



**New Client Information Packet**  
**Welcome to your first appointment.**

During your first session, your Thrive Therapist will be getting to know your family. However, some of this information is more easily gathered in writing. These forms are designed to help your therapist get to know your 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 family members to add in information if desired. You can also mark questions that you do not understand and they can be addressed during your session. Thank you!

Person completing this form: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Parent Information:**

Parent #1:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender:  Male  Female  Other- Specify \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address (City, State, Zip): \_\_\_\_\_

Highest level of education completed: \_\_\_\_\_

**Employment Information:**

Occupation: \_\_\_\_\_

Employment Status:  Full Time  Part Time  Work as parent in the home  Student  
 Unemployed  Retired  Other: \_\_\_\_\_

If employed, what is your employer or company's name? \_\_\_\_\_

If employed, what is your job title? \_\_\_\_\_

Parent #2:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender:  Male  Female  Other- Specify \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address (City, State, Zip): \_\_\_\_\_

Highest level of education completed: \_\_\_\_\_

**Employment Information:**

Occupation: \_\_\_\_\_

Employment Status:  Full Time  Part Time  Work as parent in the home  Student

Unemployed  Retired  Other: \_\_\_\_\_

If employed, what is your employer or company's name? \_\_\_\_\_

If employed, what is your job title? \_\_\_\_\_

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: \_\_\_\_\_

**Preferred Contact Information:**

Primary Contact: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_

OK to contact?

Yes  No

OK to leave message?

Yes  No

Cell: \_\_\_\_\_

Yes  No

Yes  No

Work: \_\_\_\_\_

Yes  No

Yes  No

Email: \_\_\_\_\_

Secondary Contact: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_

OK to contact?

Yes  No

OK to leave message?

Yes  No

Cell: \_\_\_\_\_

Yes  No

Yes  No

Work: \_\_\_\_\_

Yes  No

Yes  No

Email: \_\_\_\_\_

**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) \_\_\_\_\_

**Information About Child(ren) Participating in Family Therapy:**

Child #1:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender:  Male  Female  Other- Specify \_\_\_\_\_



**Academic Information:**

Name of School: \_\_\_\_\_ Child's grade level: \_\_\_\_\_

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:

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

If so, please describe:

**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.)

Please describe any concerns you may have with your child's eating and sleep patterns:

What medical conditions has your child experienced since birth?

List any current health concerns:

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

**Social and Behavioral Information:**

Please describe any concerns you have regarding your child's development or current functioning:



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

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

Please check if there have 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 do you believe are your child’s main strengths?

What do you believe are your child’s main challenges?

If parents are divorced, how old was the child when they divorced?

Describe how it has affected him/her:

Child #2:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender:  Male  Female  Other- Specify \_\_\_\_\_

**Academic Information:**

Name of School: \_\_\_\_\_ Child’s grade level: \_\_\_\_\_

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:

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

If so, please describe:

**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.)

Please describe any concerns you may have with your child's eating and sleep patterns:

What medical conditions has your child experienced since birth?

List any current health concerns:

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

**Social and Behavioral Information:**

Please describe any concerns you have regarding your child's development or current functioning:

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

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

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

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Sleep patterns         | <input type="checkbox"/> Physical activity level | <input type="checkbox"/> Eating patterns | <input type="checkbox"/> General disposition |
| <input type="checkbox"/> Behavior               | <input type="checkbox"/> Weight                  | <input type="checkbox"/> Focus           | <input type="checkbox"/> Energy level        |
| <input type="checkbox"/> Other (describe) _____ |  |  |  |

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

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

If parents are divorced, how old was the child when they divorced?



Describe how it has affected him/her:

**Child #3:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender:  Male  Female  Other- Specify \_\_\_\_\_

*Academic Information:*

Name of School: \_\_\_\_\_ Child's grade level: \_\_\_\_\_

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:

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

If so, please describe:

**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.)

Please describe any concerns you may have with your child's eating and sleep patterns:

What medical conditions has your child experienced since birth?

List any current health concerns:

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



**Social and Behavioral Information:**

Please describe any concerns you have regarding your child’s development or current functioning:

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

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

Please check if there have 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 do you believe are your child’s main strengths?

What do you believe are your child’s main challenges?

If parents are divorced, how old was the child when they divorced?

Describe how it has affected him/her:

**Family Members NOT Participating in Family Therapy Information:** (Please provide name, age, brief statement about relationship within family)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Current Situation:**

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

When did this problem start?

Are there other issues you would like support with as well? If so, please describe them.



Please describe discipline strategies you use with your child(ren)?

Do you feel like these strategies are effective?

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

What do you believe are your family's main challenges?

What are your main goals in coming to family therapy?

- 1.
- 2.
- 3.

**Trauma History:**

Is there any history of the following in the family (including among individual family members)?

History of significant trauma?  Yes  No

If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_

Physical Abuse?  Yes  No      Sexual Abuse?  Yes  No

Domestic Violence Between Parents?  Yes  No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Substance Abuse?  Yes  No

If yes, please explain (include which family member(s): \_\_\_\_\_  
\_\_\_\_\_

**Previous Treatment:**

Has anyone in the family seen a counselor or therapist in the past?  Yes  No

If yes, name family member(s), how long ago it was, and why treatment ended: \_\_\_\_\_  
\_\_\_\_\_

Has anyone in the family ever received a psychological or developmental evaluation?  Yes  No

If yes, name family member(s) and whom the evaluation was done by, and when it took place? \_\_\_\_\_  
\_\_\_\_\_





Has anyone in the family ever received a diagnosis for a psychological or developmental disability?  Yes  No

If yes, name family member(s) and what was the diagnosis? \_\_\_\_\_

Please list any and all previous psychological services any member(s) in the family have received:

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

Anyone in the family ever experience suicidal thoughts/suicide attempt(s) or any other violent behavior, please describe (Whom, ages, reasons, circumstances, how, etc):

**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?

Who referred you to Thrive for services? \_\_\_\_\_ Phone Number: \_\_\_\_\_

May we contact them to thank them for the referral?  Yes  No





## **Consent to Treatment and Business Policies**

Welcome to Thrive Therapy Studio! It is a pleasure to have your family 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. Family therapy is a unique, safe space for families to explore their relationships, challenges, and to work on improving their family communication and understanding of each other. This can be a challenging process to engage in but your therapist will do their best to ensure all family members are comfortable and feel heard. Your therapist will expect to work together towards alleviating the issues that caused you to initiate treatment. Our primary goal is to help 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 family 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 family'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 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 and 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 our account 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 our 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 your family with professional services as a mental health clinician.**

**Please note that each family member participating in family therapy will need to sign below:**

\_\_\_\_\_  
Signature Printed Name Date

\_\_\_\_\_  
Signature Printed Name Date

\_\_\_\_\_  
Signature Printed Name Date

\_\_\_\_\_  
Signature Printed Name Date

\_\_\_\_\_  
Signature Printed Name Date







## 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:



1. **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.
2. **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.
3. **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.
  4. **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.
  5. **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.
  6. **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.

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**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](http://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.**

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Signature

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Printed Name

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Date

