CLIENT INFORMATION

Information contained in this form will not be released to anyone unless authorized by you or required by the law as explained in our consent to treatment. **Please fill out completely**.

Name _____ **Date**_____

Age _____ Male ❑ Female ❑ Cell Phone (_____)_____

Referred By:

- ❑ Friend/Relative
- ❑ Internet/Website
- ❑ Client
- ❑ Staff
- ❑ Church: _____
- ❑ School: _____
- ❑ Other: _____

Office Location
(Circle one): Orange Los Alamitos Brea Costa Mesa Torrance

Name of Therapist _____

PERSONAL DATA (1)

This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in our consent to treatment. Please fill out completely.

Date_____ **Referred By**_____

Client: Name_____ Male ❑ Female ❑

Address_____ City_____ Zip Code_____

Cell Phone (_____)_____ Home Phone (____)_____Work Phone(_____)_____

May we call you at home? Y❑ N❑ At Work? Y❑ N❑ Email: _____

Age _____ Birth date _____ Highest Grade Completed _____

Occupation _____How Long?_____

Ethnicity: Caucasian ❑ African American ❑ Hispanic ❑ Asian ❑ Other ❑ _____

Person to notify in case of emergency_____Relationship_____

Phone number_____

NOTE: *It is important for the client and therapist to determine together what part spiritual/religious issues will or will not take in therapy.* Would you like spirituality/religious issues to be a part of your therapy?

Y❑ N❑ Don't Know❑ Church Affiliation (if any)_____

Are you a missionary or on staff at a church?_____

Are you currently covered by Medicare? Y ❑ N ❑

In your own words, please state the nature of your main problem:

How would you rate how serious this problem feels to you? (Circle one) 1 2 3 4 5
Mildly Upsetting Extremely Serious

What goal(s) would you like to accomplish through counseling?

I agree to be responsible for the payment of $_____per session which is payable at the time of the session.

Client Signature _____

Therapist Initials_____ **(over)**

FAMILY INFORMATION

Marital status: Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow/er ❑ Partner ❑ Dating ❑

Parents: Father: Age_____ Occupation_____ Mother: Age_____ Occupation_____

Did you grow up with both parents in the home? Y ❑ N ❑ If your parents divorced, what age were you? _____

Children: Names and Ages:_____

Are your children living with you? Yes ❑ No ❑

TREATMENT/THERAPY HISTORY

Have you ever had any previous counseling or psychotherapy? Y❑ N❑ If YES, please list from most recent:

PROBLEM	DATES	THERAPIST & LOCATION	Was Therapy Successful?

Have you ever attempted suicide? Y ❑ N ❑ If YES, when? _____

If YES, method used: _____

Were you ever hospitalized for psychiatric reasons? Y❑ N❑ If Yes, when?_____ Length of hospital stay_____

MEDICAL INFORMATION

Height_____ Current Weight_____ One Year Ago_____ Maximum_____ When_____

Do you exercise regularly? Y ❑ N ❑ How?_____

Do you sleep well? Y ❑ N ❑ Amount (hours)_____ Easy to get to sleep? Y ❑ N ❑

Primary Physician_____ City_____ Date of last physical_____

MEDICAL CONDITIONS

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Insomnia	❑	❑	❑	❑
Loss of Appetite	❑	❑	❑	❑
Back Pain	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
Phobias (Fears)	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Nervousness	❑	❑	❑	❑
Loss of temper	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑
Depression	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑
Over-eating	❑	❑	❑	❑
Mood swings	❑	❑	❑	❑
Self-harm Behaviors	❑	❑	❑	❑
Hear/See things that others don't see/hear	❑	❑	❑	❑

OTHER CONCERNS

	NEVER	SELDOM	SOMETIMES	OFTEN
Smoking	❑	❑	❑	❑
• Packs per week_____				
Alcohol Intake	❑	❑	❑	❑
• Frequency (per week):_____				
• How Much? _____				
• What do you drink? _____				
Marijuana	❑	❑	❑	❑
• Amount per week:_____				
Drugs (not medications)	❑	❑	❑	❑
• What? _____				
• Frequency:_____				

MEDICATION HISTORY

	NEVER	SELDOM	SOMETIMES	OFTEN
Appetite Suppressants	❑	❑	❑	❑
Pain Relievers	❑	❑	❑	❑
Sedatives/Tranquilizers	❑	❑	❑	❑
Sleep Aids	❑	❑	❑	❑
Stimulants	❑	❑	❑	❑
Blood Pressure Meds	❑	❑	❑	❑
Heart Medicine	❑	❑	❑	❑
Vitamins	❑	❑	❑	❑

Please list all current medications:

MEDICATION	DOSE	REASON

Comments:

PERSONAL DATA (2)

This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in our consent to treatment. Please fill out completely.

