Patient Information Form

Name: _____ Date: _____

Date of Birth: _____ Marital Status: Marital Status Sex: Sex

Address: _____ Home Phone: _____

City: _____ State: CA Zip: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Employer or School: _____ Full or Part Time: Status

Emergency Contact: _____ Phone: _____

Treatment related to employment? Y/N Auto accident? Y/N Other accident? Y/N

Referred by: _____

Insured Person Information

Name: _____ Date of Birth: _____ Sex: Sex

Address: _____ Phone: _____

City: _____ State: CA Zip: _____ Employer: _____

Patient's relationship to insured person: Relationship

Insurance Information

Insurance: _____

ID#: _____ Group #: _____ Effective Date: _____

Insurance Address: _____ Phone: _____

City: _____ State: CA Zip: _____

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.

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. **For your treatment**. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.

2. **To obtain payment for your treatment**. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.

3. **For health care operations**. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization.

1. **Psychotherapy Notes**. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

    a. For my use in treating you.

b. For my use in training or supervising other mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
c. For my use in defending myself in legal proceedings instituted by you.
d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
e. Required by law, and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. **Marketing Purposes**. As a psychotherapist, I will not use or disclose your PHI for marketing purposes**.**

3. **Sale of PHI**. As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received

another form of therapy for the same condition.

8. Specialized government functions, including**,** ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others**. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

YOUR RIGHTS YOUR REGARDING YOUR PHI
You have the following rights with respect to your PHI:

1. **The Right to Request Limits on Uses and Disclosures of Your PHI**. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.

2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. **The Right to Choose How I Send PHI to You**. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. **The Right to See and Get Copies of Your PHI**. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you.

   I will provide you with a copy of your record, or a summary of it, if you agree

to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. **The Right to Get a List of the Disclosures I Have Made**.
   You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization.

   I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. **The Right to Correct or Update Your PHI**. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. **The Right to Get a Paper or Electronic Copy of this Notice**. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES
If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice, and my address and phone number are:
_____.

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
2. Calling 1-877-696-6775; or,
3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on September 20, 2013.

Informed Consent

The following document reviews how Clarita Thoms-May, MFC, LPCC will strive to maintain a relationship that is positive to you and your family. We will review expectations, considerations, and rules that we will be following. Please take time to write down questions that you may have as we review the informed consent. After signing this form you agree to abide by the contents within.

Responsibilities to you:

I. Confidentiality

All discussions that occur within sessions are kept in confidence. Any information, names, relationships, or concerns you share remain confident. There may be certain times where we may need to consult regarding our work such as supervision but we will always guard your privacy and protect your identifying information so that individuals not involved in your care will not be able to identify you. If your safety or someone else's safety is in question we may reach out to your family/friends in emergencies only. If it is not an emergency we will always ask you for written consent to release information. You may designate who you would like information shared with and you may invite whoever you like into your sessions.

HIPAA Health Insurance Portability and Accountability Act requires our company to protect all of your electronic records when submitting or documenting towards your case. Methods of transmission will always be safeguarded and secure.

Please be aware that if we communicate via email, text, or online, your information may not be protected and you will be running the risk of exposure. There are technological risks that may occur during virtual sessions such as session ending due to poor connection, delay in video/sound, to name a few. You agree to these potential risks and to provide feedback regarding your experience so that I can improve the technology used. Hypothetically the system administrator would have access to these past logs or conversations and sites can be hacked.

If you engage in couples therapy with our program but decide to take advantage of a few individual sessions please know that what you bring up in your individual session will also be included in the couple's session. Please do not disclose anything to our therapists that you would not also want to share with your partner.

Required Reporting and ensuring your Safety

If I have any reason to believe that you may be in danger, in a crisis, or your safety is at risk we have the right to seek out information from your family and friends to ensure your safety.

If I feel you are a danger to yourself or someone else we will be contacting your friends, family, the potential victim, and the police to ensure safety for all parties involved.

If there is any reason to believe that abuse or neglect of a child or minor is occurring I am required to report to the county child welfare department or to local law enforcement (police or sheriff's department) immediately by phone. A written report must then be sent within 36 hours by fax, or it may be sent by electronic submission, if a secure system has been made available for that purpose in your county. Written reports must be submitted on the California Suspected Child Abuse Report Form 8572. If a minor reports having sexual contact with anyone 18 years of age or older we will also report this to the county/local law enforcement and we will inform you of this report. If you report any form of abuse or inappropriate conduct from another named health care provider or counselor we are required to report this to the Board of Behavioral Sciences and the California Department of Health.

