Palo Alto Therapy
Psychotherapy & Personal Counseling
A Direct Approach For Your Peace Of Mind

THERAPY CONTRACT AND CONSENT TO TREATMENT-MINOR UNDER 15

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 or if we are able to fill it with another client. ***Please initial here** _______

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**

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. Children (any client under 18 years of age) seen in individual sessions are not legally entitled to confidentiality; their parents have this right. However, unless children feel they have privacy in speaking with their therapist, the benefits of therapy may be sacrificed. Therefore, unless the minor client gives permission to disclose information to his/her parents, we will keep the specific content of the sessions confidential. This will be adjusted accordingly depending on the age of the child and the specific reasons for seeking counseling. If a parent or the therapist determines that there is a significant concern that should be discussed, effort will be made to schedule a joint session between the parents and the child.

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 Parent's 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 or 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 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:________________

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CLIENT INFORMATION FORM-MINOR UNDER 15

Please complete the form below as thoroughly as possible. This information is helpful for your therapist and will be used to provide your child and family with a better experience.

Child's Name____ Date_________________

Date of Birth_________ Age______ Parent's Name(s)__________________________________

Current Address____
House/apt #, Street, City, and Zip

Telephone #________________________ Email Address_______________________________

School Name:____ Grade:__________________

Child's Physician's Name & Tel #____

Do we have your permission to exchange information with your child's doctor? ❑Yes ❑No

If yes, parent's signature needed:____

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

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Please print clearly

Reasons for seeking counseling/help?

When did these problems begin?

What have you done or tried to do to help your child so far?

Has your child ever been hospitalized for mental health concerns? ❑Yes ❑No
Explain:

Any history of suicidal thoughts, plans, or attempts? ❑Yes ❑No
Explain:

Age of developmental milestone (if unknown use approximate age):
Walk:
Talk:
Use of toilet:

Any delays in development? ❑Yes ❑No
Explain:

Please describe any medical concerns and/or current medications:

Does your child like school? ❑Yes ❑No
Explain:

What are your child's interests, hobbies, and/or favorite games? What are his or her strengths?

Please list relatives that have or had mental/emotional problems below, including substance abuse

Relative	Difficulty (Please Describe)

What are your goals for your child's counseling/therapy? What would be different when counseling is finished? Please be as specific as possible.

Significant events in your child's history: (Please circle any that have happened)

Sexual abuse Physical abuse Emotional abuse Neglect

Witness to domestic violence Parental divorce/separation Death of a parent

Death of a sibling Significant trauma_______________ Other_____________

Additional Comments:

Please check mark ONLY the items below that are of concern to you currently about your child

Emotional Concerns

_______ Anger
_______ Anxiety, nervousness, worry
_______ Depression
_______ Guilt
_______ Isolation, withdrawal
_______ Mood swings
_______ Self-esteem/self confidence
_______ Suicidal thoughts

Behavioral Concerns

_______ Hitting, kicking, biting
_______ Spitting
_______ Tantrums
_______ Bed wetting
_______ Tearfulness, crying spells
_______ Whining
_______ Clinginess, dependent, immature
_______ Impulsiveness
_______ Defiance, argues, talks back
_______ Lying
_______ School refusal
_______ Refusal to go to the bathroom
_______ Refusal to eat or eating too much or too little
_______ Bullies, teases, bossy
_______ Cruel to animals
_______ Dawdling, procrastination
_______ Drug or alcohol use
_______ Sexual-preoccupation, inappropriate behavior
_______ Self-harming behaviors

Social or Performance Concerns

_______ Decision-making
_______ Difficulty concentrating
_______ Lack of assertiveness
_______ Lack of motivation
_______ Peer relationships
_______ Memory problems
_______ Shyness
_______ Learning disability
_______ Speech difficulties
_______ Concerns about friends' behavior

Parenting/Family Concerns

_______ Single parenting
_______ Sibling rivalry
_______ Difficulty setting rules/Discipline
_______ Arguments about parenting or discipline
_______ Household stress: ___________________

_______ **Health Problems**

_______ **Academic Concerns**

_______ **Sleep Problems, Nightmares**

________ **Other**

Additional Comments: