INTAKE INFORMATION

Date ____/____/____ *Therapist's Name* _____

CLIENT _____ Birth date ____/____/____

Address _____ Gender: ❑ Female ❑ Male

_____ Soc. Sec # _____

_____ Relationship Status: ❑ Single ❑ Married

Home Phone _____ ❑ Domestic Partner ❑ Divorced

Client's Occupation _____ ❑ Other _____

Employer or School _____ Work Phone _____Ext. _____

Address _____ Cell Phone _____

Who referred you? _____ E-Mail _____

Physician _____ Physician Phone _____

Date if Last Physical ____/____/____ Major Illness _____

Current Medications _____

History of Domestic Violence: Yes No History of Sexual Abuse: Yes No

Previous Psychotherapy? Yes No

If yes, when? _____, with whom? _____

OTHER FAMILY MEMBERS:

Name	*Birth date*	*Relationship*	*Living at home*
_____	____/____/____	_____	yes / no
_____	____/____/____	_____	yes / no
_____	____/____/____	_____	yes / no
_____	____/____/____	_____	yes / no

PERSON RESPONSIBLE FOR THE ACCOUNT _____

Address *(if different from above)* _____

Signature _____ Date ____/____/____

PERSON TO CONTACT IN CASE OF EMERGENCY:_____PH. #_____

I AUTHORIZE TREATMENT FOR THE MINOR CHILD(REN) UNDER MY CARE.

Signature _____ Date ____/____/____

Signature _____ Date ____/____/____

INSURED/INSURANCE INFORMATION
For Insurance Users Only
(Please present insurance card)

PRIMARY INSURANCE: _____

Insured _____ Gender: ❑ Female ❑ Male

Address _____

_____

Identification Number. _____

Relationship to client: ❑ Self ❑ Spouse ❑Other _____

Insured Date of Birth _____

Contact number to receive benefit information: _(____)_____

SECONDARY INSURANCE: _____

Insured _____ Gender: ❑ Female ❑ Male

Address _____

_____

Identification Number. _____

Relationship to client: ❑ Self ❑ Spouse ❑Other _____

Insured Date of Birth _____

_____

Please Note: It is the client's responsibility to confirm their own benefits. Information regarding benefits/reimbursement conveyed by our office to you is subject to change dependant on your specific policy.

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature _____ Date ____/____/____

I authorize payment of medical benefits to the undersigned physician or supplier for services described on claims.

Signature _____ Date ____/____/____

Exceptions to Confidentiality

To Our Clients:

It is important to us that you understand that anything you tell your therapist is completely confidential. Unless we have specific written permission (a Release of Information form) signed by you, we tell no one that you come there or what you say.

There are several exceptions to this rule that we want to be sure you understand:

1. Your therapist is required to report any suspected child or elder abuse (either current or past) to local child protective or law enforcement officials within 24 hours. (Section 11161.5 – Cal. Penal Code) Abuse is defined as the willful cruelty to or the unjustifiable punishment of a child or elder person or endangering the life or health or either one. This includes sexual molestation, the willful infliction of physical pain or injury, willfully causing or permitting unjustifiable mental suffering, or the willful failure to provide necessary food, clothing, shelter and medical attention. (Section 273a – Cal Penal Code) If any therapist fails to report, he or she may be both civilly and criminally liable.

2. If your therapist believes that you actually intend to do physical harm to someone else, he/she must notify the police and the intended victim.

3. If your therapist believes that you truly intent to harm to yourself, he/she will make every effort to insure your safety. If he/she is unable to do this, he/she must (by law) notify the police.

4. If you are using your insurance to pay some or all of your therapy costs, it is important for you to know that your therapist may be required to make regular reports to the insurance company regarding your diagnoses and course of treatment. He/she may also use electronic methods (FAX) to communicate with your insurance company. While we make every effort in our office to protect your privacy by having your FAX machine in a separate room and using cover sheets on all Faxed material, we are not responsible for any problems that occur once information has left our office. If this creates issues for you, please discuss alternatives with your therapist.

5. My office uses electronic claims submission with a company named Ability Network that is under contract with a confidentiality agreement for the purposes of protecting client demographics and diagnosis.

