

Palo Alto Therapy

Creating Your Peace of Mind

THErapy CONTRACT AND CONSENT TO TREATMENT

Welcome to Palo Alto Therapy. This document contains important information about our professional services and business policies. Please read it carefully as it is important that we discuss any questions or concerns that you may have at your initial meeting.

COUNSELING SERVICES

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and anxiety. On the other hand, psychotherapy has also been shown to have great benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

PROFESSIONAL FEES AND APPOINTMENTS

Our fees are as follows: Initial appointment \$____. Follow-up appointments \$____. Payment is due at the time each appointment is held. Typically, one 50-minute appointment per week is scheduled. For your convenience, bottled water and restrooms are available.

CANCELLATION POLICY

Once an appointment is scheduled, you will be responsible for full payment unless you provide 48 hours advance notice of cancellation.

Credit Card #: _____ Security Code: _____ Exp. Date: _____
(Required for delinquent payment purposes) (The three-digit number on the back of the card after the card number)

Billing Address: _____

Check here if you would also like to use this credit card for your regularly scheduled visits

ENDING COUNSELING

You can end counseling at any time, however we ask that you speak with your therapist in person when you would like to do so. If you decide to end treatment between appointments we recommend one additional appointment before ending. Sometimes negative feelings arise between sessions and an additional meeting to discuss this can lead to personal growth, allow us to provide additional relapse prevention skills, and/or end counseling in a mutually respectful manner. Please indicate if you agree with this recommendation (circle one) **YES NO**

If no, please explain: _____

CONTACTING US

You can contact us by telephone and/or email. Every effort will be made to return your call within 24 hours, with the exception of weekends and holidays. If you are unable to reach your therapist and feel that you can't wait for a return call, you may contact your family physician or call the Suicide and Crisis Service at 650-494-8420 or 408-279-3312.

CONFIDENTIALITY

Information that is provided during counseling sessions will be kept confidential, and will be released to other parties only with your expressed written consent except in the situations detailed in the HIPAA Notice of Privacy Practices.

Your signature below indicates that you have read the information in this document, agree to abide by its terms, and authorize the use of your credit card in case of delinquent payments.

Please Print Name

Signature

Date

HIPAA NOTICE OF PRIVACY PRACTICES

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

The provider is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations (See examples below). Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services. Information is only released in accordance with state and federal laws and the ethics governing the counseling profession.

Treatment

- Professionals who work for Palo Alto Therapy (in a clinical capacity) may share information about your situation among each other for the purpose of diagnosis, treatment planning, and/or counselor growth.
- At times, your particular situation or course of therapy may be discussed with professional colleagues outside of Palo Alto Therapy for the purpose of clinical consultation and/or training. This is done in a respectful manner to ensure you are receiving quality care and to assist in the learning and growing of your counselor. Your name will not be disclosed during these discussions.

Payment

- We may verify insurance coverage prior to your first appointment and obtain prior authorization and precertification when required to do so by your policy coverage.
- In some cases, delinquent payments may have to be sent to collection agencies, indicating what type of services you received.

Health Care Operations

- In preparing our financial statements, auditors may need to review samples of medical care given. We may disclose your health information to an accounting firm to prepare this material.
- During our routine health care operations, we may need to hire computer technicians and software vendors. We may disclose your health information to these vendors to maintain daily functioning in our health care operations.
- Marketing: Under no circumstances will we sell your personal information for marketing purposes. We may from time-to-time contact you via regular mail, email, telephone, and/or voice-mail to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits or services that may be of interest to you. Your written comments or feedback may be used for marketing purposes, but your identity will be kept confidential.

Other Uses and Disclosures Without your Consent

- Abuse and Neglect: We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.
- Law enforcement: We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order.
- Judicial/Administrative Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.
- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of yourself, a person, or the public.
- For Specialized Governmental Functions: We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.
- If one of the above situations occurs, every effort will be made to fully discuss it with you before taking any action.

