REFERRAL INFORMATION - Minor

David C. Lichti, LMFT
11573 Los Osos Valley Road, Suite H, San Luis Obispo, CA 93405-6497 □ (805) 602-6814

Today's Date: _____

Referral Information:

1) Referred by: _____

2) Describe in detail the behaviors that are of concern to you: _____

_____

_____

_____

Child Information:

Child's name: _____ Sex: _____ _____
Child's nickname (if any): _____ Male Female
Date of birth: _____ Age: _____
Address: _____ Grade: _____
City, St, Zip: _____ School: _____
Telephone (Home): _____ Telephone (Other): _____

Family Information:

Mother: _____ Age: _____ DOB: _____
Employer: _____ Work No.: _____
Does mother live in home? _____ Yes _____ No
If no, Address: _____ Phone No.: _____
(for insurance purposes) _____

Father _____ Age: _____ DOB: _____
Employer: _____ Work No.: _____
Does father live in home? _____ Yes _____ No
If no, Address: _____ Phone No.: _____
(for insurance purposes) _____

Others living in the home: _____ Age: _____ Sex: _____
_____ Age: _____ Sex: _____
_____ Age: _____ Sex: _____
_____ Age: _____ Sex: _____

Social Issues:

Has your child had any particular adjustment/learning problems in school? Yes _____ No _____

Explain? _____

_____

Social, religious, sports or activities that are a significant part of your family life: _____

_____

_____

With whom has the child lived with most of his/her life? _____

If not both parents, explain the circumstances: _____

Birth and Developmental History:

1) Is this child adopted? Yes _____ No _____

2) How old was the mother at the time of birth? _____

3) Were there any problems or complications during the pregnancy or delivery? Yes _____ No _____

If yes, explain: _____

4) Were there any problems during the first year of life? Yes _____ No _____

If yes, explain: _____

5) Any problems during developmental stages of learning (i.e.: feeding, walking, talking, toilet training, etc.)?

_____

6) Explain any other significant developmental situations or crisis in child's life? _____

_____

Medical History:

1) Is child now taking medication? Yes _____ No _____

If yes, what? _____

2) Does child have any allergies? Yes _____ No _____

If yes, explain? _____

3) Does the child have any recurring physical complaints? Yes _____ No _____

If yes, explain? _____

4) Does child have any physical disabilities or other limitations? Yes _____ No _____

If yes, explain? _____

5) Any childhood diseases, illnesses or hospitalizations? _____

_____

6) Has the child ever had counseling or seen a psychologist before? Yes _____ No _____

If yes, explain? _____

_____

7) Physician's name: _____ Phone: _____
Address: _____
City, St, Zip: _____

Parental Questions or Comments:

Are there any questions that you would like to discuss or further comments you would like to make?

_____

_____

_____

_____

Primary Insurance Information:

Insured's name: _____

Insured's employer: _____

Insured's SS No.: _____

Insured's ID No. (from Insurance card): _____

Insured's Group/Policy No. (from Insurance card): _____

Insured's Address (if different from patient): _____

(address continued) _____

Insurance carrier name: _____

Insurance Phone No.: _____

Patient's relationship to insured: _____

Secondary Insurance Information (if applicable):

Insured's name: _____

Insured's employer: _____

Insured's SS No.: _____

Insured's ID No. (from Insurance card): _____

Insured's Group/Policy No. (from Insurance card): _____

Insured's Address (if different from patient): _____

(address continued) _____

Insurance carrier name: _____

Insurance Phone No.: _____

Patient's relationship to insured: _____

Consent to Treat:

I hereby authorize treatment of my minor child by David C. Lichti, LMFT

_____ _____

(Client/Parent/Guardian/Conservator) **Date**

Your Relationship to the Client: _____

_____ _____

(Client/Parent/Guardian/Conservator) **Date**

Your Relationship to the Client: _____

PATIENT QUESTIONNAIRE

David C. Lichti, LMFT

11573 Los Osos Valley Road, Suite H, San Luis Obispo, CA 93405-6497 □ (805) 602-6814

Your Name: _____ Date: _____

This questionnaire is designed to help you indicate in what ways you might want some assistance.
Please check the appropriate response, or fill in the answer. **YOUR RESPONSES ARE CONFIDENTIAL**

