EMILY WINSLOW, MS LMFT
LICENSED MARRIAGE AND FAMILY THERAPIST
MFC45260

2082 MICHELSON DRIVE, SUITE 224
IRVINE, CA 92612
949-436-4594

Minor Client Information Form

Name of Client _____ **Date of birth** _____ **Current Grade** _____

Address _____ **Cell phone** (____) _____

Mother/Guardian _____ **Date of birth** _____ **Age** _____

Address _____
Therapist has permission to contact me at my mailing address: □ Yes □ No

Occupation _____ **Driver's Lic. #** _____

Home Phone (____) _____ May therapist leave a message? □ Yes □ No

Cell Phone (____) _____ May therapist leave a message? □ Yes □ No

Father/Guardian _____ **Date of birth** _____ **Age** _____

Address _____
Therapist has permission to contact me at my mailing address: □ Yes □ No

Occupation _____ **Driver's Lic. #** _____

Home Phone (____) _____ May therapist leave a message? □ Yes □ No

Cell Phone (____) _____ May therapist leave a message? □ Yes □ No

Marital status of minor's parents or guardians □ Married □ Separated □ Divorced □ Never married □ Living together

If parents are divorced or separated, specify custody arrangement Physical _____ Legal _____

In case of emergency, please notify _____

Address _____ Phone (____) _____

Please describe the reason you are currently seeking therapy for minor _____

_____

_____

Check all areas where minor is experiencing difficulty □ home □ school □ peers □ other _____

Please explain _____

_____

Referred by _____

Personal Health Information

Has the minor been in therapy previously? □ Yes □ No If YES, was it helpful? □ Yes □ No Why or why not? _____

_____

_____

Has minor ever been hospitalized for psychiatric reasons? □ Yes □ No If YES, when, and for how long? _____

Has minor ever attempted suicide? □ Yes □ No If YES, when? _____

Has minor ever been prescribed psychotropic medication? □ Yes □ No List names and provide dates taken:

_____ _____

_____ _____

If minor has ever been prescribed psychotropic medications or been in therapy previously, please complete the following information as completely as possible:

Psychiatrist _____ Address _____

Phone _____ Date and length of treatment _____

Psychotherapist _____ Address _____

Phone _____ Date and length of treatment _____

Current medical conditions, including duration and severity

_____

_____

_____

Current prescription medications

Name _____ Dosage_____ Frequency_____ Dr._____ Phone_____

Name _____ Dosage_____ Frequency_____ Dr._____ Phone_____

Name _____ Dosage_____ Frequency_____ Dr._____ Phone_____

How would you rate minor's current physical health? □ Poor □ Below average □ Good □ Very good

When was the minor's last physical exam? _____ Describe any previous serious illnesses or injuries_____

_____

How would you rate minor's current sleeping habits? □ Poor □ Some difficulty □ Few difficulties □ Very good

Please list any specific sleep problems minor is currently experiencing: _____

How many times per week does minor generally exercise? _____ What types of exercise to they participate in? _____

_____

Please list any difficulties with appetite or eating patterns _____

Does minor drink alcohol? □ Yes □ No If YES, how much/often? _____

Has minor ever used recreational drugs? □ Yes □ No If YES, please describe _____

Does minor consider themselves to be spiritual or religious? □ Yes □ No If YES, please describe your faith or belief: _____

_____

What significant life changes or stressful events has the minor experienced recently? _____

_____

_____

Family History

In the section below, identify if there is a family history of any of the following. If YES, please indicate the family member's relationship to the minor in the space provided (father, grandmother, uncle, etc.).

