BIOGRAPHICAL INFORMATION- INTAKE FORM

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16985 Placer Hills Rd Suite B Meadow Vista, CA 95722

Phone: 530-307-0101 morningstarcwc.com

Tonya E. Elliott-Walker, LMFT (CA #43311)

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MALE/FEMALE: \_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TELEPHONE (Home):\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell/ Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_**

**HIGHEST GRADE/DEGREE: \_\_\_\_\_\_\_\_\_\_ REFERRAL BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PERSON AND PHONE # TO CALL IN EMERGENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MARITAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_ FORMER/ PRESENT MARRIAGE (YRS**)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SPOUSE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHILDREN/STEP/GRAND** (Names/Ages)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIBLINGS** (Names/Ages)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENTS/STEP-PARENT(s)** (Ages or year of death)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OCCUPATION/POSITION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INSURANCE INFORMATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESENTING PROBLEM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL DOCTORS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LAST EXAM: \_\_\_\_\_\_\_\_\_\_\_\_**

**PAST/PRESENT MEDICAL CARE** (Specify: major problems, accidents, hospitalizations, current medication)**:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST/PRESENT COUNSELING/PSYCHOTHERAPY/MENTAL HOSPITALS:**

**1. Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates: \_\_\_\_** to **\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Initial reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Process and outcome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates: \_\_\_\_** to **\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Initial reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Process and outcome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INFORMED CONSENT TO ASSUME RESPONSIBILITY FOR PAYMENT FOR PSYCHOTHERAPY SERVICES WITH**

**TONYA E. ELLIOTT, LMFT AND/ OR MORNINGSTAR CWC**

**(Use this form if someone other than the client, such as a parent, is paying for the services)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to pay for psychotherapy and other clinical services for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ according to the fee agreement between the therapist and the client.

I understand the following terms apply to this agreement:

* The fee for psychotherapy, psychological testing and interpretation, consultation, letter or report writing or other clinical services is $120.00 per 50 min. session unless otherwise specified.
* All payments which are the client’s responsibility (including co-pays) will be made at the time of service. We will bill insurance carriers where applicable. The client assumes responsibility for any payment amounts not paid by those carriers up to the allowed amount.
* Please inform the therapist ahead of time or as soon as you know if there are changes in your ability or willingness to pay.
* Services will be terminated if timely payment is not made as agreed to by this consent.
* Consent to assume financial responsibility for these services does not entitle the third-party payer access to confidential information unless agreed in writing otherwise by the named above patient.
* Upon your request and upon obtaining client’s written permission, if appropriate, you will be provided with a bill, which is suitable for presenting to your insurance carrier for possible reimbursement. Not all conditions are reimbursable.
* This agreement supplements previous informed consents.

Signature of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Payee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION CONSENTING TO RELEASE OF INFORMATION**

I authorize Tonya Elliott-Walker, LMFT to **discuss** (verbally or in writing) anything that has been brought up during our psychotherapy or evaluation **with** any person/s or staff of clinic, office, agency, or institution/s named below and **receive** any relevant information **from** them.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the following reason(s):

\_\_\_\_\_\_ Consultation/Psychotherapy,

\_\_\_\_\_\_ Evaluation,

\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I may revoke this consent at any time. This consent is in effect only for five years from the date of the last session, unless revoked in writing earlier or renewed. This consent is also subject to all conditions outlined in the Office Policies form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (print) Date Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (print) Date Signature

**OFFICE POLICIES & GENERAL INFORMATION**

**AGREEMENT FOR PSYCHOTHERAPY SERVICES**



16985 Placer Hills Rd Suite C Meadow Vista, CA 95722

Phone: 530-307-0101 morningstarcwc.com

Tonya E. Elliott-Walker, LMFT (CA #43311)

***This form provides you (patient) with information that is additional to that detailed in the*** [*Notice of Privacy Practices*](http://www.drzur.com/hipaanoticepub.html) ***and it is subject to HIPAA regulations.***

**CONFIDENTIALITY**: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client’s) written permission, except where disclosure is required by law.

**WHEN DISCLOSURE IS REQUIRED BY LAW:** Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled or when client’s family members communicate to your clinician that the client presents a danger to others.

**WHEN DISCLOSURE MAY BE REQUIRED:** Disclosure may be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your clinician. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Your clinician will use her clinical judgment when revealing such information. Your clinician will not release records to any outside party unless he is authorized to do so by all adult family members who were part of the treatment.

**EMERGENCIES**: If there is an emergency during our work together, or in the future after termination where your clinician becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, they will do whatever they can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, they may also contact the person whose name you have provided on the biographical sheet.

**HEALTH INSURANCE AND CONFIDENTIALTY OF RECORDS:** Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you instruct your clinician, only the minimum necessary information will be communicated to the carrier. Your clinician has no control or knowledge over what insurance companies do with the information they submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance, or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies’ computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies’ computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to break- ins and unauthorized access. Medical data has been also reported to be legally accessed by enforcement and other agencies, which also puts you in a vulnerable position.

