Welcome to
Sequoyah Counseling Center

Date _____

GENERAL INFORMATION:

Name _____
(First) (M.I.) (Last)

Address _____

City _____ State _____ Zip Code _____

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

Occupation _____ Employer _____

Length of time at present employment _____

Age _____ Date of Birth _____ Place of Birth _____

Contact person in case of emergency _____

Phone (_____) _____ Address _____

MARITAL STATUS: (circle)

Single Engaged Married Separated Divorced Widowed Remarried

How many times have you been married? _____ Divorced? _____

Length of time in current relationship/marriage _____

Number of children _____ Names & ages _____

_____

MEDICAL HISTORY:

Doctor's name _____ Phone _____

Address _____ City _____

Date of last medical exam _____ Describe your health _____

Current medications being taken _____

_____

Current medical problems for which you are being treated _____

_____

Past and present alcohol/drug usage _____

Have you been treated/hospitalized for alcohol/drugs _____

When _____ Where _____

Have you been treated/hospitalized for a psychiatric condition _____

Diagnosis _____ When _____ Where _____

COUNSELING INFORMATION:

What brings you in for Counseling today? _____

_____

_____

When did the problem start? _____

Have you received counseling before? _____ Where/when _____

Describe the severity of your problem: mild moderate severe

What are you hoping for out of therapy? _____

_____

Who referred you to our services? _____

Thank you for taking the time to fill out this intake form.

Sequoyah Counseling Center
Policies for Psychotherapy Clients

The information below states our standard policies for psychotherapy clients. Please read carefully. You have the right to have as much information as possible that will allow you to make an intelligent decision about the service you desire. If you have questions, please discuss them with your therapist.

1. **APPOINTMENTS/MISSED APPOINTMENTS**: SCC is a private counseling center and not a crisis service. We ask that you help us facilitate the best use of the allotted time in each session by bringing initial concerns to the forefront toward the beginning rather than the end of each session. Appointments are 50 minutes in length. A regular appointment time will be set with your therapist. This established appointment time is reserved for you. There is a full fee charged for missed appointments, except in cases of emergencies. Should you choose to cancel your appointment, we ask for a **24-hour cancellation notice.** For your convenience, we provide a 24-hour confidential voice mail service at (510) 886-3300. Telephone conversations with your therapist will be kept to a 15-minute limit.

2. **FEES/INSURANCE:** Fees are due and payable to your therapist at the end of each session. Checks should be made payable to **Sequoyah Counseling Center.** If you have insurance coverage, an insurance superbill will be given to you at the end of each session, to be sent in for your reimbursement of fees.

3. **CONFIDENTIALITY:** While under most circumstances all communication between the client and therapist is confidential. California State Law mandates and/or permits the reporting of **actual or suspected child or elder abuse/fudiciary abuse** to the appropriate agency. It has also been upheld that **if an individual intends to take harmful or dangerous action against another.** It is the therapist's duty to warn the person or the family of the person who is likely to suffer the results of harmful behavior. Similar actions are permitted with clients who have **suicidal thoughts and/or intentions.**

4. **HIPPA:** Authorization for disclosure of confidential mental health information has been read.

5. **TREATMENT OF MINORS:** I, _____,
   give _____ permission to provide psychotherapy for my son/daughter, _____.

I have read and understand the above policy statement. I have been informed and do consent to receive therapy from _____ practicing at Sequoyah Counseling Center, 21168 Redwood Road, Suite 100A, Castro Valley.

_____

Signature of Responsible Party Date

_____

Signature of Responsible Party Date

I have read and understand the above policy statement. I have been informed and do consent to receive therapy from an MFT intern who shall be supervised by a licensed professional.

_____

Signature of Responsible Party Date

NOTICE OF PRIVACY PRACTICES

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

Effective Date: April 14th, 2003.

My Legal Duty

I understand that your health/mental health information is personal and I am committed to protecting this information. I am required by applicable federal and state law to maintain the privacy of your health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), also requires that I give you this Notice about my legal duties, my privacy practices, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect.

Individually identifiable information about your past, present, or future health/mental health or condition, the provision of health/mental health care to you, or payment for the health/mental health care is considered "Protected Health Information (PHI)." Whenever possible, the PHI contained in your record remains private. In some circumstances, it is necessary for me to share some of the PHI contained in your record (or your child's record). In all but certain specified circumstances, I will share only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

I reserve the right to change this notice and to make changes in my privacy practices. Any changes will be effective for all PHI that I maintain, including health/mental health information created or received before I made the changes. I will post a copy of the current notice in my reception area and on my website (if applicable). You may also request a current copy of this notice from me. For more information about my privacy practices, please contact me at number listed at the end of this notice.

How I May Use and Disclose Health/Mental Health Information About You:

The following categories describe different ways that I use and disclose your PHI. For each category, I explain what I mean, and offer an example. In some instances a written authorization signed by you is required in order for me to use or disclose your PHI; in others it is not. I have tried to identify which instances do not require your signed authorization and which do.

