The Way
Psychological Treatment Center

Office (760) 946-9300 Fax 760-334-8245

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CLIENT INFORMATION

CLIENT NAME (Last, First, Middle) GENDER HOME PHONE CELL PHONE
_____M___F___ ( ) _____ ( ) _____
TODAY'S DATE_____ /_____ /_____
PHYSICAL ADDRESS: CITY ZIP
_____
_
PO BOX _____
DATE OF BIRTH _____/_____ /_____
EMPLOYER: _____ WORK PHONE, _____ _____
OCCUPATION_____
EMPLOYER ADDRESS (Street, City, State, Zip) DRIVER'S LICENSE SOCIAL SECURITY NUMBER
_____ _____ _____ /_____ /_____

HOUSEHOLD MEMBERS

NAME	AGE	DOB	RELATIONSHIP

RESPONSIBLE PARTY INFORMATION

Parent, Guardian or Insured Spouse. **NOT INSURANCE CO**,

NAME: _____ DATE OF BIRTH _____/ _____ /_____
PHONE NUMBER: ( ) _____

ADDRESS (Street, City, State, Zip) PHONE NUMBER SOCIAL SECURITY NUMBER
_____ _____ _____/_____/_____

EMPLOYER: _____ OCCUPATION: _____
WORK PHONE: ( ) _____

EMPLOYER ADDRESS (Street, City, State, Zip) _____

I WILL BE PAYING TODAY BY ____ CASH ____ CHECK ___CREDIT ___INSURANCE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: ADDRESS (Street, City, State, Zip)

_____ _____

PHONE NUMBER ( ) _____

NAME OF INSURED RELATIONSHIP I.D. NUMBER GROUP NUMBER

_____ _____ _____ _____

SECONDARY INSURANCE COMPANY ADDRESS (Street, City, State, Zip) PHONE NUMBER

_____ _____( )_____-_____

NAME OF INSURED RELATIONSHIP I.D. NUMBER GROUP NUMBER

_____ _____ _____ _____

IF YOU WISH US TO BILL YOUR INSURANCE, PLEASE SIGN BELOW:

I authorize release of information to my insurance company for payment. I also authorize assignment of benefits to be paid to the provider.

_____ _____ _____

Signature (If client is a minor, adult must sign) Relationship Date

PERSONAL INFORMATION

CURRENT MARITAL STATUS:

_SINGLE _MARRIED _DIVORCED _WIDOWED _SEPERATED How Long? _____

HIGHEST GRADE OF EDUCATON_____ RELIGIOUS PREFERENCE _____MILITARY SERVICE_____

IN YOUR OWN WORDS, BRIEFLY DESCRIBE THE REASON YOU ARE SEEKING TREATMENT TODAY

WHO REFERRED YOU?

_____ PHONE NUMBER ( ) _____

FAMILY PHYSICIAN

_____PHONE NUMBER ( )

_____

IN CASE OF EMERGENCY, CONTACT

_____ PHONE NUMBER ( )_____

CAN WE CALL YOU AT HOME? ____YES____NO WORK?____YES ____NO

IF YOU PREFER THAT WE **NOT** CALL YOU AT HOME OR WORK, IS THERE A NUMBER WHERE WE CAN LEAVE A MESSAGE FOR YOU? ____ YES ____NO IF YES, PLEASE PROVIDE THE NUMBER ( ) _____-_____

HISTORY

HAVE YOU BEEN IN COUNSELING BEFORE? ____YES ____NO

IF YES, WHEN, WHERE AND WITH WHOM?

_____

HAVE YOU EVER BEEN HOSPITALIZED FOR A PSYCHIATRIC ILLNESS? ____YES ____NO

WHERE? _____ HOW LONG?

IS THERE ANY FAMILY HISTORY OF PSYCHIATRIC ILLNESS AND/OR DIFFICULTIES WITH ALCOHOL AND/OR DRUGS? ____YES ____NO
IF YES, PLEASE EXPLAIN:

HAVE YOU EVER HAD MEDICATION PRESCRIBED FOR PSYCHIATRIC REASONS? _YES _NO
IF YES, WHAT MEDICATION AND HOW LONG?
WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? IF NONE, PLEASE CHECK ____

MEDICATION	AMOUNT	HOW OFTEN	REASON

ARE YOU ALLERGIC TO ANY MEDICATIONS? _YES _NO IF YES, PLEASE EXPLAIN
CURRENT MEDICAL PROBLEMS? _YES _NO IF YES, PLEASE EXPLAIN

DO YOU SMOKE? _YES _NO IF YES, HOW MUCH?
DO YOU USE ALCOHOL OR ANY OTHER DRUGS? _YES _NO IF YES, PLEASE LIST
TYPE HOW OFTEN? HOW LONG?

OTHER COMMENTS:
The Way- Psychological Treatment Center

DISCLOSURES

Treatment Philosophy

Therapy is goal-directed, problem-focused treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal(s) in mind and progress is made toward accomplishment of that goal(s) in a timely manner. You will take an active role in setting and achieving your treatment goals. Your commitment to this treatment approach is necessary for you to experience a successful outcome. Standard appointment time is 30-45 minutes. If you ever have any questions about the nature of treatment or your care, please do not hesitate to ask.

