**KAREN PFEIFFER, MA LMFT**
Licensed Marriage and Family Therapist MFC #50164
155 Granada Street, Suite O, Camarillo, CA 93010
PH: (805) 418-0018 FAX: (805) 830-1560

# PATIENT INFORMATION

***(PLEASE PRINT)*** **Date: _____**

Patient Name: _____ Patient Name:_____

Address: _____ Address:_____

City: _____Zip:_____ City: _____Zip:_____

Home Phone: (_____) _____ Home Phone: (_____) _____

Cell Phone: (_____) _____ Cell Phone: (_____) _____

Age:_____ D/O/B: ____/_____/_____ Gender: M / F Age:_____ D/O/B: _____/_____/_____ Gender: M / F

Social Security #:_____ Social Security #:_____

Driver's License #:_____ State: _____ Driver's License #:_____ State: _____

Occupation:_____ Occupation:_____

Work Phone: (_____) _____ Work Phone: (_____) _____

Physician: _____ Physician:_____

Physician Phone: (____) _____ Physician Phone: (____) _____

Date of Last Physical: ___/___/____ Date of Last Physical: ___/___/____

Major Illness: _____ Major Illness: _____

**EMERGENCY CONTACT:**

Name:_____Phone :(_____) _____

Address:_____Relationship:_____

**MARITAL STATUS:** (check one) ___ Single ___ Married ___ Separated ___ Divorced
___ Widowed ___ Cohabitating ___ Remarried

**HOUSEHOLD AND FAMILY MEMBERS:** **ADULT (A) CHILDREN (C) OR STEPCHILDREN (S)** (indicated by A, C or S)

| Name: | Age: | A/C/S: | Live-in/out? | Name: | Age: | A/C/S: | Live-in/out? |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**REFERRED BY:**

Name:_____Phone: (_____)_____

__ Patient __ Internet Search __ Friend/Family __ Doctor/Provider __ Web page __ Other_____

**PREVIOUS THERAPY:** __ Individual __ Couple __ Family __ Group __ Inpatient __ Outpatient
__ MFT __ Psychologist __ Psychiatrist __ MSW __ Other_____

Name of Provider:_____ How Long? _____

For What?_____ Outcome?_____

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**MEDICATION:** List all medication you or significant others are currently taking.

| Medication and Dosage: | Prescribed For: | Prescribed & Supervised By: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**CURRENT CONCERNS & GOALS:** List your reasons for counseling at this time.

1. _____
2. _____
3. _____

**INDICATE EACH OF THE STRESSORS YOU OR OTHERS HAVE EXPERIENCED DURING THE LAST SIX MONTHS:**
**Use:** √ for Child **X** for: _____ □ for: _____

| | | |
|---|---|---|
| __ Loss of job | __ Involved in a lawsuit | __ Incarceration or conviction |
| __ Hospitalization | __ Alcohol or drug problems | __ Major accident, injury or illness |
| __ School Problems | __ Feelings of worthlessness | __ Self-control problems, including anger |
| __ Pregnancy | __ Arrest or pending charges | __ Significant weight loss or gain |
| __ Retirement | __ Panic or anxiety attacks | __ Death of close family member |
| __ Suicidal thoughts | __ Death of close friend | __ Domestic Violence |
| __ Sexual difficulties | __ Financial difficulties | __ Significant changes in memory or attention |
| __ Traumatic event | __ Suicide attempt(s) | __ Abuse-Physical/Emotional/Neglect |
| __ New family member | __ Loss of home | __ Other _____ |

| | | | |
|---|---|---|---|
| Major Change: | __ Empty nest | __ Moved | __ _____ |
| Major Change in: | __ Eating habits | __ Sleeping habits | __ Exercise habits |
| Major Change in: | __ Social activities | __ Family responsibilities | __ Work responsibilities |

**INCOME:**
The **amount** of my (mark one): __ single income __ combined family income **per month**, before taxes is:

| | | |
|---|---|---|
| __ under $2,500 | __ $3,000-$3,500 | __ $4,000-$5,000 |
| __ $2,500-$3,000 | __ $3,500-$4,000 | __ Over $5,000 |

***Please Note:*** If you are the legal representative of the patient(s) listed above, please check off the basis for your authority:

__ Power of Attorney (attach copy) __ Legal Guardianship Order (attach copy)
__ Parent of Minor __ Other: _____

**Note:(If there is a court ordered arrangement you must provide the most recent copy of the court order granting your legal custody of the minor child)*

