



6540 Lusk Blvd, Suite C-135, San Diego, CA 92121
(858) 729 0692 / (858) 638 1576 fax

FACE SHEET

Patient Name _____

Home Phone _____ Cell Phone _____

Address _____ City _____ Zip _____

SS# _____ DOB _____ Age _____ Gender _____

Marital Status: Single Married Divorced Separated Widowed

Employment: Full-Time Part-Time Retired None Self-Employed Active Military

******Responsible Party Information: Only If Different From Patient Information******

Responsible Party _____ DL# & State _____

Social Sec #: _____ Date of Birth _____

Billing Address: _____ City _____ ST ____ Zip _____

Email _____ I would like to receive SDFS updates via email*
**SDFS does not share, sell, rent, or trade any individual's contact information.*

Relationship of Patient to Responsible Party: Spouse Child Other: _____

Insurance Co: _____ Policy/Group # _____

Member ID: _____ Type of Plan: _____

Sex: __ M __ F Date of Birth: ___ / ___ / _____

Relationship of Patient to Subscriber: Self Spouse Child Other: _____

Where did you hear about us? (please specify)

- Phone Book _____ Online Directory _____ Doctor _____
- Insurance _____ Advertisement _____ Friend _____
- Brochure _____ Website _____ Other _____

*******OFFICE USE ONLY*******



Consent for Treatment

I, _____, authorize and request that San Diego Family Services provide psychological examinations, treatment, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. The frequency and type of treatment will be decided between my therapist and me.

I understand that the purpose of these procedures will be explained to me and subject to my verbal agreement.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur.

I understand that not all therapists within San Diego Family Services are licensed practitioners. All un-licensed practitioners are registered with the appropriate governing boards and practice under the scope of Dr. Wise's license (PSY19841).

I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I have read and fully understand this Consent for Treatment form.

Name: _____ Signature: _____ Date: _____

Release of Information- Insurance

I consent to the release of information to my health plan for eligibility, claims, certification/ case management/quality improvement, and other health plan purposes.

Name: _____ Signature: _____ Date: _____

Authorization to Leave Messages

From time to time, it is necessary for representatives of San Diego Family Services to leave messages for patients. The purpose of these messages is to remind patients of their appointments or to ask a patient to call San Diego Family Services. The purpose of this consent is to authorize us to leave messages with members of your household or on your answering machine.

Name: _____ Signature: _____ Date: _____

Acknowledgment of Receipt of HIPAA Privacy Statement

I acknowledge that I have received and read my information privacy rights within the HIPAA notification provided to me.

Name: _____ Signature: _____ Date: _____



Confidentiality Statement

The contents of counseling, intake, or assessment sessions are considered to be confidential. Both verbal information and written records about you cannot be shared with anyone else without your written consent. It is our policy not to release any information about you without a signed release of information from you.

Exceptions to this policy include the following:

- Duty to Warn and Protect- If you disclose the intention or a plan to harm another person, we are legally required to warn the intended victim and report this information to legal authorities. If you disclose or imply that you plan to harm or kill yourself, we are required by law to take precautions to keep you safe, which includes contacting a family member or friend, a referral to a psychiatric hospital, or police intervention if necessary.
- Abuse of Children and Vulnerable Adults- If you inform us that you are being abused, if you are under the age of 18, if you state or suggest that you are abusing a child or vulnerable adult or have recently abused a child or vulnerable adult, or a child or vulnerable adult is in danger of abuse, we are legally required to report this information to the appropriate social service and/or legal authorities. A vulnerable adult is any adult over the age of 65 or who is dependent upon others for their care.
- Prenatal Exposure to Controlled Substances- We are required to report prenatal exposure to controlled substances that are potentially harmful.
- In the Event of a Client's Death- In the event of a client's death, the parents or guardians of a deceased client have a right to access their child's records. If you are over 18, your records are strictly confidential unless you have otherwise specified this in writing, either to your attorney or have left specific instructions with us.
- Court Orders- We are required to release records of clients when a court order has been placed. This does not include subpoenas from attorneys. If we are summoned to court or requested by you to attend and/or testify, you agree to pay our fees under separate fee agreement and arrangement.
- Minors/Guardianship- Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. We ask all parents not to do this for the success of treatment of your child, but it is a parent's legal right, unless the minor meets the exceptions to mental health treatment under law.

