THRIVE
THERAPY STUDIO

Child, Teen, and Adult Psychotherapy
5230 Carroll Canyon Rd, Suite 110
San Diego, CA 92121
858-342-1304
thrivetherapystudio.com

New Client Information Packet

Welcome to your first appointment.

During your first session, your Thrive Therapist will be getting to know your child and family. However, some of this information is more easily gathered in writing. These forms are designed to help your therapist get to know your child and family situation as quickly as possible in order to move forward with therapy. Please answer the questions with as much detail as you can and encourage your child to add in information when desired. You can also mark questions that you do not understand and they can be addressed during your session. Thank you!

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female ☐ Other- Specify _____

Person completing this form: _____ Relationship to Client: _____

Parent Information:

Parent #1	Parent #2
Name:	Name:
Phone Number:	Phone Number:
Address:	Address:
Employer/Occupation:	Employer/Occupation:

Are there other caregivers involved? ☐ Yes ☐ No If so, please describe: _____

_____

Are parents separated or divorced? ☐ Yes ☐ No If yes, please describe the custody arrangement and provide documentation: _____

Contact Information:

Patient Home Address: _____City: _____State: _____Zip: _____

		OK to contact?		OK to leave message?	
Telephone:	Home: _____	☐ Yes	☐ No	☐ Yes	☐ No
	Cell: _____	☐ Yes	☐ No	☐ Yes	☐ No
	Work: _____	☐ Yes	☐ No	☐ Yes	☐ No

Emergency Contact: _____ Relationship: _____Phone Number:_____

Financially Responsible Person's Information

Name_____ Relationship to Client _____

Phone (if different from previously entered information)_____

Address (if different from previously entered information) _____

Current Situation:

What are your main reasons for seeking therapy for your son/daughter? (Be as specific as you can)

When did this problem start?

Are there other concerns that you have regarding his/her development or current functioning? ☐ Yes ☐ No

If so, please describe:

Please check if there has been any recent changes in the following:

☐ Sleep patterns ☐ Physical activity level ☐ Eating patterns ☐ General disposition
☐ Behavior ☐ Weight ☐ Focus ☐ Energy level ☐ Nervousness/Tension
☐ Other (describe)_____

What are your main goals in coming to therapy?

1.
2.
3.

What do you believe are your child's main strengths?

What do you believe are your child's main weaknesses?

Family Information and Living Situation:

Parent/Step-parent/Caregivers Involved (Please provide name, age, occupation, personality, brief statement about relationship with the child for each person heavily involved in minor's life)

1.
2.
3.
4.

If parents are divorced, how old was your child at the time of divorce? _____

Describe how it has affected him/her:

Sibling Information: (Please provide name, age, brief statement about relationship to client)

1. _____
2. _____
3. _____
4. _____

Please describe your child's current living situation (house, apartment, shared space, who else lives in home etc.):

School Information:

Name of School: _____ Client's grade level: _____ School Counselor's Name: _____

Please describe their grades:_____

Please check all that apply to your child's education below:

- ☐ Documented Learning Disability ☐ Individualized Education Plan (IEP) ☐ 504 Plan
- ☐ Gifted and Talented Program ☐ Behavior Support Plan ☐ SST Meetings
- ☐ Specialized Classroom Instruction ☐ Specialized School or Day Program ☐ Remedial Classes
- ☐ Home School or Alternate Learning Environment ☐ Tutoring Services ☐ Counseling (School based)
- ☐ Other _____

Please describe any boxes checked, giving as much detail as possible:

How would you describe your child's functioning in school? (ex. Gets along well with others, responsive to instruction, defiant, shy, outgoing, attendance, etc.)

Does your child have any behavior or academic problems in school? ☐ Yes ☐ No

If so, please describe:

How do you believe the school/teacher view your child? (Hyperactive, Timid, High Achieving, Procrastinating, etc.)

What are your child's academic strengths?

What are your child's academic challenges?

