Ashley Caravella, M.A., MFT
Licensed Marriage and Family Therapist
3233 3rd Avenue
San Diego, CA 92103
Phone: 760-607-7257, Fax: 877-912-4883

Client Information:

LAST NAME:	FIRST NAME:	SEX:	SOCIAL SECURITY #:
HOME ADDRESS:	EMAIL:	DOB: AGE:	MARITAL STATUS: □ Single □ Married □ Divorced □ Separated □ Widowed
HOME PHONE: (Message ok?) Y N	PREFERRED PHONE FOR REMINDER NOTICES OF APPTS: □ Cell Phone □ Home Phone	EMPLOYMENT STATUS: □ Full-time □ Part-time □ Retired □ None □ Self-employed □ Active Military □ Student Current occupation:	
CELL PHONE: (Message ok?) Y N			
WORK PHONE: (Message ok?) Y N			

Responsible Party Information for Parent/Guardian:

LAST NAME:	FIRST NAME:	SEX:	SOCIAL SECURITY #:
HOME ADDRESS:	EMAIL:	DOB: AGE:	MARITAL STATUS: □ Single □ Married □ Divorced □ Separated □ Widowed
HOME PHONE: (Message ok?) Y N	PREFERRED PHONE FOR REMINDER NOTICES OF APPTS: □ Cell Phone □ Home Phone	EMPLOYMENT STATUS: □ Full-time □ Part-time □ Retired □ None □ Self-employed □ Active Military □ Student Current occupation:	
CELL PHONE: (Message ok?) Y N			
WORK PHONE: (Message ok?) Y N			

Emergency Contact if different from Responsible Party:

FIRST AND LAST NAME:	PHONE NUMBER:	RELATIONSHIP TO PATIENT:

Insurance Information:

INSURANCE NAME:	INSURANCE PHONE #:	
CLAIMS ADDRESS:		
SUSBSCRIBER'S NAME:	SEX:	DATE OF BIRTH:
SUBSCRIBER'S ID #:	GROUP #:	
RELATIONSHIP OF CLIENT TO SUBSCRIBER: □ Self □ Spouse □ Child □ Other: _____		

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Informed Consent for Therapy Services

THERAPIST-CLIENT SERVICE AGREEMENT

Welcome to my practice. Thank you for choosing me for your mental health needs. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

THERAPEUTIC SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion or discuss your alternative options to treatment.

APPOINTMENTS

Appointments will ordinarily be 45-55 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your

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appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the full fee for the missed session unless we both agree that you were unable to attend due to circumstances beyond your control or if your insurance stipulates that a fee cannot be charged. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the fee of the missed session. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

For those not using insurance, the standard fee for the initial intake is $150.00 and each subsequent session is $120.00. However, the fee can be negotiated on a sliding fee scale based on your income. The range is from $150 to $60. Your set fee will have been established prior to your first session and it will be $___ per session. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check, cash, or credit card. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment. If at any course in time your income changes, then the fee can be adjusted.

INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Prior to your first session, we will discuss whether I accept your insurance or not. I will contact your insurance company to determine if you are eligible and what your co-pay will be. I will then contact you to inform you of the amount due at the first session. If you decide to use insurance and I am an in-network provider, then I will submit all claims for you. Your signature will mean that you authorize the release of any information necessary (including notes, treatment summaries, and diagnosis) to your insurance plan or EAP to process claims, determine medical necessity, or to request additional sessions. Your signature also authorizes your insurance company to remit payment directly to myself as the provider.

If I do not accept your insurance as an in-network provider, then I can either provide you with a referral to someone who does or you can call your insurance company to determine if there is any coverage for out-of-network services. If you choose to go the latter route, then I will provide you with a superbill/invoice that you can submit to your insurance company for reimbursement. Of note, your superbill will state a diagnosis if any exists. Of course, you always have the option to receive services on my sliding fee scale if you determine you do not want to use insurance.

PROFESSIONAL RECORDS

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I am required to keep appropriate records of the therapeutic services that I provide. Your records are maintained in a secure location for 10 years. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. I recommend that you initially review them with me or have them forwarded to another mental health professional to discuss the contents. You also have the right to request that a copy of your file be made available to any other health care provider at your written request. This request will be followed up within 72 hours.

CONFIDENTIALITY

Professional ethics and California law specifies that communications between the therapist and client are confidential and privileged, and cannot be released or shared without the express written permission of the client except under certain specified circumstances. For example, confidentiality of information exchanged between the therapist and client does not apply where, among other circumstances:

- Release of information is authorized in writing by the client
- The client presents a danger to self
- The client presents a danger to others
- Where child/elder/dependent adult abuse is suspected
- Where the client has filed a lawsuit in which he/she makes a claim of mental or emotional damages

Please also refer to the Notice of Privacy Practices that you were provided for further information on confidentiality.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern, in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

NOTICE OF PRIVACY PRACTICES

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You acknowledge that you have read the Notice of Privacy Practices which defines and discusses my use of Protected Health Information ("PHI") prepared pursuant to and consistent with the Health Insurance Portability Accountability Act ("HIPAA") and applicable California law. You acknowledge that you have read and fully understand the Notice which describes the types of uses and disclosures of your PHI that will occur in your treatment, payment of your bills, or in performance of health care operations. You further acknowledge your understanding that the Notice of Privacy Practices describes your rights and the duties with respect to your PHI. You have been provided with a copy of the Notice and understand that a copy of the Notice is in my office as well as on my website.

