Balanced
Health and Wellness

INTAKE FORMS PACKET

Included in this Packet

1. **Patient Registration Form**
2. **Financial Responsibility**
3. **Arbitration Agreement**
4. **Informed Consent- Psychologists/ Therapists**
5. **Release of Information**

Instructions

1. **Read, complete, sign and date the attached paperwork**
2. **Take to your appointment along with a copy of your Drivers' License and your Insurance Card**

Balanced
Health and Wellness

26400 La Alameda, Suite 208, Mission Viejo, CA 92691
Ph~ 949.606.4698 Email~ bernadette.balancedhealth@gmail.com

PATIENT REGISTRATION INFORMATION

Patient's Last Name: _____ Patient's First Name: _____
Is this your legal name?: _____ If not, what is your legal name: _____
Date of Birth: _____ Sex: ☐ M/ ☐ F Marital Status: _____
Full Home Address: _____
Street City State Zip Code
Phone #: _____ Do you consent to receive automated reminder calls at this phone number? ☐ Y/ ☐ N
If Yes, please sign _____
Full SSN: _____

Email: _____ Do you consent to allowing any/ all communication (medical &/or mental documentation, billing statements and financial information) being sent to the email address above? ☐ Yes ☐ No

Emergency Contact: _____ Phone #: _____
Relation to Patient: _____

Preferred Pharmacy: _____
Name Location Phone #

How did you hear about our clinic? _____

INSURANCE INFORMATION

(Please bring your Insurance Card & State ID/ Drivers' License to Office)

Person responsible for bill: _____ DOB: _____
Address: _____ Phone #: _____

PRIMARY INSURANCE

Insurance Company: _____ Member/Subscriber ID: _____
Subscriber's Name: _____ Relationship to Subscriber: _____
Subscriber's SSN: _____ DOB: _____ Co-payments $_____
Policy #: _____

Patient Signature: _____ Date: _____

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FINANCIAL RESPONSIBILITY

Balanced Health and Wellness participates with most major health plans and will accept payment directly from them. As a courtesy to you, we will send claims in to your primary, and secondary carriers, if necessary. However, it is important that you understand your insurance policy and that benefits are an arrangement (contract) between you and your insurance company. You are personally responsible for all allowable fees as directed by your insurance company, as well as non-covered services that you have agreed to. These fees are usually categorized as a Copay, a Co-Ins (percentage), or a Deductible. Certain insurance plans will authorize a specific number of visits for a certain period of time. Please be certain that you are aware of your benefits, as you will be personally liable for any visits that fall outside of that scope, and are denied by your plan. When in doubt, please verify this information with your insurance company. ***Additionally, please be aware that all correspondence regarding your claims will be sent to the subscriber on record of your insurance policy.*** Our staff will make their best effort to verify insurance eligibility and benefits, but ultimately it is the patient's responsibility to know their policy and coverage. All patients that present without valid insurance information will be considered a Self-Pay Patient. You are required to pay all patient responsibility portions at the time service is rendered, unless prior arrangements have been made.

Credit Card Authorization Form

Credit Card Number: _____

Expiration Date: _____ CVV: _____

Name on Card: _____

Billing Address: _____

I, _____, authorize Balanced Health and Wellness to charge the above referenced credit card for missed or canceled appointments without 24 hours of notice ($100), any letters or other administrative paperwork I request (fee TBD), other fees and services that are not covered by my insurance policy.

I have read and understand Balanced Health and Wellness' financial responsibility agreement.

By signing below I acknowledge that in order to make future appointments at Balanced Health and Wellness, I must have a form of payment on file.

_____ _____

Patient Printed Name Patient Signature, if of legal age.

_____

Date

_____ _____

Parent/Guardian Printed Name Parent/Guardian Signature

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** (Date)

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

Balanced
Health and Wellness

Clinical Psychologists & Therapists

26400 La Alameda, Suite 208 Mission Viejo, CA 92691

Ph: 949-606-4698 Fax: 949-215-2529

INFORMED CONSENT

Welcome! This document contains important information about my professional services and business policies. Please read it carefully and note any questions you might have so that we can discuss them. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Therapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular issues or concerns you bring to therapy. Your feelings about the therapy or psychologist are very important. I encourage you to discuss any questions, confusion, or frustrations you experience so that they do not become obstacles to your treatment. I believe you are the best authority on whether a treatment relationship will be helpful.

Our first few sessions will involve an evaluation of your needs and problems. By the end of the evaluation, I will be able to offer you some first impressions as to why you are experiencing the problems you have presented and what treatment I would recommend, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have any doubts about continuing, I will be happy to help you set up a meeting with another mental health professional.

BENEFITS AND RISKS

There are both benefits and risks of psychological services. During the course of therapy, it is often the case that you will feel worse before you feel better; this is natural and expected in any healing process.

The ***benefits*** may include reduced stress and anxiety, a decrease in negative thoughts and self-defeating behaviors, improved relationships, increased comfort in social, school and/or family settings, increased self-confidence, and a more hopeful attitude towards life.

The ***risks*** may include recalling or recounting painful memories and experiences, discomfort in analyzing current distress and problems, and the possibility of experiencing strong feelings of sadness, anger, fear or other difficult emotions. As your psychologist, I may from time to time challenge your assumptions or perceptions and offer a different perspective. Changes in your perspective, thoughts, or feelings may have unintended outcomes, including changes in personal relationships.

Personal growth can be difficult and slow or easy and swift. When we sign this agreement together, I commit to helping you through the entire process of therapy. This will mean helping you to achieve the goals you initially state, but also other issues or problems that may arise during our work together that require further exploration and analysis. If this happens, we will work together to revise the goals as appropriate and work towards a satisfactory solution of your problems.