Current Medical Information:

Does your child have health concerns? ☐ Yes ☐ No

If yes, please list any current health concerns:

Please list all current medications (Name, dose, frequency, reason):

Please describe any medical issues or serious injuries or illnesses (past, present):

Medical and Developmental History:

Was the pregnancy planned? ☐ Yes ☐ No Is your child adopted? ☐ Yes ☐ No

Please describe your pregnancy and any prenatal complications (include any unusual stressors or medical issues for your child's mother during pregnancy):

How often were prescription drugs, cigarettes, alcohol, illegal drugs used during pregnancy (please describe):

Please describe your child's birth and any complications:

Please describe your child's developmental milestones (walking, talking, eating, toileting, etc.):

What medical conditions has your child experienced since birth (check all that apply)?

☐ Abdominal pain	☐ Allergies	☐ Anemia	☐ Appendicitis	☐ Ear infection
☐ High fever	☐ Head injury	☐ Tic	☐ Trouble sleeping	☐ Broken bone
☐ Frequent urination	☐ Bronchitis	☐ Bedwetting	☐ Vision problems	☐ Chest pain
☐ Chronic cold/cough	☐ Constipation	☐ Chickenpox	☐ Dental problems	☐ Breathing difficulties
☐ Diarrhea	☐ Dizziness	☐ Seizures	☐ Eating problems	☐ Whooping cough
☐ Fainting	☐ Fatigue	☐ Asthma	☐ Frequent headaches	☐ Hearing problems
☐ Heart problems	☐ Measles	☐ Mumps	☐ Poor appetite	☐ Overeating
☐ Mononucleosis	☐ Nosebleeds	☐ Diabetes	☐ Sore throat	☐ Unusual movements
☐ Sinusitis	☐ Stroke	☐ Tonsillitis	☐ Tuberculosis	☐ Loss of consciousness
☐ Thyroid problems	☐ Vomiting	☐ Cancer	☐ Surgery or Hospitalization	

☐ Other (describe)_____

Does your child have any history of significant trauma? ☐ Yes ☐ No

If so, please provide details:

Is there any history of the following?

Physical Abuse? ☐ Yes ☐ No Sexual Abuse? ☐ Yes ☐ No

Domestic Violence Between Parents? ☐ Yes ☐ No

If yes, please explain: _____

_____

Previous Treatment

Has your child ever seen a counselor or therapist in the past? ☐ Yes ☐ No

If yes, how long ago and why did treatment end? _____

_____

Has your child ever received a psychological or developmental evaluation? ☐ Yes ☐ No

If yes, by whom and when?_____

Has your child ever received a diagnosis for a psychological or developmental disability? ☐ Yes ☐ No

If yes, what was the diagnosis? _____

Please list any and all previous psychological services your child has received:

Please list any history of mental health issues, substance abuse issues, or developmental disabilities in your family:

If your child has ever experienced suicidal thoughts/suicide attempt(s) or any other violent behavior, please describe (ages, reasons, circumstances, how, etc):

Please check behaviors and symptoms that occur to your child more often than you would like them to take place:

☐ Aggression	☐ Anger	☐ Anxiety	☐ Avoiding people	☐ Avoiding school
☐ Bedwetting	☐ Boredom	☐ Cheating	☐ Crying	☐ Homework difficulties
☐ Cyber addiction	☐ Depression	☐ Dieting	☐ Distractibility	☐ Dizziness
☐ Eating disorder	☐ Drug Use	☐ Fatigue	☐ Elevated mood	☐ Focus problems
☐ Hallucinations	☐ Lying	☐ Cursing	☐ Hopelessness	☐ Impulsivity
☐ Judgment errors	☐ Loneliness	☐ Irritability	☐ Low self-esteem	☐ Heart palpitations
☐ Memory impairment	☐ Mood shifts	☐ Nightmares	☐ Panic attacks	☐ Phobias/fears
☐ Sexual behavior	☐ Sick often	☐ Stealing	☐ Speech problems	☐ Sleeping problems
☐ Suicidal thoughts	☐ Texting	☐ Trembling	☐ Throwing things	☐ Tummy ache
☐ Social Media Issues	☐ Worrying	☐ Yelling	☐ Withdrawing	☐ Non-suicidal self-injurious behaviors (cutting, burning, etc.)

