Rachael Hatton, MA, Marriage and Family Therapist #79992
197 Woodland Pkwy, Suite 104 #1018 San Marcos, CA 92069 - Phone: 858-703-7620

CLIENT INFORMATION DATE: _____

Name _____ Sex _____ Age _____

Address _____

City _____ CA, Zip _____

Cell # _____ Home #_____ Email _____

Birth Date _____Marital Status _____ Spouse/Partner Name _____

Employer or School Attending _____

Occupation/Grade Level _____ Length of Employment/In School _____

COMMUNICATION PREFERENCES

(Please circle Yes or No for each item below)

May I leave a voicemail on your home phone? Yes No May I leave a voicemail on your cell phone? Yes No

May I text your cell? Yes No May I mail items to your home address? Yes No May I email you? Yes No

INSURANCE INFORMATION

Insurance _____

Name of Insured _____ ***DOB*** _____

ID Number _____ Group Number _____

Provider Phone Number (look on back of card) _____

EMERGENCY CONTACTS

Name _____

Address _____

Phone _____ Relationship _____

MEDICAL HISTORY

Psychiatrist _____ Phone _____

Diagnosis _____

Current medications (psychiatric) _____

Prior psychotherapy _____

Primary Care Physician _____ Phone _____

Date of last physical exam _____

List any current medical problems _____

Current medications (medical) _____

Medication allergies or other serious allergies _____

RISK HISTORY

(Please mark yes or no for each item)

Drug or alcohol abuse? _____ Eating disorder? _____ Abuse victim? _____

Domestic violence victim or witness? _____ Suicidal thoughts? _____ Panic attacks? _____

Legal issues? _____

OTHER MEMBERS OF THE HOUSEHOLD

Name	Relationship	Age

Where did you hear about my practice?

_____

If you were referred, may I thank that person? _____ YES _____ NO

Signature of Client or Representative date

Signature of Client or Representative date

RELEASE OF INFORMATION

I authorize the release of any medical or other information necessary to process insurance claims or obtain additional/continued authorization for services. I understand that this release includes billing and clerical personnel who are also under legal obligation to maintain confidentiality.

SIGNATURE _____

SIGNATURE _____

Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have provided for you in paper or electronic form. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice by contacting me at 197 Woodland Pkwy, Suite 104 #1018 San Marcos, CA 92069 or view and download a copy on my website at www.rhattontherapy.com. If you have any questions about my *Notice of Privacy Practices*, please contact me at: 858-703-7620.

SIGNATURE _____

SIGNATURE _____

Date _____

AGREEMENT FOR SERVICE / INFORMED CONSENT

Introduction

This Agreement is intended to provide _____
[name of patient(s)]
(herein "Patient") with important information regarding the practices, policies and procedures of Rachael Hatton, Marriage and Family Therapist (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Therapist's Background and Qualifications

Rachael Hatton is a Licensed Marriage and Family Therapist. Therapist has a Master's degree in Human Development and Family Studies with an emphasis in Marriage and Family Therapy from the University of Connecticut and a bachelor's degree in Psychology from the University of California San Diego.

Therapist's theoretical orientation can be described as Cognitive Behavioral. Cognitive Behavioral Therapy explores the relationship between thoughts, behaviors and feelings and the impact they have on our lives. Cognitive Behavioral Therapy can help one change negative thinking and behavior patterns so greater happiness, productivity and intimacy can be experienced. Therapist has experience working with families, couples, and individual children, adolescents, and adults.

Confidentiality

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another. If there is an emergency during Therapist and Patient's work together, where Therapist becomes concerned about Patient's personal safety, the possibility of Patient injuring self of someone else, or about Patient receiving proper psychiatric care, Therapist will do whatever she can, within the limits of the law, to prevent Patient from injuring self or others and ensure that Patient receive the proper medical care. For this purpose, Therapist may also contact the person whose name has been provided on the intake paperwork as emergency contact. **Initial** _____ _____

Additionally, in couple or family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Patient should also be aware that e-mail and cell phone communication can be easily accessed by unauthorized persons and hence, the privacy and confidentiality of such communication can be 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 though them. Faxes can easily be sent erroneously to the wrong number. Please notify Therapist at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail of faxes for emergencies.

Risks and benefits of Therapy

Psychotherapy is a process in which Therapist and Patient, and sometimes other family members, discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his/her life more fully. It provides and opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also

require substantial effort on the part of Patient, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge the perceptions and assumptions of the Patient or other family members, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient.

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Length of treatment can be affected by many variables. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical and legal consultation with supervisor and other appropriate professionals. During such consultation, Therapist will not reveal any personally identifying information regarding Patient or Patient's family members or caregivers.

