Kate Mosier, M.A., M.F.T.

Licensed Marriage and Family Therapist

Welcome to my practice. I understand that asking for help can be difficult and I appreciate you having the courage to be here today. Before meeting with you and your child, I need you to complete the following forms. Please print them out, complete and bring with you to the first session. This is most likely the only time I will have you do any kind of paperwork during therapy.

1. Complete the three pages of client information (about your child).

2. Read and sign the informed consent which includes policies and an agreement of participation.

3. Read and sign the Release for the Evaluation and Treatment of a Minor form.

4. Complete the form that asks you to scale your child's symptoms and behaviors. (If your child is 10 years or older, there is a form for he or she to complete as well).

5. The Notice of Privacy Practices (HIPPA) form is for you, explaining your privacy rights. Your signature indicates that you have received your HIPPA form.

Thank you and please let me know if you have any questions.

Kate Mosier
Licensed Marriage and Family Therapist

Please complete all questions to the best of your ability. If the person needing treatment is a child, the parent or guardian should complete this form. Please let me know if you have any questions.

Client name _____ Birthdate _____

Parent name (filling out form) _____

Address _____ Age _____

City, State, Zip _____ Gender _____

Home phone (____) _____ Parent cell phone (____) _____

How would you like to be contacted _____

Name of school attending _____ Grade _____

Pediatrician name _____ (____) _____
Phone

Emergency Contact _____ Relationship _____

(____) _____
(Phone)

Parent Relationship Status: Single Married Domestic Partner Separated Divorced Widowed

Spouse/Partner

Name	Length of relationship	Living with you (Y/N)

Other Children

Name	Age	Sex	Living at home (Y/N)

Please list any other persons living with you besides children or spouse/partner:

_____

_____

Primary Insurance Information

Insured Name _____

Insured SSN _____

Insured Birthdate _____

Employer _____

Payer/Health Plan _____

Client's relationship to the insured:

Self Spouse Dependent

Member # _____

Policy/Group # _____

Secondary Insurance Information

Insured Name _____

Insured SSN _____

Insured Birthdate _____

Employer _____

Payer/Health Plan _____

Client's relationship to the insured:

Self Spouse Dependent

Member # _____

Policy/Group # _____

Please describe your reason(s) for seeking treatment at this time:

_____

_____

_____

_____

When did these problems or behaviors begin? How frequently do they occur?

_____

_____

_____

_____

Has your child ever received mental health treatment before? If so, please list dates, provider name, and the issue for which treatment was sought:

_____

_____

_____

Please check if your child has or is experiencing any of the following:

___ acute or chronic illness
___ allergies
___ head injuries
___ accidents
___ seizures or other neurological problems
___ hospitalizations or surgeries
___ problems with vision
___ problems with hearing

If yes to any of the above issues, please explain in full detail:

_____

_____

_____

_____

_____

Please list any medications your child is currently taking:

_____

_____

_____

If applicable, please identify if you have ever suspected your child of using drugs or alcohol. If yes, please provide detailed information.

_____

_____

_____

_____

What are your goals for therapy? What behaviors or problems would you like to see change in your child or family?

_____

_____

_____

How did you learn of my services? Who referred you?

_____

_____

INFORMED CONSENT AND CONTRACT

Please read this information and feel free to ask me any questions about me, my experience or credentials. The last page requires your signature, indicating that you understand and agree to my office policies.

I am licensed within the State of California as a Marriage Family Therapist (MFC 45315). I provide individual and family therapy for children, adolescents and adults.

Confidentiality

All information discussed in therapy sessions and telephone contacts are confidential unless:

1. You provide written permission to release information about your treatment
2. You present a physical danger to yourself or to others
3. Child abuse, elder abuse or dependent abuse is suspected
4. When information is ordered by a judge in a court order pursuant to a legal proceeding

I am required by law to inform potential victims and legal authorities when I have determined that a client presents a serious danger of physical violence to another person. I am required by law to report instances of suspected child abuse (i.e. physical, sexual, emotional, neglect) **both present or in the past** to the Department of Children and Family Services. I am also required by law to report instances of suspected elder or dependent abuse (any person over the age of 65 or a person unable to care for him/herself and is a victim of physical abuse, financial abuse, neglect, or isolation).

If you participate in family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in treatment provide written authorization to release such information. However, it is important for you to know that I utilize a "no-secrets" policy when conducting family therapy. This means that if you participate in family therapy, I may use information obtained in an individual session with me when working with other members of your family if I feel it is necessary.