☐ Other: _____

Briefly discuss how the above symptoms impair your child's ability to function effectively:

Does or has your child use(d) any of the following?

☐ Coffee/Caffeinated Beverages/Energy Drinks If so, describe frequency and amount: _____

☐ Cigarettes If so, describe frequency and amount: _____

☐ Alcohol If so, describe frequency and amount: _____

☐ Marijuana If so, describe frequency and amount: _____

☐ Other Drugs If so, describe frequency and amount: _____

Please describe concerns related to drug/alcohol use:

Does your child engage in disordered eating behavior? ☐ Yes ☐ No ☐ Unknown

If yes, please check all that apply:

☐ Restricting ☐ Binging ☐ Purging ☐ Extreme Diets ☐ Other _____

How does he/she feel about their body?_____

How much physical activity does he/she engage in daily?_____

Social and Behavioral Information:

Please check all that apply as it relates to how your child gets along with other people:

☐ Aggression	☐ Harms self	☐ Difficulty making/keeping friends
☐ Underactive	☐ Tantrums	☐ Respectful
☐ Hyperactive	☐ Runs away	☐ Difficulty finishing a task
☐ Sadness	☐ Impulsivity	☐ Separation difficulties
☐ Oppositional	☐ Sensory sensitivities	☐ Trouble with the law

☐ Inattentive	☐ Property destruction	☐ Self-stimulatory behavior
☐ Affectionate	☐ Arguing Often	☐ Shy/Withdrawn
☐ Rigid/Controlling	☐ Friendly	☐ Leader
☐ Submissive	☐ Other: _____	☐ Other: _____

Please describe any concerns you have regarding your child's social and behavioral functioning:

Does your child get teased? ☐ Yes ☐ No Does your child tease others? ☐ Yes ☐ No

Please describe any behavioral challenges you have with your child at home (challenging times of day, outbursts, homework difficulties, etc.):

Please describe discipline strategies you use with your child?

Do you feel like they are effective?

Leisure/Recreational Interests:

Please list any and all current and past activities that your family engages in regularly (ex: art, books, crafts, sports, clubs, music, outdoor activities, church activities):

What are your family's hobbies or special interests?

What activities does your family enjoy doing together the most?

Cultural Information:

To which cultural or ethnic group(s) does your family identify? _____

Any members in the family experiencing any problems related to cultural or ethnic issues? ☐ Yes ☐ No

If yes, please describe: _____

Language(s) spoken in the home: _____

Preferred Language: _____

Religious/Spiritual:

How religious or spiritual is your family? (Circle the number that describes him/her best)

1 2 3 4 5 6 7 8 9 10

Very Somewhat Not at all

Is your family affiliated with a spiritual or religious group? ☐ Yes ☐ No Which group? _____

Would you prefer spiritual/religious beliefs to be incorporated into therapy? ☐ Yes ☐ No

If yes, please describe: _____

Is there any other information you would like your therapist to know?

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Consent to Treatment and Business Policies

Welcome to Thrive Therapy Studio! It is a pleasure to have you here and to begin our journey together. Your Thrive therapist will do everything within their professional capacity to ensure your treatment is as productive as possible. The following pages describe information for new clients who desire therapy services. Please read each section thoroughly and carefully and feel free to discuss any questions or reactions you may have with your therapist. At the end, there is a signature page to sign that indicates that you have read and understood the material. When you sign this document, it will represent an agreement between us.

Treatment Philosophy

We approach therapy from a collaborative, humanistic approach. We typically utilize behavioral strategies, supportive therapy, relaxation and mindfulness, and cognitive restructuring with adolescents. Your therapist will expect to work together towards alleviating the issues that caused you to initiate treatment on behalf of your child. This may involve recommendations for different parenting approaches to use at home as well as other services that might be helpful for you and your child. Our primary goal is to help your child and your family as a whole function better while addressing the specific concerns that brought you to treatment.

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems your child is experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to consider the things we talk about both during and between our sessions.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. In some situations, a client's problems may temporarily worsen after beginning treatment. These risks are to be expected and are a normal process when people are making important and often difficult changes in their lives. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and reductions in feelings of distress.