Records and Record Keeping

Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. Theses notes constitute Therapist's clinical and business record, which by law, Therapist is required to maintain. Such records are the sole property of Therapist' Supervisor. Therapist will not alter his/her normal record keeping process at the request of any patient. Should Patient request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Patient's records for seven years following termination of therapy. However, after seven years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

Patient Litigation

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient, and another individual, or entity, are parties. Therapist has a policy of not communicating with Patient's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such and appearance at Therapist's usual and customary hourly rate.

Psychotherapist-Patient Privilege

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by Patient or Patient's representative. Patient should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

Fee and Fee Arrangements

The usual and customary non-contracted fee for service is $210.00 per 45-50 minute session and $105.00 per 25-30 minute session. The usual and customary non-contracted intake fee is $210.00. Sessions longer than 45-50 minutes are charged for the additional time pro rata. The usual and customary non-contracted fee for groups is $50.00 per session. The agreed upon fee between Therapist and Patient/Financially Responsible Party for individual, couple, or family therapy is $210.00 and $50.00 for group therapy. Therapist reserves the right to periodically adjust this fee. Patient/Financially Responsible Party will be notified of any fee adjustment in advance.

From time-to-time, Therapist may engage in telephone contact with Patient for purposes other than scheduling sessions. Patient/Financially Responsible Party is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. Also, from time-to-time, Therapist may engage in telephone contact with third parties at the request of Patient and with the advance written authorization of Patient. Patient/Financially Responsible Party is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. Additionally, Patient/Financially Responsible Party is responsible for payment of the agreed upon fee (on a pro rata basis) for any letters and/or other paperwork or documentation to be filled out and provided by Therapist on Patient's behalf. Patient/Financially Responsible Party is expected to pay for services at the time services are rendered. Therapist accepts credit or debit card only. In the event that it is agreed upon to receive payment via personal check, Patient/Financially Responsible Party will be responsible for any returned check fees in the amount of $28 for each returned check.

For Patients who are not using insurance and are self-pay, a good faith estimate is available upon written request.
Initial _____ _____

Insurance

Currently therapist is not a contracted provider with any insurance company or managed care organization. Should Patient choose to use his/her insurance, Therapist will submit claims to insurance as a courtesy so that patient may be reimbursed. Therapist cannot guarantee that services will be covered. **Co-payments are not accepted. Full payment is due at time of service and may be made by cash, money order, or check.**
Initial _____ _____

Cancellation Policy

Since scheduling of an appointment involves the reservation of time specifically for Patient, a minimum of 24 business hours (1 business day) notice is required for rescheduling or canceling an appointment without being charged therapist's full fee for intended session. Patient is responsible for payment for any missed sessions(s) for which Patient failed to give Therapist at least 24 business hours notice of cancellation. Cancellation notice should be left on Therapist's voice mail at 858-703-7620 or email at rachael.hatton@rhattontherapy.com.
Initial _____ _____

Therapist Availability

Therapist's office is equipped with a confidential voice mail system that allows Patient to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day M-F), unless it is a holiday or if she is out of town. Therapist is unable to provide 24-hour crisis service and cannot guarantee that calls will be returned immediately. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, Patient should call 911, or the axis and crisis line at 1-800-479-3339, or go to the nearest emergency room.

San Diego County Department of Mental Health (24 Hour Crisis Line) 1-800-479-3339

Termination of Therapy

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist's scope of competence or practice, or

Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in a least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient.

If Therapist does not have contact or communication from Patient for a period of 60 days it will be assumed that Patient no longer intends to remain active in therapeutic relationship, and Patient's case will be closed. Patient understands that they can return to therapy in the future by contacting therapist if they decide they would like to resume therapy

Acknowledgement

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient agrees to hold Therapist free and harmless for any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Patient also acknowledges that although Therapist shares office space with other independent mental health professionals, therapist's records are maintained separately and those sharing office space have no access to Patient's records. Patient also gives permission for Therapist to contact Financially Responsible Party (if different for Patient) regarding finances including dates of services and amount owed.

Patient Name (please print)

Signature of Patient (or authorized representative) date

Patient Name (please print)

Signature of Patient (or authorized representative) date

I understand that I am financially responsible to Therapist for all charges including unpaid charges by my insurance company or any third party payer. I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED AN ELECTRONIC OR PAPER COPY OF THIS DOCUMENT.

Name of Financially Responsible Party and relationship to Patient (Please print)

(Address & Phone number of Financially Responsible Party if different from Patient)

Signature of Responsible Party date