60 minute session. Prolonged Exposure (PE) Therapy for PTSD is a specialty therapy that requires 90 minute sessions for approximately 10-18 sessions and will be billed at $225 per session. The total cost for PE ranges from $2250 - $3375. Payment plans and sliding scales may be available depending on circumstances and can be discussed with your therapist.

Records requests—personal or legal requests for records can be granted within one week of the request and will be billed at $10 per request.

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Services typically not covered by insurance include (but not limited to): telephone sessions, letters, disability forms and the like, site visits, consultations, and legal requests. These will be provided at the discretion of the provider and charged at the standard hourly rate.

Cancellation/Missed Appointments:

Therapy appointments not cancelled prior to 24 hours will be charged a $25 missed appointment fee for the first incidence and $60 thereafter. Insurance Companies do not pay for missed visits. Patients with three or more missed visits are subject to dismissal from the clinic.

CONFIDENTIALITY:

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

When Disclosure May Be Required:

Disclosure may be required pursuant to a legal proceeding by or against you. 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 providers at PTTC. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Your provider will use their clinical judgment when revealing such information. The clinic will not release records to any outside party unless authorized to do so by all adult family members who were part of the treatment.

Emergencies:

If there is an emergency during your treatment, or in the future after termination where your provider becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, the clinic and its designees will do whatever they 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 we may also contact the person whose name you have provided on your emergency contact 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 provider, only the minimum necessary information will be communicated to the carrier. PTTC has no control or knowledge over what insurance companies do with the information submitted 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 or even a job.

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) nor your attorney, nor anyone else acting on your behalf will call on your provider at PTTC to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

Consultation:

Providers at PTTC consult regularly with other professionals regarding clients; however, client's identity remains completely anonymous, and confidentiality is fully maintained.

Records and Your Right to Review Them:

Both the law and the standards of the psychological profession require that this clinic 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 the clinic assesses that releasing such information might be harmful in any way. In such a case PTTC will provide the records to an appropriate and legitimate mental health professional of your choice. * Considering all of the above exclusions, if it is still appropriate, upon your request, PTTC will release information to any agency/person you specify unless releasing such information might be harmful in any way.

Telephone & Emergency Procedures:

If you need to contact your provider between sessions, please leave a message at (626) 808-4030 and your call will be returned within 24 hours or as soon as possible. If an emergency situation arises, indicate it clearly in your message, and if you need to talk to someone right away, call 911.

The Process of Therapy/Evaluation and Scope of Practice:

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 treatment. 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 provider 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. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Expect to challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about or handling situations. This can cause you to feel very upset, angry, depressed, challenged or disappointed. 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, another family member views a decision that is positive for one family member quite negatively. 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. During the course of therapy your provider is likely to draw on various psychological approaches according, in part; to the problem that is being treated and his/her assessment of what will best benefit you.

Termination:

As set forth above, after the first few meetings, your provider will assess if s/he can be of benefit to you. PTTC does not accept clients who cannot be helped with the services provided here. If at any point during treatment, your provider assesses they are not effective in helping you reach the therapeutic goals, they are obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case you will be referred back to your insurance provider for help locating another contracted provider in your area. You may also ask for recommendations from your therapist, but any names provided by your therapist must be confirmed by you, through your insurance provider, to be a participating provider for your policy. PTTC does not do this research for you. If you request it and authorize it in writing, PTTC will talk to the provider 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, you can do so at any time. You also have the right to terminate treatment at any time.

Dual Relationships:

Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs your provider's objectivity, clinical judgment or therapeutic effectiveness or can be exploitive in nature. Clinicians at PTTC will carefully assess before entering into non-sexual and non-exploitative dual relationships with clients. There are chances you may know other clients or staff and providers at PTTC from the community. Providers at PTTC will not readily acknowledge working with you without your express permission if you meet them in the community. Your provider will discuss with you the often-existing complexities, potential benefits and difficulties that may be involved in such relationships if this situation is applicable to you. It is your responsibility to inform us of a dual relationship and to let us know if the dual relationship becomes uncomfortable for you in any way.

A Note Regarding The Practice

Please note that weekly sessions are intended to feel comfortable and the Practice Style is Relaxed in the sense that there is a small kitchen with tea and snacks available and there are blankets if you want to feel cozy on the couch. You are welcome to bring something to drink or to eat if you are hungry and your therapist may sometimes do the same. If this Practice Style feels "unprofessional" or uncomfortable to you in any way, we encourage you to find a practice that is less relaxed. Finding a match for your needs is important.

