Positive Change Counseling Center
A Group of Individually Licensed & Independently Practicing Counselors/Therapists

5480 Baltimore Drive, Suites 106 & 250
La Mesa, CA 91942

11590 West Bernardo Court, Suite 230
San Diego, CA 92127

Positive Change
Counseling Center

www.pccounselingcenter.com

CLIENT INFORMATION

Date of 1st Appointment: ________________ Referral Source: ____________________

(Please indicate all those participating):

ADULTS

LAST NAME	FIRST NAME	D.O.B.	AGE	SS#	OCCUPATION	RELATIONSHIP TO CLIENT (or Self")

CHILDREN

LAST NAME	FIRST NAME	D.O.B.	AGE	SS#	LEGAL GUARDIAN	RELATIONSHIP TO CLIENT (or "Self")

Home Address: ____
City/State/Zip: ____

(OK to contact you here?)

Phone #s: Home:______________________ *(Y__ N__)(msg___)*
Work: ______________________ *(Y__ N__)(msg___)*
Cell: ______________________ *(Y__ N__)(msg___)*
Email: ______________________ *(Y__ N__)(msg___)*

Appointment Reminders can be sent via: ____ Text OR ____ E-mail

Emergency Contact Person: ________________________________
Relationship to Client/Family: ________________________________
Contact #: ________________________________

Primary Care Physician: ________________________________
Physician's #: ________________________________
Medications/For What: ________________________________
____

Person Responsible for Payment: ________________________________

1) Please describe your reasons for seeking therapy at this time. If there is a particular event or situation which triggered your decision, please describe the event:

____

____

____

2) Please rate the severity of the following symptoms over the last month according to the following rating scale:
0-No difficulty
1-Mild
2-Moderate
3-Severe

_____ Decreased appetite
_____ Increased appetite/eating more
_____ Binging and/or purging
_____ Weight change? +/- _____ lbs.
_____ Depressed mood
_____ Decreased energy/fatigue
_____ Sleep changes: trouble falling asleep; trouble staying asleep; trouble waking up (*circle one*)
Avg. # hours sleep _____
_____ Decreased sexual desire
_____ Difficulty with sexual functioning
_____ Loss of interest in activities
_____ Crying
_____ Feelings of hopelessness
_____ Feelings of helplessness
_____ Hear or see things others don't
_____ Ideas that others mean you harm
_____ Inattentive/Distractible
_____ Memory problems: Long-term; short-term
_____ Self-injurious behavior
_____ Thoughts of suicide
_____ Thoughts of harming others
_____ Major medical concern
_____ Impulsivity
_____ Hyperactivity
_____ Anxiety/Nervousness
_____ Worry/Fear
_____ Flashbacks of traumatic event
_____ Difficulties making decisions
_____ Pain Management
_____ Nightmares
_____ Hyper-vigilance
_____ Obsessive thoughts
_____ Compulsions
_____ Spending sprees
_____ Racing thoughts
_____ Rapid heart beat
_____ Trouble breathing
_____ Sweating
_____ Gambling
_____ Police/Probation involvement
_____ Stealing
_____ Lying
_____ Truancy
_____ Violent behavior towards others
_____ Destruction of property
_____ Fire setting
_____ Harming animals
_____ Anger outbursts
_____ Opposition
_____ Irritability
_____ Distress about sexual orientation or gender identity
_____ Substance Abuse
_____ Alcohol
_____ Illicit Drugs
_____ Prescription Drugs
_____ Spending time with others
_____ Self-esteem
_____ Phobia/Fears
_____ Other: ___________________________

3) Please identify any history of trauma:
_____ Physical Abuse
_____ Sexual Trauma
_____ Emotional Abuse
_____ Witnessed Violence
_____ Combat Trauma
_____ Major Accident
_____ Racial Trauma
_____ Domestic Violence
_____ Other Trauma (list)
_____ Loss of loved one(s) : Who? When? How? ___________________________________

4) _____ Number of pregnancies
_____ Number of live births
_____ Number of miscarriages/still births
_____ Number of terminated pregnancies

5) What would you like to see accomplished in therapy? List 2-3 goals:

1) ____

2) ____

3) ____

6) Have you or other members of your family ever received counseling or mental health services before? If so, please list dates, provider name, the issue for which services were sought, and what you feel was accomplished: (include hospitalizations for mental health)

____

____

____

7) Please list any medications and/or other treatments you are receiving at this time (i.e., prescription/over-the-counter medications, medical care, acupuncture, chiropractic care, substance abuse treatment, etc.):

____

____

8) Please identify personal strengths as well as your support system (friends, family, religious group) that may help with your success in therapy and personal growth:

____

____

8) ****Insurance Information**(if applicable):**

Insurance Company: ______________________ Phone: ______________

Patient's ID#: ______________________ Group #: ______________

Subscriber's Name: ______________________ Phone #: ______________

Subscriber's Address: ____

Subscriber's SS#: ______________________ Subscriber's DOB: ________

Subscriber's Employer's Name: ____________________________________

Subscriber's Relationship to Patient: ______________________________

EAP Company and Authorization Number: ____________________________

We do not bill secondary insurance at Positive Change Counseling Center.
Please note: If you choose to utilize your medical insurance for payment, ***a mental health diagnosis will have to be assigned in order for insurance to cover services*. If you have questions about this, you can ask your therapist, or refer to our website for further information.

