A Caring Mind, Inc.
1028 West Avenue L-12, Suite 107
Lancaster, Ca 93534
Office (661) 400-6193
Fax (661) 457-1909
psychdrmc@yahoo.com

FOR OFFICE USE ONLY

CLIENT PERSONAL HISTORY

DATE: ________________

PERSONAL INFORMATION

CLIENT NAME: ____________________

DATE OF BIRTH: ____________________ DRIVER LICENSE: ____________________

MARITAL STATUS: ____________________ SEX: ______ SOCIAL SECURITY # ____________________

STREET ADDRESS: ____________________

CITY: ____________________ STATE: ____________ ZIP CODE: ____________________

HOME PHONE: ____________________ CELL PHONE: ____________________

EMPLOYER: ____________________ OCCUPATION: ____________________

EMPLOYER WORK PHONE NUMBER: ____________________ REFERRED BY: ____________________

WHAT IS YOUR RELIGIOUS EDUCATION: ____________________

INSURANCE INFORMATION

DO YOU HAVE INSURANCE TO COVER YOUR THERAPY: ______________

INSURANCE COMPANY: ____________________ ID #: ____________________

RESPONSIBLE PARTY (IF OTHER THAN SELF): ____________________

DATE OF BIRTH: ____________________ ADDRESS: ____________________

____

HOUSEHOLD/FAMILY INFORMATION

RELATION	NAME	GENDER	AGE	DO THEY LIVE WITH YOU?	STATUS OF RELATIONSHIP 1= POOR 5= EXCELLENT

Does anyone else live with you? ____

In case of an emergency, contact: ____

Phone Number: ________________________________ Relationship: _______________________

MEDICAL HISTORY

List any prescribed medications you are currently taking and for how long:

____

____

____

Have you been in therapy before? _______________If yes, Explain:

____

____

What brings you to therapy now?

____

____

What are your goals for therapy?

____

____

INSURANCE

Upon verification of coverage, we will bill your insurance company. You are responsible for any applicable co-payments and deductibles that may apply.

- Co-payments are to be paid when services are rendered
- I authorize payment of medical benefits to A Caring Mind, Inc. for therapy services
- We will make every effort to collect payment from your insurance company. In the event that benefits are not covered, you are responsible for the full fee

Responsible Party: ______________________________________ Date of Birth: __________________

Signature: ____ Date: _________________________

CONSENT FOR TREATMENT

I, ____________________________________, authorize and request that A Caring Mind, Inc. provide psychological examinations, treatment and/or diagnostic procedures, which now or during the course of my care as a client are advisable. The frequency and type of treatment will be decided between my therapist and me.

I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

I understand that there is an expectation that I will benefit from psychotherapy, but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I HAVE READ AND FULLY UNDERSTAND THIS CONSENT FOR TREATMENT POLICY. I HAVE READ, AND UNDERSTAND THE POLICIES AND PROCEDURES PRESENTED ON THE NEW CLIENT INFORMATION FORM.

BY SIGNING THIS FORM BELOW I ALSO ACKNOWLEDGE THAT I HAVE BEEN GIVEN A COPY OF A CARING MIND'S, "NOTICE OF PRIVACY PRACTICES" FOR MY INFORMATION AND IN ACCORDANCE WITH FEDERAL LAW.

____ _________________________

(Client/Parent/Guardian Signature) Date

____ _________________________

Client Signature Date

____ _________________________

Therapist Signature Date

NEW CLIENT INFORMATION

Please read the following information carefully. It will explain the policies and procedures of our center. If you have further questions, please ask your therapist.

