CONTRACT FOR INTAKE
Please print legibly.

Counseling Request

What **type of counseling** are you pursuing? ___ Adult Individual ___Child Individual
___ Adolescent Individual ___Couples ___ Family
___Group or Classes Please specify: _____

When are you **available** for counseling sessions? We will try to accommodate your schedule as mush as possible.
___Morning ___Afternoon ___Evening ___Saturday ___Certain days:
_____

All **T.H.E. therapists** are professionally trained; however their fees vary according to credentials. Which level of therapist would you prefer?
___Licensed Marriage & Family Therapist (MFT) ___MFT Graduate Intern

Client Information

Client's Name: _____

Today's Date_____

Soc. Sec. #: _____

Gender: M __ F___ Age: ____ Birth date: _____

Birth Place (City &State)_____

Address:_____

City, State, Zip:_____

Home Phone _____May we leave a message at home? Yes____ No____

Work Phone _____May we leave you a message at work? Yes___ No____

Cell Phone _____May we leave a message on the cell? Yes____ No____

E-mail _____

May we email you or put you on our mailing list? Yes____ No____

Responsible Party, if the client is an underage minor: Who is the legal guardian?

Name: _____

Address _____

City, State & Zip _____

Social Security#_____ Birth Date _____

Important persons to contact in case of emergency (Please provide name and telephone number):

[ ] Spouse [ ] Parent [ ] Other

Phone Number _____

Referred By? How Did You Hear About Us? (Check all that apply):

___I am a former client returning. How long ago? ____
___A client
___Brochure/Flyers
___Employee Assistance Program
___Union Representative
___Family or Friend
___Internet
___Employer/Supervisor
___School
___Yellow Pages
___Colleague

_____

___Insurance Company/Managed Care
___Physician

_____

___Court/Legal
___Probation

_____

___Another Therapist _____
___Minister/Priest/Rabbi

_____

___Word of mouth
___Other _____

PLEASE SIGN BELOW TO INDICATE THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT:

_____
Signature of Client

Date _____

_____
Signature of Parent/Legal Guardian/Foster Parent/Conservator/Other
(Required if participant is a minor, under age 18)

Date _____

INSURANCE INFORMATION
Who Is Responsible for this account? Who is the insured? What are your insurance requirements?

Primary Insurance Insured is: Self ___ Spouse/Partner ___ Child _____ Other _____

What is the insurance company name?

_____

Billing Address

_____

Phone Number (_____)_____

Is it a PPO? [ ] or HMO? [ ]

Membership/Benefit Policy Number _____ Group # _____

Plan # _____ Effective Date: _____/ _____/ _____

How much coverage do you have in a year? _____ Have you met your deductible?

Yes ___ No ____

What are your insurance company's credential requirements for pursuing counseling? (e.g. licensed MFT, registered social worker, etc.)

_____

Secondary Insurance: **Insured is:** Self ___ Spouse/Partner ___ Child _____ Other _____

What is the insurance company name?

_____

Billing Address

_____

Phone Number (_____)_____

Is it a PPO? [ ] or HMO? [ ]

Membership/Benefit Policy Number _____ Group # _____

Plan # _____ Effective Date: _____/ _____/ _____

How much coverage do you have in a year? _____ Have you met your deductible? Yes ___ No ____

Please Provide A Copy of Your Insurance Card To Office Staff So Benefits May Be Verified. Thank You.

Although **you are ultimately responsible for your fee**, health insurance may pay a portion of the charge. At your request, the Center's office staff will contact your insurance company to file your claims.

If your annual deductible has been met, it may be possible for you to pay only your portion of the fee and for the insurance company to pay the balance to the Center. If the deductible has not been met, you will be responsible for paying the full fee until the deductible has been satisfied, or you may agree to a plan with the office manager for paying the deductible and co-payment amounts. **Co-pays are due at the time of your session.**

Initial _____

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Number of sessions per year: _____

Number of sessions in a lifetime: _____

Allowable charges: $ _____

Do they consider a parity diagnosis? _____

Coverage per session: $ _____/ _____%

Allowable Co-payment: $ _____

SOURCE: _____ *DATE:* _____ *STAFF INITIALS*

_____

Notice of Privacy Practices
We respect our clients' confidentiality and only release information about you in accordance with state and federal laws.

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

This notice describes our policies related to the use of the records of your care at T.H.E. We are required to give you this Notice about (1) the use and disclosure of your health information, (2) our legal responsibilities, and (3) your rights concerning your health information and to abide by the terms of this notice.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional information, SUMBIT A WRITTEN REQUEST TO T.H.E. at truthhealingevolution@gmail.com

1. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
We use and disclose the minimum necessary health information about you for your treatment, for payment for your services, and for T.H.E.
mental health care operations.

a. **For Treatment.** We use and disclose your health information internally in the course of your treatment at T.H.E.. For example, we may give information to another T.H.E. health care professional for the purpose of referral within T.H.E. If we wish to provide information outside of T.H.E. for your treatment by another health care provider, we will have you sign an *Authorization For Release Of Information*.

b. For Payment. We may use and disclose your health information to obtain payment for services we provide to you as delineated in the "Contract, Office Procedure, and Financial Agreement" form. For example, we may need to give

insurance companies or other agencies the minimum necessary information in order for them to pay us for the service we have provided to you.

