JACI SCHOEN, MS LMFT **(949) 264-2054**
Licensed Marriage and Family Therapist - MFC 88005

INTAKE INFORMATION DATE _____

NAME _____ AGE _____ DOB _____

ADDRESS _____

PHONE _____ EMAIL (see p.5) _____

OCCUPATION _____ EDUCATION _____

MARITAL STATUS _____ YRS IN RELATIONSHIP _____ CHILDREN _____

PREVIOUS THERAPY __(Y) __(N) HOW LONG _____ CURRENTLY EXPERIENCING SUICIDAL THOUGHTS __(Y) __(N)

CURRENT MEDICATIONS _____ PSYCHIATRIST / MD NAME _____

EMERGENCY CONTACT _____ PHONE _____

How were you referred you to this office? _____

PAYMENT PROCESSING INFORMATION

Please complete the following credit card information even if you are paying with check, cash, Zelle or ApplePay. Forms Payment accepted: Visa, MasterCard, Discover, American Express, Health Savings Account debit card, checks, and cash. Electronic payment may be made through Zelle or ApplePay. Session fees for all clinical treatment, late cancellation and NSF returned check fees will be charged to the credit card on this form and the transaction will be denoted as "JACALYN SCHOEN" on your statement.

Responsible Billing Party (Name on Credit Card/Account) _____

Billing Address: Same as above _____ Other _____

SESSION FEE _____ FORM OF PAYMENT ___Credit ___Debit ___Check ___Cash ___Zelle ___ApplePay

ACCOUNT INFORMATION ___Visa ___MasterCard ___Discover ___ AMEX ___HSA

Card # _____ Exp. Date _____ Security Code _____ Zip Code _____

YOUR SIGNATURE IS CONSENT TO STORE YOUR CREDIT CARD INFORMATION ON THE ONLINE PAYMENT PLATFORM.

_____ _____
Client Signature Date

COUNSELING* SERVICES CONTRACT

*Psychotherapy, Counseling and Therapy are used synonymously herein

I, Jaci Schoen, am a California State Licensed Marriage and Family Therapist; California license number 88005.

This document contains important information about my professional services and business policies. Please read it carefully and note any questions you may have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

Your feelings about your therapy are very important. I encourage you to discuss with me any concerns so that they do not become obstacles to our work together. If after our initial consultation, you decide we are not a good fit to work together, I will be happy to offer you a referral to another mental health professional.

Initial _____

BENEFITS and RISKS

The benefits may include reduced stress and anxiety, a decrease in negative thoughts and self-defeating behaviors, improved relationships, increased comfort in social, school and/or family settings, increased self-confidence, and a more hopeful attitude towards life.

The risks may include recalling or recounting painful memories and experiences, and the possibility of experiencing strong feelings of sadness, anger, fear or other difficult emotions.

Counseling is an open and dynamic process, and its course is dependent upon our mutual willingness to collaboratively continue the process and, to a certain extent, upon life events that cannot be foreseen.

Initial _____

CONFIDENTIALITY

In general, the privacy of all communications between a client and his or her therapist is protected by law, and I can only release information about our work to others with your written permission. There are a few exceptions:

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect you or others from harm, even if I have to reveal some information about a client's treatment. In such cases, I am required to file a report with the appropriate state agency.
The following information will clarify those cases in which I am mandated and am allowed to break confidentiality:

Harm to Self or Others: When a client discloses intentions or a plan for suicide, I have a duty to warn and protect the client by notifying legal authorities and to make reasonable attempts to notify the family of the client. When a client discloses intentions or a plan to harm another person, I have a duty to warn the intended victim and report this information to legal authorities.

Abuse of Children and Vulnerable Adults: If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, I am required to report this information to the appropriate social service agency and/or legal authorities.

Prenatal Exposure to Controlled Substances: I am required to report admitted prenatal exposure to controlled substances that are potentially harmful to the unborn child to the appropriate social service agency.

Minors: Parents or legal guardians of non-emancipated minor clients have the right to access the minor client's records.

If any of these situations occur, I will make every effort to discuss it with you before taking any action.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. Included in this New Client Packet is a copy of my HIPAA Privacy Practice for your information, which includes a more comprehensive explanation of how and when your private information may be used.

Initial _____

PAYMENTS, APPOINTMENTS AND CANCELLATIONS

I offer weekly individual and couple sessions. Please inquire about current fees. Payment is due at the time of service.

PLEASE PROVIDE 24 HOURS NOTICE OF CANCELLATION or you will be charged a cancellation fee equal to the session fee.

I accept Visa, MasterCard, Discover, AMEX, Health Savings Account (HSA) debit cards, Zelle and ApplePay.
Please complete payment section on page one, even if you are paying via Electronic payment.

In addition to sessions, I charge $200.00 per hour for other professional services such as report writing, attendance at meetings with professionals you have authorized, preparation of records or treatment summaries.