Date_____ **Referred By**_____

Client: Name_____ Male ❑ Female ❑

Address_____ City_____ Zip Code_____

Cell Phone (_____)_____ Home Phone (____)_____Work Phone(_____)_____

May we call you at home? Y❑ N❑ At Work? Y❑ N❑ Email: _____

Age _____ Birth date _____ Highest Grade Completed _____

Occupation _____How Long?_____

Ethnicity: Caucasian ❑ African American ❑ Hispanic ❑ Asian ❑ Other ❑ _____

Person to notify in case of emergency_____Relationship_____

Phone number_____

NOTE: *It is important for the client and therapist to determine together what part spiritual/religious issues will or will not take in therapy.* Would you like spirituality/religious issues to be a part of your therapy?

Y❑ N❑ Don't Know❑ Church Affiliation (if any)_____

Are you a missionary or on staff at a church?_____

Are you currently covered by Medicare? Y ❑ N ❑

In your own words, please state the nature of your main problem:

How would you rate how serious this problem feels to you? (Circle one) 1 2 3 4 5
Mildly Upsetting Extremely Serious

What goal(s) would you like to accomplish through counseling?

I agree to be responsible for the payment of $_____per session which is payable at the time of the session.

Client Signature _____

Therapist Initials_____ **(over)**

FAMILY INFORMATION

Marital status: Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow/er ❑ Partner ❑ Dating ❑

Parents: Father: Age_____ Occupation_____ Mother: Age_____ Occupation_____

Did you grow up with both parents in the home? Y ❑ N ❑ If your parents divorced, what age were you? _____

Children: Names and Ages:_____

Are your children living with you? Yes ❑ No ❑

TREATMENT/THERAPY HISTORY

Have you ever had any previous counseling or psychotherapy? Y❑ N❑ If YES, please list from most recent:

PROBLEM	DATES	THERAPIST & LOCATION	Was Therapy Successful?

Have you ever attempted suicide? Y ❑ N ❑ If YES, when? _____

If YES, method used: _____

Were you ever hospitalized for psychiatric reasons? Y❑ N❑ If Yes, when?_____ Length of hospital stay_____

MEDICAL INFORMATION

Height_____ Current Weight_____ One Year Ago_____ Maximum_____ When_____

Do you exercise regularly? Y ❑ N ❑ How?_____

Do you sleep well? Y ❑ N ❑ Amount (hours)_____ Easy to get to sleep? Y ❑ N ❑

Primary Physician_____ City_____ Date of last physical_____

MEDICAL CONDITIONS

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Insomnia	❑	❑	❑	❑
Loss of Appetite	❑	❑	❑	❑
Back Pain	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
Phobias (Fears)	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Nervousness	❑	❑	❑	❑
Loss of temper	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑
Depression	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑
Over-eating	❑	❑	❑	❑
Mood swings	❑	❑	❑	❑
Self-harm Behaviors	❑	❑	❑	❑
Hear/See things that others don't see/hear	❑	❑	❑	❑

OTHER CONCERNS

	NEVER	SELDOM	SOMETIMES	OFTEN
Smoking	❑	❑	❑	❑
• Packs per week_____				
Alcohol Intake	❑	❑	❑	❑
• Frequency (per week):_____				
• How Much? _____				
• What do you drink? _____				
Marijuana	❑	❑	❑	❑
• Amount per week:_____				
Drugs (not medications)	❑	❑	❑	❑
• What? _____				
• Frequency:_____				

MEDICATION HISTORY

	NEVER	SELDOM	SOMETIMES	OFTEN
Appetite Suppressants	❑	❑	❑	❑
Pain Relievers	❑	❑	❑	❑
Sedatives/Tranquilizers	❑	❑	❑	❑
Sleep Aids	❑	❑	❑	❑
Stimulants	❑	❑	❑	❑
Blood Pressure Meds	❑	❑	❑	❑
Heart Medicine	❑	❑	❑	❑
Vitamins	❑	❑	❑	❑

Please list all current medications:

MEDICATION	DOSE	REASON

Comments:

CONSENT TO INITIAL INTAKE/TREATMENT

Welcome to the Center for Individual & Family Therapy, a Christian counseling center. The following is an agreement to enter into an INITIAL INTAKE/TREATMENT PROCESS.

INITIAL INTAKE SESSION: The first session is an initial intake. It is sometimes necessary to refer you to another CIFT clinician who can better meet your needs. If, for some reason we are not able to help you at CIFT, we will provide referrals to an outside therapist.