Name: _____ Signature: _____

Date: _____



GENERAL OFFICE POLICIES

APPOINTMENTS:

Services are provided by appointment only. Individual therapy sessions are 50 minutes. To schedule or cancel appointments call (858) 729-0692.

PAYMENTS:

Payments are due at the beginning of each session unless other arrangements have been made in advance. If other arrangements have been made, this does not relieve you of your obligation for our fee. Our fee for an individual therapy session is \$_____. Please note that fees will increase by a maximum of \$10 per year on January 1st. Also, this office charges a \$25.00 service fee for all returned checks.

INSURANCE:

This office will submit your insurance claims to your carrier, at no cost to you. However, we are not in a position to guarantee payment from your insurance carrier since the claim is based upon arrangements between you and the insurer. As a courtesy, we will attempt to verify your benefits, however, your carrier always denotes that the information they provide to this office does not provide a guarantee of payment. Also, please be aware that it is common for insurance companies to subcontract certain benefits to another company. In these instances, we may not bill your insurance company; we may be required to bill your medical group or a third party payer. I understand it is my responsibility to know if this is true and that it is my responsibility to pay for any amount not discounted and/or covered by my insurance ____ (initial).

PHONE AND EMERGENCY CONTACT:

If you need to contact us by phone, do not hesitate. When we are unavailable, please leave a message along with a phone number and the times when we can reach you. We are usually available to return calls by the end of the work day except on weekends. You will not be charged for phone calls unless we have a scheduled phone session or the conversation is of a problem solving nature that lasts more than 10 minutes. If you urgently need to reach us, state that in your message and we will attempt to return the call as quickly as possible. If it is an emergency, you can call the crisis line at 1-800-479-3339 or dial 911.

LENGTH AND FREQUENCY OF TREATMENT:

Psychotherapy typically involves regular sessions, 50 minutes in length. Duration and frequency vary depending on the nature of the problem and your individual needs. You have the right to end therapy at any time. If you wish, we will provide names of the qualified psychotherapists.

VOLUNTARY PARTICIPATION:

Seeing us is voluntary. If you wish to change providers, we will help you find another therapist who will see you. Even when the court or a social worker has said you must get therapy, you can still ask to change therapists.

LIMITS OF SERVICES

We do not guarantee results. We will do our best, but treatment results rely upon your participation and may not be what you hope for. We are not physicians and do not write prescriptions or tell you how to take medications your medical doctor may have prescribed.

I have read the above information and understand it clearly. I agree to the terms and to proceed with treatment. If I have any questions I may ask them at any time.

Name: _____ Date: _____

Signature: _____



CANCELLATION POLICY

Cancelling an appointment with insufficient notice prevents us from scheduling that time slot for other patients. All cancellations must be made at least 24 hours in advance. Cancellations not made within 24 hours of the appointment will be billed at the rate of **\$100** unless it is determined by both of us that an unavoidable emergency has occurred. If you do not show up or forget about a scheduled appointment, you will also be billed at this rate since the time was reserved strictly for you.

Please note: if insurance is paying for any portion of your sessions, you will be personally responsible for the agreed upon fee. Insurance will not pay for cancellations or no-shows.

We ask that you make every effort to show up for scheduled appointments or give us a minimum of 24 hours notification when appointments need to be cancelled or reschedule.

I have read the above information and understand it clearly. I agree to the terms and to proceed with treatment. I recognize that if I have any questions I may ask them at any time.

Name: _____ Date: _____

Signature: _____



CREDIT CARD AUTHORIZATION FORM

Please provide the following information:

Visa

MasterCard

American Express

Name: _____

Name as it appears on the Credit Card: _____

Home Address: _____
Address City State ZIP

Check here if same as home

Billing Address: _____
Address City State ZIP

Credit Card Number: _____ Exp Date: _____

3-digit CID number on back of card (4-digit for Amex): _____

*By signing below, you authorize San Diego Family Services to process your payment using the above information. You understand that all sales are final and no disputes are allowed for charges of services rendered. If your payment is unable to be processed or rejected due to dishonored payment, you will be assessed an additional fee of \$25.00. If payment is not rectified within 5 business days after being notified, it may be sent to an agency of our choice to enforce payment, plus penalties allowed to the maximum extent of the law of the State of California.

I, _____, agree to pay my bill using the above method of payment and have read and understand the terms and conditions. I understand that the terms and conditions herein are additional too, and not a substitute of, my agreement with San Diego Family Services.

I authorize San Diego Family Services to automatically charge the above credit card for each session or for any fees that I am charged while received services from San Diego Family Services.