Brief description of the problem: _____

_____

_____

_____

How long has it been a problem for you? _____

Have you had previous counseling or treatment? _____

Using the scale below, (5-Significant problem; 3-Some concern; 1-Does not apply), please circle the response that best describes problems you may have in the following areas:

Marriage/Partner? (Not applicable)	5	4	3	2	1
Family?	5	4	3	2	1
Job/School Performance?	5	4	3	2	1
Alcohol/Drug Use?	5	4	3	2	1
Relationships?	5	4	3	2	1
Financial Situation?	5	4	3	2	1
Legal Situation?	5	4	3	2	1
General Health?	5	4	3	2	1
Anxiety Level/Nerves?	5	4	3	2	1
Mood/Depressed?	5	4	3	2	1
Eating Habits?	5	4	3	2	1
Sleeping Habits?	5	4	3	2	1
Ability to Concentrate?	5	4	3	2	1
Child Rearing? (Not applicable)	5	4	3	2	1
Ability to Control Temper?	5	4	3	2	1
Spirituality?	5	4	3	2	1
Other?	5	4	3	2	1

HEALTH SUMMARY

Current Medical Problems:

Current Medications:

Allergies to Medications:

Primary Care Physician:

Smoker? ☐ Yes ☐ No If yes: # of packs per day _____ for _____ years.

If quite - year stopped: _____

Caffeine Drinks: ☐ Coffee ☐ Tea ☐ Cola ☐ Other _____

How many caffeine drinks per day? _____

Alcohol: Amount per day or week: _____

Type: _____

If now a non-user, year stopped: _____

Drugs: Amount per day or week: _____

Type: _____

If now a non-user, year stopped: _____

Family History *(Has any blood relative ever had any of the following?)*

High blood pressure	Yes	☐	No	☐	Depression	Yes	☐	No ☐
Cancer	Yes	☐	No	☐	Anxiety	Yes	☐	No ☐
Diabetes	Yes	☐	No	☐	Alcohol abuse	Yes	☐	No ☐
Heart Trouble	Yes	☐	No	☐	Drug abuse	Yes	☐	No ☐

Other: _____

Other Concerns: _____

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Informed Consent for Treatment

Consent for Treatment:

I authorize and request my practitioner to carry out psychological and/or psychiatric exams, treatment and/or diagnostic procedures which now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. **Initial here** _____

Confidentiality:

All communications made by you in the context of a therapeutic session are held in the strictest of confidence. Members of groups will be informed that they must be in agreement to participate. In order for information to be released to outside parties, you must sign a release of information. However, there are exceptions to confidentiality.

Exceptions to Confidentiality:

1) **Danger to self or others**. When information is communicated to a therapist that an individual intends to harm him/herself, or intends to harm another person(s), California law **mandates** that action must be taken to prevent harm. In the case of harm to self, such actions may include notifying family, the police, and/or psychiatric emergency teams from the county or psychiatric hospitals. In the case of harm to others, an attempt must be made to notify the intended victim and the police.

2) **Child Abuse/Elder Abuse/Abuse of Handicapped**. California law **mandates** that when a therapist (or other mandated reporter) receives information which creates a reasonable suspicion of:
   a) child abuse or neglect (under 18 year of age)
   b) elder abuse (over 65 years of age)
   c) abuse of physically or mentally handicapped adults

   information about the suspected abuse must be turned over to the appropriate governmental agency (i.e. child protective services, adult protective services).

   Examples of child abuse can include, but are not limited to: slapping the child in the face, hitting in such a manner as to leave a mark on the child's body, punishment which results in physical injury or which psychologically traumatizes the child. Abuse also includes reasonable suspicion of sexual molestation. Neglect includes acts (or absence of acts) which could be reasonably construed as dangerous to the child's safety and well being.