APPOINTMENTS: It is your responsibility to notify your therapist at least 48 hours in advance if you are unable to attend your appointment. **Cancellations of appointments less than 48 hours in advance and "no shows" are subject to the full fee charge for the appointment time.**

TELECOMMUNICATION AND EMERGENCY PROCEDURES: Your therapist may offer communication through their CIFT voicemail and email. Emails to your therapist may not include therapeutic content, including information regarding danger to one's self or others. If you choose to contact your therapist via e-mail, or any other electronic means, we cannot guarantee privacy. Your therapist is not available 24 hours a day; in case of emergency, please call 911 or go to the nearest hospital emergency room.

TREATMENT: CIFT therapists approach treatment by employing varying schools of thought including, but not limited to, Cognitive-Behavioral (CBT), Psychodynamic, and Family System therapies. Cognitive-Behavioral therapies look at the interaction of thoughts and behaviors while Psychodynamic therapies explore intra-psychic processes and their interplay with interpersonal relationships. Family System therapies view the family as an emotional unit and examines the feedback loop between each individual in the family and the family as a whole. Although the research suggests that these and other treatment approaches can be helpful, please note that therapy may be a challenging process and no outcome can be guaranteed. You may not feel better or happier and disruptions to relationships may take place. Your therapist is available to discuss these issues, including therapeutic approaches, at any time during your treatment.

PAYMENT & FEES: **Payment is expected for services at the time they are rendered, unless other arrangements have been made.** Services are rendered and charged to the client, not to the insurance company. **Payments are made by credit/debit cards only**. Upon request, your therapist will provide you with a receipt to submit to your insurance company for reimbursement. You may also incur charges for phone calls lasting more than 15 minutes, letters and testing fees. Your fee may be subject to an annual increase. Fees for any extra time required by the therapist for legal proceedings will be charged at a higher rate than session fees. If you do not pay your fee, we are legally permitted to contact a collection agency.

I, the client, agree to be responsible for the payment of $_____per session (45 minutes) which is payable at the time of the session. (credit or debit card only) I understand that I am responsible for full payment, even though I may be reimbursed by my insurance company. This is the entire agreement between the parties and cannot be changed except in writing by both parties.

Client Initials _____

LIMITS ON CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential. Your therapist may not reveal any information to anyone without written permission by all parties, except where disclosure is required by law. Disclosure may be required in the following circumstances: (1) where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; (2) where a client presents a danger to self, to others, or is gravely disabled, and (3) pursuant to a legal proceeding. The law protects the privacy of all communications between a client and a therapist. In most situations, your therapist can only release information about your treatment if you sign a written Authorization Form. **However, your therapist is permitted or required to disclose information without either your consent or authorization under the following circumstances**:

- **CONSULTATION:** Your therapist may seek advice from other professionals. During a consultation, he or she will make every effort to avoid revealing the identity of any client. The other professionals are also legally bound to keep the information confidential. Your therapist may not discuss these consultations with you. All consultations are noted in your Clinical Record.
- **GOVERNMENT AGENCIES:** If a government agency is requesting the information for health oversight activities pursuant to their legal authority, your therapist may be required to provide it to them.
- **LAWSUITS:** If a client files a complaint or lawsuit against his/her therapist, information may be disclosed regarding that client without client consent in order for the therapist to defend himself/herself.

(over)

- **ADMINISTRATIVE STAFF:** Your therapist may need to share protected information with the administrative staff for administrative purposes, such as scheduling, billing, and quality assurance. Staff members have been given training about protecting your privacy and know not to release any information outside of the practice without the direction from a professional staff member.
- **SECURITY POLICY REGARDING ELECTRONIC INFORMATION:** Electronic transmission and storage of confidential information always entails security risks. It is our policy to use it for scheduling purposes only. CIFT follows the Health Information Portability and Privacy Act (HIPPA). CIFT's security officer trains, ensures, and limits appropriate employee access to Electronic Personal Health Information (EPHI). Employees are trained by the security officer in confidentiality protocol, including EPHI. All CIFT-affiliated computers comply with HIPPA standards and are password protected.

