Laura A. Reames, M.A., LMFT

Licensed Marriage & Family Therapist, MFC43292
Certified Emotionally Focused Therapist for Couples
Certified EMDR Therapist
Office at Creekside Counseling Associates

8861 Williamson Drive, Suite 40 **Phone: (916) 546-1444**
Elk Grove, CA 95624 **Fax: (916) 670-7880**

CLIENT INTAKE FORM

Date _____

Last name _____ First name _____ MI _____

_____
(street address) (city) (state & zip)

Birth date: __/__/__ Age: ____ Sex: ❑ Female ❑ Male Social Security #: _____

	preferred	ok to leave message?
Cell phone _____	❑	❑
Home phone _____	❑	❑
Work phone_____	❑	❑

Email address _____ ❑ Yes, it's okay to contact me by email
❑ No, I prefer not to be contacted by email

If "Yes" checked, I acknowledge and am aware that email is not a confidential means of communication, but I still choose it as a means of communication and accept the risks. _____
(Signature & Date)

Religious Preference?_____ How were you referred? _____

Employer _____ Length of Employment _____
Occupation _____
Spouse's Employer & Occupation _____

Highest level of education completed: ❑ High School ❑ College degree ❑ Graduate degree
❑ Professional training ❑ Field of Study _____

Name & Phone of Emergency Contact: _____
Relationship to Client _____

RELATIONSHIP HISTORY

Relationship status: ❑ Engaged ❑ 1ST marriage ❑ Never Married ❑ Separated ❑ Widowed
❑ Re-Married 1, 2, 3 ❑ Shared Living Arrangement

Length of Relationship_____

Full Name of Children	Date of Birth	Age	In Home?

Others In Home	Relationship	Age

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MEDICAL AND PSYCHOLOGICAL HISTORY

Family Physician: _____ Phone: _____ Last Check up: _____
Names of Medications & Prescribed For What?

_____

Allergies to Medications & Medical Conditions:_____

_____

Previous Counseling? ❑ No ❑ Yes Who & How Long? _____
For What?_____Outcome?_____

Previous psychiatric hospitalization? ❑ No ❑ Yes When? _____Where _____
For what? _____

Substance Treatment? ❑ No ❑ Yes When? _____ Where? _____

Drug, Alcohol, or Prescription Medication Used/Using _____

Circle any issues that pertain to you in the present or underline any issues from the past:

Depression	Feeling Hopeless	Isolating	Thoughts/Plans of Self Harm
Suicide Attempts	Tiredness/Fatigue	Tearful	Difficulty Concentrating
Extreme sadness	Loneliness	Inferiority Feelings	Lack of Enjoyment in Activities
Overeating	Difficulty Eating	Sleeping too much	Difficulty Sleeping/Insomnia
Shy	Anxious	Nervous	Panic Feelings
Feeling Stressed	Feeling Guilty	Phobias	Fears
Nightmares	Muscle Tension	Headaches	Stomach Aches
Pain	Bowel Problems	Weight Changes	Physical Symptoms
Anger	Irritability	Violent Behavior	Temper
Thoughts of Hurting Others	Perfectionism	Impulsive	Self-Control Problem
Drug/Alcohol Use/Abuse	Judgment Difficulty	Difficulty Relaxing	Difficulty Making Decisions
Financial Difficulty	Divorce	Family Conflicts	Relationship Challenges
Dealing with Parents	Caretaking Parents	Blended Family Challenges	Challenges with Parenting
Peer Conflict	Education Problem	Sexual Problems	Change in Sexual Interest or /Function
Job Dissatisfaction	Career Choices	Conflict at Work	Work Performance Problems
Unmotivated at Work	Legal Matters	Death	Memory Problems

Reason for seeking help & what you would like to see happen as a result of therapy:

_____
_____

Responsible Party:

____ Private Pay: Responsible Party Name & Address _____
❑ Address Same as Above

____ Insurance: Company Name _____
Group Name & I.D. # _____
Name of Insured _____

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Informed Consent & Contract Agreement for Services

Welcome! Please read the following regarding my policies. Your understanding of this part of our professional relationship is important. Ask me any questions you have at the beginning of our session. Sign this only when you feel you understand it and have all your questions answered. It is my desire that your overall therapy experience is healthy and life giving for you.

