Central Coast Counseling Center, Inc.

900 E. Main St., Suite 204, Santa Maria, CA 93454 (805) 934-5088 FAX (805) 937-0877

TC_____

Counselor Review Y/N ?
Therapist's Initials_____

CLIENT INFORMATION

Please Print Clearly

Date: ____/____/____

THIS SHEET MUST BE FILLED IN COM PLETELY

Client's Social Security # _____-____-_____ **Client's Driver's License #or I.D.(if applicable)** _____

Client's First Name _____ **MI** _____ **Last Name** _____

Address _____ **City** _____ **State** _____ **ZIP** _____

Phone (H) _____ **(can we call? Y/N) (Cell)** _____ **(can we call? Y/N) (W)** _____ **(can we call?Y/N)**

Birth Date____/____/____ **Male** ____ **Female** _____ **(check one)** **Single/Married/Divorced/Widow (circle one)**

Can we send Billing Statements to client's home? Y/N If not, Where? _____

Name of Spouse/Guardian _____ Phone (_____) _____

Address _____ City _____ State _____ ZIP _____

Signature of Person Responsible for Payment **X** _____

(Must be signed for services to begin)

Driver's License # of Payer: _____ **Soc. Sec. # of Payer** _____-_____-_____

Have you ever been to counseling before? Y/N (circle one) If yes, with whom? _____

When? _____ How long? _____

Do you have children? Y/N If yes, list their names & ages: _____

_____

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship _____ Ph. _____ Work _____

Address _____ City _____ State _____ Zip _____

Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Psychiatrist _____ Phone _____

Address _____ City _____ State ____ Zip _____

_____ Phone _____

Allergies Y/N if yes, please list: _____

Referral Source

How did you hear of our clinic (or from whom)? _____

Employment Information *(If client is a child, use parent's employment)*

Client/Guardian: Place _____ Phone _____ Hrs _____

Spouse: Place _____ Phone _____ Hrs _____

Retired? Y/N

Phone _____ Relationship to referral source _____

Insurance Information

Primary Insurance _____

Phone _____

Contract/ID# _____

Group/Acct# _____

Subscriber _____

Subscriber Date of Birth ____/____/_____

Client's relationship to Subscriber _____

Self __Spouse __Child __Other _____

SELF-PAY (Circle here)

Secondary Insurance _____

Phone _____

Contract/ID # _____

Group/Acct _____

Subscriber _____

Subscriber Date of Birth ____/____/_____

Client's relationship to Subscriber _____

Self __Spouse __Child __ Other _____

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HIPAA DISCLOSURE

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

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. However, we can't cover all possible situations so please talk to our Privacy Officer about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange payment for our services or for some other business activities which are called, in the law, health care **operations**. **After you have read this Notice of Privacy Practices** (here after shown as NPP) **we will ask you to sign a Consent Form to let us use and a share your information. If you do not consent and sign this form, we cannot treat you.**

If we or you want to use or disclose (send, share, release,) your information for any other purposes we will discuss this with you and ask you to sign an Authorization to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires to do so.
4. For Workers Compensation and similar benefit programs.

Your rights regarding your health information

1. **You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.**
2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. **You have the right to look at the health information we have about you such as your medical and billing records. *You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.**
4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. **You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and you can always get a copy of the NPP from the Privacy officer.**
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

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HIPAA CONSENT

Consent to use and disclose your health information

This form is agreement between you, _____and your therapist or Central Coast Counseling Center. When we use the word "you" below, it will mean you, your child, relative, or other person if you have written his or her name here:

_____.

When we examine, diagnose, treat, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about how. We need to use this information here to decide on what treatment is best for you to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how you are protected and how we can use and/or share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at (805) 934-5088.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of client or his or her personal representative *Date*

_____ _____

Printed name of client or personal representative *Relationship to Client*

_____

Description of personal representative's authority
Date of copy given to the client/parent/personal representative or initial if a copy is not wanted.

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CONFIDENTIALITY

Confidentiality is important to the therapeutic process because it provides the basis for trust and honesty. In general, all information disclosed within a psychotherapy session is confidential and legally privileged.

Your therapist, and in some cases other staff members are the only individuals who have access to your files, unless you direct your therapist, in writing, to disclose information to specific individuals. If your therapist is an intern, he/she will be consulting closely with his/her supervisor. **However, there are some rare circumstances under which both legal and ethical guidelines mandate disclosure:**

1) When there is reasonable suspicion of child abuse.
2) When there is reasonable suspicion of dependent adult or elder abuse.
3) When you communicate that you intend to physically harm yourself or another person.
4) When a client threatens to damage property of another.

Other circumstances that allow for disclosure include the following:

Legal proceedings:
A court may require disclosure of confidential information in a legal proceeding in which your condition or treatment is a relevant concern. This may include, but is not limited to, legal proceedings such as a child custody hearing, board complaint, or criminal action.

Professional Consultation:
Our office strives to follow the strictest ethical guidelines to protect your rights and provide you with the best care. To ensure a high quality of treatment, your therapist may consult with other professional health care providers and/or supervisors regarding some aspects of your case. The consulting professional is then ethically and legally bound to maintain the confidentiality of that information.

Confidentiality in Group/Family/Couples Treatment:
Members of a group are not therapists and do not have the same ethical and legal mandates. However, if you participate in a therapy modality that includes other clients; all members are asked to respect and maintain the confidentiality of what is disclosed during the course of treatment.

Secrets Policy:
Secrets, when held from a family, spouse, partner, and/or significant others can be destructive to the relationships of the individuals involved, including the holder of the secret. When working with families, couples, or other groups, the therapist reserves the right, when asked to maintain a secret, to work toward its disclosure when disclosure has been determined by the therapist to be in the best interests of the parties involved.

Minors in Treatment:
Treatment considerations require that specific information will be treated as confidential, whenever possible, to build trust and honesty and mutual respect. However, children under the age of 12 have little legal right to maintain confidentiality from their parents or guardians. Between 12 and 18, as the individual becomes more able to understand and choose, he or she assumes more legal rights. Nevertheless, parents and guardians have the right to general information on important life issues and progress of the treatment.

Release of Records:
You must sign a Release of Records form if you would like to have any information released to a third party.

Treatment Records:
We are required to maintain treatment notes, which include but are not limited to, dates of treatment, diagnosis, and treatment interventions and goals. You are entitled to review these records with your therapist. However, if examination of any particular part of these records would have an adverse effect on you, the therapist is permitted to withhold that information and will provide sound justification for doing so. Released records may be appropriately limited to a general treatment summary.

Insurance Claims Disclosure:
Submitting a claim to insurance or other third party payer for reimbursement will require disclosure of some aspects of your treatment (e.g., diagnosis, treatment plan, and/or treatment progress). A request for us to submit a claim to your insurance carrier or other third party is consent for us to release that relevant information. Only the information necessary to process your claim will be released unless additional consent is obtained.

Non-payment of Bill:
If your account billing is overdue and no payment plan arranged, Central Coast Counseling Center might, as a last resort, use legal means to obtain payment. If this becomes necessary, your name, address, and telephone number, along with the balance you owe, and dates of service may be legally disclosed.

As you can see, the laws and rules on confidentiality are complicated. However, you should now have enough information to enter treatment well informed. Please let your therapist know if you have any questions or require further information.

I have read the information on the exceptions to confidentiality, and with my signature I affirm that I understand and comply.

_____ /_____/_____
Client Signature **Date** **Client name printed**

_____ /_____/_____
Parent/Guardian Signature **Date** **Parent/Guardian name printed**

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FINANCIAL POLICY

PAYMENT IS DUE AT TIME OF SERVICE

(We accept cash, checks, debit, Visa, and Master Card)

Insurance reimbursement: The client is responsible for meeting all deductibles and making estimated co-payments at the time of service. To bill your insurance company, we need your insurance information and may require an original claim form if requested by your insurance. **We will bill your insurance company as a courtesy, however it is your responsibility to know what your insurance covers for claims and benefits as well as what provider is authorized for your particular Behavioral Health plan. Clients are responsible to make sure that if an authorization for services is needed that the Authorization number is given to Central Coast Counseling Center prior to the first session.**

Our practice is committed to providing the best treatment for our clients. Our fees are usual and customary for the area and professional qualifications. However, your insurance company may or may not reimburse for the service at the same rate that your therapist charges. Some or all of the services provided may not be covered or considered necessary under some insurance plans. Clients who carry insurance should remember that professional services are rendered and charged to the client, not the insurance company. **It is important that you, not the insurance company, are responsible for any portion of the bill not covered by your insurance company.**

In the event that your insurance changes please notify your therapist immediately with the new insurance information. Should you switch to a plan in which we are not participating providers you will be responsible for payment.

Session rates:
Sessions are 45 to 50 minutes long, beginning at the scheduled time of appointment, which include filling out forms required for therapist information, and HIPPA law. Sessions exceeding 50 minutes will be billed in supplemental 15-minute time blocks pro-rated for the agreed upon hourly fee for the providing therapist. **Rates are: $110 per hour for Licensed Marriage and Family Therapists. All other rates are on a limited basis signed and agreed upon between the Therapist and Client.**

Minor Clients: The adult accompanying a minor, the parent(s), or guardian(s) of the minor are responsible for the full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges are paid at the time of service by cash, check or credit card.

