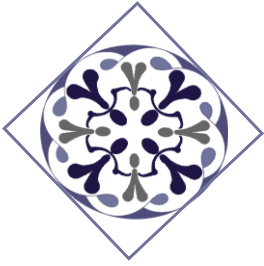


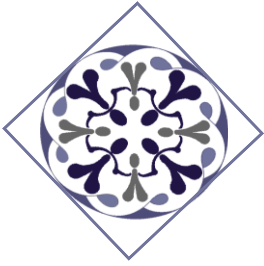
WWW.SACTHERAPISTS.COM
Allison@SacTherapists.com / RoshniP@SacTherapists.com /Danielle@SacTherapists.com
25 Cadillac Drive, Ste. 106, Sacramento, CA 95825

CHILD/ADOLESCENT INTAKE FORM

PERSONAL INFORMATION:
Today's Date: __________________
Name of person completing this form: _____________________ Relationship to client: _______________

Contact Information:
Child / Identified Client Name: ______________________ AKA: ______________
DOB: ______________ AGE: __________ Gender: ______________
Primary Parent Name(s): ______________________________
Are you able to present identification and/or verification of your authority over this child? _____________
Primary address: ______________________ City, Zip: ______________
Email: ______________________________
Cell Phone: ______________________ Alternate Phone: ______________
Primary language spoken at this home: ______________________________
Do I have client and parent permission to contact you by phone, text, email or mail? (Please circle)YES/NO
Secondary Parent Name(s) (if applicable): ______________________________
Secondary address: ______________________ City, Zip: ______________
Email: ______________________________
Cell Phone: ______________________ Alternate Phone: ______________
Primary language spoken at this home: ______________________________
Do I have client and parent permission to contact you by phone, text, email or mail? (Please circle)YES/NO
Adolescent Client Contact Info (age 12 and over) (if applicable):
Email: ______________________________
Cell Phone: ______________________ Alternate Phone: ______________
Do I have client and parent permission to contact you by phone, text, email or mail? (Please circle)YES/NO
Emergency Contact Name: ______________________ Phone: ______________
Parent/Guardianship Information (with whom the client lives) – *Check all that apply:*
( ) Father ( ) Mother ( ) Both ( ) Step-Father ( ) Step-Mother ( ) Legal Guardian
( ) Foster/Group Home ( ) Caregiver
Is the above checked person(s) the client's LEGAL guardian? ( ) Yes ( ) No If No, please complete a "Caregiver Affidavit"
If there is a legal custody agreement regarding the client, please check one:
( ) Joint Custody ( ) Sole Custody ( ) Guardian

- Specific custody restrictions must be verified by providing Therapist with a copy of the court order



Payment Method (please check one): **Cash** **Insurance** **EAP**

INSURANCE /EAP INFORMATION: ___

Name of Carrier of the insurance/EAP plan: ___

Relationship to Insured: ___ DOB of Insured: ___ SSI No. of Insured: ___

Name of Insurance/EAP Carrier's Employer: ___

Insurance ID No./EAP Authorization No: ___ Date Expires: ___

Number of authorized sessions? ___

BIOPSYCHOSOCIAL INFORMATION:

MAIN PROBLEMS Please list the major problems that you would like help with in therapy, and rate the severity of each one according to the scale below:

1----------2----------3----------4----------5----------6----------7----------8----------9----------10 RATING:

Not a Problem Mild Problem Moderate Problem Severe Problem Couldn't be worse

1.___ ___

2.___ ___

3.___ ___

Wellness Information:

Primary Physician**:** ___ Phone: ___

Please list any significant health conditions: ___

___

___

Previous diagnoses: ___

Please list any current prescribed medications & dosages? ___

___

Prescribed by whom? ___ Phone: ___

Exercise Type: ___ Frequency: ___

Please describe any drug/alcohol use including frequency and dates of use:

___

___

Have you ever been treated for drug/alcohol abuse? ___ If yes, when? ___

Do you drink caffeinated beverages? ___ If yes, how many times per day? ___

Education Information:

Name of current school: ___

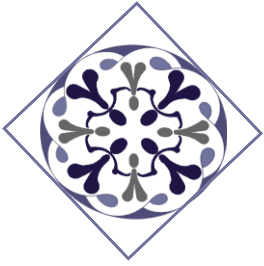
Current Grade Level: ___

Have there been school changes: ___ If yes, please explain: ___

___

Are there any school related concerns? (Please explain) ___

___

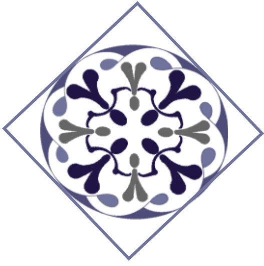


Has your child had any of the following difficulties at school? (check all that apply)
( ) Suspension ( ) Incomplete homework ( ) learning problems ( ) referrals or detention
( ) Poor grades ( ) teased or picked on ( ) speech problems ( ) attendance / tardiness ( ) other
Does your child have an after-school provider? ____ If so, who? ___________________________________
Has your child ever repeated or skipped a grade? ____________ If so, which one(s)? _________________
Has your child ever received Special Education services?__________ If yes, please describe which services:
____
Is your child involved in any school or community extra curricular activities and/or programs?
____
Is your child employed? ____
FAMILY INFORMATION:

Family Information:

What is client's ethnic/family culture? ____
List any family members medical/mental health conditions: ______________________________________
____
Any significant death of a close relative or friend? ____
What is your child's social support network (check all that apply):
( ) Family ( ) Neighbors ( ) Friends ( ) Students ( ) Support groups ( ) Other
( ) Religious/Spiritual Center (which one?) ____
Does this child have siblings? _____________ If yes, please give names & ages: ______________________
____
Who lives at home with the child? ____
____
Where was this child born? ____
Has this child moved? _______________ Please explain: ____
____
Please describe your child's strengths, skills and talents: ____
____
Describe any special areas of interest or hobbies (art, books, sports, etc.): __________________________
____
Has this child suffered any abuse/neglect/trauma? ____
____
____

- Please feel free to attach any additional information



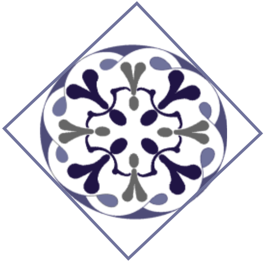
AGREEMENT FOR SERVICE / INFORMED CONSENT FOR ADULTS

Introduction
This Agreement is intended to provide (name of patient) ____ (herein "Patient") with important information regarding the practices, policies and procedures of the 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.

Risks and Benefits of Therapy
Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so the Patient can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties the Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings. It will also involve substantial effort on the part of the Patient, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above. Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Patient's perceptions and assumptions, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient. 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. The Patient should address any concerns he/she has regarding his/her progress in therapy with the Therapist.

Professional Consultation
Professional consultation is an important component of a healthy psychotherapy practice. As such, the 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
The Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute the Therapist's clinical and business records, which by law, the Therapist is required to maintain. Such records are the sole property of the Therapist. The Therapist will not alter 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. The Therapist reserves the right, under California law, to provide the 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.



Electronic communications between the Therapist and Patient will be limited to text messaging, emailing and digital voice mail messaging and will be limited to appointment scheduling and other administrative purposes, such as sending billing information, transmitting scanned forms for clients' review, and sending referrals. Occasionally the Therapist will exchange communications of a clinical nature via fax with other treatment providers per Patient consent to do so. The Therapist will respond to electronic messages within 24 business hours.

Confidentiality

The information disclosed by the Patient is generally confidential and will not be released to any third party without written authorization from patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, 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

The Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient and other 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. The 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 $110 per hour.

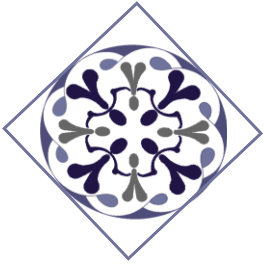
Psychotherapist-Patient Privilege

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-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. Electronic transactions between the Patient and Therapist, will be protected by the Therapist-Patient privilege and are subject to become part of the Patient's clinical record.

Fee and Fee Agreements

The usual and customary fee for service is $125 per 50-minute session for initial assessment, and/or couples/family therapy. The usual and customary fee for service for individual therapy is $110 per 50—minute session. Sessions longer than 50-minutes are charged for the additional time pro rata. 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 payers, r by agreement with Therapist.

The agreed upon fee between Therapist and Patient is $110 for individual, $125 for assessment/couples or other agreed upon fee of _________________. 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 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 longer than 10 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. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than 10 minutes.
Patients are expected to pay for services at the time services are rendered. Therapist accepts cash, checks, and major credit cards, including Visa, MasterCard, American Express & Discover.

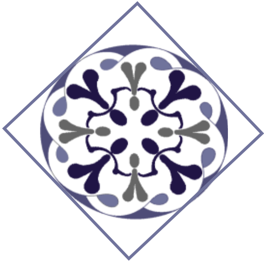
Insurance
Patient is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payer. Patient is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles.
Please check with the Therapist to confirm their current contracting status with your health insurance and/or EAP company plan. Therapist participates, 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.
OR
If the Therapist is not a contracted provider with your insurance company, manager care organization. Should Patient choose to use his/her insurance, Therapist will provide Patient with a statement, which Patient can submit to the third-party of his/her choice to seek reimbursement of fees already paid.