Our first few sessions will involve an evaluation of your child and family's needs during which you will be offered initial impressions of how our work together will be helpful and some of the difficulties that could be addressed through treatment. You should evaluate this information as well as your impressions of how comfortable you will be working with your therapist. The relationship in therapy is of significant importance and as such, should be carefully considered prior to proceeding. Please address any concerns you have regarding therapy with your therapist, who will attempt to address them directly or determine the best course of action to take.

Because people often disclose to their therapists many deeply felt personal thoughts and experiences, the relationship can become very close and important. Sometimes clients and their families come to want the relationship to become more than a therapeutic relationship. Although these feelings are understandable, it is necessary for all clients to recognize that their therapist cannot at any time, during or after your course of therapy, be friends or engage in any business endeavors. Should you meet your therapist by chance on the

street or at a social gathering, they will not initiate communication to maintain your confidentiality. Should you approach them, conversation will be kept to a minimum. Even though you might invite your therapist, they will not attend family gatherings or community events with you. While talking about sexual thoughts or feelings may be a part of therapy for many people, actual sexual relations between clients and psychotherapists are never acceptable. These boundaries are important for ethical, effective psychotherapy. Even after therapy has ended, these boundaries remain in place.

Sessions

Therapy sessions will be scheduled at both of our convenience. Typically, we will begin meeting once per week. As treatment continues, we will decide collaboratively when more time is needed between sessions.

Professional Fees

Payments for services provided can be paid by check, credit card, or cash. Payment is required at the beginning of every session.

In addition to regular appointments, Thrive charges your therapy rate per hour for other professional services you might need, though charges will be broken down into 15 minute increments of the hourly cost if the therapist works for periods of less than one hour. Other services may include report writing, consultation with other authorized professionals, extended telephone conversations, attendance of meetings, preparation of records or treatment summaries, and time spent performing any other service you may request. At times, we may engage in telephone contact with you for purposes other than scheduling sessions. You are responsible for payment of the agreed upon fee for any telephone call lasting longer than ten minutes either with you or with any authorized third parties.

If deemed therapeutically appropriate, sessions may take place in the home and/or community. Additionally, observations may be requested in a child's school or other setting, particularly when a child is having behavioral problems. These observations would only occur with the consent of the family and the child's school or alternate setting. Observing behaviors in their natural environment can be extremely beneficial and informative in treatment and at times leads to improved behavioral planning and collaboration with other professionals. Session time begins when your therapist leaves the office to drive to the given location and continues until they return to the office.

Late Appointments

Sessions are 45-50 minutes in length. If you are late for an appointment, you will be provided services for the remainder of the scheduled time and will be responsible for the fee of the entire session.

Cancellation Policy

If you are unable to keep your appointment, we ask that you cancel as soon as possible. If this is done at least 24 hours prior to your appointment time, there will be no charge for the cancellation. However, if you fail to attend or cancel with less than 24-hour notice, you will be charged your regular session fee.

Billing and Payment for Services

Clients are expected to pay for services at the time services are rendered, including co-pay. We accept cash, checks, and major credit cards. There will be a $50 surcharge for each returned check.

If you fail to make a payment for 2 consecutive sessions, you will be unable to schedule an appointment until payment is made in full. If any legal action is taken against Thrive such as needing to employ a professional collection agency and/or attorney to enforce this Agreement, you agree to pay for any legal costs accrued by Thrive in securing payment for services.

Your therapist will assume that your agreed-upon fee-paying relationship will continue as long as services are provided to you. You have a responsibility to pay for any services you receive. If there are any problems with

charges, billing, or other money related concerns, please bring them to your therapist's attention as soon as possible.

Insurance Reimbursement

Please be aware that most insurance companies require a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans and progression made toward treatment goals, even when engaging in out of network billing. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they will do with it once it is in their hands. We will provide your insurance company with only the information required in order to meet their administrative needs.

We will bill insurance plans directly when able, however, if we are unable to submit a claim or the insurance company pays only a portion of the bill or rejects the claim entirely, then you are responsible for the total amount of billed services. You retain all financial responsibility for the services obtained. If you have a co-pay, it is expected to be paid at the time of service.