PARENTS AND NON-EMANCIPATED MINOR CLIENTS 12 YEARS OF AGE OR OLDER can consent to psychological services subject to the involvement of their parent(s) or guardian(s):

- Unless the therapist determines that parental involvement would be detrimental.
- A client over 12 years of age may independently consent to psychological services if he or she is mature enough to participate in such services, and/or the minor would present a danger to him or herself or others, or is the alleged victim of incest or child abuse.
- Clients over 12 years of age may independently consent to alcohol and drug treatment in some circumstances.
- Non-emancipated patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records, unless the therapist determines that access would have a detrimental effect on the professional relationship with the client, or have a negative effect on his/her physical safety or psychological well-being.
- It is our policy to request an agreement between minors (over 12 years of age) and their parents about access to information. This agreement provides that during treatment the therapist will provide parents with only general information about the progress of the treatment, and a record of client's attendance at scheduled sessions. Therapists will encourage parent participation when appropriate.

PRE-LICENSED THERAPISTS:

I understand that my therapist is a: ❑MFT Trainee ❑MFT Intern ❑Doctoral Student ❑Psych. Assistant and, therefore, is not licensed, but is functioning under supervision. I acknowledge that my treatment will be reviewed and supervised weekly by a licensed supervisor. I understand that the primary supervisor has full access to treatment records. I have received the business card of my therapist, with the supervisor's information.

_____ (therapist) working under the direct supervision of

_____ (supervisor), have my permission to audio/video-tape counseling sessions to be used for supervision purposes.

I understand that my sessions will be taped only with my knowledge, will be used only for supervision purposes, and will be erased as soon as this purpose is fulfilled. **Client Initials**_____

TERMINATION OF THERAPY: It is to the client's advantage that a decision to end therapy will be discussed candidly and thoroughly with the therapist in advance of leaving. It is within the client's right to terminate therapy at any time. Whenever your therapist assesses that he/she cannot provide the help you need or that he/she is not effective in helping you, he/she is obligated to discuss the situation with you and will provide a number of referrals within or outside CIFT that you can contact for necessary services.

Your signature below indicates that you have read this agreement and agree to its terms. Please feel free to discuss any concerns you may have with your therapist or our Clinical Director at 714-558-9266.

Client Signature	Client Name (Please Print)	Date
Client Representative Signature	(If Rep., Print Name & Relationship to Client)	Date

NOTICE OF POLICIES AND PRACTICES TO PROTECT

THE PRIVACY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION AS PER THE HEALTH INFORMATION PRIVACY PROTECTION ACT (HIPPA) REQUIREMENTS. PLEASE REVIEW IT CAREFULLY.

I. Disclosures for Payment

A CIFT therapist may use or disclose your protected health information (PHI), for payment without your authorization.

II. Disclosures with Authorization

A therapist may disclose PHI when your appropriate authorization is obtained. When we are asked for information your therapist will obtain an authorization from you before releasing this information. You may revoke or modify all such authorizations (of PHI or psychotherapy notes) at any time; however, the revocation or modification is not effective until we receive it.

III. Uses and Disclosures with Neither Consent nor Authorization

A therapist may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** Whenever a therapist, in his or her professional capacity, has knowledge of or observes a child he or she knows or reasonably suspects has been the victim of child abuse or neglect, he or she must immediately report to CPS. Also, if a therapist has knowledge of or reasonably suspects that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, the therapist may report such to the above agencies.
- **Serious Threat to Health or Safety:** If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.
- **Adult and Domestic Abuse:** If a therapist, in his or her professional capacity, has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult; if a therapist is told by an elder or dependent adult that he or she has experienced these; or if a therapist reasonably suspects such, the therapist must report the known or suspected abuse immediately to the local law enforcement agency.

  A therapist is not required to report such an incident if the therapist has been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect and the therapist is not aware of any independent evidence that corroborates the statement that the abuse has occurred; (a) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservator ship because of a mental illness or dementia; and (b) in the exercise of clinical judgment, the therapist reasonably believes that the abuse did not occur.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services that I have provided you, I cannot release your information without (a)your written authorization or the authorization of your attorney or personal representative; (b)a court order; or (c)a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides me with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified me that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case. If a complaint is filed against a therapist with the California Board of Psychology or the California Board of Behavioral Science, the Board has the authority to subpoena confidential mental health information from the therapist relevant to that complaint
- **Worker's Compensation**: If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of your initial examination, and at subsequent intervals as may be required by the administrator of the Worker's Compensation Commission in order to determine your eligibility.

(over)

IV. Client's Rights and Therapist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request/denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

V. Complaints

- If you are concerned that a therapist has violated your privacy rights, or you disagree with a decision they have made about access to your records, you may contact the Clinical Director at 714-558-9266.
- You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on May 1, 2005. CIFT reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that our therapists maintain. Please feel free to discuss any concerns you may have with your therapist as they arise or contact our Clinical Director at 714-558-9266.

Client Signature	Client Name (Please Print)	Date
Client Representative Signature	(If Rep., Print Name & Relationship to Client)	Date