Susana Marquez, LMFT

Patient Registration

Date: _____

Patient Information

Name: _____ Date of birth: _____ Age:____
Address:_____ City: _____,CA, _____
SS# _____ DL# _____ Sex: M F Marital Status:_____
Home phone: { } ____-____ Message OK? ☐ Yes ☐ No Occupation: _____
Work phone: { } ____-____ Message OK? ☐ Yes ☐ No Employer: _____
Cell phone: { } ____-____ Message OK? ☐ Yes ☐ No Email: _____
Emergency Contact:_____ Relationship to Patient: _____
Emergency Contact home phone:{ }____-____ Emergency Contact work phone:{ }____-____

Billing information (if different from above or patient is a minor)

Name: _____ Date of birth: _____ Age:____
Address:_____ City: _____,CA, _____
SS# _____ DL# _____ Sex: M☐F☐ Relationship to Patient: _____
Home phone: { } ____-____ Work phone: { } ____-____ Other phone: { } ____-____
Occupation: _____ Employer: _____ Email: _____

Insurance information ☐ **Not applicable, will be cash patient**

Primary carrier: _____ Effective date:_____
Phone number:{ } ____-_____ Policy number:_____ Group # _____
Policy holder:_____ SS# _____ Relationship to Patient: _____

Secondary carrier: _____ Effective date:_____
Phone number:{ } ____-_____ Policy number:_____ Group # _____
Policy holder:_____ SS# _____ Relationship to Patient: _____

In order for a claim to be submitted for services rendered, we must have your written authorization to release Protected Health Information (PHI) to your insurance carrier. See the Notice of Privacy Policies for further clarification. You are responsible to check your policy regarding necessary referrals, waiting periods, deductibles, pre-existing clauses, or any other limitations of coverage.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits to be paid directly to my provider listed on the claim.
I understand I am responsible for all charges regardless of insurance payment.
A copy of this signature is as valid as the original for billing and/or collection purposes.

_____ _____ _____
Signature Print Name Date

The *Informed Consent for Psychotherapy and Office Policies* and *Notice of Privacy Policies* must be read, understood, and signed by the end of the first session. Please feel free to ask your therapist any questions you might have regarding these documents.

Susana Marquez, LMFT

INFORMED CONSENT FOR PSYCHOTHERAPY SERVICES & OFFICE POLICIES

This form provides you (patient) with information that is additional to that detailed in the Notice of Privacy Practices. Please initial each paragraph in the space provided indicating that you have read and understood the content of that paragraph.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (patient's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the Notice of Privacy Practices that you received with this form. Initial _____

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; and where a patient presents a danger to self, to others: or is gravely disabled (see also Notice of Privacy Practices form). Initial _____

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your therapist. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Your therapist will not release records to any outside party unless they are authorized to do so by **all** adult family members who were part of the treatment. Initial _____

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be highly sensitive and of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you, nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify at any proceeding, nor will a disclosure of the psychotherapy records be requested. Initial _____

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier, HMO/PPO/MCO/EAP, or other third party payer in order to process the claims. Only the minimum necessary information will be communicated to the carrier. Unless authorize by you explicitly the Psychotherapy Notes will not be disclosed to your insurance carrier. Your therapist has no control or knowledge over what insurance companies do with the information they submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information, including diagnosis, is entered into insurance companies' computers and will also be reported to the congress-approved National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to have been sold, stolen, or accessed by enforcement agencies; therefore, you are in a vulnerable position. Initial _____

Confidentiality of E-mail, Cell Phone and Faxes Communication: It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify your therapist at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail or faxes for emergencies. Initial _____

Social Media: **Your therapist does not use Facebook, Twitter, LinkedIn or other social media platforms for professional purposes.** As such, "friend" requests or similar connection requests from clients are not accepted. This may first appear to be cold; it is designed to protect your interests and your privacy. You still may find that these platforms present some risk to our confidentiality. They are known to match people using descriptions like "People You May Know" simply if you and the other person share the same contact in your phone, and have given the social media site access to your contacts. As such, you may be suggested as a potential contact for other clients, and other

clients may be suggested as a potential contact for you. Your therapist does not provide client contact information to any social media platforms, and has no ability to control or alter how they use information about you**. The ultimate choice and responsibility for protecting your confidentiality relative to social media lies with you.** Initial _____

