SUNSET
COUNSELING CENTER
• I N C O R P O R A T E D •

Policies, Information & Informed Consent for Psychotherapy

Please initial below that you have reviewed the following sections of these policies on our website:

______ **CONFIDENTIALITY**
______ **WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW**
______ **EMERGENCY**
______ **HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS:**
______ **LITIGATION LIMITATION**
______ **CONSULTATION**
______ **E–MAILS, CELL PHONES, COMPUTERS, AND FAXES**
______ **RECORDS AND YOUR RIGHT TO REVIEW THEM**
______ **TELEPHONE & EMERGENCY PROCEDURES**
______ **PAYMENTS & INSURANCE REIMBURSEMENT**
______ **MEDIATION & ARBITRATION**
______ **THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE**
______ **TREATMENT PLANS**
______ **TERMINATION**
______ **DUAL RELATIONSHIPS**
______ **MINORS IN THERAPY:**
______ **SOCIAL NETWORKING AND INTERNET SEARCHES**
______ **CANCELLATION POLICY**
______ **HIPAA PRIVACY PRACTICES**

I have read the above Office Policies and General Information, Agreement for Psychotherapy Services or Informed Consent for Psychotherapy carefully; I understand them and agree to comply with them.

Primary Client's Name (print)	**Signature**	**Date**
Other Client's Name (print)	**Signature**	**Date**
Guardians or Parent's Name/Mother (print)	**Signature**	**Date**
Guardians or Parent's Name/Father (print)	**Signature**	**Date**

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Biographical/Demographic Information – Intake Form

Please fill out this biographical background form as completely as possible. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. Please print or write clearly and bring it with you to the first session.

How did you hear about us: ____

Name: ____________________ SS#: _____-____-______ Date of Birth: ___ / ___ / ______ Age:______

Home Address: ___________________________ City: _______________ Zip: ___________

Home Phone: (____) __________ Cell Phone: (____) __________ Work Phone: (____) __________

Can we identify who we are? Yes___ No ___ Voice msg? Yes___ No ___ Txt msg? Yes___ No ___

Can we contact you by email? Yes___ No___ Email Address: ____________________________

Emergency Contact: ___________________ Relation: ____________ Phone: (____) ________

Marital Status: ___________________ Spouses Name: ____________________________

Occupation: ____________________ Employer: _________________________________

Parent/Guardian Name (if minor): ___________________ Custody: Sole Legal ___ Joint Legal ___

School: ___________________ Teacher: __________________ Grade: _______

Highest Grade Completed in School/College: ____

Primary Care Physician: __________________ Phone: (____) ________ Last Seen: ______

Psychiatrist: ___________________________ Phone: (____) ________ Last Seen: ______

Medications currently taking (Name and Dosage): _____________________________________

Reason for seeking therapy: ____

Prior therapy (Name and dates attended) ____

PAST & PRESENT MARRIAGE/S (names, years together, and statement about the nature of the relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile).

____

PRESENT SPOUSE/PARTNER: Education: ____________ Occupation: ______________________________

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person.)

1. ______________________________ 4. ______________________________

2. ______________________________ 5. ______________________________

3. ______________________________ 6. ______________________________

PARENTS/STEPPARENTS (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship.):

Father:____

Mother: ____

Stepparents:____

SIBLINGS (name/age, if deceased: age and cause of death and brief statement about the relationship.):

1. ______________________________ 4. ______________________________

2. ______________________________ 5. ______________________________

3. ______________________________ 6. ______________________________

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness, etc.):

____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

____

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (describe: ages, reasons, circumstances, how, etc.)

____

FAMILY MEDICAL HISTORY (Describe any <u>illness</u> that runs in the family: e.g., cancer, epilepsy, etc):

____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY:

____

DESCRIBE YOUR CHILDHOOD, IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

____

DEVELOPMENTAL MILESTONES (Did you meet all developmental milestones on time? Any trauma/abuse/neglect or disrupted attachment from 0-5 years old?):

____

IF PARENTS DIVORCED (Your age at the time): ______ CUSTODY (Who you lived with) ____________________
Describe how the divorce affected you at the time:

____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

____

What gives you the most joy or pleasure in your life?

____

What are your main worries and fears?

____

What are your most important hopes or dreams?

____

How are you hoping counseling can better your life?

____

Other information you want us to know?

____

____

____

____

____

____

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____

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INSURANCE / EAP INFORMATION FORM

This form MUST be *completely* filled out and signed if billing insurance or EAP for services rendered.

Please attach a copy of your Insurance Card (front and back) and a copy of your CA Drivers License,

as we are required to obtain proof of identify for *all* clients utilizing Insurance/EAP benefits.