II. Record Keeping

All of your records are maintained and kept in a secure location within our office. You may always have access to your records or ask for a summary. If your records are court ordered, we are required by law to provide our case notes.

III. Approach to Care

The approach to Clarita's care is a comprehensive. I will be looking into several aspects which influence and affect you and your family's life. I hope to find what you believe is healthy and will support you and your family in obtaining the best possible version of health.

Several models may be used in our therapeutic approach. Services are offered in office, over the phone, and virtually through a HIPAA compliant telehealth platform. Know that you may be asked to engage in specific activities within the sessions and you may be asked to complete homework outside of sessions. You are welcome to engage in all of some of our options for therapy. Your individual sessions are most confidential. If you engage in family, couple, or group sessions you may freely disclose to your comfort level and I may coach

you to share additional aspects with other members. All clients will be asked to maintain confidentiality of other clients when attending groups.

Expectations for the client:

I. Scheduling

As the client you are required to call and/or use our online scheduling system (in progress) to book your own appointments. Please also reserve your couples sessions, family sessions, and groups you plan on attending due to limited availability. If the date or time you have requested is full you may be put on the cancellation list and you will be notified if I am able to meet your request.

II. Cancelations

Please call at least 24 hours before your appointment time. If the 24 hour notice is not given, I have the right to bill for our regular session fee of $145.00.

III. Missing Appointments

If you miss an appointment I will call you by the next business day to ask about rescheduling. If I am unable to reach you it is your responsibility to call and make another appointment.

IV. During Sessions

While in sessions you are only required to disclose what you are comfortable with sharing. If I ask you additional questions you do not wish to answer or explore you may simply refuse. I may decide to switch to a different therapeutic model during therapy which would enhance our sessions. If this occurs, I will ask for verbal consent in the therapy session before exploring anything new. I may give additional homework or ask you to engage in activities during our sessions. I highly encourage you to try these activities as they will enhance and speed up your therapy process. Please feel encouraged to engage.

V. Stopping Therapy

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

VI. Contacting Us

You may contact Clarita Thoms-May via phone at 619-890-0853. If you are calling after hours for an emergency call 911 or the crisis hotline at

888-724-7240. If you attempt contacting your therapist's personal email, phone numbers, or social media sites it is our policy to ignore and delete these requests. Texting is allowed via my work line above for scheduling needs only, all other content text messages will be ignored. Please journal about your needs in between sessions to address at our next scheduled appointment.

VII. Fees

a. The counseling fee will be $145 for each 50-minute session. Group therapy rate is $45.00/hour. Phone consultations over 10 minutes in length will be billed at the full session rate. If you have any questions about your fee, please speak directly to your therapist.
b. I am solely responsible for payment for services provided by my therapist.
c. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment. I also understand that my therapist reserves the right to pursue all legal measures necessary to satisfy payment for services.

h. Third Party Reimbursement

a. As a courtesy, Clarita Thoms, MFT, LPCC will bill my insurance, if eligible, for services provided. Payment for charges not covered by your health insurance plan (co-payments, co-insurance, and deductibles) is due in full at the time services are provided unless prior arrangements have been made.

i. Diagnosis

If you choose to have your insurance cover payment for services we are required to submit a diagnosis for you to obtain reimbursement for services. Diagnoses are technical terms for what you are experiencing and come from the DSM-5. We will review your diagnosis, if you are given one and explain its meaning in detail.

j. Ability to Consent

You must be of clear and sound mind when giving consent to enter into therapy and while therapy sessions are occurring. If we have any reason to believe that you are not of sound mind we will not conduct therapy until it is safe to do so. Limitations to providing consent include:

a. Being under the influence of substances
b. Being in a psychotic/suicidal/homicidal state (requires hospitalization)
c. Being a minor or vulnerable adult
d. Having history of diagnosis of developmental delay

*If you or your loved ones fall into any of these categories we will first ensure your safety and then present you and your caregivers with additional options for obtaining consent.

k. Concerns or Complaints

If you have any concerns or complaints regarding our process or sessions, I hope you feel comfortable to address these with me. I am open to your feedback and would like to improve the process with every opportunity. You have the following options to report your concerns:

Clarita Thoms-May, MFC 33419, ILPCC 924
619-890-0853
cthomsmay@outlook.com

or

Board of Behavioral Sciences
1625 N Market Blvd., Suite S-200
Sacramento, CA 95834
BBS Main Phone Line: (916) 574-7830
BBS Main Fax: (916) 574-8626
BBSWebmaster@dca.ca.gov

l. Client consent to therapy

I have read and understand the above responsibilities and client bill of rights that apply to my services. I have had all my questions answered fully. I do hereby seek and consent to take part in the treatment by the therapist named above. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.
I agree to maintain the terms and discuss questions as they arise. I agree to the use of diagnosing if needed for billing purposes. I understand and agree to the legal requirements of confidentiality. I agree to the fee schedule and will be held accountable for accrued fees. If I choose I may terminate this agreement at any time without consequence. I agree to begin services with Clarita Thoms-May, MFC 33419, ILPCC 924.