		List family member(s)
Alcohol/Substance Abuse	□ Yes □ No	_____
Anxiety	□ Yes □ No	_____
Depression	□ Yes □ No	_____
Domestic Violence	□ Yes □ No	_____
Sexual Molestation	□ Yes □ No	_____
Verbal/Emotional Abuse	□ Yes □ No	_____
Eating Disorders	□ Yes □ No	_____
Obesity	□ Yes □ No	_____
Obsessive Compulsive Behavior	□ Yes □ No	_____
Schizophrenia	□ Yes □ No	_____
Bipolar Disorder	□ Yes □ No	_____
Suicide Attempts	□ Yes □ No	_____

Does the minor have siblings or step-siblings? □ Yes □ No If YES, please list names and ages

Age	Name	Relationship	Is this child currently living with you?
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No

Has minor experienced any traumatic events in the past? □ Yes □ No If YES, please explain _____

_____

_____

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Informed Consent for Treatment to Minors

Introduction

This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by Emily Winslow, MS LMFT, MFC45260 for the minor child(ren) _____ _____ (herein "Patient") and is intended to provide [name of parent(s)/legal guardian(s)] _____ _____ (herein "Representative(s)") with important information regarding the practices, polices and procedures of Emily Winslow, MS LMFT, MFC45260 (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Policy Regarding Consent for the Treatment of a Minor Child

Therapist generally requires the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for psychotherapy, Therapist will require that Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services.

Therapist Background and Qualifications

Therapist is a Licensed Marriage and Family Therapist (MFC45260) in the state of California. Therapist's theoretical orientation can be described as attachment based.

Risks and Benefits of Therapy

A minor patient will benefit most from psychotherapy when his/her parents, guardians or other caregivers are supportive of the therapeutic process.

Psychotherapy is a process in which Therapist and Patient, and sometimes other family members, discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, as well as his/her caregivers and/or family members, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge the perceptions and assumptions of the Patient or other family members, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships.

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

Professional Consultation
Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Patient or Patient's family members or caregivers.

Confidentiality & Contribution to Knowledge
Your therapist is committed to both her continued professional development and the advancement of psychology. She spends professional time teaching and training others. The use of casework, including your own, may be useful for case consultation, teaching case illustrations, etc., to learn and/or make concepts clearer. Illustrations such as this do not require releasing the personal identity or identifying information about the person. Unless you notify your therapist to the contrary, it will be assumed that you have no objection to this work. One potential advantage among many is that the struggles and difficulties of your life might do some good to future generations of therapists and fellow human beings whose lives have similar issues.

Confidentiality
The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

Representative should be aware that Therapist is not a conduit of information from Patient. Psychotherapy can only be effective if there is a trusting and confidential relationship between Therapist and Patient. Although Representative can expect to be kept up to date as to Patient's progress in therapy, he/she will typically not be privy to detailed discussions between Therapist and Patient. However, Representative can expect to be informed in the event of any serious concerns Therapist might have regarding the safety or well being of Patient, including suicidality.

In regard to **Group Therapy**, confidentiality is held by/within the group. While Therapist will discuss and encourage confidentiality with the group, Therapist cannot be held responsible for a breach in confidentiality made by another group member.

Patient Litigation
Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient, or Representative, and another individual, or entity, are parties. Therapist has a policy of not communicating with Representative's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's, or Representative's, legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Representative agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of $_____ per 50-minutes. In addition, Therapist will not make any recommendation as to custody or visitation regarding Patient. Therapist will make efforts to be uninvolved in any custody dispute between Patient's parents.

Psychotherapist-Patient Privilege
The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by a person with the authority to waive the privilege on Patient's behalf. When a patient is a minor child, the holder of the psychotherapist-patient privilege is either the minor, a court appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the psychotherapist-patient privilege for their

minor children, unless given such authority by a court of law. Representative is encouraged to discuss any concerns regarding the psychotherapist-patient privilege with his/her attorney.

Patient, or Representative, should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient, or Representative, should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

Fee and Fee Arrangements

The usual and customary fee for service is $_____ per 50-minute session. Sessions longer than 50-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Representative will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, HMOs, managed care organizations, or other third-party payers, or by agreement with Therapist.

From time-to-time, Therapist may engage in telephone contact with Patient or Representative for purposes other than scheduling sessions. Representative is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at the request of Patient or Representative and with the advance written authorization of Patient or Representative. Representative is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.

Representative is expected to pay for services at the time services are rendered. Therapist accepts cash and personal checks. Fee for returned checks is $25.00.

