Free Clinic of Simi Valley

Adult Informed Consent & Intake Packet

Date_____

Name_____ Age_____ Date of Birth _____

Address_____ City_____
Zip_____

Occupation _____ Employer_____ City of Employer _____

Home Phone ( )_____ Work ( )_____ Cell/Pager( )_____

Do we have your permission to calll you at home _____ Y N At work_____ Y N Cell _____ Y N

May I identify myself/leave message? Y N Email Address_____Please see Risks on Page 4

Reason(s) for seeking therapy?

_____

_____

Who referred you to the Free Clinic? _____ May I thank them? Y N

Marital Status - Single Married Divorced Widow/Widower Separated How Long_____ Previous Marriage(s) Y N

Previous Counseling? Y N When_____ Duration_____Was it a good experience?_____

Have you ever been hospitalized for psychological treatment?_____When?_____Where_____

Are you currently under a physician's and/or psychiatriatrist's care?_____

M.D. & Phone_____Date of Last Physical Exam_____

Medications Currently Taking (use back of page if needed)_____

_____

Please indicate your higest level of education:

Some High School_____ H.S. Diploma_____ Some College_____ College_____ Degree_____ Graduate Degree_____

SPOUSE/SIGNIFICANT OTHER INFORMATION:

Name_____Age_____ Birthdate_____

Address (if different than above)_____

Occupation_____ Employer_____ Address _____

Home Phone ( )_____ Work ( )_____ Cell ( )_____

CHILDREN:

Name _____ Birthdate _____Name _____ Birthdate _____

Name _____ Birthdate _____Name _____ Birthdate _____

Name _____ Birthdate _____Name _____ Birthdate _____

OTHERS LIVING IN HOME: _____

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY:

Name _____ Phone _____ Relationship _____

Agreement for Psychotherapy Services

Client(s) Name(s):_____ Date:_____

Information About Your Therapist

Name of Therapist _____

Your Therapist is a Pre-Licensed Professional – which means he/she is currently enrolled in, but not yet completed a graduate university program, or they graduated a university program and are in the process of acruing clinical hours that are required for licensure as a Mental Health Professional. At the start of treatment your therapist will discuss his/her professional background with you and provide you with information regarding experience, education, and professional orientation. You are free to ask questions at any time about this information.

Your Therapist is a :

Marriage and Family Therapist Trainee □ Resistered Associate Marriage and Family Therapist □

Professional Clinical Counselor Trainee □ Registered Associate Professional Clinical Counselor □

Associate Clinical Social Worker □

Name of Clinical Supervisor	License Type	License#
_____	_____	_____

The Process of Therapy

A therapy session typically lasts 45 - 50 minutes, beginning on the hour and ending at 10 - 15 minutes before the next hour. I encourage you to mentally "switch gears" before you arrive and take advantage of the entire session time.

Risks and Benefits: 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 active involvement, honesty and openness in order to change your thoughts, feelings, and/or behaviors. I will ask for your feedback regarding your therapy, its progress and other aspects of your treatment, and I encourage you to respond openly and honestly.

During therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing discomfort or strong feelings of anger, sadness, worry, fear, etc. It is also possible to experience increase in anxiety, depression, insomnia, etc. As your therapist, I may challenge some of your assumptions or perceptions, or propose different ways of looking at, thinking about, or handling situations that cause you to feel 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, life style, 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 often it will be slow

and maybe frustrating. Although I certainly expect that psychotherapy will yield positive or intended results, there is no way to guarantee this.

Sometimes more than one approach can be helpful in dealing with a difficult situation. During the course of therapy, I will draw on various psychological approaches, based in part, on the problem that is being treated and my assessment of what will best benefit you. These approaches may include but are not limited to behavioral, cognitive, psychodynamic, system/family, developmental, EMDR, somatic experiencing, expressive therapy, evidence based, psychological testing and/or psycho-educational techniques.

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my 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, or about the treatment plan, please let me know. 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 I do not provide, I have an ethical obligation to assist you by referring you to a professional who may provide these treatments.