24 HOUR CANCELLATION POLICY

If you must cancel or reschedule please notify the office, 24 hours in advance. *THE FULL CONTRACTED FEE OF SERVICE WILL BE CHARGED FOR ANY CHANGES TO YOUR APPOINTMENT WITH LESS THAN 24 HOURS NOTICE.*

- If you are using your insurance, you will be charged for the full contracted insurance rate, not just the co-pay.
- If you are receiving any scholarship from A Caring Mind, Inc. or another outside source, you will be charged the full fee.
- If you are receiving any Victims of Crime or another outside source, you will be charged the full fee.
- I understand that if I no show or cancel my appointment less than 24 hours, I am responsible to pay the full fee.

FEES AND PAYMENTS

The fee for one individual therapy session with a licensed clinician is $150.00. For a Marriage and Family Intern is $90.00. A sliding scale is available for cash patients.

- We accept cash, checks, credit or debit cards, Victims of Crime and Insurance.
- Checks can be filled out ahead of time and made payable to A Caring Mind, Inc. or Dr. Maegan Munro
- A Fee charge is charged for Debit and Credit Cards

CHARGES WILL BE SET BEFORE OR AT FIRST APPOINTMENT

FEE CONFIRMATION

I understand my fee has been confirmed at $_____________, co-pay/cash session and that I am responsible for payment at the time of service.

_________________________________ _________________________________

Signature Date

WHENEVER POSSIBLE, USING THE STATE LAW GUIDELINES, THE THERAPIST WILL TAKE ALL STEPS TO FIRST SHARE WITH THE CLIENT ANY CONCERNS THE THERAPIST HAS ABOUT THE NEED TO REPORT.

____

Therapist Name

I HAVE READ AND UNDERSTAND THE THERAPIST RESPONSIBILITY TO MAKE SUCH DECISIONS WHEN NECESSARY.

_________________________________ _________________________________

Client Signature Date

EXCLUSIONS TO CONFIDENTALITY

Confidentiality and privileged communication remain rights of all clients of Marriage, Family and Child therapist(s) according to state law. However, the law mandates that therapists make reports to appropriate authorities in the following situations:

1. In the case of suspected child abuse, dependent adult or elder abuse (past or present) the law mandates that the therapist make a written or verbal report to county Welfare (Public Social Services Agency) or to law enforcement officials.

2. If you directly communicate to me a serious threat of physical violence against a reasonable identifiable victims or victim, I am required by law to make reasonable efforts to communicate that threat both to said victim(s), and to a law enforcement agency. Part of this duty might require warning individuals who could warn the intended victim(s).

OTHER EXCEPTIONS TO CONFEDENTIALITY (NOT REQUIRED BY LAW)

1. If I believe you might harm yourself, I have an ethical responsibility to intervene which may mean breaking confidentiality by informing family, significant others, police, or a psychiatric evaluation team.

2. MFT Interns and trainees are supervised by licensed therapists who will at times share their cases with their supervisors. This may occur in an individual or group setting with other interns and trainees for training purposes.

3. I keep written notes of each session in a locked file. These records may be subpoenaed by a court of law. Your records will not be released unless I am compelled to do so in compliance with the laws of the State of California.

4. Generally minors (under age of 18) are entitled to the protection of confidentiality unless there is an applicable legal or ethical exception (threats of violence to another, suicide, etc.) an additional exception is the right of parents to inspect the therapist's records concerning their child when the treatment is with parental consent. If full disclosure is not in the best interest of the minor client, the therapist can provide a summary.

______________________________________ _______________________

Client/Parent/Guardian Signature Date

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, ________________________________ hereby authorize, _____________________________ to disclose
(Client Name) (Provider)

any information including,

My appointment date and time: Y/N Payment Information: Y/N

To the following people: (Who may be calling to confirm, or cancel appointments as well as inquire about billing).

Name: ____

Name: ____

People *Restricted* from receiving any information:

Name: ____

Name: ____

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by recipient and that the Federal Privacy Rule may no longer protect such information, although re-disclosure of such information may be protected by applicable California Law.

Provider is authorized to disclose the protected health information specifically listed above.

Signature: ____ Date: ________________________________
Client

*If signed by other than Client, please indicate the relationship between Client and his/her Representative:

____