Insurance

Therapist is not a contracted provider with any insurance company, managed care organization. Should Representative choose to use his/her insurance, Therapist will provide Representative with a statement, which Representative can submit to the third-party of his/her choice to seek reimbursement of fees already paid.

Cancellation Policy

Representative is responsible for payment of the agreed upon fee for any missed session(s). Representative is also responsible for payment of the agreed upon fee for any session(s) for which Representative failed to give Therapist at least 48 hours notice of cancellation. Cancellation notice should be left on Therapist's voice mail at 949-436-4594.

Therapist Availability

Therapist's office is equipped with a confidential voice mail system that allows Patient or Representative to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, Patient or Representative should call 911, or go to the nearest emergency room.

Termination of Therapy

Therapist reserves the right to terminate therapy at his/her 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, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient or Representative has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient or Representative.

Acknowledgement

By signing below, Representative acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Representative has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Representative's satisfaction. Representative agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Representative agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____

Patient Name (please print)

_____ _____

Signature of Patient (if Patient is 12 or older) Date

_____ _____

Signature of Representative (and relationship to Patient) Date

_____ _____

Signature of Representative (and relationship to Patient) Date

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payer.

_____

Name of Responsible Party (Please print)

_____ _____

Signature of Responsible Party (and relationship to Patient) Date

_____

Name of Responsible Party (Please print)

_____ _____

Signature of Responsible Party (and relationship to Patient) Date

NOTICE OF 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.

I. Disclosures for Treatment, Payment and Health Care Operations

A therapist may *use* or *disclose* your *protected health information* (*PHI*), for certain *treatment, payment, and health care operations* purposes without your *authorization*. In certain circumstances, he or she can only do so when the person or business requesting your PHI provides 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"* is when a therapist or another healthcare provider diagnoses or treats you. An example of treatment would be when a therapist consults with another health care provider, such as your family physician or another psychologist, regarding your treatment.
- *"Payment"* is when a therapist obtains reimbursement for your healthcare.
- "*Use*" applies only to activities within premises such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of premises such as releasing, transferring, or providing access to information about you to other parties.
- *"Authorization"* means written permission for specific uses or disclosures.

II. Uses and Disclosures Requiring Authorization

A therapist 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 asked for information for purposes outside of treatment and payment operations, your therapist will obtain an authorization from you before releasing this information. 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.

III. Uses and Disclosures with Neither Consent nor Authorization

A therapist may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** Whenever a therapist, in his or her professional capacity, has knowledge of or observe a child he or she knows or reasonably suspects has been the victim of child abuse or neglect, he or she must immediately report such to a police department, sheriff's department, county probation department, or county welfare department. Also, if a therapist has knowledge of or reasonably suspects that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, the therapist may report such to the above agencies.
- **Adult and Domestic Abuse:** If a therapist, in his or her professional capacity, has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult; if a therapist is told by an elder or dependent adult that he or she has experienced these; or if a therapist reasonably suspects such, the therapist must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency.

  A therapist is not required to report such an incident if the therapist has 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 and the therapist is not aware of any independent evidence that corroborates the statement that the abuse has occurred; (a) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservator ship because of a mental illness or dementia; and (b) in the exercise of clinical judgment, the therapist reasonably believes that the abuse did not occur.

- **Health Oversight:** If a complaint is filed against a therapist with the California Board of Psychology or the California Board of Behavioral Science, the Board has the authority to subpoena confidential mental health information from the therapist relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services that I have provided you, I must not release your information without (a) your written authorization or the authorization of your attorney or personal representative; (b) a court order; or (c) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides me 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 me 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 for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.
- **Serious Threat to Health or Safety:** If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.
- **Worker's Compensation**: If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of the your initial examination, and at subsequent intervals as may be required by the administrator of the Worker's Compensation Commission in order to determine your eligibility for worker's compensation.

IV. Patient's Rights and Psychologist's Duties
Client's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request/denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

V. Complaints

- If you are concerned that a therapist has violated your privacy rights, or you disagree with a decision he or she has made about access to your records, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The therapist can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on May 1, 2005. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by U.S. Mail.

Client Name (Please Print)	Client Signature	Date