Payment
Accepted forms of payment are cash, check, or credit/debit card (Visa, MasterCard, Amer. Express or Discover). For insurance companies that the Therapist is not an in-network provider for, the Patient is responsible for payment. Some companies may reimburse you for out-of-network benefits. Check with your company.

Cancellation Policy
The 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 the Therapist's voice mail.

Therapist Availability
The 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. The Therapist is unable to provide 24-hour crisis service. In the event that the Patient is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room. The emergency room closest to my office for mental health is Sutter Center for Psychiatry, 7700 Folsom Blvd, Sacramento, CA 95826 (916) 386-3000. The closest medical emergency facility to my office is Mercy General Hospital/Dignity Health, 4001 J St, Sacramento, CA 95819, (916) 453-4545.

Termination of Therapy
Therapist reserves the right to terminate therapy at 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, the 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. The Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient.

Acknowledgement of Informed Consent

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. Moreover, Patient agrees to hold Therapist fee and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

____ Date____________________

Patient Signature

____

Patient Name (please print)

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.

____ Date____________________

Parent Signature

____

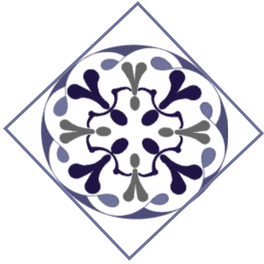
Parent Name (please print)

____ Date____________________

Parent Signature

____

Parent Name (please print)



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.

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with the Notice of Privacy Practices ("Notice"). I must abide by the terms of the Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of the Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

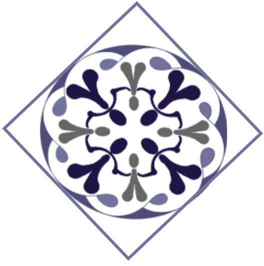
Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. **For your treatment.** I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.
2. **To obtain payment for your treatment.** I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.
3. **For health care operations.** I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization.

1. **Psychotherapy Notes.** I do keep "psychotherapy notes" as that term is defined in 45 CFR S 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
   a. For my use in treating you.
   b. For my use in training or supervising other mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
   c. For my use in defending myself in legal proceedings instituted by you.
   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
   e. Required by law, and the use or disclosure is limited to the requirements of such law.
   f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
   g. Required by a coroner who is performing duties authorized by law.
   h. Required to help avert a serious threat to the health and safety of others.



2. **Marketing Purposes.** As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. **Sale of PHI.** As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

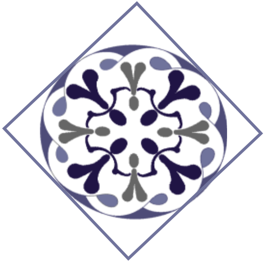
1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain and Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

YOUR RIGHTS REGARDING YOUR PHI: You have the following rights with respect to your PHI:

1. **The Right to Request Limits on uses and Disclosures of Your PHI.** You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for



out-of-pocket in full.

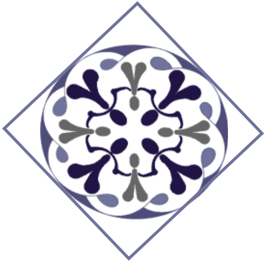
3. **The Right to Choose How I Send PHI to You.** You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. **The Right to See and Get Copies of Your PHI.** Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. **The Right to Get a List of the Disclosures I Have Made.** You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. **The Right to Get a Paper or Electronic Copy of this Notice.** You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice, and my address and phone number is:
25 Cadillac Drive, Ste. 106, Sacramento, CA 95825 Phone: (916) 342-4576

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington D.C. 20201;
2. Calling 1/877/696-6775; or,
3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

I will not retaliate against you if you file a complaint about my privacy practices.
EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on June 1, 2014.



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by referring to my website at www.SacTherapists.com.

If you have any questions about my Notice of Privacy Practices, please contact me at: 25 Cadillac Drive, Suite 106, Sacramento, CA 95825 and you can reach me by phone:
Allison Suznovich, LCSW at 916-342-4576
Roshni Patel, LMFT at 916-501-5450
Danielle Dass, LCSW at 916-241-3397

I acknowledge receipt of the Notice of Privacy Practices

Signature: ____ Date: ______________
(patient)
Parent Signature: ____ Date: ______________
(patient)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including ______________________________. However, because ______________________________ I was unable to obtain my patient's acknowledgement.

Signature of Provider: ________________________________ Date: ______________

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