Name Of Minor: ___________________________ Today's Date:__________________

Minor's Mother:______________________ Minor's Father:_______________________

Address:__________________________________ Date of Birth:__________________

____ Email:________________________

Phone: CELL:_________________________ HOME:____________________________

Ok to leave messages: Y____N____ Ok to leave messages: Y___ N___

SSN:__________________________________ Occupation:_________________________

(SSN required if you are using your health insurance)

Relationship Status of Parents: ____

Please note, if parents are divorced, and/or a custody order is in place, a copy of the formal custody order is required to proceed with therapy

Emergency Contact:____

Name, Relation, Phone Number

-By providing this information you are authorizing therapist to contact this person in the case of an emergency-

Others living in your home (Name, Age, Relation):___________________________________

____

____

Primary Care Physician:____

Phone:______________________________ Fax:___________________________________

Please describe your reasons for seeking treatment:__________________________

____

When did the issue arise, was there an event that made these issues surface: ___

____

What do you expect from therapy:____

____

Please indicate and rate the issues you would like to work on in treatment:

1-Not an Issue 2-Mild Issue 3-Moderate Issue 4-Severe Issue

__Depression
__Anxiety
__Controlling Stress
__Loss of Loved One
__Problems at School
__Problems at Work
__Other_______________

__ Lack of Friends
__Loneliness
__Problems Coping
__Abuse
__Financial Problems
__Legal Matters: ______
____

__Realtionship Issues
__Sexuality/Sexual Issues
__Family Conflict
__Behavioral Problems
__Drugs/Alcohol
__Other Maladaptive Habit____________________

Personal Medical History

Allergies (including food/medication):____________________________________

Current Medications:____

____

Past Hospitalizations/Surgeries/Major Medical Issues:_______________________

____

____

Date of Last Physical and Findings:_____________________________________

____

Are you currently being treated for medical issues:__________________________

____

LIFESTYLE/HABITS

	Amount Currently Using	Most Ever Used	When
Coffee (cups/day)			
Other Caffiene			
Cigarettes/Vaping			
Alcohol			
Drugs			

	Type(s)	Frequency
Current Exercise		
Current Hobbies		

Hrs/week at work____

Do you have a history of blackouts, seizures, or withdrawals? (if yes, describe):__

____

Have you ever received mental health/substance abuse treatment before:______

Provider	Date first seen	Date last seen	medication (if applicable)

____
____

Family Medical History

Has anyone in your family had a serious medical illness-please explain:__________

____

Has anyone in your family had a mental health issue or mental illness:___________

____

Has anyone in your family had a substance abuse issue:_______________________

____

INFORMED CONSENT REGARDING PROVIDERS

This is intended to clarify the relationships of the providers in this office. The provider you are being treated by, Abby Withee, MFT, is an independent provider. She is not an employee of or partner in a group. Although the providers in this office share space, they are not partners, nor otherwise affiliated. Each provider in the office is independently licensed, carries their own business license, and do not practice together. **They are not responsible for one another's practice or clients.**

___ I have read the above and understand that Abby Withee, MFT is an independent provider.

___ The above has been explained to me by Abby Withee, MFT

________________________________ ________________________

Print Name Date

____

Signature

CONSENT FOR TREATMENT AND CONFIDENTIALITY POLICY

Therapist

Abigail T. Withee, MFT, is a licensed Marriage and Family Therapist engaged in private practice providing mental health care services to clients directly and also as an independent contractor/provider for various insurance/managed care entities.

______Initials

Policy Regarding Consent for the Treatment of a Minor Child

Therapist generally requires the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for psychotherapy, Therapist will require that Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services. Therapist is not a custody evaluator and will not make statements regarding custody or parent fitness.

______ Initials

Risks and Benefits of Therapy

Therapy with a minor is usually most beneficial with participation of parents/caregivers. Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his/her life more fully. It provides an opportunity to better understand oneself, as well as, any problems or difficulties Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Patient's perceptions and assumptions, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient.

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

Although you will be charged for the first session, keep in mind that the first session is an evaluation session, after which the therapist will determine whether it is appropriate to begin treatment or refer you to a more appropriate therapist or another venue of care.

______Initials

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Patient.

