CLIENT INFORMATION & BACKGROUND Date_____

Name_____ Age_____ Date of Birth _____
Address_____ Cell Phone ( ) _____
City_____Zip_____Email _____
Occupation _____ Employer_____ Work ( )_____
Address _____City_____ _____Zip_____
Who referred you or how did you hear about me _____
Marital Status (Circle) S M D W Sep How Long?_____Previous Marriage(s)?_____
Previous Counseling? Y N When_____ Duration_____How as your experience?_____
Have you ever been hospitalized for psychological treatment? _____When?_____Where_____
Are you currently under physician and/or psychiatrist's care_____
Date of Last Physical Exam _____Doctor's name_____
Medications Currently Taking (use back of page if needed) _____
_____
_____
Education: Some High School___ H.S. Diploma___ Some College___ College Degree___ Graduate Degree____

SPOUSE/SIGNIFICANT OTHER INFORMATION:
Name_____ Age_____ Date of Birth _____
Address (if different from above) _____ Cell Phone ( ) _____
City_____Zip_____Email _____
Occupation _____ Employer_____ Work ( )_____
Address _____City_____Zip_____

CHILDREN :
Name _____ Birthdate _____
Name _____ Birthdate _____
Name _____ Birthdate _____

SIBLINGS:
Name _____ Birthdate _____
Name _____ Birthdate _____
Name _____ Birthdate _____

Whom do you live with: _____
_____

IN CASE OF EMERGENCY, WHOM SHOULD I NOTIFY:
Name _____ Phone _____ Relationship _____

INSURANCE
Insurance Co/Plan _____ ID # _____

PLEASE PRESENT INSURANCE CARD AND CREDIT CARD FOR PHOTOCOPYING AUTHORIZATION TO PAY

I/We do hereby authorize_____(name of insurance company) to pay directly to Barbara Freie, medical benefits otherwise payable to me for mental health services. I understand that I am financially responsible for charges not paid by my insurance company.

Date:_____ Signature:_____
I/We, hereby authorize Barbara Freie, MFT to release to my insurance company any information required in the course of my treatment, for billing and/or audit purposes.

Date:_____ Signature:_____

Name_____ Date_____

What brings you to therapy now? Describe reasons for seeking help.

What help do you expect from therapy?

Is there anything from your past history that may be related to the difficulties you are having now? (trauma, abuse, substance use, learning difficulties etc....)

On a scale of 1-10 with 1 being mild and 10 being severe, how would you rate the severity of your problem(s)?

Are you depressed at this time? Yes____ No_____ Sometimes_____
How serious would you say your depression is? (Scale of 1-10) _____
Have you had any suicidal thoughts? Yes_____ No_____
Have you ever attempted suicide? Yes_____ No_____
Any history of suicide attempts in family members? Yes_____ No_____
Who?_____
Whom have you presently consulted about your present problems?
_____
List your five worst fears: Worst fear first. 1)_____ 2)_____
3)_____ 4)_____ 5)_____

What do you consider your strengths?
_____
Please check all of the following which are, or have been, problems for you:

__ Anxiety	__Loneliness	__Claustrophobia	__Marital problems
__Shyness	__Nightmares	__Bowel problems	__Lack of appetite
__Tension	__Overweight	__Can't have fun	__Can't keep a job
__Tremors	__Child abuse	__Hearing noises	__Can't concentrate
__Dizziness	__Underweight	__Suicidal ideas	__Lack of exercise
__Headaches	__Can't decide	__Take sedatives	__Can't make friends
__Parenting	__Palpitations	__Fainting spells	__Don't like weekends
__Tiredness	__Feel panicky	__Unable to relax	__Bad home conditions
__Alcohol use	__Unemployment	__Memory problems	__Inferiority feelings
__Drug use	__Over-ambitious	__School problems	__Sexual problems
__Depression	__Seeing things	__Sexual assault	__Sexual abuse
__Physical abuse	__Eating disorder	__Sleeping trouble	__ADD (ADHD)
__Fearful	__Angry	__Depressed	

Other issues:_____
_____

Name_____ Date_____

Your Physical History - Check any that may apply, past or present:

__Heart problems
__Liver problems
__Shortness of breath
__Cancer
__Immune disease
__Hepatitis/jaundice
__Pain or pressure in chest
__Severe headaches
__Diabetes
__High blood pressure
__Head injury
__Tuberculosis
__Sexually transmitted
__Stroke
__Alcoholism disease
__Drug Abuse
__Epilepsy/convulsions
__Asthma
__Allergies
__Seizures
__Kidney problems
__Bedwetting/soiling
__PMS
__Hormone therapy
__Pregnancy #___
__Abortion #___

Your Substance Usage - Please indicate past and current use:

Alcohol_____Amount_____Frequency_____

Marijuana_____Amount_____Frequency_____

Cocaine_____Amount_____Frequency_____

Methamphetamine_____Amount_____Frequency_____

Others_____

Family of Origin History (Parents, siblings, grandparents, children, aunts, uncles)
Please circle any that apply:

Depression	Bipolar (manic/depression)	Pornography	Alcoholism
Violence	Child abuse/sexual abuse	Jail	Drug abuse
Anxiety	Attention deficit disorder	Trauma	Eating disorder
Schizophrenia	School failure	Gambling	Suicide

Alcohol or other substance use:

Barbara Freie, MA, LMFT #102618

INFORMED CONSENT FOR PSYCHOTHERAPY

General Information
The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process
You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of grief, anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstances will change. I can promise to support you and do my very best to understand you and your repeating patterns, as well as to help you clarify what it is that you want for yourself. I work from an eclectic approach, utilizing psychological assessments, tools and interventions as I deem appropriate for your treatment. We will work together to formulate your treatment plan and review this on a regular basis to assure that we are working toward your goals.

Confidentiality
The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person or dependent adult who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a disclosure is required by law.
7. If a court of law issues a legitimate subpoena for information stated on the subpoena.
8. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature	Print Name	Date
Signature	Print Name	Date

Barbara Freie, MA, LMFT #102618

NOTICE OF PRIVACY PRACTICES

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:
I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes,

among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
   a. For my use in treating you.
   b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
   c. For my use in defending myself in legal proceedings instituted by you.
   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
   e. Required by law and the use or disclosure is limited to the requirements of such law.
   f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
   g. Required by a coroner who is performing duties authorized by law.
   h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made.You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment,

payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on October 13, 2017

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature Print Name Date

Signature Print Name Date

Barbara Freie, MA, LMFT #102618

OFFICE POLICIES

APPOINTMENTS AND CANCELLATIONS

A scheduled appointment means that time is reserved only for you. The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist in order for time to be scheduled in advance. Maximum benefit will occur with consistent attendance. Please cancel or reschedule 24 hours in advance. If an appointment is missed or cancelled with less than twenty-four (24) hours notice, you will be billed according to the scheduled fee or if applicable, according to the rules of the patient's health plan. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time. Many health plans do not allow a provider to bill for a missed session, so you will be responsible for payment of the full session fee.

PAYMENT is due at the beginning of every session, unless other arrangements are made, my fee is $_____ per 50 minute session. A $30.00 service charge will be charged for any checks returned for any reason for special handling. Cancellations and re-scheduled sessions will be subject to a full charge if NOT RECEIVED AT LEAST **24 HOURS IN ADVANCE.**

DELINQUENT ACCOUNTS

If your account becomes delinquent (past 30 days) our office may begin collection procedures. We will attempt to contact you directly. However, if your account remains delinquent, we may utilize the services of an outside collection agency, we may retain an attorney, or small claims court action may be taken. In order to avoid this complication, please submit credit card number and authorization to charge for any session not paid at the time of service.

Credit Card Number_____

Expiration Date_____

Three Digit Identifier_____

Signature_____

TELEPHONE ACCESSIBILITY

If you need to contact me between sessions, please text me or leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that face-to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone or video sessions are available. Telephone calls exceeding 10 minutes will be billed on a pro rata basis based on your 50 minute session fee. At your request and with your written authorization, I may

communicate with people other than you. If any of these calls exceed 10 minutes, you will be billed on a pro rata basis based on your 50 minute session fee. Insurance companies will not be billed for telephone time, unless prior authorization is obtained. If a true emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it. I do not share contacts with any email or social media sites, and request that you also do not share my name as a contact as this may compromise your confidentiality. I cannot be responsible for a loss of confidentiality if you have chosen to share my contact information with your social media site.

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

(1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
(2) All existing confidentiality protections are equally applicable.
(3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.
(4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.
(5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective

therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client.

Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences.

When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

MINORS

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

COUPLES

If I am treating you as part of a couple, both of you need to sign this agreement. Please see the separate "No Secrets" policy document.

CONTACT INFORMATION CHANGES

Please advise me if you change your address, telephone, email, place of employment or insurance coverage. Please advise me of any change in your emergency contact information as well.

LITIGATION CHARGES

If I am required to attend a deposition, hearing or other legal proceeding in the capacity of your current or past therapist, you will be billed at $ 250.00 per hour for my time, including preparation, travel time, and time at the hearing. If you are a current or past client, my testimony will not include any forensic opinions.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the

length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if

- I determine that the psychotherapy is not being effectively used
- I do not believe that I can provide you with effective treatment
- Your needs are outside the scope of my experience or training
- You desire to terminate treatment or we mutually agree it is time to terminate treatment
- You fail to comply with my treatment recommendations
- A conflict of interest develops
- You fail to pay my fee on a timely basis
- You or I believe it is in your best interest
- You are in default on payment.

I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If either you or I decide to terminate therapy services, I will recommend at least one closure session. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature Print Name Date

Signature Print Name Date