Terminating Treatment: You always have the option to terminate treatment at any time, for any reason. It is necessary to discuss this with me in session, so that we may address any concerns. When the time does come to complete treatment, I do request that you do come in to discuss leaving and any feelings that may be associated with the process. The process of saying goodbye, when done properly, can take some time and resolve discomfort. Please honor yourself by participating in this healthy process. As your therapist, I have the right and duty to terminate therapy under the following circumstances: when I assess that treatment is no longer helpful or beneficial to you, if I determine that another professional would better serve your needs, or if you have failed to show up for your last two sessions without the required 24 hour notice of cancellation. In all cases I will be happy to provide you with resources and referrals as necessary.

Telephone and Emergency Procedures: If you need to contact me between sessions, you may reach me at: _____. I will respond at my earliest convenience. If an emergency arises, please indicate it clearly in your message. If you have not heard from me after a few hours, please call again (there are occasions where your message does not reach me due to technological error.) Please feel free to call the clinic during clinic hours Monday – Friday 5PM to 8 PM. The office number is (805) 522-3733. **If there is a life-threatening emergency, please call 911 or go to the closest emergency room.**

Confidentiality: An important aspect of our therapeutic relationship is confidentiality. Knowing that I will keep our communications private helps to make this a safe place for you to explore, to learn and to grow. Please be aware that the only **exceptions to confidentiality** are: 1) when you have given written consent for me to share information, 2) when I am required to do so by law, as in cases of suspected child, elder or dependent adult abuse, or actual or potentially dangerous behavior toward yourself or others, 3) as required/allowed by HIPPA (Health Information Privacy Practices Act - please read the HIPPA form for further clarification of the privacy of your health information and records), and 4), because I am in training, I will be sharing information with my supervisors, instructors, and other associates/trainees during supervision. In this way, you receive the benefit of several therapists working together for your best interests. I may also consult with Free Clinic Medical or Administrative staff as deemed necessary. **Initial Here_____**

Agreement for Psychotherapy Services

Client(s) Name(s): _____ Date:_____

Technology/Social Media Policy:
In an age of fast-changing technology, it is important to understand the risks and benefits involved in any communication, especially of a private nature such as in therapy. I will take reasonable steps to protect your privacy, however, it is important that you understand and accept the risks to privacy when using these methods of communication. If you provide your email address I will presume you have granted permission to use this method of communication. **If you do NOT want to be contacted via email/text etc**. please specify here_____.

Please **limit tech communications to non-urgent matters** such as items that are not critical or private as there can be a delay in my receipt and/or response using such methods. Communication via technology should not be considered a substitute for face-to-face therapy communication. Please note that any communication between a client and therapist can be part of the clinical record.

Therapists at the Simi Free Clinic of Simi Valley do not accept personal friend or contact requests from current/ former clients on any social networking site. We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Video and Audio Recording: Because I am a Pre-Licensed Professional and in training, I must be supervised by licensed therapists to help me provide you the best possible therapy. I will be video or audio taping our sessions from time to time. I will notify you in advance of the recording. I will protect your identity and destroy the tape after viewing. I will be presenting video during my individual or group supervision sessions at the Free Clinic of Simi Valley. Additionally, some institutions of higher education may require client audio/video and other clinical information to be sent to the supervising professor in order to evaluate student progress. Any electronic transmission of such PHI (Personal Health Information) will be handled in accordance with all other laws and guidelines in order to maintain privacy in the highest of educational and professional standards.

Please feel free to ask me any questions about this process. By signing this agreement, you release the Free Clinic of Simi Valley and myself from any legal liability. Consent for use of video/audio tapes shall remain in effect until I am no longer utilizing services at the Free Clinic of Simi Valley. **Initial Here**_____

Financial Terms

Fees: The Free Clinic of Simi Valley **suggests** a minimum donation for psychotherapy of $40 per 50 minute session, **unless we have made other arrangements**. After we discuss this (on or before our first session), I will note any different arrangements here:_____Initial Here_____.