INFORMED CONSENT & NOTICE OF PRIVACY PRACTICES

Welcome to my practice. This packet contains important information about my professional services and business policies. I believe that a person who understands and participates in his or her care can achieve better and quicker results. Please read this carefully and jot down any questions you might have so that we can discuss them at our next meeting.

Introduction

The therapists at Positive Change Counseling Center are Licensed Marriage and Family Therapists, Clinical Psychologists, Licensed Professional Clinical Counselors and Licensed Clinical Social Workers in the state of California. I am individually and independently licensed in the state of California to practice as a mental health provider. As your therapist, I am solely responsible for the legal and ethical treatment that I provide to you as my client. All treatment provided by me is done without the supervision or control of any third party.

IF YOU HAVE AN EMERGENCY

Call 9-1-1 or go to your nearest emergency room. If you have a crisis and you need to speak with someone immediately, call 1-888-724-7240 and someone will assist you. If you absolutely must speak with me, please leave a message on my direct line and your call will be returned as quickly as possible. PLEASE NOTE your call may not be returned for up to 24 business hours. **In case of crisis, emergency or urgent matters please call - DO NOT text or email.** Routine (non-emergency/non-urgent) messages will be responded to within 24-48 business hours.

Therapeutic Services

Sessions typically last forty-five to fifty(45-50) minutes. In the case of complex situations, we may choose to extend the length of the therapy session. Duration of treatment will depend on your needs, your treatment goals, and other factors related to your treatment responsibilities. As with any type of growth or change process, individual factors can significantly impact the rate and the degree of effectiveness of the therapeutic process. We will discuss your progress throughout treatment, including expected length of therapy. Weekly sessions are generally recommended at the onset of treatment. If you have any specific scheduling needs, it is strongly recommended that you schedule several visits in advance in order to avoid lapses in treatment and to ensure convenient appointment times. Therapy is strictly voluntary in nature. You have the right to terminate therapy at any time. As your therapist, I may also choose to terminate therapy for a variety of reasons. If therapy is terminated by me, you will be provided with at least three referrals for alternate therapists.

What to Expect in a Therapy Session

During the first couple of sessions I will be gathering information and creating treatment goals with you. Therapy works best when you have specific goals you wish to accomplish and you and I work together to develop a treatment plan to achieve your goals. During the time between sessions it is beneficial to think about and work on what was discussed. At times, you may be asked to take certain actions outside of the therapy sessions such as reading a relevant book or keeping records. For therapy to "work," you must be an active participant, both in and outside of the therapy sessions.

Fees

The fee for direct clinical services will be agreed upon prior to the commencement of services. It is customary to pay for professional services at the time they are rendered. You may pay by cash, check, or credit/debit card made payable directly to Positive Change Counseling Center.

If at any time you experience difficulties making your payment, I will be glad to discuss your concerns with you. In the event your check is returned for non-sufficient funds, you will be expected to pay for services by cash or money order and will also be charged a $35.00 fee for your returned check. Please be advised: if your insurance carrier denies payment for services rendered, you will be responsible for payment in full.

There may be circumstances under which you may be billed for time outside your actual therapy sessions, such as consultation time between your therapist and other professionals working with you, telephone consultations that last more than five (5) minutes, special reports and psychological evaluations, and other services deemed necessary for continuity of your care and effectiveness of treatment. Letters and reports that I complete on your behalf will be billed in half-hour (1/2 hour) increments of my normal hourly fee ($150) for the service. These charges are not covered by your insurance company, and therefore, you are fully responsible for payment.

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be electronically billed for you and your therapist at Positive Change Counseling Center will be paid directly by the carrier. You will be responsible for any applicable deductibles and co-payments at the time of service, prior to the session beginning.

Please note that myself or administrative staff of Positive Change Counseling Center will automatically charge the card on file if outstanding fees are less than $50. We will reach out should your fees exceed this amount, but will automatically charge if your account is past due more than 15 days.

Client fees that are more than 90 days past due will be sent to collections.