Please note: State law requires that the therapist report such abusive situations even when the abuse was in the past, if there is reasonable suspicion that the child, elder, or handicapped individual is still in the situation where the abuse occurred, or if the abuser has direct access to their children, elders, or handicapped individuals. For example: If an adult states that he/she was abused as a child by a parent, and if that parent still has charge over the children, the situation must be reported.

3) **Escaping Prosecution**. When a client attempts to use therapy as a means of escaping prosecution for the commission of a crime.

4) **Insanity Plea**. When a client makes an "insanity plea" as a defense in criminal proceedings.

5) **Court order**: When a court orders a psychological evaluation as part of legal proceeding, or your medical record is subpoenaed by the court, all information provided is accessible to the court.

6) **Minors**. While it is useful for minors to have confidentiality during therapy, except in cases specified by law, the parents have a right to information provided by the minor in the course of therapy.

Other circumstances when confidentiality may be broken:

1) **Client's choice**. If the client chooses to have a therapist release information to another individual(s) (i.e. medical doctor, new therapist, family member, clergy, etc.) he/she may do so by signing consent from which lists the person(s) or agency to receive the information, the type of information which will be released, and the duration for which the consent is valid.

2) **Insurance**. Confidentiality may be broken in order to provide the necessary information for processing insurance claims for reimbursement of clinical services. The client must consent to this release of information. The client's refusal to allow the release of such information to an insurance carrier places the client at full financial responsibility for the consequences which may result.

This information is provided so that the client of psychotherapy can understand the legal and voluntary limits of confidentiality. It is not intended to discourage someone from disclosing a problem where a problem exists. If a problem, such as outlined above exits, it is best to acknowledge it and seek help from the appropriate agency.

I have read and understand the "Informed Consent for Treatment".

Signature:

(Client/Parent/Guardian/Conservator)	**Date**
Your Relationship to the Client	
(Client/Parent/Guardian/Conservator)	**Date**
Your Relationship to the Client	

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NOTICE OF PRIVACY PRACTICES (MENTAL HEALTH)

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable mental health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your mental health information is used. "HIPAA" provides penalties for covered

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your mental health information and how we may use and disclose your health information.

We may use and disclose your mental health records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing mental health care and related services by one or more mental health care providers.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to
- **Health care operations** include the business aspects of funding our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected mental health related information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosure of protected mental health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications or protected mental health information form us by alternative means or at alternative locations.
- The right to inspect and copy your protected mental health information.
- The right to amend your protected mental health information.
- The right to receive an accounting of disclosures of protected mental health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected mental health information and to provide you with notice of our legal duties and privacy practices with respect to protected mental health information.

This notice is effective as of _____, 20_____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revise Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S. W.
Washington, D. C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Signature:

_____ **Date:** _____
(Client/Parent/Guardian/Conservator)

_____
Your Relationship to the Client:

_____ **Date:** _____
(Client/Parent/Guardian/Conservator)

_____
Your Relationship to the Client:

David C. Lichti, LMFT: 11573 Los Osos Valley Road, Suite H, San Luis Obispo, CA 93405-6497 □ (805) 602-6814

Authorization for Disclosure of Confidential Mental Health Information (HIPAA)

Client Name: _____

Date of Birth: _____

My therapist; _____

is authorized to release and disclose information to:

_____

(Name of Person or Organization)

(If applicable) _____ (Name of Person or Organization)

is authorized to release and disclose information to my therapist; (Name of Therapist)

Specific Information to be Released/Obtained (Please select only one):

_____ All health/mental health information including diagnosis and treatment received.

_____ Only the following records or type of information:

Please specify if any information is to be excluded:

This disclosure of information authorized by Client is required for the following purpose:

This authorization shall become effective on: _____/_____/_____ and will expire in one year.

A photocopy or facsimile of this form is to be considered as valid as the original.