_____ _____

Client's Signature Date

_____ _____

Parent's Signature (if Client is under 18 years of age) Date

_____ _____

Family Member's Signature Date

_____ _____

Family Member's Signature Date

Nahed Sammani Stefany, MS LMFT
Licensed Marriage and Family Therapist License # 47679
360 Mobil Ave. Suite 218E , Camarillo, CA 93010
PH (805) 407-5069

OFFICE POLICIES HIGHLIGHTS PAGE

Session Rates: $120 if insurance is not being used. Please pay your copay or fee at the beginnings of each session by check, visa, master card or cash.

Cancellations:

If you need to cancel a session, please remember I require **24 hour notice**. You can leave a message on my voice mail 24 hours a day, 7 days a week: (805) 407-5069. Otherwise, you will be charged for your missed session (charged to you, not your insurance company for the full fee). If we have set reoccurring appointments you will be charged for the duration of two more schedule appointments without contact to cancel those appointments (see Termination section). If you had an extreme emergency I will offer you an alternative date if possible to make-up for late cancelation within the same week. If that offer doesn't work for you, unfortunately you will be charged the full fee.

Telephone/E-mails and Text Messaging:

Telephone/e-mail and text messaging time is limited to 10 minutes, beyond which I will bill you at my standard rate rounded to the next half hour. Payment will be expected at the next regularly scheduled appointment, or sooner by mail.

Treatment of minors:

Children under the age of 18 years must have the consent of all parents/guardians who hold "legal custody." I will not treat children without this written consent. I prefer to involve all parents/guardians as much as is therapeutically appropriate. I will be glad to discuss how, when, and if this can be accomplished in your case.

Limits to Confidentiality:

Review thoroughly in the attached Therapeutic Contract/Informed Consent for Treatment the section called Limits to Confidentiality.

Court involved cases:

Please provide me with a copy of court orders. Please understand that any court letters, appearances, necessary phone calls or any other time spent on litigation issues are not covered by your insurance. I will be charging you personally for any time spent on court issues by my hourly rate. If my appearance in court is necessary, I have a set fee of $800 per day spent at court due to loss of a work day.

Please read the attached Therapeutic Contract/Informed Consent for Treatment thoroughly. I have read and fully understand this Office Policies Highlights Page.

Signature _____ Date_____

Signature _____ Date_____

Nahed S. Stefany, MS LMFT
Nahed Sammani Stefany, MS LMFT
Licensed Marriage and Family Therapist License # 47679
360 Mobil Ave. Suite 218E, Camarillo, CA 93010
PH (805) 407-5069

Consent for Treatment

I herby authorize the request Nahed S. Stefany, LMFT to carry out psychological examinations, diagnostic procedures and/or treatment, which now or during the course of my care as a patient are advisable.

I understand that the purpose of any procedure will be explained to me and be subject to my agreement.

I have read and fully understand this Therapeutic Contract/Informed Consent of Treatment.

Client's Signature . _____ Date _____

Client's Signature . _____ Date _____

Therapist Signature . _____ Date _____

Nahed Sammani Stefany, MS LMFT
Licensed Marriage and Family Therapist License # 47679
360 Mobil Ave. Suite 218E, Camarillo, CA 93010
PH (805) 407-5069

Please be sure to legibly fill out the Intake Information Page completely including your address, date of birth and social security number, home and cell phone numbers, and signature(s).

Acknowledgement

Federal law requires that all patients be given a copy of the California Notice Form. The Notice describes in detail how patient health information is used and shared with others. All reasonable efforts will be made to protect the privacy of patient health information, whether it is maintained on paper or electronically, regardless of how it is communicated.

I hereby acknowledge that I received the link to view online for the the California Notice Form (Notice of Privacy Practices.):
http://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Notice-of-Privacy-Practices-English.pdf

Name (Print): _____

Signature: _____

Date: _____ Date of Birth: _____

Name (Print): _____

Signature: _____

Date: _____ Date of Birth: _____

When the patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Name (Print): _____

Signature: _____

Date: _____ Relationship to Patient: _____