Valencia Relationship Institute

28494 Westinghouse Place, #213, Valencia, Ca. 91355

CHILD / ADOLESCENT INTAKE FORM

To be filled out by parent or guardian requesting services for a minor child. This information will help your therapist understand your child. It, as all communications with your therapist, will be kept confidential.

BACKGROUND INFORMATION **Date:_____**

Child's name: _____ Date of birth _____ Age: ____

Address/City/Zip Code: _____

Home phone: _____

Child/Adolescent cell phone: _____

Child / Adolescent lives with _____

Previous Counseling / Therapy? _____ (If yes, with whom and for how long?)

_____

Emergency contact (other than parent(s)_____ Phone _____

Child / Adolescent's special interests, hobbies, extra-curricular activities:

_____

_____

Who may I thank for referring you to my office today?

_____

MOTHER'S INFORMATION

Name: _____ BD:_____ Age:_____

Address: (if different from patient) _____

Home phone: (If different from patient) _____

Cell phone: _____

Employer: _____ Occupation: _____

Work phone / Ext. _____

FATHER'S INFORMATION

Name: _____ BD:_____ Age:_____

Address: (if different from patient) _____

Home phone: (If different from patient) _____

Cell phone: _____

Employer: _____ Occupation

FINANCIALLY RESPONSIBLE PERSON´S INFORMATION:

Name: _____Relationship to Client:_____

Phone: (if different from above)_____

Address: (if different from above)_____

_____ _____

Patient's Signature/Parent of Minor Date

SCHOOL INFORMATION

Name of School_____ Grade_____ Teacher/Counselor_____

Does your child have any educational concerns/peer problems?

_____

_____

Does your child have a 504 plan or IEP? _____

MEDICAL HISTORY

Child's Pediatrician_____ Phone #_____

Date of Last Physical Exam: _____

Is your child currently being seen by a psychiatrist?

If yes, name of psychiatrist: _____ Phone #_____

Current Medications: _____

List any injuries and/or hospitalizations. Indicate age when occurred and describe how severe.

_____

_____

DESCRIBE THE CONCERNS FOR SEEKING TREATMENT FOR YOUR CHILD:_____

_____

_____

LIST 3 GOALS FOR YOUR CHILD/ADOLESCENT THAT YOU WOULD LIKE TO SEE ACHIEVED THROUGH COUNSELING:

1._____

2._____

3._____

VALENCIA RELATIONSHIP INSTITUTE

28494 Westinghouse Place, #213 Valencia, CA 91355

Informed Consent

INTRODUCTION: Welcome! Thank you for choosing me as your therapist. I, **_Morgan Fung_**, am a Registered Marriage & Family Intern in the State of California, under the supervision of April De Higes, Licensed Marriage & Family Therapist (MFC#35513) and Ellen Bradley-Windell, LCSW (LC#11250), Clinical Directors. I have training in the general practice of psychotherapy with adults, children, adolescents, and families. My approach to treatment requires that we work together as a team to assist you in accomplishing your goals. Your treatment plan is personalized according to your unique needs.

Initial_____

PROCESS OF THERAPY: Clients often enter therapy with some uncertainties or questions about what to expect. The process of therapy is similar to a book in that it has a beginning, middle, and end. In the beginning stage of therapy, I will gather information about your current life circumstances and relevant historical information. I may inquire about situations or behaviors that seem unimportant or irrelevant to the concerns that brought you into therapy, but please remember that a thorough initial evaluation is more likely to yield a successful treatment plan. After the first few sessions, I will discuss my understanding of the problem, propose a treatment plan, and share my view of the possible outcomes of therapy. During the middle stage of therapy, progress toward the agreed upon goals will be attempted and hopefully achieved. This can sometimes be the most challenging part of the therapeutic process. Ideally, the end stage is reached when the specific concerns that led you to seek therapy are resolved. However, sometimes therapy may end for other reasons, such as when one member of a couple refuses to continue or a non-custodial parent withdraws their consent for a minor child's treatment.

Initial_____

TERMINATION: A good match between therapist and client is essential to a positive therapeutic outcome. As a result, we will assess during the first few sessions, whether continuing our work together will be of benefit to you. Participation in therapy is always voluntary and you have the right to terminate treatment at any time. If you are dissatisfied with the services you are receiving from me, please talk with me about your concerns. If you have unanswered questions about any of the procedures or interventions used in the course of your therapy, my expertise in employing them, or about your treatment plan, please ask. I am happy to explain my rationale. If at any time you would like to consult with another therapist, I can provide you with a list of qualified professionals.

Initial_____

CONSENT FOR TREATMENT OF A MINOR: (IF APPLICABLE)
I give consent for treatment of my child, ___Morgan Fung_____. I assert that I have discussed the goals, objectives, methods, and time frame of my child's treatment with Valencia Relationship Institute. I understand the above may be modified as therapy progresses. I understand I have the right to refuse treatment or to terminate counseling should I choose. I understand fully the risks, alternatives, and the nature of treatment

performed. I am aware we will discuss these or any other issues should I request. At this time, I consent to work and to support the achievement of the objectives stated in my child's treatment plan. It is without any pressure or coercion that I sign this consent.

Initial_____

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone other than my supervisors without your written permission, except where disclosure is required by law.

Initial_____

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled or when client's family members communicate to **___Morgan Fung__** that the client presents a danger to others.

Initial_____

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by **__Morgan Fung___.** In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. **___Morgan Fung____** will use her clinical judgment when revealing such information and she will not release records to any outside party unless she is authorized to do so by all adult family members who were part of the treatment.