______Initials

Records and Record Keeping

Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient. Should Patient request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Patient's records for ten years following termination of therapy, or ten years after the patient turns 21. However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

______Initials

Confidentiality

Discussions between a therapist and client are confidential. No information can be released without the client's signed consent/authorization, unless release of information is mandated by law. California state law mandates the reporting of actual or suspected child or elder abuse to the appropriate agencies. A therapist is mandated to report whenever s/he has knowledge of, or reasonably suspects, that a minor/child or elder has been physically abused, sexually abused, severly emotionally abused, or that the minor/child's or elder's health is endangered due to lack of medical care, food, clothing, shelter or supervision. Elder abuse also includes financial abuse and restriction of physical freedom. Child abuse also includes a client owning, using, or in any way engaging in child pornography.

It has also been legally mandated that if an individual intends to take harmful or dangerous action against another, it is the therapist's duty to warn the person and/or the family of the person who is likely to suffer the results of harmful behaviors; as well as to notify the police.
______Initials

Payment

If you choose to use your insurance, it is your responsibility to check your benefits. Benefits will not be known fully until an explanation of benefits is received. In the event that benefits are quoted incorrectly or insurance does not reimburse for sessions, the financial responsibility is on the client and the client will be billed for the balance. ______Initials

Client or representative, ______________________________, allows therapist, Abby Withee, MFT, to release the necessary information to client's insurance provider in order to bill for sessions and authorize continued sessions.

______Initials.

Patient Litigation

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient and another individual, or entity, are parties. Therapist has a policy of not communicating with Patient's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of $150 an hour, this includes all preparation, drive, and wait time.

_____Initials

Psychotherapist-Patient Privilege

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by Patient or Patient's representative. Patient should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

______Initials

Therapist Availability

Therapist's office is equipped with a confidential voice mail system that allows Patient to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

______Initials

Text and Email

Therapist and clients may communicate via email or text about appointments only. Clinical information may not be submitted via these means. Email and text messages are not encrypted therefore confidentiality cannot be guaranteed.

______Initials

Social Media

Therapist will not friend or follow clients on social media. Therapist has a "work only" Instagram account (that_thing_i_said_in_session) that clients are welcome to follow, out of respect for client privacy, therapist will not follow clients back.

______Initials

Termination of Therapy

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient.

Acknowledgement

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

____

Patient Name (please print)

___________________________________ ______________

Signature of Patient (or authorized representative) Date

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

____

Name of Responsible Party (Please print)

___________________________________ ______________

Signature of Responsible Party Date

Cancellation Policy

A scheduled appointment means that this time has been reserved for you. **If an appointment is missed or cancelled less than 24 hours prior to session you will be charged the full fee of the session in accordance with your health plan.** Your health plan does not cover payment for missed sessions, therefore you, the client, are held responsible. In addition, any balance over 30 days will be charged to this card.

A credit card will be held for payment in the case of a late cancel or no show. **This is required** for the following reasons:

- When an appointment time is reserved for you, it is not available for other clients.
- When an appointment time is reserved for you, your therapist prepares for your appointment and sets that time aside for you.
- Because insurance does not compensate for missed sessions, your therapist is not compensated for their time if you miss the session.

Credit Card Number: ______________________ Type:______________________
Expiration Date:____________________________ CCV Code:_________________

I authorize Abby Withee, MFT to charge the above card for the full fee of a session in accordance with my insurance in the event of a missed or late canceled session.

______________________________________ ______________________________
Signature Date

If you would also like to use the above card to cover your payment for sessions (copays/coinsurances) please sign below:

______________________________________ ______________________________
Signature Date

NOTICE OF PRIVACY PRACTICES 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.

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website. Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. For your treatment. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.
2. To obtain payment for your treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.
3. For health care operations. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization.

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
    a. For my use in treating you.
    b. For my use in training or supervising other mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
    c. For my use in defending myself in legal proceedings instituted by you.
    d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
    e. Required by law, and the use or disclosure is limited to the requirements of such law.
    f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
    g. Required by a coroner who is performing duties authorized by law.
    h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10.Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.
Certain Uses and Disclosures Require You to Have the Opportunity to Object.
1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations. YOUR RIGHTS YOUR REGARDING YOUR PHI You have the following rights with respect to your PHI: 1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice, and my address and phone number are . You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:
1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201; 2. Calling 1-877-696-6775; or, 3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints. I will not retaliate against you if you file a complaint about my privacy practices.
EFFECTIVE DATE OF THIS NOTICE This notice went into effect on January 1, 2016.

I have read this NOTICE OF PRIVACY PRACTICES and have received a copy.

____

Patient Name (please print)

________________________________ __________

Signature of Patient (or authorized representative) Date