Client Rights

- Request a restriction on certain uses and disclosures of your protected health information by delivering the request in writing to our office. We are not required to grant the request, but we will comply with any request that has been granted.
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at our office.
- Request that you be allowed to inspect and receive a copy of your health record and billing record. You may exercise this right by delivering the request in writing to our office. You may also appeal a denial of access to your protected health information except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office. We are not required to grant the request, but if denied you have the right to file a disagreement statement.
- Obtain an accounting of disclosures of your health information by delivering a written request to our office. The accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request.
- Request that we release your medical records to others by delivering a written request to our office. Ability to revoke this release in writing.
- To receive any changes in this Notice by calling or requesting a copy of our Notice or by visiting the office to obtain a copy.
- To Request Information or File a Complaint. If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the following person: Ernest S. Schmidt, LCSW, at 650-384-0342. You may also file a complaint by mailing or e-mailing it to the Secretary of Health and Human Services. We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from our office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

I have read, understood, and acknowledge the HIPAA NOTICE OF PRIVACY PRACTICES from Palo Alto Therapy. I am also aware that this is available on their website at www.paloaltotherapy.com.

Signature of Patient or Responsible Party: _____ Date: _____

Client Information Form

Contact information

Date: _____

Your Name: _____

Address: _____

House/apt #, Street, City, and Zip

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

Email: _____

Current Physician's Name and Tel #: _____

Do we have your permission to exchange information with your doctor? (circle on) Yes No

If yes, signature needed: _____

Emergency contact: **(Required)** Name: _____

Relationship: _____ Phone: _____

Address: _____

May we communicate with you through, Regular Mail: Yes No Email: Yes No

Social and family information

Age: _____ Date of birth: _____

Ethnicity (circle one): Caucasian African American Hispanic Asian

Other: _____

Religious background: (circle one) Protestant Catholic Jewish Muslim No affiliation

Other: _____

Marital status: (circle one) Single, never married Married Separated Divorced Widowed Cohabiting

If divorced, when did you divorce your previous partner? _____

How long were you married? _____

If you are widowed, when did your spouse die? _____

Names of persons living in your home and your relationship to them:

<u>Name</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have a partner or spouse, how long have you been together? _____

Spouse/partner's occupation, if applicable: _____

Please list names and ages of your children that are not in your home, if applicable:

Name	Age	Biological?	Name	Age	Biological?
_____	_____	Y / N	_____	_____	Y / N
_____	_____	Y / N	_____	_____	Y / N

Family of origin

Mother's Information

If deceased, year and cause of death: _____

If living, age and health status: _____

If living, where does she live now? _____

Her occupation (past and/or present): _____

Father's Information

If deceased, year and cause of death: _____

If living, age and health status: _____

If living, where does he live now? _____

His occupation (past and/or present): _____

Siblings:

<u>Name</u>	<u>Age</u>	<u>Occupation</u>	<u>Where does s/he live?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Where did you grow up? _____

Did your parents get divorced? Yes No If yes, when? _____

Do any biological relatives have any history of psychiatric or emotional problems? Yes No

If yes, which family members and what types of problems?

Education/Work

Occupation: _____

Are you working now? No Yes If yes, circle one: Full-time Part-time

Are you going to school now? No Yes If yes, circle one: Full-time Part-time

What is the highest degree you earned in school? _____

Did you ever receive any special education services (e.g. academic tutoring, IEP, classroom accommodations, etc.)? Yes No

If yes, give details: _____

Please provide some general information on your work history:

Type of job held

How long?

Presenting complaint

Please briefly describe the problem(s) that bring you to therapy.

What are the symptoms, how intense are they, and how often do they occur?

Have there ever been problems like this before? Yes No

If yes, when? _____

Have you experienced any particular sources of stress in the last year? Yes No

If yes, please explain: _____

Are you presently seeing another therapist? Yes No

If yes, please provide the following information: Therapist's name: _____

Date treatment began: _____ Therapist's phone number: _____

Problem for which treatment was sought: _____

What are your current goals for counseling/therapy? What would be different in your life when counseling is finished? Please be as specific as possible.