Consultation: Your therapist may consult with other professionals regarding their patients; however, the patient's name or other identifying information is never mentioned. The patient's identity remains completely anonymous, and confidentiality is fully maintained. This is done to provide you with the best care possible. Initial _____

THE PROCESS OF THERAPY: 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. Psychotherapy requires your very active involvement, honesty, and openness in order to change. Your therapist will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. During therapy, remembering or talking about painful memories, unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings. This may include anger, sadness, worry, fear, shame, anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions and/or perceptions and propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing perceptions, beliefs, behaviors, employment, substance use, 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 more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, your therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and their assessment of what will best benefit you. Sometimes more than one approach can be helpful in dealing with a certain situation. These approaches may include, but are not limited to: cognitive-behavioral, psychodynamic, EMDR, behavioral, existential, systems/family of origin, developmental (adult, child, family), biblio-therapy, or psycho-educational. Initial _____

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, your therapist will discuss with you their working understanding of the problem, treatment plan, therapeutic objectives, and view of the possible outcomes of treatment. If you have any unanswered questions about the course of your therapy, the possible risks, your therapist's ability, or about the treatment plan, please ask and you will be answered fully. 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 your therapist does not provide, they have an ethical obligation to assist you in obtaining those treatments. Initial _____

Termination: You have the right to terminate therapy at any time. Ideally, this happens when the goals of therapy have been met. If at any point during psychotherapy, your therapist believes they are not effective in helping you reach the therapeutic goals, they are obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, they would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, your therapist will talk to the new psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, your therapist will assist you in finding someone qualified, and with your written consent will provide her or him with the essential information needed.
Initial _____

Dual Relationships: A dual relationship exists when you have some type of relationship with your therapist outside the clinical setting. This may include civic and philanthropic groups, religious communities, sports leagues, etc. Appropriate dual relationships are not unethical. Therapy never involves sexual or any other dual relationship that can be exploitative in nature, or impairs your therapist's objectivity, clinical judgment and/or therapeutic effectiveness. Appropriate non-sexual dual relationships can be clinically beneficial, and may, in fact, be the reason you chose your therapist. Your therapist will discuss with you the potential benefits and difficulties that may be involved in dual relationships and will discontinue the dual relationship if it interferes with the effectiveness of the therapeutic process.
Initial _____

CANCELLATION: Since scheduling of an appointment involves the reservation of time specifically for you, a **minimum of 24 hours** (1 day) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Insurance companies do not reimburse for missed sessions. Initial _____

PAYMENTS & INSURANCE REIMBURSEMENT: Patients are expected to pay the standard fee of $120.00 per 45-50 minute session at the end of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please notify your therapist if any problem arises during the course of therapy regarding your ability to make timely payments. Health insurance is a contract between you and your insurance company. Patients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. As was indicated in the section *Health Insurance & Confidentiality of Records,* be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/ conditions/problems which are the focus of psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. Initial _____

Alternative Fee Agreement: I agree to pay $ _____ per session, to be paid: ☐ at time of service ☐ when billed.
Therapist approval of Alternative Fee Agreement: _____

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact your therapist between sessions, please leave a message with your therapist's voice mail and your call will be returned as soon as possible. E-mail, Text Messaging, and faxes (E-communication) are read and responded to during normal business hours. Please remember E-communications are inherently unreliable, and if you have not heard back from your therapist during the business day, your E-communication may not have gone through. Your therapist checks messages a few times a day and is notified that new messages are waiting in voicemail. Understand that your therapist may charge you for services rendered over the phone or E-communication. Please clarify with your therapist about their policy in this regard.

If an emergency situation arises, please indicate it clearly in your voice message. Do not use E-communication for emergencies. Each therapist in our office covers emergencies for their own patients unless they are out of town, in which case whom-ever your therapist has made on-call arrangements with will respond to you as soon as possible

In case of medical emergency, or when there is immediate danger or potential for harm, call 911 or go immediately to the closest emergency room Initial _____

I have read the above Informed Consent for Psychotherapy Services & Office Policies carefully; I understand them and agree to comply with them:

_____ Relationship to patient: _____
Signature Name (print) Date

_____ Relationship to patient: _____
Signature Name (print) Date

_____ Relationship to patient: _____
Signature Name (print) Date

_____
Therapist Signature Date

Susana Marquez, LMFT

Confidential History

Date: _____

Name _____
Education level _____ Current Occupation _____
Satisfied with your occupation? ☐ Yes ☐ No comment:_____
Ethnicity _____ Religion _____
Complete if different from patient registration:
Sex ☐ M ☐ F Age _____ Language spoken at home? ☐ English ☐ Other: _____
Present Address _____# _____
City _____ State _____ Zip _____
Home Phone # {___} _____-_____ Work Phone # {___} _____-_____ Email: _____

Marital Status (Check all that apply): Years Married _____
☐ married ☐ living together ☐ never married ☐ divorced ☐ separated
☐ custodial parent remarried ☐ non-custodial parent remarried
Are there current marital problems? ☐ Yes ☐ No comments: _____
_____

Spouse's Name _____ Highest level of education _____
Occupation _____ Satisfied with job? ☐ Yes ☐ No

Children
Name_____ Sex ☐ M ☐ F Age _____
Name_____ Sex ☐ M ☐ F Age _____
Name_____ Sex ☐ M ☐ F Age _____

Mother's Name _____ Step-mother? ☐ Yes ☐ No
Occupation _____ Highest level of education _____
Father's Name _____ Step-father? ☐ Yes ☐ No
Occupation _____ Highest level of education _____

Siblings
Name_____ Sex ☐ M ☐ F Age _____
Name_____ Sex ☐ M ☐ F Age _____
Name_____ Sex ☐ M ☐ F Age _____

With whom were you raised (Check all that apply)?
☐ Biological Parents ☐ Parent and Step Parent ☐ Foster Parents
☐ Single Parent ☐ Adoptive Parents ☐ Relatives
☐ Institution ☐ Legal Guardian ☐ Other: _____
Marital Status of Parents (Check all that apply): Years Married _____
☐ married ☐ living together ☐ never married ☐ divorced ☐ separated
☐ custodial parent remarried ☐ non-custodial parent remarried
comments: _____
_____

Please list any major medical conditions in your family: _____
_____
_____
_____

Your medical conditions or health issues: _____

_____

_____

Current Physician: Dr. _____ Phone # (____)____-_____

Date of most recent visit _____ Reason _____

Medications you take ☐ I do not take prescription medication at this time

Medication: _____ For what condition: _____

Medication: _____ For what condition: _____

Medication: _____ For what condition: _____

Medication: _____ For what condition: _____

Please describe other serious illnesses or injuries: _____

_____

Is there any family history of treatment for psychological/psychiatric conditions? ☐ Yes ☐ No

Comments: _____

Have you had previous counseling or psychotherapy? ☐ Yes ☐ No

With whom and when: _____

_____

Have you ever felt suicidal? ☐ Yes ☐ No Do you feel that way now? ☐ Yes ☐ No

Comment: _____

Are involved in any legal proceedings? ☐ Yes ☐ No comment: _____

_____

Have you ever been arrested? ☐ Yes ☐ No Have you been convicted of a crime? ☐ Yes ☐ No

Comment: _____

Do you drink alcohol? ☐ Yes ☐ NoWhat type: _____ Frequency: _____

Do you use tobacco? ☐ Yes ☐ NoWhat type: _____ Frequency: _____

Do you use other drugs? ☐ Yes ☐ NoWhat type: _____ Frequency: _____

What are your main concerns/reasons for seeking treatment? _____

_____

_____

_____

Did a specific event lead to this session? ☐ Yes ☐ No Comment: _____

_____

_____

Have you been a victim of physical or sexual abuse/assault? ☐ Yes ☐ No Comment:_____

_____

Is there anything significant the form did not ask that you would like to add?

_____

_____

_____

_____

_____

Susana Marquez, LMFT

HEALTH INFORMATION PORTABILITY and ACCOUNTABILITY ACT
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.

It Is Your Therapist's Legal Duty To Safeguard Your Protected Health Information (PHI). By law your therapist is required to insure that your PHI is kept private. The PHI constitutes information created or noted by your therapist that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. Your therapist is required to provide you with this Notice about their privacy procedures. This Notice must explain when, why, and how your therapist would use and/or disclose your PHI. Use of PHI means when your therapist shares, applies, utilizes, examines, or analyzes information within the practice; PHI is disclosed when your therapist releases, transfers, gives, or otherwise reveals it to a third party outside the practice. With some exceptions, your therapist may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, your therapist is always legally required to follow California law and the privacy practices described in this Notice.