Cancelled or missed (no show) appointments: Because the scheduled session time is set aside specifically for you, and cannot be used by others, **a minimum of 24 hours notice is required for rescheduling or cancellation of an appointment. Unless cancelled 24 hours in advance, our policy is to charge for a missed appointment at the rate of a normal office visit. THIS INCLUDES TRICARE CLIENTS.**

Telephone calls: If you need to contact your therapist between sessions, please feel free to call Central Coast Counseling Center. If the therapist is in session or out of the office, leave a message with reception or voice mail and your call will be returned within a reasonable period. **In case of a clinical emergency,** call the office, and they will page your therapist directly. However, **should you require immediate attention for a clinical emergency** and cannot reach your therapist, call 911 for emergency services.

Telephone contacts to and for clients, as well as requested letter or reports written by the therapist, will be billed at the standard hourly rate. Time tracking for telephone calls begins when the therapist makes contact and concludes when the call ends. You will be billed for telephone calls at 15 minute increments.

Court appearances: Should your therapist be subpoenaed or requested to appear or testify to the court on your behalf the hourly fee will be a minimum of $350 to be paid by the client prior to the court appearance. The therapist will be an expert witness only. It is not acceptable to only be paid as a percipient witness, especially if your case needs hours of the therapist's professional time. This fee allows for travel time, testimony and preparation, court delays, and rescheduling of other clients.

Non-payment of bill: If you fail to pay your bill or make adequate alternative arrangements, actions will be taken to collect the unpaid balance. such actions may include the use of a collection agency, court litigation, a negative credit report, and /or filing a 1099-C with the IRS. If these actions become necessary you will be responsible for the amount owed as well as court costs and lawyer fees incurred. Such actions will be pursued only as a last resort. If it becomes necessary to use any of the above-mentioned actions, your name, address, and telephone number, along with the balance you owes, may be disclosed as necessary. No other information about your treatment will be revealed.

I have read the Financial Policy and with my signature I affirm that I understand and agree to abide by this policy.

Client signature	Date	Client name printed
Parent/Guardian signature	Date	Parent/Guardian name printed

Revised 10.20.15

Clinical Assessment

A. DESIRED GOALS/OUTCOME OF TREATMENT: _____

_____

B. WHAT CHANGES WOULD LOOK LIKE IN LIFE WITH DESIRED GOALS/OUTCOMES: _____

_____

C. NUMBER OF SESSIONS YOU ANTICIPATE: _____

PRESENTING PROBLEM (Include precipitating Events/Current stressors/Relevant History):

_____

_____

_____

Current Risk Factors

A. Suicide: ⌗ None ⌗ Idea ⌗ Plan ⌗ Intent with means ⌗ Intent without means ⌗ Other_____
B. Homocide: ⌗ None ⌗ Idea ⌗ Plan ⌗ Intent with means ⌗ Intent without means ⌗ Other_____
C. If Risk Exists - Client has contracted not to harm: ⌗ Self ⌗ Others
D. Impulse Control: ⌗ Sufficient ⌗ Moderate ⌗ Minimal ⌗ Inconsistent ⌗ Explosive
E. Medical Risks: ⌗ Yes ⌗ No If yes, please explain: _____

F. Current/Past Physical/Sexual Abuse, or Child/Elder Neglect: ⌗ Yes ⌗ No If yes, patient is ⌗ Perpetrator ⌗ Victim
Has the abuse been legally reported? ⌗ Yes ⌗ No If yes, to any of the above, please explain: _____

G. Risk History—Please explain any history of suicidal, homicidal, or impulse control behavior that may affect your level of functioning: _____

Drug and Alcohol History

⌗ None ⌗ Abuse ⌗ Dependence
Document substance(s), quantity, frequency, date of last use, duration of use, number of attempts at sobriety, prior Chemical Dependency treatment:

_____

Previous Treatment (Please check ALL that apply):

⌗ Outpatient Chemical Dependency ⌗ Inpatient Psychiatric ⌗ Self-Help Group Support
⌗ Outpatient Psychiatric (Psychotherapy) ⌗ Psychotropic Medication/Management ⌗ None
⌗ Inpatient Chemical Dependency ⌗ Other Hospitalizations ⌗ Other
If any of the above is checked, please give dates of treatment: _____

Current Medications

Name of Medication	Current Dosage / Frequency	Start Date

Medical Health Issues/ Concerns

Prescribing physician (indicate if Primary Care Provider or Psychiatrist): _____
Date of last Physical Exam: _____ Name of Primary Care Physician: _____

Family History

⌗ Alcohol abuse/ dependence ⌗ Suicide attempt ⌗ Divorce ⌗ Other psychiatric problems
⌗ Drug abuse/ dependence ⌗ Mood disorder ⌗ Emotional abuse ⌗

If "yes" to any, please explain: _____

_____

_____