Signature

I have read the above Agreement, Informed Consent, Office Policies and General Information carefully (total 5 pages), I understand them and agree to comply with them.

	First Name	Middle Name	Last Name
Patient Name:			

Date:

Signature:

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PTTC - General Info Form

Patient Name:

First Name	Middle Name	Last Name

Date of Birth:

MM	DD	YYYY

Social Security Number:

Gender:

Marital Status:

Employment Status:

Is English your primary language?

- ◯ YES
- ◯ NO

Contact Information:

Preferred Phone:

Mobile Phone: ( ) -

Home Phone: ( ) -

Work Phone: ( ) - ext.

Email Address:

Do you share the email account entered above?

◯ YES ◯ NO

Home Address:

Street Address 1:

Street Address 2:

City:

State: CA - California

Postal Code: Country: US – United States

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Primary Insurance Company:

Insurance Company Name:

Insurance Company Phone: ( ) -

Policy Holder's Name:	First Name	Middle Name	Last Name

Policy Holder's Phone:

Phone: ( ) -

Type of Phone:

Policy Holder's Address:

Street Address 1:

Street Address 2:

City:

State:

Postal Code:

If your insurance is provided by your employer:

Employer's Name:

Co-Pay:

$

Deductible:

$

Insured's ID Number:

Insured's Policy Group:

Policy Holder's Date of Birth:

MM	DD	YYYY

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Personal History & Therapy Questionnaire

The following questions gather important information about your history. This information is vitally important for understanding both your background and any current issues you are facing. Your therapist will check in about any "Yes" answers and the information will be used to help determine your treatment plan. This information will never be shared with ANYONE without your written request and signed consent.

Did you experience emotional abuse as a child?	☐ NO	☐ YES
Did you experience physical abuse as a child?	☐ NO	☐ YES
Did you experience sexual abuse as a child?	☐ NO	☐ YES
Did your parents argue or fight in front of you?	☐ NO	☐ YES
Did you witness violence or other frightening things as a child?	☐ NO	☐ YES
Where you exposed to drug use or abuse growing up?	☐ NO	☐ YES
Did any aspect of your younger years feel traumatic, depressing, or difficult in any way?	☐ NO	☐ YES
Did you suffer from childhood depression, anxiety, behavioral issues, or mood swings?	☐ NO	☐ YES
Were you ever a part of the foster care or probation system as a child?	☐ NO	☐ YES
Did you use drugs growing up?	☐ NO	☐ YES
Have you experienced emotional abuse as an adult?	☐ NO	☐ YES
Have you experienced physical abuse or domestic violence as an adult?	☐ NO	☐ YES
Have you experienced sexual abuse as an adult?	☐ NO	☐ YES
Have you served our country in the armed forces?	☐ NO	☐ YES
If yes, did you experience emotional, mental, physical, or sexual trauma of any kind during your service?	☐ NO	☐ YES
Are you currently seeking support for these issues or others related to integration back into civilian life?	☐ NO	☐ YES
Do you practice a religion as a part of your daily life? If yes, which religion? Click here to select.	☐ NO	☐ YES
Have you ever worked with a counselor in the past?	☐ NO	☐ YES
If yes, for how long? If yes, what year did you start therapy? Years: Months:		
Did the therapy you receive help you with the issues you were there to address?	☐ NO	☐ YES

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Have you ever worked with a psychiatrist in the past?	☐ NO	☐ YES
If yes, for how long? Years: Months:	If yes, what year did you start therapy?	
Are you currently prescribed medications?	☐ NO	☐ YES

If yes, please list the medications and what they are being prescribed for.