You should be aware that not all Thrive therapists accept insurance. You can request a superbill from your therapist and self submit to your insurance carrier for possible reimbursement. Please note that many insurances will not cover services rendered, however, if you have PPO insurance with Out of Network benefits, you can submit the superbill for possible reimbursement of a percentage of the fees paid. However, you are responsible for paying all fees up front whether or not your insurance reimburses you.

Termination of Therapy

Termination is inevitable and part of the therapeutic process. It should not be done casually and is a valuable part of our work together. Either of us may want to terminate our work together if we believe that it is in your best interest. We reserve the right to terminate therapy at your therapist's 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, client's needs being outside the scope of competence or practice, or the client not making adequate progress in therapy. You also have the right to terminate therapy at your discretion. If either party decides to terminate therapy, we recommend that we meet for at least one session to review our work together, our goals and accomplishments, any further work to be done, and our options. This process is intended to facilitate a positive termination experience and give both parties the opportunity to reflect on the work that has been done. We will also attempt to ensure a smooth transition to a new therapist by providing referrals when necessary.

Client Litigation

We will not voluntarily participate in any litigation, or custody dispute in which you and another individual, or entity, are parties. We have a policy of not communicating with attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in a legal matter. We will generally not provide records or testimony unless compelled to do so. Should we be subpoenaed, or ordered by a court of law to appear as a witness, you agree to reimburse your therapist for any time spent for preparation, travel, or other time in which we were available for such an appearance at the rate of $300 per hour. Time spent in court or being deposed will be billed at $350 per hour.

Records and Record Keeping

We are required by law to maintain records of your treatment. We will keep progress notes, which include information regarding treatment progress and strategies used in session. Such records are Thrive Therapy Studio's sole property. Should you request a copy of records, such a request must be made in writing. We reserve the right, under California law, to provide you with a treatment summary in lieu of actual records, if deemed more appropriate. We will maintain your records for 10 years after termination of therapy. After 10 years, your records will be destroyed in a way that preserves your confidentiality.

Confidentiality

In general, the confidentiality of all communications between a client and a therapist is protected by law and we can only release information about our work to others with your written permission. However, there are a number of exceptions. In most judicial proceedings, you have the right to prevent your therapist from providing any information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require testimony if he/she determines that resolution of the issues before him/her demands it.

1. If a client is threatening serious bodily harm to another, your therapist is required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization.
2. If a client threatens to harm himself/herself, your therapist may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection.
3. If your therapist believes that a child, an elderly person, or a disabled person is being abused, your therapist must file a report with the appropriate state agency.
4. If your therapist assesses the patient to be a danger to self, or unable to take care of himself/herself, the appropriate authorities may be notified.
5. In the event of failure to pay a bill in reasonable time, the name of the patient may be given to a collection agency to collect payment or may be recorded in small claims court.
6. Some legal actions initiated by the patient or the patient's estate may result in the court ordering the release of records.
7. Records and information regarding your diagnosis and treatment must be submitted to your insurance carrier for determination of benefits and authorization for continued treatment.

Professional Status Statement

Please note that, pursuant to the laws of the State of California, clinical work done by Psychological Assistants, Marriage and Family Therapy interns (MFTI), and Social Work Interns (ASW), must be supervised by a licensed clinician. This means that Dr. Erica Wollerman, a licensed psychologist, may be reviewing your records and your psychotherapy if she is supervising your therapist.

Telecommunication

Between sessions your therapist is available by phone, fax, and email. Please be aware that information communicated these ways will be held with as much confidentiality as possible but that there are risks inherent to these modes of communication including but not limited to the information being seen/heard by individuals other than those intended.

Agreement to Arbitrate

It is understood that any dispute as to psychological malpractice, that is as to whether any psychological services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the psychologist and the psychologist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including claims for loss of consortium, emotional distress or punitive damages. A demand for arbitration must be communicated in writing to all parties. 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. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request.