***I HAVE ANSWERED THESE QUESTIONS TO THE BEST OF MY KNOWLEDGE.***

_____ _____
**SIGNATURE** ***(Parent if Client is under 18 years of age)*** **DATE**

_____ _____
**SIGNATURE** ***(Parent if Client is under 18 years of age)*** **DATE**

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# INSURED/INSURANCE INFORMATION

**(*Please present insurance card*)**

## PRIMARY INSURANCE:

Name of Insurance Company:_____Phone:_____

Address: _____ City: _____ Zip: _____

Plan or Policy #: _____ Certificate #: _____ Individual ID #: _____

Authorization No#:_____

This policy covers: __ psychotherapy __ group psychotherapy __ psychological testing

Name of insured if different from patient:_____

Insured Date of Birth: _____/_____/_____ Gender: ___ Female ___ Male

Relationship to client: ___ Self ___Spouse __ Parent __ Legal Guardian ___ Other:_____

## SECONDARY INSURANCE:

Name of Insurance Company:_____Phone:_____

Address: _____ City: _____ Zip: _____

Plan or Policy #: _____ Certificate #: _____ Individual ID #: _____

Authorization No#:_____

This policy covers: __ psychotherapy __ group psychotherapy __ psychological testing

Name of insured if different from patient:_____

Insured Date of Birth: _____/_____/_____ Gender: ___ Female ___ Male

Relationship to client: ___ Self ___Spouse __ Parent __ Legal Guardian ___ Other:_____

***Please Note:*** It is the Patient's responsibility to confirm their own benefits. Information regarding benefits/reimbursement conveyed by our office to you is subject to change dependant on your specific policy.

***Patient's or Authorized Person's Signature:*** I authorize the release of any medical or other information necessary to process claims/billing operations. I authorize payment of medical benefits to be the undersigned physician or supplier for services described on claims.

Signature: _____ Date: ___/___/_____

Signature: _____ Date: ___/___/____

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# AGREEMENT FOR SERVICES/ INFORMED CONSENT

**Introduction:** This Agreement is intended to provide [name of patient]_____ (herein "Patient") with important information regarding the practices, policies and procedures of *Karen Pfeiffer, MA LMFT* (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 Background and Qualifications**: Therapist (Karen *Pfeiffer, MA LMFT)* is a Licensed Marriage and Family Therapist who holds both a Bachelor's and Master's degree in Psychology. Therapist has worked in the field of psychology and behavioral change for over 13 years. Therapist utilizes a multimodal approach including- Play Therapy and Art Therapy, Family Systems, Solutions Focus Therapy, Prolonged Exposure Therapy, Positive Psychology, and Cognitive Behavioral Therapy in her therapy practice. Therapist works with children, adolescents, couples, families, and individual adults. Therapist treats a variety of issues, including but not limited to depression, anxiety, grief and loss, trauma, abuse, parenting issues, and other behavioral issues, and relationship problems within couple and family relationship.

**Nature and Course of Treatment:** Therapy is a collaborative effort between the patient and the therapist. During the initial evaluation period, the patient and therapist will work together to the clarity the primary treatment issues and to develop a treatment plan. The treatment plan may include attending support groups or accessing other community resources, reading selected materials, completing specific written or verbal assignments and/or getting a medical evaluation. Throughout the course of therapy, the patient is expected to follow the treatment plan, attend sessions regularly, and to abstain from all non-prescription mood-altering substances. The course of therapy will depend upon the selected treatment goals and duration will be decided collaborative between the patient and the therapist.

**Risks and Benefits of Participation:** Therapy is designed to be helpful and to effect positive changes; however, there is no guaranteed outcome and that the treatment may at times be difficult and uncomfortable. 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. 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 appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Patient.

**Records and Record Keeping:** Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. 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 ten years following termination of therapy. However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

**Confidentiality:** The information disclosed by Patient is *confidential* and will not be released to any third party without written authorization from Patient, except where required or permitted by law as a mandated reporter. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse (physical, emotional and neglect), 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.