Cancellation Policy

If you are unable to attend your session for any reason, please notify me at least 48 hours in advance. Failure to do so will result in a full appointment fee and will either be charged to your card on file or will be expected to be paid at your next session. Insurance companies do not reimburse for missed sessions, therefore this will be your responsibility. Appointments may be cancelled by leaving a voice mail on my direct voicemail or the main office line (619) 733-6414, 24 hours a day, 7 days a week. If you are cancelling via text or email, please also call if you do not receive confirmation that I received your message.

Confidentiality and Mandated Reporting

All information exchanged between patient and therapist is considered strictly confidential. I will not release any information about your therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State Laws
2. The patient presents an imminent danger to himself or herself or to others
3. There is any reason to suspect the abuse or neglect of a child, dependent adult or elderly person
4. As necessary for continuity of care (this may include communication between myself and your other mental health or medical providers)
5. As required to collect payment for services
6. If a judge determines that therapeutic discussions are not confidential, the judge may order that specific information be released
7. If you are bringing your child for treatment, it is up to the therapist to determine the level of confidentiality he or she will require. As a general rule, children ages 12 and up will retain confidentiality from their parents, prohibiting me from discussing the content of sessions with parents. (Except in the cases of numbers 2 and 3).
8. If you participate in couples counseling as part of your treatment, please be advised that no information will be released without the written consent of both parties. As a standard, our clinicians will follow the "minimum necessary" rule for information being released.
9. No Secrets Policy: When working with couples it is essential for the effectiveness of treatment that you know I do not keep secrets from partners in couples. Should I happen to speak with either party individually the content of those conversations will not be kept

secret from the partner/spouse. The only exception is if there is an immediate or ongoing safety issue.

In the cases of numbers 2 and 3, all licensed therapists in the state of California are mandated by law to inform potential victims and legal authorities so that protective measures can be taken.

Health Insurance and Confidentiality of Records

Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/EAP in order to process the claims. Please refer to the Federal Health Insurance Portability and Accountability Act (HIPAA) form provided to you (located at www.pccounselingcenter.com – initial paperwork/forms) with regard to the use and disclosure of your Protected Health Information (PHI). Only the minimum necessary information will be communicated to the carrier. By signing this contract, you are consenting to a release of information about your treatment to your health plan for claims, authorization and case management for the purposed of treatment and payment. Positive Change Counseling Center has no control or knowledge over what insurance companies do with the information we submit or who has access to this information. You must be aware that submitting a mental health claim for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance. Also, please note that in order to bill your insurance company for services, I must make a mental health disorder diagnosis and this will become part of your medical records.

Electronic Communication

E-mail

Many people feel comfortable communicating via e-mail. However, there may be risks involved. There is no guarantee that spy-ware or other such programs will work 100% of the time. All e-mails will be stored on a password protected account that only I will have access to. Although I have no reason to believe that our e-mail communications will be read by any third party, communication via e-mail is, by nature, impossible to completely secure and it is possible that my e-mail may be accessed by a third-party without my knowledge. If you agree to e-mail communications, myself and Positive Change Counseling Center will not be held liable for breach of confidentiality should these messages be viewed. Should you choose to send an e-mail containing personal/clinical information, you give myself and/or Positive Change Counseling Center permission to respond by referencing the information you have included.

Text Messages

Do not text me if you have an URGENT OR EMERGENT message or situation. If you would like to use texting for appointment changes, please discuss with me ahead of time.

Recording of Sessions is not allowed without written permission by all present.

Appointment Reminders

You have the option to receive an automated e-mail or text reminder of your appointment. If you have provided a valid cell phone number you will receive a text message reminder. If you prefer an e-mail reminder, please provide a valid e-mail address. If you have not provided this information you will not receive an appointment reminder. Reminder messages are a COURTESY only – it is your responsibility to keep track of all appointments. Even if you do not receive a reminder you are still responsible for all late cancelation/no-show fees.

Social Networks/Dual Relationships

Please understand that I will not accept friend requests or any other request to be added to any social network (including, but not limited to: Facebook, Twitter, Snapchat, LinkedIn and Google+). In addition, I do not engage in friendships and/or business relationships with clients outside of their treatment, even after treatment has terminated.

Consultation

In order to provide you with the best care possible, I will periodically meet with other licensed mental health providers to discuss my cases. If your case is discussed, every effort will be made to keep identifying information confidential.

Appeals and Grievances

You have the right to request reconsideration in the case that outpatient care (number of visits) is denied certification by your insurance company. You are able to request an appeal through me, your therapist, and you risk nothing in exercising this right. You may also submit grievance to the California Board of Behavioral Sciences at 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834or at 916-574-7830, the Board of Psychology at 1625 N Market Blvd, Suite N-215 Sacramento CA 95834 or at 916-574-7720 or the California Department of Managed Health Care (DMHC) at 888-466-2219.

