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

CHILD/ADOLESCENT PATIENT INFORMATION

(PLEASE PRINT) **Date: _____**

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

Address: _____ City: _____Zip:_____

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

Occupation: _____ Work Phone: (_____) _____ F/T P/T Temp

School:_____ Grade:_____ Social Security #:_____

Physician: _____ Physician Phone: (____) _____

Date of Last Physical: ___/___/____ Major Illness: _____

EMERGENCY CONTACT:

Name:_____Phone :(_____) _____

Address:_____Relationship:_____

PARENTS 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?_____

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

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

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

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: _____

ACADEMIC:
__ classwork
__ homework
__ test grades
__ inattentiveness
__ anxious in class
__ often absent/tardy
__ constantly in motion
__ Other: _____
__ Other: _____

__ impulsive
__ angry
__ shyness
__ aggressive behavior
__ defiance
__ unhappy; cries often
__ withdrawn
__ poor self-concept
__ Cutting

BEHAVIOR:
__ peer relationships
__ steals; takes things
__ cries often; seems sad
__ lies
__ temper tantrums
__ homeless
__ abuse
__ suicidal Ideation
__ Other: _____

OTHER:
__ grief
__ neglect
__ hygiene
__ worried
__ changes in family
__ always tired
__ chronic illness
__ inappropriate sexual behavior
__ eating disorder

PARENT/GUARDIAN INCOME:

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

__ under $2,500
__ $2,500-$3,000
__ $3,000-$3,500
__ $3,500-$4,000
__ $4,000-$5,000
__ 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)
__ Parent of Minor
__ Legal Guardianship Order (attach copy)
__ 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/Legal Guardian if patient is under 18 years of age)*** **DATE**

_____
Print Name

_____ _____
SIGNATURE ***(Parent/Legal Guardian if patient is under 18 years of age)*** **DATE**

_____
Print Name

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

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: ___/___/____

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

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.)

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

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.

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

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*.

_____ _____

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

_____ _____

Signature (or authorized representative) ***Signature (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***

Relationship to Patient: _____

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

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-

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

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: _____

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

CHILD/ADOLESCENT INTAKE ASSESSMENT

GENERAL: Date: _____

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

Address: _____ City: _____Zip:_____

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

School:_____ Grade:_____ Email: _____

Child lives with: _____

Address: _____ City: _____Zip:_____

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

Ethnicity/Race: __ Caucasian __ African American __ Asian __ Native American __ Hispanic/Latino

__ South Pacific Islander __ Other: _____

Language: __ English __ Spanish __ Other: _____

In probation: __ Yes __ No Probation Officer: _____ Tel: _____

In Foster Care: __ Yes __ No Social Worker: _____ Tel: _____

Does your child/adolescent have a learning disability? __ Yes __ No Please explain: _____

Is the child/adolescent receiving special services: __ RSP __ Speech __ ELD __ GATE __ Other: _____

What presenting behaviors (maladaptive behaviors) does the child/adolescent have that indicates help is needed?

BEHAVIOR	**TIMES OCCURS PER DAY/ PER WEEK**

What do you think is presently causing these behaviors? _____

_____

_____

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

_____

Have you sought help before? __ Yes __ No For what? _____ Date: _____

Is your child/adolescent currently receiving counseling from: __ Yes __ No

If yes, name of therapist or provider: _____ Tel: _____

Address: _____ City: _____ Zip: _____

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

HEALTH HISTORY:

Physicians Name: _____Tel: _____

Do you or your child/adolescent have medical insurance? __ Yes __ No Insurance: _____

Date of child/adolescent last physical exam: ___/____/_____

Is he/she presently taking ANY medication prescribed by a physician? __ Yes __ No

Medication and Dosage:	**Prescribed For:**	**Prescribed & Supervised By:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

If taking medications, does it affect his or her behaviors? __ Yes __ No If yes, please describe _____

_____

_____

Does your child/adolescent have any limitations that could affect his/her activities in the classroom or on the playground?

__ Yes __ No If yes, please describe _____

_____

_____

Does your child/adolescent have any significant illnesses?

__ Yes __ No If yes, please describe _____

_____

_____

Has child/adolescent ever been involved in any of the following? If so, at what age?

__ Head injury	__ Fractures	__ Auto Accident
__ Falls	__ Burns	__ Poison Ingestion
__ Ear Infections	__ Asthma	__ Frequent colds
__ Wear glasses	__ Stomach problems	__ High fevers
__ Convulsions	__ Heart problems	__ Urinary problems
__ Bladder infections	__ Allergies	__ Itching, Sneezing, runny nose
__ Food/medication sensitivity	__ Abuse	__ Molestation
__ Trauma	__ Domestic Violence	__ Other: _____

Please give a short expiation of questions checked yes? _____

_____

_____

_____

_____

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

CHILD/ADOLESCENT PREGNANCY/BIRTH HISTORY:

Was the pregnancy with child planned? __ Yes __ No Length of pregnancy: _____

Prenatal Care: __ Yes __ NoPregnancy: __ Full Term Premature by : _____ weeks

Mother's age at child's birth: ____ Father's age at child's birth: ____

Child number _____ of _____ total children.