Initial_____

Emergencies: If there is an emergency during our work together, or in the future after termination where __Morgan Fung__ becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, she will do whatever he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, she may also contact the person whose name you have provided on the biographical sheet.

Initial_____

Health Insurance & confidentiality of records: Disclosure of confidential information may be required by your health insurance carrier or PPO in order to process the claims. If you instruct _Morgan Fung__, only the minimum necessary information will be communicated to the carrier. However, I have no control or knowledge over what insurance companies do with the information I submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in

question as computers are inherently vulnerable to break in's and unauthorized access. Medical data has been also reported to be legally accessed by enforcement and other agencies, which also puts you in a vulnerable position.

Initial_____

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorneys, nor anyone else acting on your behalf will call on __Morgan Fung_____ to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

Initial_____

Consultation: Sometimes consultations with other therapists can be helpful. While I consult regularly with other professionals regarding my clients, I do not disclose client's names or other identifying information. I maintain the confidentiality of my clients even when consulting with other professionals.

Initial_____

E - Mails, Cell phones, Computers and Faxes: It is very important to be aware that computers and e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, __Morgan Fung____'s e-mails are not encrypted. Faxes can easily be sent erroneously to the wrong address. _____Morgan Fung__ computers are equipped with a firewall, a virus protection and a password. I also back up all confidential information from my computers on to a hard-drive on a regular basis. The hard-drive is stored securely off-site. Please notify ___Morgan Fung_____ if you decide to avoid or limit in any way the use of any or all communication devises, such as e-mail, cell-phone or Faxes. If you communicate confidential or highly private information via e-mail, _Morgan Fung_____ will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and I will honor your desire to communicate on such matters via e-mail. Please do not use e-mail or Faxes for emergencies.

Initial_____

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact _____Morgan Fung_____ between sessions, please leave a message on the answering service (661) 259-8200 and your call will be returned as soon as possible. I check my messages a few times during the daytime only, unless I am out of town. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away please call 911, contact the National Crisis and Suicide Prevention Hotline at (800) 784-2433 or go to your local emergency room. Please do not use e-mail or Faxes for emergencies.

Initial_____

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee of $_150.00___ per 50 minute sessions as services are rendered. In order to

further maximize our time together, payment is expected at the beginning of each session. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify _Morgan Fung_____ if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, I will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose. As was indicated in the section *Health Insurance & confidentiality of records,* you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt with in psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If payment is made by check, please make the check payable to **Valencia Relationship Institute**.

Initial_____

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hours (2 days) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

Initial_____

I have read the above Agreement, Informed Consent, Office Policies and General Information carefully, I understand them and agree to comply with them:

_____

Client name (print) Date Signature (Parent if Minor)

_____

Client name (print) Date Signature

_____

Psychotherapist Datte Signature

***If you would like a copy of the informed consent, please advise your therapist.**

VALENCIA RELATIONSHIP INSTITUTE
28494 Westinghouse Place, Ste. 213
Valencia, CA 91355
661-259-8200

NO SHOW, RESCHEDULING & CANCELLATION POLICY

In an effort to provide quality medical care, we believe that keeping appointments and arriving to your appointments in a timely fashion is essential. We would appreciate it if you would call 48 hours prior to your appointment. Additionally, not providing adequate notice to your inability to keep an appointment is expensive for this practice to endure. We always try to do our best to accommodate our patients, and our office strives to treat patients in a timely manner, we expect the courtesy to be returned**. A 48 hour notification** must be given to avoid a no show/cancellation fee due to the inconvenience caused to the office and others.

Please understand that when an appointment is made, this time has been reserved just for you.

Our fees are as follows:

Office Visit: $_150.00_____

Thank you

_____

Patient Name

_____

Patient Signature/Parent Signature Date

VALENCIA RELATIONSHIP INSTITUTE
28494 Westinghouse Place, Ste. 213
Valencia, CA 91355

PRE-AUTHORIZED HEALTH CARE FORM

I authorize Valencia Relationship Institute to keep my signature on file and to charge my credit card account for:

1. Balance of charges not paid by me and not to exceed $_____ for:
This visit only_____ All visits_____

2. Recurring charges (on-going treatments) of $_____ every
_____ from _____ to_____. (fee)
(frequency) (date) (date)

**I understand I may revoke this agreement at any time by providing a request in writing.

Client´s Name_____

Cardholder´s Name_____

Cardholder´s Address_____

City_____State_____Zip_____

VISA___ MASTERCARD___

Account number_____Expiration_____
Security Code on the back of the card_____

Signature_____Date_____

Therapist agrees to only charge for services rendered or for cancellation fee if appointment is not cancelled within 48 hours.

_____ _____
Therapist's Signature Date

VALENCIA RELATIONSHIP INSTITUTE
*28494 Westinghouse Pl. * Ste 213 * Valencia, CA 91355*

Record of Patient Disclosures

In order to best insure your privacy and meet stated HIPPA guidelines, please let me know how to best contact you with any information I need to relay via telephone, email, fax or otherwise.

I prefer to be contacted in the following manner (check all that applies):

Home Telephone _____
___ Okay to leave message with the detailed information
___ Leave message with call back information only

Cell Phone _____
___ Okay to leave message with the detailed information
___ Leave message with the call back information only

Email _____
___ Okay to leave message with the detailed information
___ Leave message with the call back information only

Written Communication
___ Okay to mail to my current address
___ Okay to fax detailed information to this fax number_____

Other _____
_____

Patient Signature (Parent signature if patient is a minor) _____
Print name _____
Patient's birth date _____

Responsible Party Signature _____
Print name _____
Relationship to Patient _____
Date _____, 201_