**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 herself available for such an appearance at Therapist's usual and customary hourly rate of *$100.00.*

**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 received 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.

**Treatment of a Minor and Families:** While parent/legal guardians have the legal right to information regarding their child's (anyone under the age of 18) treatment, it is recommended that certain aspects of the Therapist-Patient communication remain confidential in order to enhance the therapeutic effectiveness. However this will be collaboratively determined between the minor, their parent(s)/ legal guardians and the therapist. Parent(s)/ legal guardians will be informed if a minor poses a danger to self or others. Furthermore parent(s)/ legal guardians are strongly encouraged to participate in the therapeutic process by ensuring attendance by the minor, presenting therapy as a positive experience, and by adhering to the mutually agreed upon confidentiality guideline. If a family is in treatment, limits of confidentially will be established collaboratively except when reporting laws of child/adult dependent/elder abuse, danger to self or others, or treatment emergency laws apply. Please provide copies of all court documents. (i.e.: Custody Orders, Restraining Orders, etc.)

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**Fee and Fee Arrangements:** The usual and customary fee for service is _____ per 50-minute session. Sessions longer than 50-minutes are charged for the additional time pro rata to the next half hour. Therapist reserves the right to periodically adjust this fee. Patient will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with Therapist.

The agreed upon fee between Therapist and Patient is _____. Therapist reserves the right to periodically adjust fee. Patient will be notified of any fee adjustment in advance.

From time-to-time, Therapist may engage in *telephone/email* contact with Patient for purposes other than scheduling sessions. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls/emails longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at Patient's request and with Patient's advance written authorization (case management services, i.e.: link services on behalf of patient). Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls /emails longer than ten minutes.

Patients are expected to pay for services at the time services are rendered. Therapist accepts cash, checks, and major credit cards. Session rate will increase 4% when using your credit card for payment. A *$30.00 fee* for each NSF check plus the amount owed for the service(s) will be due and payable prior to the next scheduled visit in cash or money order/cashier's check. In addition, Therapist reserves the right to revoke the Patients privilege to write another check to pay for services.

**Insurance:** Patient is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. Patient is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles.

Therapist is a contracted provider with the following companies: United Behavioral Health-Tricare, and has agreed to a specified fee. If Patient intends to use benefits of his/her health insurance policy, Patient agrees to inform Therapist in advance. ***Patient is responsible for balances due of what insurance does not pay.***

**Release of Information to a Health Plan:** If the Patient is participating in a Health Plan, certain information may be required for reimbursement. This information may include: diagnosis, expected course of treatment and treatment goals. If the Patient has any questions or concerns regarding specific information transmitted to a Health Plan, the Patient should discuss this with the Therapist. Therapist may use secure electronic methods (billing services/email/FAX) to communicate with your insurance company. While Therapist make every effort in office to protect your privacy by using secure programs, email, and FAX cover sheets, Therapist are not responsible for any problems that occur once information has left our office. If this creates issues for you, please discuss alternatives with your Therapist. The Patient will receive a copy of "Notice of Privacy Practices" as defined by the Health Insurance Portability and Accountability Act (HIPPA) regulations of 1996, effective since April 14, 2003. Therapist will adhere to HIPAA policies practices.

**Cancellation Policy**: Patient is responsible for payment of the agreed upon fee for any missed session(s). Patient is also responsible for payment of the agreed upon fee for any session(s) for which Patient failed to give Therapist at least ***24 hours*** notice of cancellation. Cancellation notice should be left on Therapist's voice mail at ***(805) 418-0080***.

If an appointment is cancelled with less than ***24 hours*** notice, the Patient may be required to pay a ***$50.00*** rescheduling fee. Frequent cancellations and/or missed appointment may result in the termination of treatment.

**Therapist Availability/Emergency:** 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), but cannot guarantee the calls will be returned immediately. If an emergency situation arises, please state this when you leave your message and I will return your call as soon as possible. Therapist is unable to provide *24 hour* crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance (Emergency), he/she should call 911, or go to the nearest emergency room.

**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 at 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.

**Appeals and Grievances:** The Patient has the right to request reconsideration ("appeal") in the case that outpatient care (number of sessions) is not authorized. The Patient can request an appeal through the health plan, at no risk to the Patient. If the Patient has a complaint (grievances) at any time about any aspect of treatment, the Patient has the right to submit a grievance directly to the Patient's *Health Plan* and/or *California Board of Behavioral Science*. However, the Patient is encouraged to first approach the Therapist with concerns.

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**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.

**Consent for Treatment:**

Patient herby authorize the Therapist (*Karen Pfeiffer, MA LMFT*) to carry out psychological examinations, diagnostic procedures and/or treatment, which now or during the course of my care as a patient are advisable.