1. **Introduction**: I am a Licensed Marriage and Family Therapist. For 18 years, I've been providing individual and joint therapy for adults, couples, groups and families. I have been licensed since June 30, 2006. My therapeutic style invites a collaborative process, incorporates a whole view of a person and focuses on strengths and interpersonal interactions. I utilize a variety of approaches to assist needs and to shift patterns of living getting in the way of present satisfaction.

2. **Private Practice:** I am the sole practitioner in private practice and the sole owner. I am affiliated with a group of private practice therapists with common goals and standards that share office space.

3. **Confidentiality**: Information that you reveal to me is private and it is your right to have that information kept confidential. There are certain situations in which information may be released with or without your permission. These situations are:

1. When you sign a form authorizing me to release information to a specified person or allow me to acquire information from another person.
2. If I have a reasonable suspicion of child abuse or neglect, or see physical signs of elder abuse or the abuse of a dependent adult, a report must be made to the designated protective agency.
3. If you tell me of a serious intent to physically harm another person, then I must warn that person and the police.
4. If you appear to be dangerous to yourself or others, or unable to care for yourself, I will take measures to attempt to ensure your safety which may mean releasing private information to secure assistance from others assistance in creating a safety plan.
5. Information or records may need to be disclosed in the event of a court order.
6. Disclosure of confidential information may be required by your health insurance carrier in order to process claims.

On occasion, I will consult with other professional colleagues about my work in order to provide better service to you. In case of such consultation, your name and any identifying information will be protected.

4. **Therapy Process:** Therapy may result in a number of benefits to you, including improved relationships, a better understanding of your personal goals and values, and resolution of the specific concerns that led you to seek therapy. However, psychotherapy is a joint endeavor, the results of which cannot be guaranteed. I will contribute knowledge, skills and support; however, progress depends on many factors, including your motivation and commitment to your own growth, change and care; honesty and other life circumstances such as your interactions with family, friends and other associates. Sometimes change will be easy and swift and sometimes it will be slow and frustrating. Talking about unpleasant events, feelings or thoughts during therapy may result in discomfort for you. Psychotherapy may involve the risk of remembering unpleasant events and can arouse intense emotions such as fear, anger, sadness, depression, anxiety, frustration or loneliness. Attempting to resolve the issues that brought you into therapy, such as issues in interpersonal relationships, may result in change not originally intended. Positive change may not be apparent immediately after each session but should be noticed over time.

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5. **Shared Information:** If you or your partner should disclose information with me in private, I will encourage you to share this information voluntarily to your partner in our couple's session. If you do not share this information, I may need to share this information in order to preserve my neutral position in our therapeutic relationship.

6. **Appointments**: Therapy sessions are normally 55-60 minutes in length. Your appointments will be scheduled according to availability while making careful effort to accommodate your schedule. Please note that you are reserving time in your name.

If you cannot make your appointment, please notify me as soon as possible by voicemail
(916) 685-5258 ext. 24
so that the time may be offered to others waiting to be scheduled.

Please allow **24 hours advance notice when cancelling a session**; otherwise **you will be charged the usual per hour rate** for your appointment time. Regular attendance is recommended to insure continuity of services and to enhance the effectiveness of the therapy.

7. **Professional Fees and Payments**:

a. Professional Fee - My fee is $160 for a 55 minute session. The fee is due at the **beginning** of each session unless other arrangements have been made in advance. In order to maximize the use of the therapy hour, please consider the following about your choice of payment:

- If paying by cash, bring in the correct amount of cash for your session
- If paying by check, make it out to "Laura Reames" prior to your appointment
- If your insurance company covers mental health services, I will provide you with a monthly statement of charges so that you may submit the statement to your insurance company for reimbursement to you. Payment for each session is payable by you. Insurance arrangements other than this need to be discussed prior to initiating services.
- Session expenses not paid by your insurance company are your responsibility.

b. Cancellation Fee - If you need to cancel or reschedule an appointment, you will be charged the full counseling fee for an appointment cancelled less than 24 hours in advance. Exceptions include sudden illness of you or a child and emergencies. Work schedule changes are not an exception. Insurance doesn't cover missed sessions and they will be your financial responsibility.