In the event of an emergency or unexpected absence during which I am unable to attend your scheduled appointment, I will provide a referral to a colleague; or if your issue is urgent or life-threatening, please call 911 or go to your local emergency room.

Your initials below authorize me to charge fees to the credit card on file (page 1).

Initial _____

INSURANCE

In-Network Provider: CIGNA. Please confirm your coverage prior to scheduling your first appointment.

Should your insurance cover services provided by me, please be aware that most insurance companies will only approve mental health services for individuals with a **severe mental disorder diagnosis**. Information such as treatment plans or summaries of your sessions will become part of the insurance company's file, your medical history file, and may be stored on a computer. I am not responsible for the confidentiality of their records. At your request, I will provide you with a copy of the submitted report.

Out-of-Network Provider: If you would like to seek reimbursement from your health insurance company please confirm your coverage. I will discuss with you preparing an insurance-ready monthly superbill for you to submit for reimbursement.

Initial _____

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

Client Signature Date

TELEHEALTH CONSENT FORM

Electronic systems used during telehealth therapy sessions will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

The laws and professional standards that apply to in-person therapy sessions also apply to telehealth therapy sessions. This document does not replace other agreements, contracts, or documentation of informed consent.

These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Client files and any notes taken during each telehealth therapy session will be securely stored in a locked file cabinet.

Please initial for consent:

_____ I will take precautions to ensure that my communications are directed only to my therapist by keeping the technology I use compliant / updated with security measures.

_____ Should video service be disrupted we may revert to telephone communication.

_____ During my telehealth therapy sessions, details of personal health information may be discussed between myself and my therapist through the use of interactive video, audio or other telecommunications technology.

_____ My therapist and I will regularly reassess the appropriateness of continuing to conduct telehealth therapy sessions through the use of the technologies we have agreed upon today, and modify our plan as needed.

_____ I may decline telehealth therapy sessions at any time without jeopardizing my access to future care, services, and benefits.

_____ _____

Client Signature Date

OUTSIDE OF SESSION COMMUNICATIONS and SOCIAL NETWORKING POLICIES

I, _____ (client) am open to receiving brief texts and email messages for purposes of:

____ Appointment scheduling

____ Crisis management between regularly scheduled appointments

____ Sharing information that would be critical to ensuring continuity of care between appointments

Therapist will respond to all forms of communication **during business hours**. If you have an urgent issue, please call 911 or visit your nearest emergency room.

Please review the guidelines below regarding the limits to confidentiality when communicating using these methods.

E-MAILS:
E-mail communications can be accessed by unauthorized persons and/or entities and are not encrypted, which may compromise the privacy and confidentiality of such communications. E-mails from client will be included in client's clinical record, which could be subpoenaed in the event of a situation that would legally require therapist to provide mental health records for review by a court of law.

CELL PHONES:
Like e-mails, calls and texts made via cell phones are not fully secured from unauthorized access.

FAXES:
Fax messages may be sent erroneously to the wrong address and/or fax machine.

COMPUTERS
This therapist's computer is equipped with a firewall, virus protection and a password, and all confidential information is regularly backed up. However, unfortunately, theft is a reality to consider and thus, computers and laptops may be stolen, and with them, all information stored on them.

SOCIAL NETWORKING
This therapist does not accept "friend requests" on any social networking venue.

INFORMED CONSENT
If client communicates confidential or private information via e-mail, text, or fax, this therapist will accept these communications as client's informed consent and authorization to communicate in this manner. Client understands and accepts the risk that such communications may be intercepted and/or compromised, in some manner, by unauthorized persons or entities.

Please notify this therapist if you change the agreed upon use of e-mail, text, cell phones or e-faxes.

Please do not use e-mail, text, or faxes for communicating about emergencies. Due to computer or network problems, e-mails or e-faxes may not be deliverable, and this therapist may not check for texts or emails when traveling.

I (client) have read and understand the guidelines above:

_____ _____

Client Signature Date

HIPAA Privacy Practices

We have been, and always will be, totally committed to maintaining your confidentiality. We will only release information about you in accordance with HIPAA policies, state and local laws.

Your mental health information may be disclosed to other health care professionals for the purpose of providing treatment.

Our duties as your counselor: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are required to abide by the privacy policies and practices that are outlined in this notice.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the condition being treated.

Law Enforcement: In the event of reported violence or life-threatening dangers, your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Other uses and disclosures that require your authorization: Disclosure of your mental health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you must submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual rights: You have certain rights under the federal privacy standards.

These rights include, but are not limited to:

- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Request to inspect protected health information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting us during normal business hours. Your request may or may not be granted, depending upon the reasoning for disclosure.

Contact person: You may contact us for further information concerning our privacy practices.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to our office. If you believe that your privacy rights have been violated, you should send a letter describing the cause of your concern to our office. You will not be penalized or otherwise retaliated against for filing a complaint.

I will provide a copy of her HIPAA practices upon request.

If you have any questions or concerns regarding this policy, please discuss them with me.

Please initial here, indicating you have read and understand this policy. Initial _____