I understand that the purpose of any procedure will be explained to me and be subject to my agreement.

I have read and fully understood this *Agreement of Services-Informed Consent*.

---

_____ _____

***Patient Name (please print)*** ***Patient Name (please print)***

_____ _____

***Signature of Patient (or authorized representative)*** ***Signature of Patient (or authorized representative)***

_____ _____

***Date:*** ***Date:***

---

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

_____

***Name of Responsible Party (Please print)***

_____ _____

***Signature of Responsible Party*** ***Date***

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# NOTICE OF PRIVACY PRACTICES

**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**.
Mental health records have always been protected by strict confidentiality laws. Effective *4/14/03*, The Federal Government's Health Insurance Portability and Accountability Act (HIPAA) has further clarified and protected your rights of privacy and access to your Patient Health Information (PHI). This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

In order to prevent delay of provision of health care, HIPAA privacy laws now permit the disclosure of PHI (includes health history, test results, condition(s), and treatment) for the routine purpose of treatment, payment and healthcare operations. However, psychotherapy/process notes now qualify for higher protection status and are excluded from and segregated from the standard medical and billing records. Therefore, your very private conversations with your provider (therapist) will not be included in any record transfer. Additionally, this office will attempt to notify you any request for your records, even from your own primary care physician, in order to provide maximum privacy, and to allow you an opportunity to object to any or part of your PHI from being released.

## How we use and disclose your protected health information with your consent:

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization (***Release of Information***) form to allow this.

If you do not want your PHI records to be shared with your *Primary Care Physician*,

Please sign here: _____ _____
***Signature*** ***Date***

**Disclosing your health information without your consent:**
There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to you or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us 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 in a particular way or at a certain place that is more private for you. 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 can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records, upon written request. You may be given access within 5 days, or 10 days if we opt to provide a summary of the PHI, and 15 days if copies are to be transmitted. You can get a copy of these records, but we may charge you for it. Access to certain parts of PHI may be denied if it is determined that disclosure may cause substantial harm to patient.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this. If we change this notice, we will notify you in writing if privacy policies change.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services, Attn: Office of Civil Rights, 50 United Nations Plaza, Room 322, San Francisco, CA 94103, Tel: (415) 437-8310. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

If you have any questions regarding this notice or our health information privacy policies, please contact *Karen Pfeiffer, MA LMFT*, can be reached by phone at (805) 418-0080 or by email at ***karenpfeiffermft@gmail.com.***

**The effective date of this notice is _____.**

-OFFICE FILE-

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**ACKNOWLEDGEMENT:**

Federal law requires that all patients be given a copy of the California Notice Form (Notice of Privacy Practices). The Notice describes in detail how patient health information is used and shared with others. All reasonable efforts will be made to protect the privacy of patient health information, whether it is maintained on paper or electronically, regardless of how it is communicated.

I hereby acknowledge that I received that California Notice Form (Notice of Privacy Practices).

Name (Print):_____

Signature: _____

Date: _____ Date of Birth: _____

Name (Print):_____

Signature: _____

Date: _____ Date of Birth: _____

When the Patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Name (Print):_____

Signature: _____

Date: _____ Date of Birth: _____

Relationship to Patient: _____

Name (Print):_____

Signature: _____

Date: _____ Date of Birth: _____

Relationship to Patient: _____

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# INTAKE ASSESSMENT

**GENERAL:** Date: _____

Patient Name: _____ Patient Name:_____

Address: _____ Address:_____

City: _____Zip:_____ City: _____Zip:_____

Home Phone: (_____) _____ Home Phone: (_____) _____

Cell Phone: (_____) _____ Cell Phone: (_____) _____

Age:_____ D/O/B: ____/_____/_____ Gender: M / F Age:_____ D/O/B: _____/_____/_____ Gender: M / F

Occupation:_____ Occupation:_____

Education: _____ Grade: _____ Education: _____ Grade: _____

**MARITAL STATUS** (check one): __ Single __ Married __ Separated __ Divorced
__ Widowed __ Cohabitating __ Remarried

**HOUSEHOLD AND FAMILY MEMBERS:** **ADULT (A) CHILDREN (C) OR STEPCHILDREN (S)** (indicated by A, C or S)

| Name | Age | A/C/S | Live-in/out | Name | Age | A/C/S | Live-in/out |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