_____

Signature date

_____

Signature date

General Intake Form

Please provide the following information for our records. You may leave blank any question that you do not wish to answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Please bring your completed form to your first session or arrive 30-45 minutes early to complete the form in the office. You may send the completed form via email prior to your appointment, but please be aware that email may not be confidential.

CLIENT INFORMATION **Date: _____**

Name: _____
(Last) (First) (Middle Initial)

If Minor, relationship to child_____

Age: _____ **Birth Date: _____ /_____ /_____** **Gender:** □ Male □ Female

Marital Status: □ Single/Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Spouse/Partner's Name:

_____

Current Address:

_____
(Street) (City) (State) (Zip)

Occupation/Student: _____Employer/School: _____

Referred by: _____

Reasons for seeking therapy:

_____

CONTACT INFORMATION

Preferred method of contact: □ Home Phone □ Cell Phone □ Work Phone □ Email

Home Phone: _____ Ok to leave a message? □Yes □No
Cell Phone: _____ Ok to leave a message? □Yes □No
Work Phone: _____ Ok to leave a message? □Yes □No

Special Instructions:

_____

E-mail: _____ *(Please be aware that email may not be confidential.)*

EMERGENCY CONTACT

Name: _____Phone: _____Relationship: _____

FAMILY & COMMUNITY

Please list all members of household:

Name	Age	Relationship to Child

Please provide any relevant details regarding the client's family situation:

_____

_____

Please provide any relevant details regarding the client's school/work situation:

_____

_____

Please provide any relevant details regarding any legal situations involving the client:

_____

_____

PHYSICAL HEALTH INFORMATION

Primary Care Physician: _____Phone: _____

Date of most recent physical examination: _____

1. How would you rate your current physical health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

_____

3. Please list any currently prescribed medications and dosages:

_____

_____

4. On average, how many hours do you sleep per night? _____
Are you having any difficulty with your sleep habits? □ Yes □ No
If yes, please describe:

_____

5. On average, how many times per week do you exercise? _____ For how long? _____

6. Are you having any difficulty with your appetite or eating habits? □ Yes □ No
If yes, please describe:

_____

7. Have you experienced significant weight change in the last 2 months? □ Yes □ No

9. Do you drink caffeine? □ Yes □ No
If yes, how much and how often?

_____

8. Do you drink alcohol? □ Yes □ No
If yes, how much and how often?

_____

6. Do you smoke tobacco? □ Yes □ No
If yes, how much and how often?

_____

7. Do engage recreational drug use? □ Yes □ No
If yes, which drugs and how often?

_____

MENTAL HEALTH INFORMATION

1. Are you currently in therapy elsewhere? □ Yes □ No
If yes, please provide the name of your therapist:

_____

2. Have you had therapy in the past? □ Yes □ No
If yes, please provide the name of your therapist:
_____

3. In the last year, have you experienced any significant life changes or stressors?
_____

4. Please list any currently prescribed psychiatric medication (antidepressants or others):
_____

_____

5. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never

6. Have you had homicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never

7. Have you or anyone in your family (either immediate or extended family members) experienced difficulties with the following?

Difficulty	*Check if applicable:*		**List family member**
	Self	**Family**	
Depression			
Bipolar Disorder			
Anxiety Disorders			
Panic Attacks			
Schizophrenia			
Alcohol/Substance Abuse			
Eating Disorders			
Learning Disabilities			
Trauma History			
Suicide Attempts			

RELIGIOUS/SPIRITUAL INFORMATION
Do you consider yourself to be religious? □ Yes □ No

If yes, what is your faith?

_____

If no, do you consider yourself to be spiritual? □ Yes □ No

ADDITIONAL INFORMATION

What do you consider to be your strengths?

What do you like most about yourself?

What are the coping strategies that you use when stressed?

What are your goals for therapy?

Is there anything that I did not ask about here that would be important for me to know about you?