c. Telephone Fees - If you need telephone time with me between sessions, please leave a message on my voice mail. I will return your call. If you need more than 5 minutes, please let me know as we will most likely need to schedule a time. My regular fee applies to telephone appointments, prorated.

d. Administrative Fees – Other requests for a letter, treatment summary reports or any other administrative request will be billed at the regular per hour fee, prorated. In the case of a subpoena requesting court appearance, the rate is $250/hour.

e. Increase in Fees - My fees may increase over the course of treatment, but only with prior notification and a discussion with you. I encourage open, honest communication about the fee arrangement so that both of us are clear on expectations.

8. Telephone Accessibility and Emergencies: I will check my voicemails periodically on weekdays and will return your call at my earliest opportunity. If you have not heard back from me in a reasonable amount of time (around 24 hours), call again, because errors do happen with voicemail. Since I have voice mail and do not carry a pager, I am not available for emergencies of an immediate nature. In choosing to work with me, it is important that you fully understand this. If you do not have a friend or family member available in an emergency, you can:

- Call 911
- Contact the Sutter Center for Psychiatry Call Center at (916) 386-3077
- Call the Suicide Prevention Hotline at (916) 368-3111

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9. **Insurance**:

- ❑ I do not have insurance.
- ❑ I have insurance but I choose to not bill my insurance.
- ❑ I have insurance and wish to utilize my insurance company for payment. Fill out the insurance information on the "Client Intake" Form.

If you have any questions on any of these policies, please discuss your questions with me at our first appointment. Your signature below indicates that you have thoroughly read and understand all the policies covered in this document, that any questions have been addressed to your satisfaction and that you are willing to receive therapeutic services based on these policies.

_____
Print Name

_____
Signature Date

_____
Print Name (Additional Client)

_____
Signature (Additional Client) Date

_____
Provider's Signature Date

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Laura Reames, LMFT

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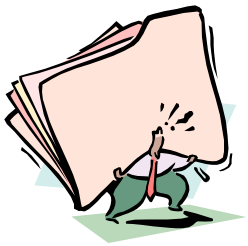
MFC43292

NOTICE OF PRIVACY PRACTICES

Your privacy is important to us



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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation. Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. For your **treatment**. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.

2. To obtain **payment** for your treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.

3. For health care **operations**. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

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Certain Uses and Disclosures *Require* Your Authorization

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

- **a.** For my use in treating you.
- **b.** For my use in training or supervising other mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
- **c.** For my use in defending myself in legal proceedings instituted by you.
- **d.** For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
- **e.** Required by law, and the use or disclosure is limited to the requirements of such law.
- **f.** Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
- **g.** Required by a coroner who is performing duties authorized by law.
- **h.** Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures *Do Not Require* Your Authorization.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Certain Uses and Disclosures *Require* You to Have the Opportunity to Object

Disclosures to family, friends, or others: I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

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YOUR RIGHTS REGARDING YOUR PHI

You have the following rights with respect to your PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI: You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full: You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You: You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI: Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made: You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI: If you believe that there is a mistake in your PHI, or that a piece of important information is missing from
your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice, and my address and phone number are:

Creekside Counseling Associates,
8841 Williamson Dr. #40, Elk Grove, CA 95624.
(916) 546-1444

You can also file a complaint with the U.S. Department of Health and Human Services
Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;

2. Calling 1-877-696-6775; or,

3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints. I will not retaliate against you if you file a complaint about my privacy practices. **This notice went into effect on September 20, 2013.**

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ACKNOWLEDGEMENT OF RECEIPT:

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have received a copy of the Providers 'Notice of Privacy Practices'.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Print Name Relationship to Patient

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Print Name Relationship to Patient

_____
Interpreter (if applicable)

Written Acknowledgement Not Obtained

- ☐ Notice of Privacy Practices Given – Patient Unable to Sign
- ☐ Notice of Privacy Practices Given – Patient Declined to Sign
- ☐ Notice of Privacy Practices Mailed to Patient – Awaiting Signature
- ☐ Other Reason Patient Did Not Sign

_____

_____