---

**THERAPY AREAS OF CONCERN:**

What issues/concerns prompted you to seek therapy? (Please describe): _____

_____

_____

_____

Do you have any specific goals, if you have identified any, would you like to achieve with therapy? _____

_____

_____

Do you have any particular concerns/fears with regards to therapy? _____

_____

_____

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Have you experienced any changes in any of the following? *Please mark each that apply and note when the change began.*

__ Appetite/Eating Behavior _____
__ Weight Gain or Loss _____
__ Sleep/Insonia/Parsomina_____
__ Sexual Drive/Behavior _____
__ Physical Energy/Behavior _____
__ Sadness/Crying _____
__ Mood Swings _____
__ Current or history or Self-abuse (cutting,) _____

## PSYCHOLOGICAL HISTORY:

Have you ever received mental health services and/or therapy? __ Yes __ No

When and for how long? _____

What was the focus of treatment? _____

_____

Name of treating provider(s), address (es), and telephone number(s): _____

_____
(***Note: Patient will have to authorize for release of information if any former provider(s) may be contacted***.)

Have you ever been subjected to one or more psychological tests? __ Yes __ No

If so, by whom? _____
***(Note: Patient will have to authorize for release of information if any former provider(s) may be contacted.)***

Have you ever been hospitalized for mental and/or emotional problems? __ Yes __ No

When and for how long? _____

Why were you hospitalized? _____

_____

What, if any, medications are you currently taking for a mental or emotional condition? _____

_____

Since when? _____

Have you ever attempted suicide? __ Yes __ No

When? _____

_____

Please describe the circumstances that led to that attempt. _____

_____

Are you currently having any suicidal thoughts? If so, please describe. _____

_____

_____

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Were you ever a victim or perpetrator or witness of verbal, physical, emotional, neglect, sexual abuse? __ Yes __ No

I was the: __ Victim __ Perpetrator

Please identify which and identify by whom and to whom, identify when this occurred, and describe. _____

_____

_____

Have you ever been a victim of a violent crime (deaths, domestic violence, suicide, assault, rape, violence, accident, war, molestation, etc.)

Please describe. _____

_____

**LEGAL HISTORY**:

Do you have any history of arrest and/or convictions? __ Yes __ No How about family members? __ Yes __ No

Please describe. _____

_____

Are you now or have you ever been involved in a lawsuit? __ Yes __ No

Please describe. _____

_____

**MEDICAL HISTORY:**

Physician Name: _____ Date of last physical: _____/_____/_____

Have you ever been diagnosed with a serious illness? __ Yes __ No

Please describe. _____

_____

Do you have any medical conditions that may affect your mental health treatment? __ Yes __ No

Please describe. _____

_____

Please describe your overall health today and rate it on a scale of 1 to 10, with 10 being best. Rate: _____

Please describe. _____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional or stress-related condition? __ Yes __ No

If yes, please describe _____

_____

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Have you ever been in a 12-step program? __ Yes __ No

If yes, please describe _____

_____

Do you smoke? __ Yes __ No How much? _____ For how long? _____

Do you drink alcohol? __ Yes __ No How much? _____ For how long? _____

On average, how much alcohol do you consume in a week? _____

Current drug use (legal/illegal), (type, frequency, quantity, duration) Please describe.

_____

_____

Family history of alcohol/ drug use/abuse: __ Yes __ No

Whom: _____ Type: _____

Whom: _____ Type: _____

History/current gambling or spending issues- self and/or family: __ Yes __ No

Whom: _____ Type: _____

Whom: _____ Type: _____

History/current sexual issues (sex addiction, pornography, otherwise) self and/or family: __ Yes __ No

Whom: _____ Type: _____

Whom: _____ Type: _____

History/current eating disorder issues (anorexia, bulimia, overeating, etc.) self and/or family: __ Yes __ No

Whom: _____ Type: _____

Whom: _____ Type: _____

Rate the following on a scale of 1 to 10 with 1 being the lowest level and 10 being the highest level:

- Daily level of worry and anxiety: _____
  - Has it increased or decreased over the past year. ___ Increased ___ decreased
- Daily level of fear/panic: _____
  - Has it increased or decreased over the past year. ___ Increased ___ decreased
- Daily level of anger/rage: _____
  - Has it increased or decreased over the past year. ___ Increased ___ decreased
- Daily level of sadness/depression: _____
  - Has it increased or decreased over the past year. ___ Increased ___ decreased
- Coping skills/strategies _____
  - Has it increased or decreased over the past year. ___ Increased ___ decreased