Signature

Date



HIPAA Notice of Privacy Practices

I. 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.

II. IT IS OUR LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law we are required to insure that your PHI is kept private. The PHI constitutes information created or noted by me 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. We are required to provide you with this Notice about our privacy procedures. This Notice must explain when, why, and how we would use and/or disclose your PHI. Use of PHI means when we share, apply, utilize, examine, or analyze information within our practice; PHI is disclosed when we release, transfer, give, or otherwise reveal it to a third party outside our practice. With some exceptions, we 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, we are always legally required to follow the privacy practices described in this Notice.

Please note that we reserve the right to change the terms of this Notice and our privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with us. Before we make any important changes to our policies, we will immediately change this Notice and post a new copy of it in our office and on our website. You may also request a copy of this Notice from us, or you can view a copy of it in our office or on our website, which is located at www.sdfamilyservices.com.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

We will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of our uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. We may use and disclose your PHI without your consent for the following reasons:

1. For treatment. We can use your PHI within our practice to provide you with mental health treatment, including discussing or sharing your PHI with trainees and interns. We may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, we may disclose your PHI to her/him in order to coordinate your care.
2. For health care operations. We may disclose your PHI to facilitate the efficient and correct operation of our practice. Example: Quality control - We might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services.
3. To obtain payment for treatment. We may use and disclose your PHI to bill and collect payment for the treatment and services we provided you. Example: We might send your PHI to your insurance company or health plan in order to get payment for the health care services that we have provided to you.
4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that we attempt to get your consent after treatment is rendered. In the event that we try to get your consent but you are unable to communicate with us (for example, if you are unconscious or in severe pain) but we think that you would consent to such treatment if you could, we may disclose your PHI.)

B. Certain Other Uses and Disclosures Do Not Require Your Consent. We may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: We may make a disclosure to the appropriate officials when a law requires us to report

- information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
 3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
 4. If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
 5. To avoid harm. we may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).
 6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if we determine that disclosure is necessary to prevent the threatened danger.
 7. If disclosure is mandated by the California Child Abuse and Neglect Reporting law. For example, if we have a reasonable suspicion of child abuse or neglect.
 8. If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law. For example, if we have a reasonable suspicion of elder abuse or dependent adult abuse.
 9. If disclosure is compelled or permitted by the fact that you tell us of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
 10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, we may need to give the county coroner information about you.
 11. For health oversight activities. Example: We may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
 12. For specific government functions. Example: We may disclose PHI of military personnel and veterans under certain circumstances.
 13. For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.
 14. For Workers' Compensation purposes. we may provide PHI in order to comply with Workers' Compensation laws.
 15. Appointment reminders and health related benefits or services. Example: we may use PHI to provide appointment reminders.
 16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
 17. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess our compliance with HIPAA regulations.
 18. If disclosure is otherwise specifically required by law.

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

1. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, we will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that we haven't taken any action subsequent to the original authorization) of your PHI by us.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in our possession, or to get copies of it; however, you must request it in writing. If we do not have your PHI, but we know who does, we will advise you how you can get it. You will receive a response from us within 30 days of our receiving your written request. Under certain circumstances, we may feel we must deny your request, but if we do, we will give you, in writing, the reasons for the denial. We will also explain your right to have our denial reviewed. If you ask for copies of your PHI, we will charge you not more than \$.25 per page. We 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.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. While we will consider your request, we are not legally bound to agree. If we do agree to your request, we will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make.

C. The Right to Choose How We Send Your PHI 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). We are obliged to agree to your request providing that we can give you the PHI, in the format you requested, without undue inconvenience. We may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that we have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no cost, unless you make more than one request in the same year, in which case we will charge you a reasonable sum based on a set fee for each additional request.

E. 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 we correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of our receipt of your request. We may deny your request, in writing, if we find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of our records, or (d) written by someone other than me. Our denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and our denial be attached to any future disclosures of your PHI. If we approve your request, we will make the change(s) to your PHI. Additionally, we will tell you that the changes have been made, and we will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email. You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If, in your opinion, we may have violated your privacy rights, or if you object to a decision we made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. 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 our privacy practices, we will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact San Diego Family Services, 10505 Sorrento Valley Rd., Suite 450, San Diego, CA 92075 (858) 729-0692 and ask for the privacy compliance officer.

VII. EFFECTIVE DATE OF THIS NOTICE.

This notice went into effect on November 1, 2005.