There is no guarantee that therapy will yield any or all the benefits listed above. Neither is there any certainty that the risks listed above will be encountered during our work together. Therapy is an open and dynamic process, and its course is dependent upon our mutual willingness to collaboratively continue the process and, to a certain extent, upon life events that cannot be foreseen.

CONFIDENTIALITY

In general, the privacy of all communication between a patient and a mental health professional is protected by law and I can only release information about our work to others with your written permission. However, there are a few exceptions:

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a *reasonable suspicion* of child, dependent or elder, abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled. Please feel free to ask me if you need further details regarding State mandated or permitted breach of confidentiality.

When Disclosure May Be Required: Disclosure may be required pursuant to a *legal proceeding*. 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 me. Disclosure may also be required *in couple and family therapy*, or when different family members are seen individually. When conducting therapy where the unit of treatment is more than one person, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I am authorized to do so by <u>all</u> adult members who were part of the treatment (i.e., partner, spouse, parents).

Emergencies: If there is an emergency during our work together, or in the future after termination, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I 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, I may also contact the police, hospital or the person whose name you have provided on the intake form.

Confidentiality of E-mail, Cell Phone, Text Messaging and Faxes Communication: It is very important to be aware that e-mail, cell phone (also cordless phones), and text message communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be easily compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can be sent erroneously to the wrong address. Please notify me at the beginning of treatment if you prefer to avoid or limit any of these above forms of communication. **Please do not use e-mail, text message or faxes in emergency situations**.

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 (i.e. **divorce and custody disputes**, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf, will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Consultation: I consult from time to time with other professionals regarding my clients; however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking action. Considering all the above exclusions, if it is still appropriate, upon your request, I will release information to any agency/person you specify unless I conclude that releasing such information might be harmful in any way. This includes allowing you to see your own medical records.

MEETINGS

Therapy sessions last approximately **60-minutes** and I will try to schedule these meetings at a time that works in your schedule. Since certain times are in greater demand, I would recommend scheduling appointments some time ahead in order to reserve a time that is best for you. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome.

CANCELLATIONS AND LATE ARRIVALS

Since scheduling an appointment involves the reservation of time specifically for you, a **minimum of 24 hours (1 day's) notice is required for re-scheduling or canceling an appointment**. You will be receiving automated reminders 1-2 days in advance and we do require that you respond to these

reminders so that we are assured that you intend on keeping your scheduled appointment. Office policy is to charge a $100 fee to the credit card on file for appointments that are missed without proper notification. This fee is not reimbursable by any insurance you may have **Initial your understanding of this Policy here~ Patient/ Guardian Initials_____ ☐**

Since our time together is reserved for you in 60-minute blocks, if you are late to your session, I will be able to see you for the remainder of the 60 minutes left in your scheduled 60 minutes only. I am not able to give you extra time as this is not fair to other clients who have reserved their time as well and want to utilize their entire 60-minute session. You are still responsible to pay for the entire session as this time was reserved for you whether you are able to use it all or not. If you continue to have a difficult time getting to your session on time, discuss this with me as it may be better to find a time that will work better for you in my schedule. I want you to be able to use all the time reserved for you.

PSYCHOLOGIST AVAILABILITY/ EMERGENCIES

I am available for regularly scheduled appointment times. Dates of vacations and other exceptions will be given out in advance, if possible. You may leave a message for me anytime on the main office phone (949-606-4698). I am available to return messages Monday through Friday, 9 am to 6pm. In the event of an emergency involving a threat to your safety or the safety of others, please call 911, the 24-hour crisis Suicide Prevention Center (877) 727-4747 or go to your nearest emergency room.

DUAL RELATIONSHIPS

A "dual relationship" refers to situations in which the therapist has more than one role with the client. For example, I cannot be your therapist and your friend, cannot hire you or recommend you for anything, cannot accept expensive gifts or anything that might influence how I treat you. This includes "friending" or "following" each other on personal social media pages. I hope our relationship will be warm and close, but it will be about **you** and helping **you.** It is not a mutual relationship in that you will not learn much about me, about my personal life, and you are not responsible for tending to my needs and feelings. If there is a potential dual relationship, it needs to be discussed and evaluated to see if it would be wiser to continue therapy or transfer you to a different therapist. Avoiding dual relationships leaves you freer to be open and honest with me.

TERMINATION OF THERAPY

You may terminate therapy at any time. If is it determined that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include referrals, changing your treatment plan, or terminating your therapy.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

Signature of Patient (or Guardian) **Date**

_____

Printed Name of Patient (or Guardian)

Statement of the Psychologist/ Therapist. This document was discussed with the client and any questions were discussed. I have assessed the client's mental capacity and found the client capable of giving an informed consent at this time.

Indicate here if you would like a copy of this consent: Yes ☐ No☐

_____ _____

Provider Name (Printed) **Date**

_____

Provider Signature

Clinical Psychologists & Therapists

Balanced Health and Wellness
26400 La Alameda, Suite 208
Mission Viejo, CA 92691
949-606-4698

RELEASE OF INFORMATION

I, _____ (patient name), hereby authorize _____ (provider name) to **release information** and/or records pertaining to my evaluation, diagnosis, and/or therapy sessions to (please provide name, address, and phone number):

_____

_____

For the specific purpose of_____

_____

I understand that authorization shall remain valid from the date of my signature below and for one year thereafter ending on: _____

I have been informed that I may only revoke this authorization in writing. I certify that this form has been fully explained to me and that I understand its contents.

_____ _____

Signature of Patient/ Guardian Date of Authorization

_____ _____

Provider Name Printed Date

_____

Provider Signature