c. For Health Care Operations. We may use and disclose your health information within T.H.E. as part of our internal health care operations. For example, this could mean a review of records to assure quality. Alternatively, we may provide information to the student intern who is your therapist and is authorized to receive training at T.H.E. and to staff who supervise him or her. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

2. INFORMATION DISCLOSED WITHOUT YOUR CONSENT

Under California and federal law, information about you may be disclosed without your consent in the following circumstances.

a. Emergencies. Sufficient information may be shared to address an immediate emergency you are facing.

b. Judicial and Administrative Proceedings. We may disclose your personal health information in the course of a judicial or administrative proceeding in response to a valid court order or other lawful process, including if you were to make a claim for Workers Compensation.

c. Public Health Activities. If we felt you were an immediate danger to yourself or others, we may disclose health information about you to the authorities, as well as alert any other person who may be in danger.

d. Child/Elder Abuse. We may disclose health information about you related to the suspicion of child and/or elder abuse or neglect.

e. Criminal Activity or Danger to Others. We may disclose health information if a crime is committed on our premises or against our personnel, or if we believe there is someone who is in immediate danger.

f. National Security, Intelligence Activities, and Protective Services to the President and Others. We may release health information about you to authorized federal officials as authorized by law in order to protect the President or other national or international figures, or in cases of national security.

g. Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These activities might include audits or inspections and are necessary for the government to monitor the health care system and assure compliance with civil rights laws. Regulatory and accrediting organizations may review your case record to ensure compliance with their requirements. The minimum necessary information will be provided in these instances.

h. Business Associates. T.H.E. may disclose the minimum necessary health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, T.H.E. contracts with a financial audit firm to review the finances of T.H.E. on a yearly basis. In the process of the audit, they may encounter client-billing records. All of our business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

I. Research/Supervision. Under certain circumstances, T.H.E. may use and disclose health information for research and/or supervision. Before we do so, the project will go through a special approval process that includes a consent form for clients to sign if they are included in the research study/supervision. Even without the special approval, however, T.H.E. may permit researchers affiliated with T.H.E. to look at non-identifying information to help them plan research projects.

j. Marketing. T.H.E. may send you newsletters or information about services we provide in which we feel you might be interested. You may at any time request that your name be removed from our mailing list. We will not disclose any information to a third party for their use in telemarketing, direct mail marketing, or marketing through electronic

mail.

k. Fundraising/Activities. T.H.E. may use certain client demographic information-such as your name and address-to contact you about fundraising, ministries, workshops, training events, calendars of events, etc. T.H.E. LLC regularly seeks contributions from the general public to support our charitable and educational programs such as free care for children and families in low-income communities, a reduced-fee clinic, student scholarships, and research projects. If you do not wish to be contacted about fundraising, send a written request to: Truth, Healing & Evolution at truthhealingevolution@gmail.com

l. Scheduling Appointments. T.H.E. may use your phone number to call you and leave messages to schedule or remind you of appointments.

3. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

a. Right to Inspect and Copy. You have the right to look at or get copies of your health information, with limited exceptions. Your request must be in writing. If you request a copy of the information, a reasonable charge may be made for the costs incurred.

b. Right to Amend. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We have the right to deny your request under certain circumstances.

c. Right to an Accounting of Disclosures. You have the right to receive a list of instances in which we have disclosed your health information for a purpose other than treatment, payment, or health care operations. To request an accounting of disclosures, you must submit your request in writing to the Executive Director. Such accountings are available for disclosures beginning April 14. 2014, and remain available for eight years after the last date of service at T.H.E.

d. Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you could ask that we not share information with an insurance company, in which case you would be responsible to pay in full for the services provided. While you are in treatment, a written request should be made with your therapist. To request a restriction after therapy is completed, you must make your written request to the Executive Director of T.H.E. We are not required to agree to your request, but we will consider the request very seriously. If we agree, we will abide by our agreement unless the information is needed in an emergency or by law.

e. Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you may ask that we contact you only by mail or at work. You must make this request in writing and it must specify the alternative means or location that you would like us to use to provide you information about your health care. We will make every attempt to accommodate reasonable requests.

f. Right to Obtain a Paper Copy of this Notice. You have the right to receive a paper copy of this notice and any amended notice upon request. Any other uses and disclosures not set out in the information above will be made only with your written authorization. You may revoke a written authorization for release of information at any time. The revocation must be in writing and will become effective when it has been received by the records department of T.H.E. and will only be for disclosures not already completed.

We reserve the right to change our privacy practices provided such changes are permitted by applicable law. Before the effective date of a material change, however, we will change this Notice and make a new Notice available to you at the reception desks or lobbies at each Center site and on our web site.
Beginning April 14, 2014 and we are required to abide by the terms of Notice.

QUESTIONS AND COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us, or you may file a complaint with the U. S. Department of Health & Human Services www.hhs.gov/ocr/hipaa/. To obtain additional information, or to file a complaint with us, contact us at (909) 989-9030. We will not retaliate in any way if you choose to file a complaint.

This Notice is effective 4-1-07 (Revised 09/09)