Date:

1. Primary Client name:

Mailing Address

City

Home Phone Work Phone

Mobile Phone

Email

Date of birth Place of Birth

Ethnicity

Can we leave a message for you identifying the caller:

Yes No

Education (Highest Degree):

Occupation

Employer

Spiritual/Religious Orientation

Living Arrangements:

Whom do you presently live with?

Marital Status (circle):

Single Married Separated Domestic Partnership Divorced Widowed

Spouse/Partner/Parent:

Name of Spouse/Partner (Parent of Minor)

Home Phone Mobile Phone

Children:

Names of Children (if minor - name siblings) Age

Physician:

Family Physician

Phone

Address

City

Zip

Person to contact in case of emergency:

Relationship

Phone

Address

Reference:

Who referred you to this office?

May we acknowledge the referral? Yes No

2. BACKGROUND INFORMATION:

What brought you here today?

What are your goals for counseling?

What are your fears and concerns about being in counseling?

Are you experiencing stress in any of these areas? (circle) If so, describe:

Grief

Financial

Work/School

Relationships

Family

Legal

Other:

Who are the people you feel supported by?

Have you ever had a relationship with substance abuse?

If so, can you describe?

Substance and quantity:

Frequency

Last Use

Have you taken any psychotropic medications in the past at any time?

Antipsychotics

Antidepressants Anti-Anxiety

Are you taking any medications currently?

Medication

Amount

Frequency Purpose

Alcohol

Are you or have you been involved in AA/NA/CODA?

Other:

Previous Counseling Experience:

Outpatient/Inpatient

For how long:

With whom:

Have you had any experience with sexual or emotional abuse? Yes No

Have you had any treatment for it? Yes No

Have you had any traumatic incidents? Yes No

Have you had treatment for trauma? Yes No

Are you currently working with any other therapist, psychologist, group, etc.?

May we contact them? Yes No

Name

Phone

MEDICAL HISTORY:

Current medical problems:

Name of Physician:

Phone:

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING IN THE PAST YEAR?

Fatigue/Sleep Disturbance:

Depression/Extreme Sadness:

Loss of Interest in Daily Activities:

Panic/Anxiety:

Decreased Concentration/Memory Loss:

Mood Swings:

Weight Gain/Loss:

Excessive Worthlessness/Guilt:

Paranoia/Obsessive Behavior:

Isolation/Loneliness:

Attempted or seriously considered suicide? Yes No When?

Self-mutilated/cutting/burning? Yes No How?

Concerns about your sexuality with your partner or for yourself? Yes No

Have You Ever Had:

Seizures

Hallucinations

Blackouts

Scary Thoughts

Confusion

Tremors

Heart Palpitations

Difficulty Breathing

Stomach Problems

Diabetes

Other

Any Other Comments/Concerns:

Please describe any past or impending issues that apply to your family:

Self

Mother

Father

Sibling(s)

ALCOHOL ABUSE

Drug abuse

Emotional problems

Psychiatric hospitalizations

Anxiety

Depression

Other mental illness

Ulcers/colitis Asthma

Anorexia Bulimia

Insomnia

Attempted/completed suicide

Serious physical illness

Epilepsy Physical abuse

Sexual abuse Numerous childhood illness

Frequent relocations

Learning problems Deaths

Divorce Financial crisis/unemployment Legal problem

3. INFORMED CONSENT

CLIENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.1 CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY

Confidentiality is the legal right to privacy for all clients who receive psychological services. That is, all personal information presented in this office will not be discussed with persons or agents outside of this office except as authorized by a written release or as required by law. However, there are exceptions to confidentiality. Understand that all information discussed in this office will remain confidential except under the following circumstances:

• You consent in writing for Laurence Rosenthal. M.A. MFT 86497 to release and

disclose information.

• A breach of confidentiality is required or permitted by law. The State of

California requires that if there is a reasonable possibility of child abuse or elder abuse, this must be reported to the proper protective service immediately. There is no statute of limitations according to California law, so a report might be required for instances of abuse that occurred many years ago even if they are no longer occurring. Depending on the exact circumstances, this could result in an investigation. Any investigation would determine if the law has been broken and if legal action is warranted.

• Ethically and legally, if there is a reasonable possibility of harming others or yourself, then as a Marriage Family Therapist, Laurence Rosenthal, M.A., MFT is responsible to inform others, in order to protect them or yourself. For this reason or if there is an emergency during our work together, who would you like me to contact:

Name: Phone:

Address:

3.1 CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY (CONT’D)

• Laurence Rosenthal, M.A., MFT in his discretion decides to obtain consultation on your case with a consultant, colleague or legal counsel, in which case no identifying information will be revealed.

• You fail to make regular payments on your outstanding bill, which can result in your bill being turned over to a Collection Agency or submitted to Small Claims Court.

• This is a Social Service Agency case, wherein all information shared with Laurence Rosenthal. M.A., MFT will be conveyed to the assigned Social Worker and/or other SSA representatives and agents.