Medication	Reason for Prescription

Personal Psychiatric History

(please check all items that apply)

- ☐ Depression
- ☐ Psychosis/Schizophrenia
- ☐ Learning Disabilities
- ☐ Attention Deficit Disorder
- ☐ Alcohol Addictions
- ☐ Drug Addictions
- ☐ Other:
- ☐ Suicide Attempts
- ☐ Mania or Bipolar Disorder
- ☐ Anger/ Abuse Issues
- ☐ Anxiety/Panic
- ☐ Post-Traumatic Stress Disorder
- ☐ Obsessive Compulsive Disorder

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Family Psychiatric History

(please check all items that apply)

- ☐ Depression
- ☐ Psychosis/Schizophrenia
- ☐ Learning Disabilities
- ☐ Attention Deficit Disorder
- ☐ Alcohol Addictions
- ☐ Drug Addictions
- ☐ Other Addictions
- ☐ Other:
- ☐ Suicide or Suicide Attempts
- ☐ Mania or Bipolar Disorder
- ☐ Anger/ Abuse Issues
- ☐ Anxiety/Panic
- ☐ Post-Traumatic Stress Disorder
- ☐ Obsessive Compulsive Disorder

Please explain any of the above items you checked and note your relation to the individual:

Do you have a history of any past or current legal problems? If yes, please explain.

What are the main symptoms/ concerns you are here to address?

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Medical Questionnaire

The following medical questions are being asked because medical problems can have a profound effect on how a person feels on an emotional level and, conversely, emotions can have a significant impact on a person's health. I am not a medical doctor and I do not treat medical conditions. However, I do approach my client's from a holistic perspective and I have general knowledge about how certain ailments can impact mental health issues. If you are having health care issues, I recommend that you follow up with an appropriate health care professional to address your health concerns. I can help you locate a provider if you require assistance.

Do you suffer from any illness you would consider severe or chronic? If yes, please provide a short description:	☐ NO	☐ YES
Do you or have you ever suffered from chronic pain? If yes, please provide a short description:	☐ NO	☐ YES
Have you ever been knocked unconscious?	☐ NO	☐ YES
Are you taking any medications on a regular basis? If yes, which medications and what are they treating:	☐ NO	☐ YES
Do you have parts of your body that you consider injured or weak? If yes, please provide a short description:	☐ NO	☐ YES
When was the last time you had a complete physical? Month: Year:		
After your last physical, did your doctor express any concerns? If yes, please provide a short description:	☐ NO	☐ YES
How would you rate your current level of pain? (0=Low to 10=High)		

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Please check off any conditions that you have been treated for in the past or are currently experiencing.

- ☐ Migraines, Headaches
- ☐ Dizziness
- ☐ Concussion/Head Trauma
- ☐ Stroke
- ☐ Vision Problems/Loss
- ☐ Hearing Loss or Ringing in Ears
- ☐ Allergies, Seasonal or Other
- ☐ Heart Attack
- ☐ High or Low Blood Pressure
- ☐ Other Heart Conditions
- ☐ Asthma\Gastric Reflux or Ulcers
- ☐ Pancreatic or Gall Bladder Disease
- ☐ Other Digestive Problems
- ☐ Urinary Problems
- ☐ Sexual Dysfunction
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Cancer
- ☐ Bleeding Problems/Easy
- ☐ Bruising
- ☐ Back or Joint Pains/Arthritis
- ☐ Nerve Numbness/Sensitivity
- ☐ Muscle Weakness/Injury
- ☐ Arthritis
- ☐ Menstruation Irregularity
- ☐ Hysterectomy
- ☐ HIV
- ☐ Hepatitis
- ☐ Sleep Apnea
- ☐ Other Neurological
- ☐ Autoimmune Disorder(s)
- ☐ Currently Pregnant
- ☐ Seizures

Please provide a short description for any of the items checked above.

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Consent For Treatment Of A Minor

I, First Name | Middle Name | Last Name ,

hereby grant Jacqueline G Woods, and whomever she may suitably designate, the authority to provide and/or obtain medical treatment for the following child:

Name of Child:	First Name	Middle Name	Last Name

Date of Birth: Gender:

The above care provider is authorized to:

- Provide mental health counseling.
- Obtain medical treatment procedures for the child as may be appropriate in emergency circumstances, including treatment by physicians, hospital and clinic personnel, and other appropriate health care providers.

This grant of temporary authority shall begin on , and shall remain effective until terminated by the undersigned.

Parent/Guardian Signature

Relationship to the child listed above:

Signature's Name:	First Name	Middle Name	Last Name

Signature Date:

Signature: Relationship:

Provider Signature

Relationship to the child listed above: Mental Healthcare Provider

Provider's Name:	First Name	Middle Name	Last Name
	Jacqueline	G	Woods

Signature Date:

Signature:

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