Contacting Your Therapist

Your therapist often will not be immediately available by telephone as we do not answer calls during meetings or therapy sessions. As such, leaving a voicemail message is typically the best way to reach us. If you leave a message, your call will be returned between 24-48 hours after you call, depending on the urgency of the situation and the day that you call. Generally, messages are returned daily except Saturdays, Sundays, and holidays. If your therapist will be unavailable for an extended time, you will be provided with the name of a colleague to contact, if necessary.

If you are having an emergency, such as suicidal thoughts, and your therapist does not respond quickly enough for your needs, please either call the Access and Crisis line at 1-888-724-7240 or go to a hospital emergency room. If you are experiencing a medical emergency, call 911.

Your signature below indicates that you have reviewed the information contained in the Consent to Treatment document, that you have received a copy of the document, and that you agree to abide by its terms during our professional relationship. With your signature you are providing permission to provide you and/or your child with professional services as a mental health clinician.

_____	_____	_____
Signature	Printed Name	Date
_____	_____	_____
Minor Signature (age 12+)	Minor Printed Name (age 12+)	Date

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Consent for Treatment of Minors

Minor's Information

Name: _____ Date of Birth: _____

School: _____ Grade: _____

This document certifies that I give permission to Thrive Therapy Studio for the psychological treatment of my child. I understand that this treatment may include individual therapy, parent consultation, and family therapy. In order to ensure continuity of care, your therapist may request that you sign a release of information form to consult with other professionals that are involved in your child's care including: Pediatricians, School Personnel, and past therapy providers.

California state law mandates the reporting of certain types of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, and emotional and physical abuse. All actual or suspected acts of child abuse will be reported to the appropriate authorities.

If parents are divorced, please specify the custody arrangement: _____
_____

*Please note: Except in rare circumstances, both biological parents or all involved guardians and adopted parents need to sign this form prior to treatment beginning. Please ask your therapist for further clarification if needed.

Parent #1

_____ _____ _____
Print Name of Parent/Guardian (with legal custody) Signature of Parent/Guardian Date

_____ _____
Street Address City, State, Zip

_____ _____
Home Phone Cell Phone

Parent #2

_____ _____ _____
Print Name of Parent/Guardian (with legal custody) Signature of Parent/Guardian Date

_____ _____
Street Address City, State, Zip

_____ _____
Home Phone Cell Phone

Please add additional Parent/Guardian information and signatures to the back of this form if there are more than two Parent/Guardian(s) involved and with custody.

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Privacy in Therapy for Adolescents

Welcome to Thrive! Please take the time to read and sign the following information prior to your first appointment. Please ask me any questions you may have about this information. I am looking forward to getting to know you better!

What to expect in therapy:
The purpose of meeting with a therapist is to get help and support with problems that are bothering you or preventing you from being successful in your life. Therapists help with a wide range of problems including but not limited to academic, emotional, behavioral, and relational areas. We may be meeting because you requested to talk to someone. We may also be meeting at the request of your parents because someone in your life has concerns about how you are doing. When we meet, we will discuss whatever issues have brought you to treatment as well as other things you would like to talk about. Your therapist will do everything they can to help you feel comfortable in therapy and most adolescents enjoy attending therapy after they become comfortable with the person they meet with.

It is important that you feel comfortable talking about issues that are bothering you so that your therapist can help you. Sometimes these issues will include things you do not want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their therapist. Privacy, also called confidentiality, is an important and necessary part of good and effective therapy.

As a general rule, your therapist will keep the information you share in sessions confidential, or private, unless they have your written consent to disclose certain information. There are important exceptions to this rule that are important for you to understand before you share personal information in a therapy session. In some situations, your therapist is required by law or the guidelines of their profession to disclose information even if they do not have your permission.

These situations are listed below:

- The intention to hurt yourself
- The intention to hurt someone else
- Reports of child abuse
- Reports of elder or dependent adult abuse

If you mention any of these situations during one of your sessions, your therapist is required by law to break confidentiality and contact the proper authorities. This may include hospitalization to keep you safe and to prevent you from doing something you will likely regret, notifying possible victims, and notifying the police. If you communicate to your therapist a serious threat towards yourself or another person, your therapist will always contact your parents/guardians for your safety.