• If you are a party in litigation, including divorce litigation, and you tender your mental condition as an issue, your privilege may be waived. In custody cases, you may be required to waive your privilege to facilitate an evaluation by a court ordered evaluator. Laurence Rosenthal. M.A., MFT may be required to produce your records and/or testify at deposition or trial if he is served with subpoenas or court orders. Laurence Rosenthal, M.A., MFT cannot give you legal advice as to what actions may or may not waive your privilege.

• Please be aware that under California’s Family Code, a parent without custody may still be entitled to information about his or her child’s treatment.

• We frequently contact clients by Cellular Phone and Email. These technologies are not guaranteed of privacy. Please circle whether you authorize contact by Cell Phone and Email. YES / NO

• NOTE TO PARENTS ABOUT CHILDREN’S CONFIDENTIALITY: If your child participates in treatment, please understand the importance of allowing him/her to develop a confidential relationship with Laurence Rosenthal. M.A., MFT As such, you understand that most personal information that your child discusses with his/her therapist will not ordinarily be shared with you. Rather, your child’s therapist will provide you with general summaries of your child’s progress without private details. However, please understand that this office is committed to informing you about unusual or dangerous symptoms or behaviors.

3.2 GENERAL OFFICE POLICIES

Appointments

Services are provided by appointment only. Your scheduled appointment time is reserved specifically for you. While one hour is typically scheduled for an appointment, you will only be seen for 50 minutes. The remainder of the time is used to maintain a clinical record.

Phone Calls

I am available to return calls Monday through Friday between the hours of 9am and 8pm. If you leave a message for me and I do not respond within twenty-four hours, please call again to ensure that my phone system worked properly.

If you need to make more than occasional calls that are other than scheduling related, I may encourage you to increase the amount of time we have together in the office. I have found this to be the best way to address your needs. Where phone consultations are necessary, and it lasts more than ten minutes, you will be billed for the time, which will appear on your next statement. I will inform you at the time if you will be billed for the phone consult. You will not be billed for routine scheduling or information calls. In case of an emergency, please call your own medical doctor or go to your local emergency room.

Initial: \_\_\_\_\_\_

Cancellations

Normally, APPOINTMENTS CANCELLED WITH LESS THAN 48 HOURS NOTICE WILL BE CHARGED AT THE REGULAR FEE. If an emergency arises and you cannot keep your appointment, please call so that we can discuss the possibility of rescheduling. I also ask that MONDAY APPOINTMENTS MUST BE CANCELLED BY FRIDAY 8PM.

Initial: \_\_\_\_\_\_

Termination

When it is time for therapy to end, it is important to complete the last sessions. These are an important part of the therapeutic process. If you decide at any time that you want to terminate, please inform me so we can discuss this process.

Initial: \_\_\_\_\_\_

Fees

Our agreed-upon fee is $250.00 for a 50-minute individual, psychotherapy session. Fees are due when services are rendered. Fees may be paid in cash, through Venmo or by check in advance.

Balances not paid within 30 days are ‘PAST DUE’. Balances not paid within 60 days may be sent to our collection agency or pursued through Small Claims Court. If you are not able to make a full payment, please discuss this issue with Laurence Rosenthal, M.A., MFT so we may look at other possible options.

When planning a fee increase, I will give you at least four weeks notice. Returned check fee is $25.00.

Initial: \_\_\_\_\_\_

Insurance Claims

You are obligated to pay for services at the time rendered, regardless of which charges your insurance company covers. Laurence Rosenthal, M.A., MFT does not accept private insurance, nor Medicare nor MediCal.

Laurence Rosenthal, M.A., MFT can provide you with a “super bill” which you may submit to your insurance company. You have the right to verify coverage with your insurance company prior to beginning services. The filing of insurance claims is your responsibility. A super bill will be mailed monthly to the above address for you to file your claim with your insurance company.

Initial: \_\_\_\_\_\_\_

Other Services

Charges for other services, such as hospital visits, consultations with other therapists, home visits, or any court-related services will be based on the time involved in providing the service at my regular fee schedule.

Initial: \_\_\_\_\_\_

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Arbitration Agreement

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be

determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Commitment

I realize that my services involve a substantial amount of money and time. I encourage you to make a commitment to yourself that you to work hard and honestly with yourself and me to make the most of your sessions. Please do not hesitate to ask any questions about therapy, the process, my experience and qualifications, risks and benefits of therapy or any concerns you may have.

My signature below shows that I understand and agree with the confidentiality and limits to confidentiality as well as the general office policies.

Client signature:

4. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge RECEIPT of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full. My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at 424.253.6566. If you have any questions about my Notice of Privacy Practices, please contact me at 435 N. Bedford Drive, Beverly Hills, CA #401 Beverly Hills, CA 90210

I acknowledge receipt of the Notice of Privacy Practices of Laurence Rosenthal, M.A., MFT

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patient/parent/conservator/guardian