Cancellation and Missed Appointment Policy. I have reserved an appointment time especially for you. I request at least a 24 hour notice for cancelled appointments. Please note that it is important for you to attend your sessions on a regular basis. Due to the importance of attendance and an overwhelming demand for psychotherapy services at the Free Clinic of Simi Valley, **two consecutive missed appointments, without notification, could result in termination of therapy**.

Agreement for Psychotherapy Services

Client(s) Name(s): _____ Date:_____

Please help me to continue to provide the best service to our clients by honoring your appointment time. Our entrance is at the door on the left side of the building. Please ring the bell and your therapist will greet you at your appointment time. Please do not ring the bell early as I may be in session with another client.

Initial here:_____

Child Care: There are no facilities for the supervision of children while you are seeing your therapist. Please make arrangemnents for safe, reliable supervision of your children off site during your therapy session.

If there are specific phone numbers you WOULD like me to use to contact you, please note, and give me directions as to what I may and may not say, directly or in a message:

Consent for Treatment

I authorize and request my therapist to carry out psychological evaluations, treatment and/or diagnostic procedures that 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 are outlined above in this document, and that they are subject to my agreement.

I have read the above and agree to the contents.

_____ _____

Client Signature **Date**

_____ _____

Therapist Signature **Date**

Name_____ **Date**_____

Why are you here? Describe reasons for seeking help.

What help do you expect from therapy?

Is there anything from your past history that may be related to the difficulties you are having now? (trauma, abuse, substance use, learning difficulties etc….)

On a scale of 1-10 with 1 being mild and 10 being severe, how would you rate the severity of your problem(s)?
Are you depressed at this time? Yes_____ No_____ Sometimes_____
How serious would you say your depression is? (Scale of 1-10) _____
Have you had any suicidal thoughts? Yes_____ No_____
Have you ever attempted suicide? Yes_____No_____
Any history of suicide attempts of members in your family? Yes_____ No_____
Who? _____
Whom have you presently consulted about your present problems?
_____

List your five worst fears: Worst fear first. 1)_____ 2)_____
3)_____ 4)_____ 5)_____

What do you consider your srengths? _____
_____
Please check all of the following which are, or have been, problems for you:

__ Anxiety	**__Loneliness**	**__Claustrophobia**	**__Marital problems**
__Shyness	**__Nightmares**	**__Bowel problems**	**__Lack of appetite**
__Tension	**__Overweight**	**__Can't have fun**	**__Can't keep a job**
__Tremors	**__Child abuse**	**__Hearing noises**	**__Stomach problems**
__Insomnia	**__Nail biting**	**__Money problems**	**__Can't concentrate**
__Dizziness	**__Underweight**	**__Suicidal ideas**	**__Lack of exercise**
__Headaches	**__Can't decide**	**__Take sedatives**	**__Can't make friends**
__Parenting	**__Palpitations**	**__Fainting spells**	**__Don't like weekends**
__Tiredness	**__Feel panicky**	**__Unable to relax**	**__Bad home conditions**
__Alcohol use	**__Unemployment**	**__Memory problems**	**__Inferiority feelings**
__Drug use	**__Over-ambitious**	**__School problems**	**__Sexual problems**
__Depression	**__Seeing things**	**__Sexual assault**	**__Sexual abuse**
__Physical abuse	**__Eating disorder**	**__Sleeping trouble**	**__ADD (ADHD)**
__Fearful	**__Angry**		

Other problems:_____
_____

Client Questionnaire (cont)

Name_____ **Date**_____

Physical History- Check any that may apply, past or present:

__Heart problems	__High blood pressure	__Allergies
__Liver problems	__Head injury	__Seizures
__Shortness of breath	__Tuberculosis	__Kidney problems
__Cancer	__Sexually transmitted	__Bedwetting/soiling
__Immune disease	__Stroke	__PMS
__Hepatitis/jaundice	__Alcoholism disease	__Hormone therapy
__Pain or pressure in chest	__Drug Abuse	__Pregnancy #___
__Severe headaches	__Epilepsy/convulsions	__Abortion #___
__Diabetes	__Asthma	

Family of Origin History - This includes parents, siblings, grandparents, aunts, uncles.
Please circle any that apply:

Depression	Bipolar (manic/depression)	Pornography	Alcoholism
Violence	Child abuse/sexual abuse	Jail	Drug abuse
Anxiety	Attention deficit disorder	Trauma	Eating disorder
Schizophrenia	School failure	Gambling	Suicide

Alcohol or other substance use:
Please indicate past and current use.