Client Name: ______________________________ SS#: _____-___-______ DOB: ____ / ____ / ______

Name of Insured (If not client): ____________________ SS#: _____-___-______ DOB: ____ / ____ / ______

Insured's Employer: ____

Insured's Address (If different than Client's): ______________________________

Insured's Phone Number (If different than Client's): __________________________

Primary Insurance: __Yes __No

Insurance Company: ________________________ Out-of-Network Benefits: ___Yes ___No

Policy Number: ____________________________ Group/Plan Number: ______________

EAP: __Yes __No EAP Provider: __________________ Auth # (EAP): __________________

THE INSURANCE INFORMATION BELOW IS *REQUIRED* AT YOUR INITIAL APPOINTMENT

Contact Member Services via the toll-free number on the back of your Insurance Card, to gather the information below, including your annual individual deductible and your current remaining deductible owed, as well as your co-pay for out-patient Mental Health Services.

Do you have a deductible? ___Yes ___No Amount of Individual Annual Deductible: $________

Have you met your deducible for the year? ___Yes ___No Amount Remaining: $__________

Do you have a Co-Payment? ___Yes ___No Amount of your Co-Payment: $__________

Authorization to Bill Insurance or EAP Provider

I, the undersigned, assign insurance benefits directly to Sunset Counseling Center, Inc. for services rendered. I agree to the release of all information necessary to secure payment of benefits, including dates of service, diagnosis, clinical reviews, and the use of this signature on all insurance submissions. **I understand that I am responsible for *all charges* incurred regardless of insurance coverage**. I understand and agree that all accounts are due and payable at the time of service and that insurance is being billed as a courtesy. In insurance assigned cases, Sunset Counseling Center, Inc. agrees to accept the charge determination of the insurance carrier as the full charge. I am only responsible for the deductible, co-payment and non-covered services.

If my insurance denies payment for these services, I agree to be responsible for the payment and account balance.

______________________________ ______________________________ ____________

Client Signature (Parent or Guardian) Client Name (Parent or Guardian) Date

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CREDIT CARD/VISA CHECK CARD AUTHORIZATION

Please complete the following information. This form will be **securely** stored in your clinical file and may be updated upon request at any time. **ALL** clients are ***required*** to have a valid Credit Card/Visa Check Card Authorization on file. This is to ensure payment of services rendered, if insurance or EAP declines reimbursement.

I, ______________________________________, authorize Sunset Counseling Center, Inc. to charge my card for professional services and understand and agree that my card will or could be charged for the following:

- Recurring charges in the amount of $_______ per session for office co-pays.
- Fee(s) ***not covered*** by Insurance or EAP in the amount of $ _______ per session.
- **Missed Appointment or No Show Fee in the amount of $ 60.00 per session. ****

I understand and agree that my card will be charged should any of the following situations arise:

- Cancellations with less than 48 hours notice.
- Appointments I miss without notice (no-shows).
- Insurance refusal to pay for services.
- I will not dispute charges ("charge back") for sessions I have received, non-payment by insurance company, or appointments I missed according to the missed or cancelled appointment policy.

Card Type: ___Visa ___MasterCard ___Discover

Card #: ________ - ________ - _______ - ________ Expiration Date: ___________ Security Code: ______

Name on Card: _________________________________ Billing Address: ____

____ ________________________________ ____________

Card Holder Name Card Holder Signature Date

****CANCELLATION NOTICE:**
Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hours (2 days) notice is required for re-scheduling or canceling an appointment. There is a $60.00 no show/late cancellation fee that will be charged to your credit/debit card for appointments missed without 48hr notification.

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Authorization Consenting to Release Information

I, ____________________________________, (Client or Parent/Guardian of Client) hereby authorize my provider with Sunset Counseling Center, Inc. (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Client, including, but not limited to, therapist's diagnosis of Client, and to receive relevant information from the following person(s) and/or organization(s):

Primary Care Physician: ___________________________ **Phone:** ___________________ **Fax:** ___________________
Psychiatrist: ____ **Phone:** ___________________ **Fax:** __________________
Emergency Contact: ____ **Phone:** ___________________________________
Other: ____ **Phone:** ___________________________________

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider's office address to be effective.

Therapist shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid until the end of treatment with provider.

____
Client Name **Date of Birth**

____
Parent OR Guardian Name (for Minor Clients)

____
Signature **Date of Consent**

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Minor Consent for Treatment

I, ___________________________ (parent or guardian), give my consent that ____________________ **(**Sunset Counseling Center, Inc. Provider), will be conducting psychotherapy with __________________ (minor).

I was also notified that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in the Office Policies form, which I have read and signed.

I am aware that it is the legal parent's or custodial parent's responsibility to inform the non-custodial parent regarding minor's treatment with Therapist. I also give my consent for the non-custodial parent(s), to be contacted for the purpose of assessment/treatment.

Non-Custodial Parent Name: ____________________________________ Telelphone: ________________________

In the case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept the Therapist judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the client's wellbeing.

_______________________________________ ____________________ ____________________________ _______________

Parent/Legal Guardian Name (print) Relationship Signature Date

_______________________________________ ____________________ ____________________________ _______________

Parent/Legal Guardian Name (print) Relationship Signature Date