

CLIENT INTAKE QUESTIONNAIRE — AREAS OF CONCERN

No need to write complete sentences -- it's OK to list key points.

Briefly describe the issue(s) or concern(s) that caused you to seek treatment.

Do you have specific goals regarding your treatment?

What are your concerns or fears (if any) with regard to treatment?

CLIENT INTAKE QUESTIONNAIRE — PSYCHOLOGICAL HISTORY

No need to write complete sentences -- it's OK to list key points.

Have you received mental health treatment in the past?

When and for how long?

What was the focus of treatment(s)?

Name of treating therapist(s), address(es), and phone number(s):

Have you ever taken any psychological tests?

If yes, what type and who administered the test(s)?

CLIENT INTAKE QUESTIONNAIRE — PSYCHOLOGICAL HISTORY

No need to write complete sentences -- it's OK to list key points.

Have you ever been hospitalized for mental or emotional problems?

Why, when, and for how long were you hospitalized?

Name of treating therapist(s), address(es), and phone number(s):

Have you ever attempted suicide?

If yes, when and what circumstances led you to attempt suicide?

Are you currently having any suicidal thoughts?

If yes, please describe those thoughts:

Have you ever intentionally hurt (injured) yourself (e.g., skin-cutting, burning, scratching, banging or hitting body parts, scab picking, hair pulling, swallowed toxic substances or objects)?

If yes, please describe:

CLIENT INTAKE QUESTIONNAIRE — PSYCHOLOGICAL HISTORY

No need to write complete sentences -- it's OK to list key points.

In a few words, please describe your childhood:

Have you (as a child or adult) been subjected to verbal, physical, emotional, or sexual abuse?
If yes, please describe:

Have you ever been a victim of a violent crime?
If yes, please describe:

CLIENT INTAKE QUESTIONNAIRE – MEDICAL HISTORY

No need to write complete sentences -- it's OK to list key points.

Have you ever been diagnosed with a chronic or serious illness or disease?

If yes, please list:

Do you have any medical conditions that may affect your mental health treatment?

Please describe your overall health today:

Are you experiencing any medical/physical symptoms that you attribute to mental, emotional, or stress-related conditions?

If yes, please describe:

Prescription Drugs That You Take			
Name of Drug	Taking to Treat What?	Taking How Long?	Prescribed By

In the past, what other medications (not listed above) have you taken for a mental or emotional condition?

CLIENT INTAKE QUESTIONNAIRE — SOCIAL HISTORY

No need to write complete sentences -- it's OK to list key points.

Do you smoke cigarettes?

If yes, many cigarettes do you smoke per day, and how long have you been smoking?

Do you drink alcohol?

If yes, at what age did start drinking, and about how much alcohol do you drink in a week?

Do you smoke marijuana (pot)?

If yes, at what age did try pot, and about how often do you smoke pot?

Do you use other illegal drugs?

If yes, what drugs and how often?

Have you been in a 12-step program?

If yes, please describe:

CLIENT INTAKE QUESTIONNAIRE — FAMILY HISTORY

No need to write complete sentences -- it's OK to list key points.

Mother's name, age (or age at death), and description of relationship with your mother:

Father's name, age (or age at death), and description of relationship with your father:

Brother's name(s), age(s), or age(s) at death, and description of relationship with your brother(s):

Sister's name(s), age(s), or age(s) at death, and description of relationship with your sister(s):

List any other family or personal relationships that you feel are relevant to your therapy:

CLIENT INTAKE QUESTIONNAIRE — OTHER

No need to write complete sentences -- it's OK to list key points.

Describe your spiritual identity/orientation:

List your interests and hobbies:

Please feel free to include any other information that you believe is relevant to your mental health treatment:

DISCLOSURE STATEMENT & AGREEMENT FOR SERVICES

INTRODUCTION

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist (Linda S. Barnard) any questions that you may have regarding its contents.

At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

Linda S Barnard, Ph.D. is a Licensed Marriage and Family Therapist, license number MFC18721. She is a Board Certified Expert in Traumatic Stress and Board Certified in Domestic Violence through the American Academy of Experts in Traumatic Stress. A copy of her curriculum vitae is available at your request.

FEES

The fee for services is \$105 per therapy session, generally lasting approximately 50 minutes. Fees are payable at the time that services are rendered unless other arrangements are agreed to in writing. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure.

I do not take insurance payments and am not on any insurance panels at the current time. If you wish to utilize insurance for services, it will be expected that you pay for services at the time you receive them, and you will be provided with a monthly statement for you to submit to your own insurance company for reimbursement.

If, for some reasons, you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

DISCLOSURE STATEMENT & AGREEMENT FOR SERVICES (continued)

CONFIDENTIALITY

All communication between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in couple or family therapy, your therapists will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release.

As a psychotherapist, I am committed to protecting your privacy and confidentiality to the full extent of the law. This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. This notice conforms to the Federal Health Insurance Portability and Accountability Act (HIPAA) effective April 15, 2003. It also conforms to the health care privacy laws of California. Please review it carefully.

Uses and Disclosures That Do Not Require Your Authorization

New federal and state laws allow psychotherapists and other health care workers to use or disclose your Protected Health Information (PHI) for certain treatment, payment, and health care operations purposes without your authorization. Protected Health Information (PHI) records include the medications, crisis risk, symptoms, test results, billing, and treatment plans. This record does not include any detailed written psychotherapy notes I may keep about our work together. Psychotherapy notes are separate notes and are given more privacy and confidentiality protection by law.

Disclosure of your PHI without your authorization may include, but is not limited to, sending insurance billings, case management and/or care coordination with your insurance company or HMO, and consulting with your family physician and your other health care providers.

In addition, there are some legal circumstances where I may use or disclose your PHI without your written authorization or consent. These include the following:

Child Abuse: Whenever I, in my professional capacity, have knowledge of or observe a child I know or reasonably suspect has been the victim of child abuse or neglect, I must immediately report such to a police department, sheriff's department, county probation department, or welfare department. Also, if I have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that this or her emotional well-being is endangered in any other way, I may report such to the above agencies.

DISCLOSURE STATEMENT & AGREEMENT FOR SERVICES (continued)

Uses and Disclosures That Do Not Require Your Authorization (continued)

Elder or Dependent Adult Abuse: If I, in my professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these or if I reasonably suspect such, I must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency.

But, I do not have to report such an incident if:

1. I am not aware of any independent evidence that corroborates the statement that abuse has occurred;
2. That elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia, and;
3. In the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

Health Oversight: If a complaint is filed against me with the California Board of Behavioral Sciences, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made about the professional services that I have provided you, I must not release your information without 1) your written authorization or the authorization of your attorney or personal representation; 2) a court order; or, 3) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides me with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified me that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.

Serious Threat to Health or Safety: If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.

DISCLOSURE STATEMENT & AGREEMENT FOR SERVICES (continued)

Uses and Disclosures That Do Not Require Your Authorization (continued)

Worker's Compensation: If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of your initial examination, and at subsequent intervals as may be required by the administrative director of the Worker's Compensation Commission in order to determine your eligibility for worker's compensation.

Other: There may be other situations when I am specifically required by law to release your PHI.

Uses and Disclosures Requiring Your Authorization

In order to use or disclose your PHI in situations other than those previously discussed, I must obtain your written authorization. This authorization must be obtained before information is released. I will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes I have made about our conversations during an individual, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke or modify all such authorizations (of PHI or psychotherapy notes) at any time. However, the revocation or modification is not effective until I receive it.

Patient's Rights and Provider Duties

Patient's Rights:

Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and At Alternative Locations-You have the right to request and receive confidential communications PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

Right to Inspect and Copy-You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in

some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

DISCLOSURE STATEMENT & AGREEMENT FOR SERVICES (continued)

Right to Amend-You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to Accounting-You have the right to obtain a paper copy of this notice from me upon request.

Provider's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with this notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice and to make the new notice provisions effective for all PHI that I maintain. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I substantially revise my policies and procedures, I will immediately change this notice and make the revision available. I will notify you verbally of such a change at our next meeting and upon request I will provide you with a paper copy of the revised notice.

Complaints –If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me at (916) 606-8748.

Effective Date This notice will go into effect on November 1, 2012.

I acknowledge receipt of this notice:

Signature _____

Printed Name _____

Date _____

Minors and Confidentiality

Communication between therapists and patients who are minors (under the age of 8) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the

parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

DISCLOSURE STATEMENT & AGREEMENT FOR SERVICES (continued)

Appointment Scheduling and Cancellation Policies

You and your therapist will determine how frequently your sessions occur. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance of your appointment. If you do not provide your therapist with at least 24 hours notice in advance of your appointment, you are responsible for payment for the missed session.

Therapist Availability/Emergencies

I am often not immediately available by telephone. While I am usually in my office between 9 AM and 6 PM on Tuesdays and Wednesdays, I will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by a voice mail that I monitor frequently. I will make every effort to return your call within 24 hours of the time you called in, with the exception of weekends and holidays. If you are unable to reach me and feel that you can't wait for me to return your call, contact the Sutter Center for Psychiatry crisis line at 386-3077 or, in an emergency, call 911. If I will be unavailable for an extended period of time, I will provide you the name of a colleague to contact, if necessary.

You can leave a message on my confidential voicemail if you wish to have your call returned. However, be sure to leave your name, phone number (s), and a brief message concerning the nature of your call. Even if you think I already have your phone number, leave it anyway, since I often respond to calls from remote locations where I do not have access to your contact information.

Therapist Communication

Your therapist may need to communicate to you by telephone, mail, or other means. Please indicate your preference by checking the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

Therapist may call me at my home. My home number is _____

Therapist may call me on my cell phone. My cell phone number is _____

Therapist may call me at work. My work phone number is _____

Therapist may send mail to me at my home address

Therapist may contact me by email. My email address is _____

Therapist may text me at the following number _____

About the Therapy Process

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask your therapist to address any questions or concerns that you have about this information before you sign.

LINDA S. BARNARD, Ph.D.

418 Alhambra Blvd.

Sacramento, CA 95816

(916) 606-8748

Name of Patient

Signature of Patient

Date

“No Secrets” Policy for Family Therapy and Couple Therapy

This written policy is intended to inform you the participants in family therapy or couple therapy, that when I agree to work with a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (the treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since these sessions can and should be considered a part of the family or couple therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosure to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen, the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be share with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the patient (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual’s interest may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the _____ (couple/family or other unit) being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with the therapist, and that we enter couple/family therapy in agreement with this policy.

LINDA S. BARNARD, Ph.D.

418 Alhambra Blvd.

Sacramento, CA 95816

(916) 606-8748

Signature _____
Date _____

Signature _____
Date _____

Signature _____
Date _____

Signature _____
Date _____