Uses and Disclosures of PHI For Which No Signed Authorization is Required:

For Treatment: I may use/disclose your PHI (or your child) to provide you with mental health treatment or services. For example, I can disclose your PHI to physicians, psychiatrists, and other licensed health care providers who provide you with health care services or are involved in your care. If a psychiatrist is treating you, I can disclose your PHI to your psychiatrist in order to coordinate your care.

For Payment: I may use/disclose your (or your child's) PHI in order to bill and collect payment (from you, your insurance company, or another third party) for services provided by me. For example, I may send your PHI to your insurance company to get paid for the services we provided to you or to determine eligibility for coverage.

For Health Care Operations: I may use/disclose your (or your child's) PHI to your health care service plan or insurance company for purposes of administering the plan, such as case management and care coordination.

Appointment Reminders or Changes in Appointments: I may use/disclose your (or your child's) PHI to contact you as a reminder that you have an appointment. I may also contact you to

notify you of a change in your appointment. For example, if I am ill, I may have someone in my office contact you to notifying you that the appointment is cancelled. *If you do not wish me to contact you for appointment reminders or changes in appointment times, please provide me with alternative instructions (in writing).*

When Disclosure is Required by state, federal or local law; judicial or administrative proceedings; or law enforcement: I may use/disclose your (or your child's) PHI when a law requires that I report information about suspected child, elder or dependent adult abuse or neglect; or in response to a court order. I must also disclose information to authorities that monitor compliance with these privacy requirements.

To Avoid Harm: I may use or disclose limited PHI about you when necessary to prevent or lessen a serious threat to your health or safety, or the health and safety of the public or another person. If I reasonably believe you pose a serious threat of harm to yourself, I may contact family members or others who can help protect you. If you communicate a serious threat of bodily harm to another, I will be required to notify law enforcement and the potential victim.

Law Enforcement Officials: I may disclose your (or your child's) PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or grand jury or administrative subpoena.

For Health Oversight Activities: I may disclose PHI to a health oversight agency for activities authorized by law. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

Specialized Government Functions: I may disclose you (or your child's) PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

Disclosure to Relatives, Close Friends and Other Caregivers: I may use or disclose your PHI to a family member, other relative, a close personal friend or any other person that you indicate is involved in your care or the payment of your care unless you object in whole or in part. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, I may exercise my professional judgment to determine whether a disclosure is in your best interests. If I disclose PHI to a family member, other relative or a close personal friend, I would disclose only information that I believe is directly relevant to the person's involvement with your health care or payment related to your health care.

Workers' Compensation: I may disclose your PHI as authorized by and to the extent necessary to comply with California law relating to workers' compensation or other similar programs.

As required by law: I may use and disclose your (or your child's) PHI when required to do so by any other law not already referred to in the preceding categories.

Uses and Disclosures of PHI For Which a Signed Authorization is Required: For uses and disclosures of PHI beyond the areas noted above, I must obtain your written authorization. Authorizations can be revoked at any time in writing to stop future uses/disclosures (except to the extent that I have already acted upon your authorization).

<u>Your Rights Regarding Your (or Your Child's) PHI</u>:

You have the following rights regarding PHI I maintain about you (or your child):

Right to Inspect and Copy: You have the right to inspect and copy your (or your child's) health/mental health information upon your written request. However, some mental health

information may not be accessed for treatment reasons and for other reasons pertaining to California or federal law. I will respond to your written request to inspect records. A charge for copying, mailing and related expenses will apply.

Right to Request Restrictions: You have the right to ask that I limit how I use or disclose your PHI. I will consider your request, but I am not legally required to agree to the request. If I do agree to your request, I will put it into writing and comply with it except in emergency situations. I cannot agree to limit uses and/or disclosures that are required by law.

Right to Amend: If you believe that there is a mistake or missing information in my record of your health/mental health information, you may request, in writing, that I correct or add to the record. I will respond to your request within 60 days of receiving it. I 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, I may deny your request to amend information that: was not created by me, not part of my records, not part of the information that you would be permitted to inspect and copy or is accurate and complete.

Right to an Accounting of Disclosures: You have a right to get a list of when, to whom, for what purpose, and what content of your (your child's) PHI has been disclosed. This applies to disclosures other than those made for purposes of treatment payment, or health care operations. Your request must be in writing and state a time period (which may not be longer than six [6] years and may not include dates before April 14, 2003). I will respond to your request within sixty (60) days of receiving it. The first list you request within a 12 month period will be free. There may be a charge for more frequent lists. In such a case, I will notify you of the cost involved and you may choose to change or withdraw your request before any costs are incurred.

Right to Request Confidential Communications: You have the right to request that I communicate with you about health/mental health matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail. To request confidential communications, you must make your request in writing. Please specify how or where you wish to be contacted. I will accommodate all reasonable requests.

Right to a Paper Copy of this Notice: You have a right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time.

Complaints:

If you think that your privacy rights have been violated you may contact me at (510) 646-0123 or you may file a complaint the Secretary of the United States Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Client's Name: _____ Date of Birth: _____

Parent/Guardian's Name (if client is a minor): _____

By signing below, I hereby acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Signature of Client (Parent or Guardian if Client is a minor)

Date