Has the child's mother had any occurrences of miscarriage or stillborns? __ Yes __ No

While pregnant, was there any:

Smoking __ Yes __ No Amount: _____

Alcohol __ Yes __ No Amount: _____

Drugs __ Yes __ No Amount: _____

While pregnant, did the mother have any medical or emotional difficulties? (ex: surgery, hypertension, medication) __ Yes __ No

If yes, describe: _____

Length of labor: _____ Induced: __ Yes __ No Caesarian: __ Yes __ No

Baby's birth weight: _____ Lbs. _____ Oz Baby's birth length: _____

Describe any physical or emotional complications with the delivery for mother or baby:

_____

_____

Length of hospitalization: Mother: _____ Baby: _____

INFANCY/TODDLER: (Check all that apply)

__ Breast fed	__ Milk allergies	__ Vomiting	__ Diarrhea
__ Bottle fed	__ Rashes	__ Colic	__ Constipation
__ Not cuddly	__ Cried often	__ Rarely cried	__ Overactive
__ Resisted solid food	__ Trouble sleeping	__ Irritable when awakened	__ Lethargic

DEVELOPMENTAL HISTORY: (please not the age at which the following behaviors took place)

Sat alone: _____	Weaned: _____	Rode two-wheeled bike: _____
Took 1st steps: _____	Fed self: _____	Toilet trained: _____
Spoke words: _____	Dressed self: _____	Dry during day: _____
Spoke sentences: _____	Tied shoes laces: _____	Dry during night: _____

Compared with others in the family, child/adolescent development was: __ Slow __ Average __ Fast

AGE FOR FOLLOWING DEVELOPMENTS (fill in where applicable:)

Began puberty: ____	Breast development: ____	Convulsions: ____
Voice change: ____	Menstruation: ___	Injuries/Hospitalation: _____

SOCIAL/ EMOTIONAL DEVELOPMENT AND CONCERNS

Does your child/adolescent prefer to play: __ Alone __ W/Other Children __ Both

What types of playmates does the child/adolescent prefer? (Circle all that apply)

Older Younger Own Age All Ages Adults Male Female Both Gender

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

When playing with other children/adolescent does your child generally? __ get along well with peers __ engage in conflict with peers

How does child/adolescent spend free time?

_____

_____

What kind of play does child/adolescent enjoy? _____

What special interest, hobbies, skills or sports does the child engage in? _____, _____, _____

_____, _____, _____, _____, _____

Has your child/ adolescent experience any of the following? If so, at what age?

YES:	NO:	AGE:	
			Sleep problems
			Frequent nightmares
			Toileting difficulties
			Excessive fears
			Bed wetting (Frequency: □ daily □ weekly : _____ □ monthly: _____)
			Excessive lying
			Eating problems
			Often showing strain or nervousness
			Nervous habits, ex: □ finger nail biting □ hair twisting □ Other: _____
			Excessively aggressive or submissive
			Excessively shy
			Lack of control of temper
			Experience emotional trauma: □ illness □ divorce □ abuse □ grief and loss

Explain:

_____

_____

_____

PARENTING STATUS:

You are this child/adolescent? __ Biological Parent __ Adoptive Parent __ Foster Parent __ Other: _____

Custody: __ Solo Custody __ Joint Physical __ Joint Legal __ Joint Physical/Legal __ Other: _____

Marital Status of Mother:

__ Married __ Never Married
__ Divorced (date)_____ __ Remarried (date) __
__ Separated (date)____ __ Other: _____

Marital Status of Father:

__ Married __ Never Married
__ Divorced (date)_____ __ Remarried (date) _____
__ Separated (date)_____ __ Other: _____

Family Status at Child/Adolescent Primary Residence:

__ Single Parent __ Extended Family Parenting
__ Step Family __ Blended Family

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

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

Do the siblings get along? __ Yes __ No

If no, explain:_____

_____

_____

How does the child/adolescent feel about the other children in the household? _____

_____

_____

List other people who are living in the same household as the child / relationship and what child calls person?

_____

_____

_____

DISCIPLINE:

How do you discipline your child/adolescent? Circle all that apply

Set and Enforce Rules	Discussion	Lecture	Other Physical Punishment
Spank	Isolate	Denial of Privileges	Other: _____

Who discipline child/adolescent? Circle all that apply

Mother	Father	Both	Other: _____

Parental agreement on discipline? __ Yes __ No

If no, why not?

_____

_____

Child/Adolescent reaction to discipline? Circle all that apply

Cry	Tantrum	Ignore	Walk Off	Pout	Other: _____
Talk Back	Hit	Complain	Yell	Accept	Other: _____

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

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: _____

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

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-