CONTACTING ME

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible for urgent matters (usually within 3 hours), but it may take a day or two for non-urgent matters. If it is a medical or psychiatric emergency, please hang up and dial 911 or go to the closet ER. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____ _____

Signature of Client or Personal Representative Date

_____

Printed Name of Client or Personal Representative

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ADULT INTAKE QUESTIONNAIRE

Briefly describe the reason for your appointment today.

_____
_____
_____
_____
_____
_____

Approximately when did the problem start? _____

Psychiatric History:

Please list any family history of psychiatric illness or treatment.

_____
_____
_____
_____

Please list any previous psychiatric treatment you have received before today. List dates, for how long treatment lasted, and what was the name of the provider.

_____
_____
_____
_____

Please list any past and present psychiatric medications prescribed to you. Include the dose and how often they are/were taken.

_____
_____
_____
_____

Please list any psychiatric hospitalizations. Include hospital name, dates, and reason for admission.

_____
_____
_____
_____

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Trauma History:

Physical Abuse:	Y or N	Victim of Violent Crime	Y or N
Emotional Abuse:	Y or N	Domestic Violence	Y or N
Sexual Abuse:	Y or N	Other Incident	Y or N

Substance Use:

Coffee/Caffeine How many cups/day? _____

Alcohol How many drinks/week? _____

Please list any drug use including type, amount, how often, how many years of use, and most recent use.

_____
_____
_____

Please list any kind of substance abuse treatment including detox, IOP, NA/AA, etc. Include dates and names of treatment facilities.

_____
_____
_____

Medical History:

Please list any medical conditions and/or illnesses for which you are currently being treated or have been treated for in the past and give dates of treatment.

_____
_____

Please list all current prescription medications:

_____
_____

Do you have any allergies to medications? Y or N
If yes, which medication? _____

Name of Primary Physician: _____ Phone Number: _____

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Client Signature Date

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Therapist Signature Date

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Problem Checklist

0 = NONE 1 = MILD 2 = MODERATE 3 = SERIOUS 4 = SEVERE

0 1 2 3 4 Previous episodes of depression
0 1 2 3 4 Previous episodes of elation
0 1 2 3 4 Feel sad
0 1 2 3 4 Cry easily
0 1 2 3 4 Feel hopeless
0 1 2 3 4 Feel helpless
0 1 2 3 4 Feel guilty
0 1 2 3 4 Feel irritable
0 1 2 3 4 Feel anxious
0 1 2 3 4 Feel worthless
0 1 2 3 4 Think about suicide
0 1 2 3 4 Past suicide attempts
0 1 2 3 4 Not able to have fun
0 1 2 3 4 Loss of interest in usual pleasures
0 1 2 3 4 Unmotivated to complete tasks
0 1 2 3 4 Loss of interest in sex
0 1 2 3 4 Sexual performance problems
0 1 2 3 4 Confusion
0 1 2 3 4 Loss of energy
0 1 2 3 4 Fatigue
0 1 2 3 4 Body feels slowed down
0 1 2 3 4 Racing Thoughts
0 1 2 3 4 Unhappy with weight
0 1 2 3 4 Recent weight gain or loss
0 1 2 3 4 No appetite
0 1 2 3 4 Binge eating
0 1 2 3 4 Intentional vomiting
0 1 2 3 4 Trouble falling asleep
0 1 2 3 4 Sleeping too much
0 1 2 3 4 Trouble staying asleep
0 1 2 3 4 Waking up too early
0 1 2 3 4 Nightmares

0 1 2 3 4 Memory problems
0 1 2 3 4 Problems concentrating
0 1 2 3 4 Indecisiveness
0 1 2 3 4 Withdrawal from others
0 1 2 3 4 Episodes of panic
0 1 2 3 4 Fear of being in public
0 1 2 3 4 Phobias
0 1 2 3 4 Fear of weight gain
0 1 2 3 4 Trouble making friends
0 1 2 3 4 Loneliness
0 1 2 3 4 Unwanted, distressing thoughts
0 1 2 3 4 Repetitive behaviors
0 1 2 3 4 Constant worry
0 1 2 3 4 Bowel disturbances
0 1 2 3 4 Ongoing laxative use
0 1 2 3 4 Chronic pain
0 1 2 3 4 Worry over health
0 1 2 3 4 Medical problems
0 1 2 3 4 Skipped menstrual periods
0 1 2 3 4 Hear voices
0 1 2 3 4 Suspiciousness/paranoid thoughts
0 1 2 3 4 See things that aren't there
0 1 2 3 4 Strange thoughts
0 1 2 3 4 Fits of rage
0 1 2 3 4 Think about hurting someone
0 1 2 3 4 Poor self control
0 1 2 3 4 Work/school problems
0 1 2 3 4 Relationship problems
0 1 2 3 4 Problems with food
0 1 2 3 4 Problems with money
0 1 2 3 4 Problems at home
0 1 2 3 4 Legal problems

Client Signature

Date

Therapist Signature

Date