**KAREN PFEIFFER, MA LMFT**
Licensed Marriage and Family Therapist MFC #50164
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**YOU AND YOUR FAMILY HISTORY:**

List history of relationships/marriage(s), duration and reason for relationship ending, if known: _____

_____

Parenting issues? _____

What do you consider to be your strengths and positive qualities? _____

_____

_____

What do you consider to be your weaknesses and areas you would like to work on? _____

_____

_____

Current work satisfied and/or unsatisfied? _____

_____

Financial Support/Economic Challenges? _____

_____

Community/Group(s)/Clubs? _____

_____

Spiritual identify/orientation? _____

Please list any interest(s)/ hobbies (s)? _____

_____

_____

What are the three (3) happiest times in your life?

1. _____
2. _____
3. _____

What are the three (3) unhappiest times in your life?

1. _____
2. _____
3. _____

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# CREDIT CARD PAYMENT AUTHORIZATION FORM

Sign and complete this form to authorize ***Karen Pfeiffer, MA LMFT*** owned and operated to make payments using debit to your credit card listed below.

By signing this form you give me permission to debit your account for the amount indicated on or after the indicated date. This is permission for a multiple transactions only while you are a client. It does not provide authorization for any additional unrelated debits or credits to your account. Session rate will increase 4% when using your credit card for payment.

**PLEASE COMPLETE THE INFORMATION BELOW:**

I _____ authorize ***Karen Pfeiffer, MA LMFT*** to charge my credit card
(*full name*)

account indicated below for _____ on or after _____. This payment is for
(*amount*) (*date*)

_____.
(*description of goods/services*)

Billing Address: _____ Phone#: _____

City, State, Zip: _____ Email: _____

**Account Type:** (Circle one) Visa Card MasterCard American Express Discover Card

Cardholder Name: _____

Account Number: _____

Expiration Date: _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX): _____

---

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for multiple transaction(s). I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

_____ _____
Signature Date

Print Name: _____

_____ _____
Signature Date

Print Name: _____

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# NOTICE OF PRIVACY PRACTICES

**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**.
Mental health records have always been protected by strict confidentiality laws. Effective *4/14/03*, The Federal Government's Health Insurance Portability and Accountability Act (HIPAA) has further clarified and protected your rights of privacy and access to your Patient Health Information (PHI). This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

In order to prevent delay of provision of health care, HIPAA privacy laws now permit the disclosure of PHI (includes health history, test results, condition(s), and treatment) for the routine purpose of treatment, payment and healthcare operations. However, psychotherapy/process notes now qualify for higher protection status and are excluded from and segregated from the standard medical and billing records. Therefore, your very private conversations with your provider (therapist) will not be included in any record transfer. Additionally, this office will attempt to notify you any request for your records, even from your own primary care physician, in order to provide maximum privacy, and to allow you an opportunity to object to any or part of your PHI from being released.

### How we use and disclose your protected health information with your consent:

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization (***Release of Information***) form to allow this.

If you do not want your PHI records to be shared with your *Primary Care Physician*,

Please sign here: _____ _____
***Signature*** ***Date***

**Disclosing your health information without your consent:**
There are some times when the laws require us to use or share your information. For example:

5. When there is a serious threat to you or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
6. When we are required to do so by lawsuits and other legal or court proceedings.
7. If a law enforcement official requires us to do so.
8. For workers' compensation and similar benefit programs.

**Your rights regarding your health information:**

7. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. 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.
8. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
9. You have the right to look at the health information we have about you, such as your medical and billing records, upon written request. You may be given access within 5 days, or 10 days if we opt to provide a summary of the PHI, and 15 days if copies are to be transmitted. You can get a copy of these records, but we may charge you for it. Access to certain parts of PHI may be denied if it is determined that disclosure may cause substantial harm to patient.
10. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
11. You have the right to a copy of this. If we change this notice, we will notify you in writing if privacy policies change.
12. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services, Attn: Office of Civil Rights, 50 United Nations Plaza, Room 322, San Francisco, CA 94103, Tel: (415) 437-8310. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

If you have any questions regarding this notice or our health information privacy policies, please contact *Karen Pfeiffer, MA LMFT*, can be reached by phone at (805) 418-0080 or by email at ***karenpfeiffermft@gmail.com.***

**The effective date of this notice is _____.**

-PATIENT FILE-