What do you think is a realistic time frame for solving your problem? _____

Treatment history

Have you previously been in counseling, including individual, group, marital or family therapy?

Yes No

Name of therapist: _____ Dates: _____

Name of therapist: _____ Dates: _____

If yes, in what way was it helpful?

If not, in what way was it unsatisfactory?

Have you ever been hospitalized for mental or emotional difficulties? Yes No

If yes, when and why? _____

Have you ever attempted suicide? Yes No If yes, when and how? _____

Have you ever taken medications for mental or emotional difficulties prescribed by a Dr.? Yes No

If yes, what medications were prescribed, when and for what symptoms?

Are you currently using any prescribed medications? Yes No

Please indicate what medications you are taking:

Medication	Dosage	When started	Prescriber
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

General health

Do you currently have, or have you had in the past, any serious, chronic or recurrent health problems or disabilities? Yes No

If yes, please describe: _____

List dates of any hospitalizations you have had for physical problems:

Date	Problem
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_____	_____
_____	_____

When was your last physical examination by a doctor? _____

What was the outcome? _____

Substance use

Have you ever used any drugs or medications other than as prescribed? (This includes prescription medications, marijuana, amphetamines, barbiturates, cocaine, opiates, Ecstasy and others): Yes No

Are you currently using? Yes No

If yes:	Type	Frequency/amount	Duration	How taken
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If you have used any substances listed above, do you feel they have caused any problems in your work, school or relationships? Yes No

If yes, please explain: _____

Do you drink alcohol? Yes No

If yes, please answer the following questions:

How much alcohol do you drink? _____ drinks per _____

Do you feel your drinking has caused any problems in your work, school or relationships? Yes No

If yes, please explain: _____

Have you ever been treated for drug or alcohol abuse?

Yes No

If yes, please describe: _____

Abuse/trauma

Have you ever had a physical fight with your spouse or partner (including throwing things, hitting, shoving, etc.)? Yes No

Did you ever have sexual contact with someone else that you did not want? Yes No

Have you experienced or witnessed any traumas (events that felt life-threatening)? Yes No

Have you experienced physical or sexual abuse or assaults? Yes No

PERSONAL PROBLEM OVERVIEW

Please check mark ONLY those items that are of personal concern to you currently.
If any of your concerns are not listed, please write them in the "OTHER" space at the end.

Abuse Issues

- Emotional abuse
- Physical abuse
- Sexual abuse

Control Issues

- Alcohol (beer, wine, or liquor)
- Cocaine, speed, ecstasy, substance abuse
- Eating Disorder
- Gambling
- Internet addiction
- Marijuana use

Emotional Concerns

- Anger
- Anxiety, Nervousness
- Depression
- Guilt
- Isolation, withdrawal
- Mood swings
- Self-control
- Suicidal thoughts
- Worry
- Stress

Social or Performance Concerns

- Decision making or setting goals
- Difficulty concentrating
- Lack of assertiveness
- Lack of motivation
- Loneliness
- Memory problems
- Prejudice
- Public speaking anxiety
- Shyness or discomfort in social settings

Violence Issues

- Date rape
- Relationship violence
- Sexual assault
- Stranger rape

Life Circumstances

- Work
- Credit card debt
- Death, grief, loss, separation
- Financial matters
- Housing
- Illness of someone close
- Legal problems
- Life transitions (Leaving home relationship changes,

Personal Issues

- Body Image
- Concern about coming out
- Confusion about values morals, and/or beliefs
- Cultural conflict/adjustment
- Sexual concerns
- Loss of faith in my religion or religious uncertainty
- Self-esteem/self confidence

Relationship Issues

- Family members (parents siblings, etc.)
- Interracial dating
- Interreligious dating
- Parenting concerns
- Partner/spouse
- Peer Relationships
- Relationship breakup or divorce
- Sex

Academic Concerns

Career Concerns

Health Problems

Sleep Problems

Other