Communication between therapists and clients who are minors (under the age of 18) are confidential. While parents or guardians have a legal right to information, I will use my professional judgment to determine what I will disclose about a minor's treatment. If the child is in danger I **will** discuss this information with parents.

I **do not** perform custody evaluations but can refer you to colleagues who can provide this type of service. Therapy is very different from conducting a child custody or visitation evaluation. Providing court testimony can be detrimental to my relationship with your child because they may not feel comfortable sharing their thoughts or feelings in therapy. I **cannot** provide the court with any recommendations or professional opinions regarding the custody or visitations of your child. By consenting to treatment, you are agreeing to instruct your attorney not to subpoena myself or your child's therapy records for court proceedings.

In order to provide you with the best care, I regularly consult with colleagues and participate in mandatory continuing education. At no time would your name or identifying data be revealed to others without prior written consent from you.

Fees and Financial terms

My standard fee for service is $_____ per 50 minute session. You will be expected to pay for each session at the time it is held. At this time, I only accept cash or check. I do offer a sliding scale in case of financial hardship. We will discuss your fee before the first session.

I am not a provider for any insurance companies at this time but can create what is called a *Super Bill* for you at the end of each month which details the number of sessions which you can submit to your insurance company. You would pay me my full fee and then get reimbursed for part (amount varies for each insurance company) of the payment after submitting the Super Bill. Please ask your insurance company if they will reimburse for outpatient psychotherapy from a Licensed Marriage and Family Therapist working in private practice. If yes, ask if they will accept a Super Bill completed by the therapist and then reimburse you for services.

Cancellation Policy

A scheduled appointment means that time is reserved for you. I believe that progress in therapy is dependent upon your commitment to this process. If you miss your appointment or cancel with less then 24 hours notice, you will be billed according to the scheduled fee. You must cancel within the hours of 8:00 am- 6:00 pm, Monday through Friday to avoid being charged.

Emergency Procedures

If you need to contact me, please leave a message on my office phone and I will make every effort to return your call within 24 hours with the exception of weekends and holidays. If an emergency arises, follow the emergency procedures as stated on my voicemail and/or state that your call is an emergency. **Please note that for phone calls that go beyond 15 minutes, you will be charged based on my hourly rate.** In the event of a medical emergency or emergency involving a threat to your safety or the safety of others, please call 911 or go to your nearest hospital. You should also be aware of the following resources that are available in to assist individuals who are in crisis:

Crisis Hotline: 1-800-273-TALK
Domestic Violence: 1800-799-SAFE
Youth Shelters: 800-442-HOPE
Little Company of Mary Hospital: (310) 540-7676
Del Amo Hospital: (310) 530-1151
Hermosa Beach Police: (310) 318-0360

About the therapy process

Although therapy is designed to be helpful, it can be difficult and uncomfortable at times. Experiencing and expressing intense feelings and emotions **can** help you work through things in your life that are making you feel stuck or unhappy. I believe that therapists and clients are partners in this process and you have the right to agree or disagree with my recommendations. I will provide feedback to you regarding your progress and encourage you to participate in the discussion. The length of your treatment depends on your goals and progress. You may stop therapy at any time. If you feel that you are not benefiting from treatment, please let me know so we can discuss alternatives.

Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask me to address any questions or concerns you have about this information before you sign.

I understand and agreed to all of the above information.

_____

Client (or parent/guardian) Name- Printed Date

_____

Client (or parent/guardian) Name- Signature Date

Release for the evaluation and treatment of a minor

As the parent/legal guardian of _____

I hereby authorize his/her evaluation and treatment. As parent or legal guardian, I have the right to request information regarding the above minor's evaluation and treatment.

Signature _____ Date _____

Relationship to client _____

Witness _____ Date _____

Please complete this form for your child. Read each statement and circle the number that best describes your child's symptoms or behaviors.

0 = Never **1= Sometimes** **2= all the time**

1.	argues a lot	0	1	2
2.	difficulty concentrating or paying attention	0	1	2
3.	cries a lot	0	1	2
4.	disobeys at home	0	1	2
5.	disobeys at school	0	1	2
6.	does not get along with other kids	0	1	2
7.	gets into a lot of fights	0	1	2
8.	nervous and tense	0	1	2
9.	eats too much	0	1	2
10.	often tired	0	1	2
11.	difficulty making friends	0	1	2
12.	lies and cheats	0	1	2
13.	acts or does things without thinking first	0	1	2
14.	difficulty sitting still	0	1	2
15.	steals things	0	1	2
16.	gets angry easily	0	1	2
17.	teases and picks on others	0	1	2
18.	difficulty sleeping	0	1	2
19.	cuts class or skips school	0	1	2
20.	low energy and fatigue	0	1	2
21.	appears sad	0	1	2
22.	worries a lot	0	1	2
23.	irritable or grouchy	0	1	2
24.	bad dreams or nightmares	0	1	2
25.	low self esteem	0	1	2

If you are 10 years old and up, please complete this form.