**LITIGATION LIMITATION:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc..), neither you (client’s) nor your attorney’s, nor anyone else acting on your behalf will call on your clinician to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

**CONSULTATION**: Your clinician consults regularly with other professionals regarding her clients; however, client’s identity remains completely anonymous, and confidentiality is fully maintained.

**E-MAILS, CELL PHONES, COMPUTERS & FAXES**: It is very important to be aware that computers and e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, your clinician’s e-mails are not encrypted. Faxes can easily be sent erroneously to the wrong address. Your clinician’s computers are equipped with a firewall, a virus protection and a password and they also backs up all confidential information from their computers into storage devices on a regular basis. The storage devices are stored securely. Please notify your clinician if you decide to avoid or limit in any way the use of any or all communication devices, such as e-mail, cell-phone or faxes. Please do not use e-mail or faxes for emergencies.

**RECORDS AND YOUR RIGHTS TO REVIEW THEM:** Both the law and the standards of your clinician’s profession require that they keep appropriate treatment records for at least 7 years. If you have concerns regarding the treatment records please discuss them with your clinician. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when your clinician assesses that releasing such information might be harmful in any way. In such a case, your clinician will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, upon your request, your clinician will release information to any agency/person you specify unless your clinician assesses that releasing such information might be harmful in any way. When more than one client involved in treatment, such as in cases of couple and family therapy, your clinician will release records only with the signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

**TELEPHONE & EMERGENCY PROCEDURES:** If you need to contact your clinician between sessions, please leave a message on their confidential voice-mail and your call will be returned as soon as possible. Your clinician checks their messages a few times during the daytime only, unless they are out of town. If an emergency situation arises, please call 911. Please do not use e-mail or faxes for emergencies. Your clinician does not always check their e-mail or faxes daily.

**PAYMENTS & INSURANCE RE-IMBURSEMENTS:** Clients are expected to pay the standard fee of $120.00 per 50 minute session, at the beginning of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless otherwise indicated or agreed upon. Please notify your clinician if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, your clinician will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose. As was indicated in the section *Health Insurance & Confidentiality of Records,* you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, your clinician and/or Morningstar CWC can use legal or other means (courts, collection agencies, etc.) to obtain payment.

**MEDIATION & ARBITRATION:** All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of your clinician and/or Morningstar CWC and client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Placer County, CA in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, your clinician and/or Morningstar CWC can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum as and for attorneys’ fees. In the case of arbitration, the arbitrator will determine that sum.

**THE PROCESS OF THERAPY/ EVALUATION AND SCOPE OF PRACTICE:** Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Your clinician will ask for your feedback and views on your therapy, it’s progress and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc, or experiencing anxiety, depression, insomnia, etc. Your clinician may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, your clinician is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. Your clinician provides neither custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within their scope of practice.

**DISCUSSION OF TREATMENT PLAN:** Within a reasonable period of time after the initiation of treatment, your clinician will discuss with you (client) their working understanding of the problem, treatment plan, therapeutic objectives and his view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, your clinician’s expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that your clinician does not provide, she has an ethical obligation to assist you in obtaining those treatments.

**TERMINATION**: As set forth above, after the first couple of meetings, your clinician will assess if she can be of benefit to you. Your clinician does not accept clients who, in her opinion, she cannot help. In such a case, she will give you a number of referrals who you can contact. If at any point during psychotherapy your clinician assesses that she is not effective in helping you reach the therapeutic goals, she is obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, she would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, your clinician will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional’s opinion or wish to consult with another therapist, your clinician will assist you in finding someone qualified, and if she has your written consent, she will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, your clinician will offer to provide you with names of other qualified professionals whose services you might prefer.

**DUAL-RELATIONSHIPS:** Not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs your clinician objectivity, clinical judgment or can be exploitative in nature. Your clinician will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. The Auburn, CA area is, realistically, a smaller community and many clients know each other and your clinician from the community. Consequently, you may bump into someone you know in the waiting room or into your clinician out in the community. Your clinician will never acknowledge working with anyone without his/her written permission. Many clients choose their clinician as their therapist because they know them before they enter into therapy with them and/or are personally aware of their professional work and achievements. Nevertheless, your clinician will discuss with you (their client/s) the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it and often it is impossible to know that ahead of time. It is the client’s responsibility to communicate to their clinician if the dual or multiple- relationship becomes uncomfortable for them in any way. Your clinician will always listen carefully and respond accordingly to your feedback and will discontinue the dual relationship if she finds it interfering with the effectiveness of the therapy or the welfare of the client and of course you can do the same at any time.

**CANCELLATION:**  Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 72 hours (3 days) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

I have read the above Agreement, Informed Consent, Office Policies and General Information carefully; I understand them and agree to comply with them:

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Client name (print) Date Signature

Client name (print) Date Signature

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Psychotherapist Date Signature