Please note: If you have authorized the disclosure of your mental health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

Your Rights:

- You may refuse to sign this Authorization.
- effective when your therapist received it. However, this revocation will not extend to information that was already obtained or released (used or disclosed) prior to the revocation.
- You have the right to receive a copy of this Authorization.
- You may inspect or obtain a copy of your mental health information, within the limits of California and federal laws.
- Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on your providing or refusing to provide this Authorization.

Signature:

Date:

(Client/Parent/Guardian/Conservator)

Your Relationship to the Client:

Date:

(Client/Parent/Guardian/Conservator)

Your Relationship to the Client:

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Authorization for the Request, Release, or Exchange of Information

Client Name: _____

Information requested/released/exchanged:

Name/Agency _____

Address: _____

Information requested/released/exchanged:

_____	Psychiatric evaluation	_____	Insurance Information for	_____	Judicial documents
_____	Psychological tests/results		claims for payment of services	_____	Consultation reports
_____	Progress Notes	_____	Dates of hospitalization	_____	All educational records
_____	Medication plans	_____	Chemical recovery reports	_____	Education tests/reports
_____	Treatment plans	_____	Diagnoses		
_____	Other (specify):	_____			

Purpose for release/exchange:

_____	Diagnoses and treatment	_____	Insurance purposes
_____	Other (specify):	_____	

This information may be communicated in the following manner:

_____	All means listed	_____	Oral and written/photocopies	_____	FAX
_____	Oral	_____	Written/photocopies		

Authorization For The Request, Release, Or Exchange Of Information

The authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, this authorization expires one year from the date of signing. I am aware or have been advised of the provisions of state and federal statues, rules and regulations which provide for my right to confidentiality of the information in these records. I realize that this is a voluntary consent and I must willingly and knowingly sign this authorization before any records can be released. I may refuse to sign, but in that event the records cannot and will not be released/exchanged. I realize the quality of my care may be affected by failure to secure these records. Failure to sign this for purposes of insurance reimbursement may jeopardize financial reimbursement by the insurance company.

_____ _____

Signature of client/parent/guardian/conservator Date

_____

Relationship to client

_____

Signature of David C. Lichti, LMFT, or representative

_____ _____

Information released by Date

To parties receiving this document: A photocopy or FAX of this release is as valid as the original.

David C. Lichti, LMFT: 11573 Los Osos Valley Road, Suite H, San Luis Obispo, CA 93405-6497 □ (805) 602-6814

Emergency Access Procedure

Emergency Access:

If you have an emergency, after regular office hours, you should call the main office number (602-6814) to access your therapist personal voice mail extension and from there you will be instructed on how to reach your therapist or how to leave your therapist a message. If this is an extreme emergency and you are unable to leave a message or wait for your therapist to call you back please hang up and call 911.

I have read and understand the above statement.

Signature:

_____ **Date:** _____

(Client/Parent/Guardian/Conservator)

_____

Your Relationship to the Client:

_____ **Date:** _____

(Client/Parent/Guardian/Conservator)

_____

Your Relationship to the Client:

Cancellation Policy:

When an appointment is booked, this therapist reserves the whole hour especially for you, therefore the following cancellation policy is in place.

This therapist requires 24 hour notice to reschedule or cancel a session without incurring any extra fees. This policy is in place to allow me to offer the allocated time to another client who may be on a waiting list for an appointment.

With regard to commercial insurance and self-pay clients, if this 24-hour requirement is not met, a $25 late-cancel no show fee will be assessed. If there is a second occurrence, a $50 fee will be assessed, and a third occurrence $75.

The only exception to this policy is if this therapist is able to reschedule you/the client for later in the week.

You/the client may call this therapist at 805-602-6814 even after hours and leave a text or voicemail. This therapist will get back to you as soon as is possible.

This therapist understands that sometimes you may have sudden illness or unexpected emergencies arise. Such situations will be discussed and handled on an individual basis.

Please sign to acknowledge you have read and agree to this policy, thank you, _____ .