Please note that your therapist reserves the right to change the terms of this Notice and the privacy policies at any time. Any changes will apply to PHI already on file with your therapist. Before your therapist makes any important changes to the policies, they will immediately change this Notice and post a new copy of it in the office. You may also request a copy of this Notice from your therapist, or you can view a copy of it in the office.

How Your Therapist Will Use And Disclose Your PHI. Your therapist will use and disclose your PHI for many different reasons. Most of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of your therapist's uses and disclosures, with some examples.

Uses and Disclosures Related to Treatment, Payment, or Health Care Operations That Do Not Require Your Prior Written Consent:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement.** Your therapist may make a disclosure to the appropriate officials when the law requires them to report information to courts, government agencies, law enforcement personnel, and/or in an administrative proceeding. This includes search warrants and court orders for release of records. If you, or anyone else, places your mental condition as part of any litigation (such as divorce, custody, or personal injury), your therapist may be compelled to release your PHI.
2. **Disclosure is compelled or permitted when you are in such mental or emotional condition as to be dangerous to yourself and if your therapist determines that disclosure is necessary to prevent potential harm.** For example, suicidal or serious self-destructive behavior.
3. **Disclosure is mandated by the California Child Abuse and Neglect Reporting law.** For example, if your therapist has a reasonable suspicion of child abuse or neglect.
4. **Disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.** For example, if your therapist has a reasonable suspicion of elder abuse or dependent adult abuse.
5. **Disclosure is mandated when you tell your therapist of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims. .** Also, recent California case law requires if a third party reports you have made a threat, it is treated as if you have made the threat. Confidentiality does not apply to disclosure of crimes planned for the future. This applies to interests of national security, such as protecting the President of the United States or assisting with intelligence operations to prevent future terror activities..
6. **When disclosure is required to obtain payment for treatment.** Your therapist might send your PHI to your insurance company, health plan, or other third party payer in order to receive payment for services your therapist provided to you. Your therapist may also provide your PHI to business associates, such as billing companies or others that process health care claims for the office.
7. **Appointment reminders and health related benefits or services.** Your therapist may use PHI to provide appointment reminders. Your therapist may use PHI to give you information about alternative treatment options, or other health care services or benefits your therapist offer**.**
8. **When disclosure is otherwise specifically required by law.**

Other Uses and Disclosures Require Your Prior Written Authorization. For situations not described above, your therapist will require written authorization before disclosing any of your PHI. This includes communication with family members or other health care providers. Even if you signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future disclosures.

What Rights You Have Regarding Your PHI:

The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in your therapist's possession, or to get copies of it; however, you must request it in writing. You will receive a response from your therapist within 5 days of receiving your written request. Under certain circumstances, your therapist may deny your request. If they do, your therapist will give you, in writing, the reasons for the denial. You have the right to have the denial reviewed. If you ask for copies of your PHI, you will not be charged more than $.25 per page. Your therapist may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that your therapist limit how your therapist uses and discloses your PHI. You do not have the right to limit the uses and disclosures that they are legally required or permitted to make.

The Right to Choose How Your PHI is Sent to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail).

The Right to a List of the Disclosures Your Therapist Has Made. You are entitled to a list of disclosures of your PHI that your therapist has made after April 15, 2003. The list will not include uses or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that your therapist correct the existing information or add the missing information. Your request must be made in writing. Your therapist may deny your request, in writing, if your therapist finds that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of their records, or (d) written by someone other than your therapist. Your therapist's denial must be in writing and must state the reasons for the denial. You have a right to file a written statement objecting to the denial. You have the right to ask that your request and the denial be attached to any future disclosures of your PHI. When approved, your therapist will advise others who need to know about the change to your PHI.

The Right to Get a Copy of This Notice. You have the right to get this notice by email or paper hard copy.

How To Complain About Your Therapist's Privacy Practices
If, in your opinion, your therapist may have violated your privacy rights, or if you object to a decision your therapist made about access to your PHI, you are entitled to file a complaint with your therapist or if applicable, their clinical supervisor. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about privacy practices, your therapist will take no retaliatory action against you**.**

I acknowledge the terms of this notice and the privacy practices of this office.

_____ _____Relationship to patient: _____
Signature Name (print) Date

_____ _____Relationship to patient: _____
Signature Name (print) Date

_____ _____Relationship to patient: _____
Signature Name (print) Date