AGREEMENT FOR SERVICES

After reading and understanding the information above, please acknowledge your consent to begin services by initialing and signing the following agreement:

I have read, understand, and agree to the policies and procedures described above. _______ (initial)

I have received/reviewed a copy of HIPAA regulations. _______(initial)

I have read and understand the PHONE, E-MAIL and TEXT policies and consent to e-mail or text reminders._____(initial)

I understand that regular attendance will produce the maximum possible benefits but that I am free to discontinue treatment at any time in accordance with the policies of this office. I understand that a 48-hour notice is required for cancellation of my scheduled appointments. I agree to pay the full fee for services for any missed appointments or late cancellations. _______ (initial)

I agree to pay any fees at the beginning of each appointment. Payment is to be made to Positive Change Counseling Center. I understand that if for any reason my insurance does not cover services, I am responsible for payment, even if this determination is made after services are rendered. ______(initial)

If I am consenting on behalf of a minor child, dependent or beneficiary, I hereby authorize Positive Change Counseling Center therapists to deliver mental health services to the patient. I understand that all policies stated in this packet apply to the patient(s). I further accept that although my participation may be required as part of the patient's treatment, the patient's records are confidential, and by law I cannot access these records if the therapist at Positive Change Counseling Center believes such access would be detrimental to the patient. _____(initial)

I authorize my therapist and/or the administrative staff at Positive ChangeCounseling Center to release medical or other information necessary to process insurance claims for services rendered as part of my treatment. ______(initial)

I have been informed and understand the limits of confidentiality, which include mandated reporting situations. ________ (initial)

***By signing below, I consent to psychotherapy with ___________________________________ at Positive Change Counseling Center and acknowledge that I fully and completely understand that my therapist is an independent contractor and not an employee or representative of Positive Change Counseling Center. I understand that my therapist is solely responsible for the care he or she provides to me and does not receive any supervision by Positive Change Counseling Center.

_________________________________ _________________________________ ______
Printed Name D.O.B. Signature Date

_________________________________ _________________________________ ______
Printed Name D.O.B. Signature Date

A Message to Our Clients About Arbitration

Please Read Before Continuing to Arbitration Agreement

The attached contract is an arbitration agreement. By signing this agreement, we are both agreeing that any dispute arising out of the services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. I believe that the method of resolving disputes by arbitration is one of the fairest systems for both clients and providers. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement, you are changing the **place** where your claim will be presented. **You are not forfeiting your right to file a claim should you feel the need arises.** You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators) who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for **both** patients and providers. Further, both parties are spared some of the rigors of a trial and the publicity that may accompany judicial proceedings.

Our goal is always to provide mental health services in such a way as to avoid any such disputes. Still, we know that most problems begin with miscommunication. **If you have any questions at any time about your care, please ask us immediately.**

Please sign/initial the highlighted areas below. A copy of this agreement will be provided to you upon your request.

THERAPIST-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical/mental health 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 or arbitration proceedings. Both parties to this

contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the therapist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the therapist, and the therapist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the therapist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the therapist within 30 days, or signature. It is the intent of this agreement to apply to all medical/mental health services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical/mental health services.

____
Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT. IF YOU WISH TO HAVE A COPY OF THIS CONTRACT, YOU MUST REQUEST ONE. PLEASE NOTIFY YOUR PROVIDER AND A SIGNED COPY WILL BE PROVIDED.

By_____________________________________ __________
Provider's Signature (Date)

By: _____________________________________
Printed Name of Provider

By: ___________________________________ ______
Primary Patient's or Representative's Signature (Date)

By: _____________________________________
Printed Patient's Name

By: ____
Printed Representative's Name and Relationship to Patient

Credit Card Information

The undersigned hereby authorizes Positive Change Counseling Center to charge my credit card (provided below) for the amount of the therapy session, or co-pay, on the date of service, or if there is an outstanding balance more than 15 days after the date of service.

I understand that by signing this authorization, I give Positive Change Counseling Center permission to charge my credit card in the amount of the "full session fee" (this may be more than your usual copay) for a missed appointment without notice or any cancelled appointment that is within 48 hours of the scheduled time. I understand that this amount can be charged on the day of the missed appointment.

A current credit card number must be on file at all times, regardless of your preferred method of payment. Your card will not be charged if you pay by cash or check by the time your payment is due.

The credit card to remain on file is:

Card Number: ____

Expiration Date: _________________

Security Code: ____________ (3 digits on back of card MC/Visa/Discover: 4 digits on front of Amex)

Name as it appears on the card: _________________________________

Billing Address with zip code: _________________________________

____

The Undersigned understands and agrees to be bound to such agreements as outlined in this document. Please provide your signature below. If there is more than one adult participating in treatment, both must sign below.

SIGNATURE: _________________________________ DATE: _____________

PRINT NAME: ________________________________

SIGNATURE: _________________________________ DATE: _____________

PRINT NAME: ________________________________