Limits of confidentiality Statement

All information between practitioner and patient is held strictly confidential. There are legal exceptions to this:

1. The patient authorizes a release of information with a signature.
2. The patient's mental condition becomes an issue in a lawsuit.
3. The patient presents as a physical danger to self (Johnson v County of Los Angeles, 1983)
4. The patient presents as a danger to others (Tarasoff v Regents of University of CA, 1967)
5. Child or elder abuse and/or neglect is suspected (Welfare & Institution and/or Penal Code)

In the latter two cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken.

All written and spoken material from any and all sessions is confidential: unless written permission is given to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of the treatment, details of the group discussion are not to be discussed outside of the counseling sessions.

Release of Information

I authorize release of information to my Primary Care Physician, other health care provides, institutions, and referral sources for the purpose of diagnosis, treatment, and consultation and professional communication. I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

Emergency Access

Practitioners are available after hours to handle emergencies. By calling the main office number during after hours, you will be instructed how to contact the on-call practitioner.

I have read the above disclosures and understand them.

Signature of Patient/Guardian: _____ Date: _____

Financial Policy and Agreement

You are responsible for obtaining prior authorization for treatment from your insurance carrier. We will bill your primary insurance, however, you are responsible for co-payment amounts and deductibles as set by your benefit plan. We will not bill your secondary insurance (if there is one you may have). Missed appointments are not covered by your insurance and the charges associated with them are your responsibility.

If you are being seen under your **EAP**, services are paid by your employer.

If you have an **HMO**, co-payment amounts are set by your benefit plan. These payments are due and payable at each appointment. The co-payment set by your plan for each visit is as per your Insurance card and or Explanation of Benefits (EOB) statement

If you have **PPO**, you are responsible for a deductible and co-pay according to your benefit plan.

At any time during treatment should I become ineligible for insurance coverage, I will notify the practitioner and understand I will become responsible for 100% of the bill.

If you are without insurance or your fees are covered by an outside agency, the fee for services is as per current The Way's fee schedule. Payment is due at the time of treatment unless other arrangements have been made.

The practitioner is responsible for informing you of costs when you are beyond or outside your benefits. For special modalities of treatment not covered by your benefit plan, a written agreement needs to be signed between you and this office/practitioner. This agreement should outline your understanding that it is not a covered benefit, should cover fees and the treatment plan you may expect.

Cancellation and Missed Appointment Policy

Scheduled appointment times are reserved especially for you. If an appointment is missed or cancelled with less than 24 hours notice, you will be billed according to the scheduled fee or instructions of your benefit plan. Repeated "no-show" appointments could result in referring you back to the insurance company for reassignment to another practitioner. Your insurance company will not be billed for fees associated with missed or cancelled appointments.

CALIFORNIA LAW STATES that children under the age of 12 cannot be left unattended. Therefore, please bring only children who will be participating in treatment to your sessions.

I have read the above, and agree to accept treatment and I further agree to all conditions set forth herein.

Signature of Patient/Guardian: _____ Date: _____

Consent for Treatment

I authorize and request my practitioner to carry out psychological exams, treatments and/or diagnostic procedures that now or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.

If patient is child or dependent:
I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner/group to deliver mental health care services to the patient. I also understand that all policies described in the above statement apply to the patient I represent.

_____ _____
Patient/Guardian/ Legal Representative Signature Date

_____ _____
Witness Signature Date

RELEASE OF INFORMATION

As a mental health practitioner who wishes to provide my patients with the best possible care, we occasionally consult with colleagues regarding treatment planning and aftercare recommendations. We make every effort to protect your anonymity by discussing basic facts without disclosing your name. We also coordinate care with your Primary Care physician. We believe that it is in your best interest to coordinate care with any health care professional you are currently seeing, or have seen recently.

Insurance companies are required by their regulatory agencies to monitor for quality of care and may from time to time request to review records. Additionally, it is necessary to share some information with your health plan in order to secure for you the sessions you need and to process claims for payment.

Initials

_____ I **authorize** release of information to my **Primary Care Physician** and other health care providers and institutions as well as **referral sources for the purpose of diagnosis, treatment, follow-up care, and quality assurances activities.** Additionally, I release information for the purposes of consultations and professional communication in which my therapist or physician may engage in order to provide me with the **best treatment**.

_____ I **further authorize** the release of information to process claims, and for certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

_____ I refuse the release of _____ to _____. I acknowledge that this may impede coordination of care, and this practitioner's ability to access and secure needed benefits for me.

This release expires one year from the conclusion of treatment or immediately at my request.

CONSENT TO USE FACSIMILE OR CELLULAR PHONES

While The Way, Psychological Treatment Center staff/associates will always handle all information given by you, the client, with the utmost confidentiality, circumstances may arise which are beyond our control.

In the event of a crisis where you need to be connected with your Therapist, he/she may be using a cellular phone, or situations may occur where our office may need to correspond with another medical provider or your insurance company regarding your treatment via facsimile. In either case the scanning of a cell phone or misdirection of a facsimile may occur.

I have read the above statement and do hereby give my permission to The Way, Psychological Treatment Center staff/associates to correspond via facsimile or cellular phone during the course of my treatment if needed. I understand that the scanning of a cell phone or the misdirection of a facsimile may result in the unintentional violation of my confidentiality.

Signed: _____ Date:_____

Patient or Guardian: _____ Date:_____

Witness:_____ Date:_____