Alcohol_____ **Amount**_____**Frequency**_____

Marijuana_____**Amount**_____**Frequency**_____

Cocaine_____**Amount**_____**Frequency**_____

Methamphetamine_____**Amount**_____**Frequency**_____

Others_____

NOTICE OF PRIVACY OF PRACTICES
FACT SHEET

THIS NOTICE BRIEFLY DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE FREE CLINIC OF SIMI VALLEY AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. (Protected health information is information about you, including demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services.) PLEASE REVIEW THIS NOTICE CAREFULLY. ATTACHED IS A MORE COMPLETE DESCRIPTION OF THIS INFORMATION.
If you have any questions about this notice, please contact our COMPLIANCE COORDINATOR at 522-3733

We are required by law to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect.

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

For Treatment
For Payment
To Individuals Involved in Your Care or Payment for Your care
To Determine Treatment Alternatives
For Health-Related Benefits and Services
For Health Care Appointment Reminders
To Coroners or Medical Examiners
For National Security and Intelligence Activities
As Required By Law Enforcement
Military and Veterans
To Avert a Serious Threat the Health or Safety
To Workers Compensation
To Resolve or Prevent Public Health Risks
In You Are an Inmate
In Lawsuits and Disputes
For Health Oversight Activities

- You have the right to inspect and copy medical information that may be used to make decisions about your care.
- If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the medical information kept by or for the Free Clinic of Simi Valley; is not part of the information which you would be permitted to inspect id copy; or is accurate and complete.
- You have the right to request a list of the disclosures we made of medical information about you other that our own uses for treatment, payment and health care operations, as those functions are described above.
- You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, additional information may be needed to provide you emergency treatment.
- You have the right to request that we communicate with you about medical matters in a certain way or at certain location.
- You have the right to a paper copy of this notice.

We reserve the right to change this notice. Each time Free Clinic of Simi Valley services are initiated, we will offer you a copy of the current notice in effect. If you believe your privacy rights have been violated, you may file a complaint with the Free Clinic of Simi Valley or with the: Secretary of the Department of Health and Human Services. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission.

I have read this notice and have received a full copy of the Free Clinic of Simi Valley “Notice of Privacy Practices” which more fully explains these practices, lists examples and provides phone numbers for contact.

_____ _____

Client Signature Date

FREE CLINIC OF SIMI VALLEY

NOTICE TO CLIENTS

To be provided to the individual client before mental health services are provided, except in emergency cases when notice may be provided as soon after the emergency as is practicable

or

to a parent or legal guardian when the client lacks legal responsibility for his/her care under State law.

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA) , (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, mental health or related functions by any free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (0)).

Certain free clinic health care professionals providing health care services to patients at this free clinic may be covered by the above Federal law.

[1] If the free clinic imposes charges based on a patient's ability to pay, this will negate the FTCA coverage of the volunteer(s) for the specific services for which the clinic received payment.

[2] A licensed or certified health care practitioner is an individual required to be licensed, registered, or certified by the State, Commonwealth or territory in which a Free Clinic is located. These individuals include, but are not limited to, physicians, dentists, registered nurses, and others required to be licensed, registered, or certified (e.g., laboratory technicians, social workers, mental health workers, medical assistants, licensed practical nurses, dental hygienists, and nutritionists). The definition will vary dependent upon legal jurisdiction.

[3] Examples of cases in which a free clinic could grant temporary privileges to a LIP in order to meet important patient care needs for a limited period of time include:

1. A current LIP becomes ill or takes a leave of absence, and another LIP is needed to cover patient care until the current LIP returns; or
2. A current LIP does not have the necessary skills to provide needed patient care.

Acknowledgement

Patient Signature	Patient Name	Date