If you are involved in a court case and a request is made for information about your therapy, your therapist will not disclose information without your agreement unless the court requires them to. We will do all we can within the law to protect your confidentiality. If we are required to disclose information to the court, we will inform you that this is happening.

Communicating with your parent(s) or guardian(s)
Except for situations such as those mentioned above, your therapist will not tell your parent or guardian specific things you share in private therapy sessions. Your therapy sessions are a place for you to feel safe and comfortable and where your therapist can help you make important decisions while guiding you towards helpful goals. In order for this to be effective, most information you share will remain private.

However, if you are engaging in risky behaviors (alcohol, drugs, sex, illegal activities, etc.) your therapist will need to use their professional judgment to decide whether you are in serious and immediate danger of being harmed. If your therapist feels that you are in such danger, they will communicate this information to your parent or guardian. Your therapist will always do their best to let you know of these situations ahead of time and if possible, involve you in the conversation with your parents in order to mediate the situation as effectively as possible. You can always ask questions about the types of information your therapist would disclose prior to disclosing information.

Additionally, there may be situations where your therapist believes it is important for your parents/guardians to know what is going on in your life. In these situations, they will encourage you to tell your parents/guardians and will help you find the best way to tell them. Also, when meeting with your parents, your therapist may describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

You should also know that by law in California, your parent/guardian has the right to see any written records kept about our sessions. However, it is extremely rare that a parent/guardian requests to look at these records. Additionally, a treatment summary may be provided to them instead of the full records.

Communicating with other adults

School: Your therapist will not share any information with your school unless they have your permission and permission from your parent/guardian. Sometimes your therapist may request to speak to someone at your school to find out how things are going for you or provide them with suggestions on how they might be more helpful to you in your education. Your therapist will always try to discuss this with you before speaking to any school professionals, even if they contact them first.

Doctors: Sometimes your doctor and therapist may need to work together particularly if you are taking medication in addition to going to therapy. Your therapist will get your permission and permission from your parent/guardian prior to sharing information with your doctor. The only time your therapist will share information with your doctor without your permission is if they believe you are at risk for serious and immediate physical/medical harm.

Thank you for taking the time to read this information. While we are working together, please keep in mind that your therapist is most concerned with your well-being and general satisfaction in life. Any disclosures made to your school, family, or doctors are always working in what we believe to be your best interest.

Welcome to Thrive. We are looking forward to getting to know you better!

_____	_____	_____
Minor Signature (age 12+)	Minor Printed Name (age 12+)	Date
_____	_____	_____
Parent Signature	Printed Name	Date

THRIVE THERAPY STUDIO
5230 Carroll Canyon Rd, Suite 110
San Diego, CA 92121
858-342-1304
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CALIFORNIA NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice conforms to the Federal Health Insurance Portability and Accountability Act (HIPAA) effective April 14, 2003. It also conforms to the Health Care Privacy Laws of California.

1. Disclosures for Treatment, Payment, and Health Care Operations: We may use or disclose your protected health information (PHI), for certain treatment, payment, and health care purposes without your authorization. In certain circumstances, we can only do so when the person or business requesting your PHI gives us a written request that includes certain promises regarding protecting the confidentiality of your PHI.

To help clarify these terms, here are some definitions:

- **"PHI"** refers to information in your health record that could identify you.

"Treatment and Payment Operations"

- **"Treatment"** is when we provide treatment or another healthcare provider diagnoses or treats you. An example of treatment would be when your therapist consults with another health care provider, such as your family physician or another psychologist, regarding your treatment.
- **"Payment"** is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- **"Health Care Operations"** is when we disclose your PHI to your health care service plan (for example your health insurer), or to your other health care providers contracting with your plan, for administering the plan, such as case management and care coordination.
- **"Use"** applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **"Disclosure"** applies to activities outside of our office such as releasing, transferring, or providing access to information about you to other parties.
- **"Authorization"** means written permission for specific uses or disclosures.

2. Uses and Disclosures Requiring Authorization: We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment and payment operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes your therapist have made about our conversation during a private, group, joint, or family counseling session, which we 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 we receive it in writing.