Read each question and circle the number that you think describes how you feel or act.

0 = Never **1= Sometimes** **2= all the time**

For example, if you argue with your parents, siblings, or kids at school all the time, you would circle the number: **2.** If you never argue, you would circle the number: **0.**

1.	I argue a lot	0	1	2
2.	I have trouble concentrating or paying attention	0	1	2
3.	I cry a lot	0	1	2
4.	I disobey my parents	0	1	2
5.	I disobey my teachers	0	1	2
6.	I don't get along with other kids	0	1	2
7.	I get into a lot of fights	0	1	2
8.	I am nervous and tense	0	1	2
9.	I eat too much	0	1	2
10.	I feel tired a lot	0	1	2
11.	I feel lonely	0	1	2
12.	I lie and cheat	0	1	2
13.	I act or do things without thinking first	0	1	2
14.	I have trouble sitting still	0	1	2
15.	I steal things	0	1	2
16.	I get mad easily	0	1	2
17.	I tease and pick on others	0	1	2
18.	I have trouble sleeping	0	1	2
19.	I cut class and skip school	0	1	2
20.	I don't have a lot of energy	0	1	2
21.	I feel sad	0	1	2
22.	I worry a lot	0	1	2
23.	I feel irritable or grouchy	0	1	2
24.	I have bad dreams or nightmares	0	1	2
25.	I don't like myself	0	1	2

Notice of Privacy Practices

I. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

II. I have a legal duty to safeguard your protected health information (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And I am legally required to follow the privacy practices described in this Notice.

III. How I may use and disclose your PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Use and disclosures relating to treatment, payment, or health care operations do not require your prior written consent. I can use and disclose your PHI without your consent for the following reasons:
   1. For treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can also disclose your PHI to physicians, psychiatrists, psychologists and other licensed health care providers who provide you with health care services or are involved in your case. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.
   2. To obtain payment for treatment. I can use and disclose your PHI to bill and collect payment for treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies and others that process my health care claims.
   3. For health care operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants or others to further my health care operations.
   4. Patient incapacitation or emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think you would consent to such treatment if you were able to do so.

B. Certain other uses and disclosures also do not require your consent or authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:
   1. When federal, state or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.
   2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or claim for workers' compensation benefits, I may have to use or disclose your PHI in

response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.

3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in a response to a search warrant.
4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.
5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.
6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.
7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.
8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or give you information about treatment alternatives, other health care services or other health care benefits that I offer that may be of interest to you.

C. 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.

D. Other uses and disclosures require your prior written authorization. In any other situation not described in sections III A, B, and C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. What rights you have regarding your PHI

You have the following rights with respect to your PHI:

A. The right to request restrictions on My Uses and Disclosures. You have the right to request restrictions or limitations on my use or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your case or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.
B. The right to choose how I send PHI to you. You have the right to request that I send confidential information to you at an alternate address (for example, sending information to your work address instead of your home address) or by alternate means (e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and when appropriate, you provide me with information as to how payment for such alternate communications will

be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The right to inspect and receive a copy of your PHI. In most cases, you have the right to inspect and receive a copy of such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you in writing, my reasons for the denial and explain your right to have it reviewed. If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The right to receive a list of the disclosures I have made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003. I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you made more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. The right to amend your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete , (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that my denial be attached to all future disclosures of your PHI. If I approve of your request, I will make the changes to the PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The right to receive a paper copy of this notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via email.

V. How to complain about our privacy practices

If you think that I may have violated your privacy rights or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. Person to contact for information about this notice or to complain about my privacy practices

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Kate Mosier, MFT 2200 Pacific Coast Hwy. Suite 305. Hermosa Beach, CA 90254.

VII. Effective date of this notice

This notice went into effect on April 14th, 2003.

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 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 (310) 784-5566.

If you have any questions about my *Notice of Privacy Practices*, please contact me at:

Kate Mosier, LMFT
2200 Pacific Coast Hwy. Suite 305 Hermosa Beach, CA 90254
(310) 784-5566

I acknowledge receipt of the *Notice of Privacy Practices of* Kate Mosier.

Signature:_____ Date: _____
(*patient/parent/conservator/guardian)*