3. Uses and Disclosures with Neither Consent nor Authorization: We may use or disclose PHI without your consent or authorization in the following circumstances:

a. **Child Abuse:** Whenever your therapist, in their professional capacity, has knowledge of or reasonably suspect that a child has been the victim of child abuse or neglect, they must immediately report such to Children Protection Services (CPS). Also, if they have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional wellbeing is endangered in any other way, they may report such to CPS as well.

b. **Elder or Dependent Adult Abuse:** If your therapist, in their 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 they are told by an elder or dependent adult that he or she has experienced these or if they reasonably suspect such, your therapist must report the known or suspected abuse immediately to Adult Protective Services (APS) or the local law enforcement agency.

Your therapist does not have to report such an incident if:

- They have been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect;
- They are not aware of any independent evidence that corroborates the statement that the abuse has occurred;
- the 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
- in the exercise of clinical judgment, they reasonably believe that the abuse did not occur.

c. **Health Oversight:** If a complaint is filed against Thrive or your therapist with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from us relevant to that complaint.

d. **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services that we have provided you, we must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; or 3) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides us 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 us 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 by a third party or where the evaluation is court-ordered. We will inform you in advance if this is the case.

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

f. **Workers' Compensation:** If you file a worker's compensation claim, your therapist must furnish a report to your employer, incorporating their 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.

4. Patient's Rights and Psychologist's Duties:

a. Patient's Rights:

i. Right to Inspect and Copy: You are entitled to receive a copy of your medical record unless your therapist believes that receiving that information would be emotionally damaging. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records or receive a copy of your records, we require written notice to that effect, and we would expect to discuss your request with you in person. If we deny you access to your records, you can request to speak with an independent colleague of ours about your request. Your request for independent review of your request should also be made in writing. If you are provided with a copy of your medical record information, we may charge a fee for any costs associated with that request.

ii. Right to Amend: If you believe that the information we have about you is incorrect or incomplete, you may ask us to amend that information. It is our practice to accept this sort of request in writing, and that any information you may wish to add to your record also be provided to us in written form.

iii. Right to an Accounting of Disclosures: You have the right to request an "Accounting Of Disclosures." This is a list of the disclosures we have made of medical record information. That

information is listed on the Authorization To Release Information, and will be provided to you at your written request.

iv. **Right to Request Restrictions:** You have the right to privacy, and to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. As noted above, we will not release your confidential information without your written permission. Any restrictions to your Authorization To Release Information should be specified on the Authorization.

v. **Right to Request Confidential Communications:** You have the right to request that we communicate with you only in certain ways. For example, you can ask that we not leave a telephone message for you, or that we only contact you at work or by mail.

vi. **Complaints Regarding Privacy Rights:** If you believe your privacy rights have been violated, you may file a written complaint with your therapist, or with an independent colleague of theirs, or with the U.S. Department of Health and Human Services, 50 United Nations Plaza, Room 322, San Francisco, CA, 94102. You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

vii. You have the right to a paper copy of this document, and you will be offered one when you sign the original for your medical record. We reserve the right to change our policies as outlined herein. If they change, you will be informed of that change and will provided with a copy of the current document if desired.

b. Psychologist's Duties:

i. We are required by law to maintain the privacy of your PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

ii. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

iii. If we revise our policies and procedures, we will provide you with a revised notice either in person or by mail.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you hereby acknowledge receipt of this office's Notice of Psychologists' Policies and Privacy Practices that we have provided to you. This Notice of Psychologists' Policies and Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

This Notice of Psychologists' Policies and Privacy Practices is subject to change. The most recent version will be on the Thrive website at www.thrivetherapystudio.com. If we change the notice, you may obtain a copy of the revised notice from your therapist by contacting them via telephone or visiting our website.

If you have any questions about this Notice of Psychologists' Policies and Privacy Practices, please contact us via telephone at (858) 342-1304.

_____	_____	_____
Signature	Printed Name	Date
_____	_____	_____
Minor Signature (age 12+)	Minor Printed Name (age 12+)	Date