Kevin S. Thomas, Ph.D.

Child and Adult Psychology

228 West Main Street, Tustin, CA 92780
Phone (714) 852-1231

NEW CLIENT INFORMATION

PATIENT'S NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____ MARITAL STATUS: _____

HOME ADDRESS: _____ CITY / STATE / ZIP: _____

HOME PHONE: (____)_____ BUSINESS PHONE: (____)_____

☐ CELL ☐ PAGER: _____ PATIENT SOCIAL SECURITY: _____

I AUTHORIZE THE THERAPIST TO LEAVE MESSAGES AT THE FOLLOWING NUMBER(S):

☐ HOME ☐ BUSINESS ☐ CELL ☐ PAGER (Check all that apply) PLEASE INITIAL:

_____

STUDENT STATUS: ☐ Non Student ☐ Full Time ☐ Part Time ☐ Unknown

EMAIL: _____

REFERRED BY: _____ ADDRESS: _____

CITY / STATE / ZIP: _____ PHONE: _____ FAX: _____

What is the Relationship of Person Filling Out This Form to the Patient: _____

Person financially responsible for payment of services.	
OCCUPATION / TITLE:	BUSINESS PHONE: ( )
EMPLOYED BY:	Message O.K.?: ☐ Yes ☐ No
SUBSCRIBER RELATIONSHIP TO PATIENT: ☐ Self ☐ Parent ☐ Spouse ☐ Dependent ☐ Other	
EMPLOYMENT: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Unknown ☐ Retired Retired Date:	

Below For Office Use Only

Provider Name: _____ Code: _____

Services: ☐ Individual ☐ Family ☐ Testing ☐ Group ☐ Other CoPay: _____

Primary Diagnosis: Code: _____ Description: _____

Secondary Diagnosis: Code: _____ Description: _____

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Office Policies and General Information Agreement to Provide Mental Health Services

CONFIDENTIALITY

All Written or spoken material from any and all sessions, including psychological testing, will be considered confidential unless:

1. the patient authorizes release of information with his / her signature.
2. the patient presents a physical danger to self.
3. the patient presents a danger to others.
4. child/elder/dependent adult abuse/neglect are suspected.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken. Disclosure *may also be pursuant to legal proceedings.*

Records: Your clinical file will consist of (a) legal forms such as this document, (b) a record of visits and payments, and (c) clinical progress notes. These progress notes will contain enough information about your treatment to justify it, should such justification ever become an issue.

It is understood that cases are sometimes discussed among professionals for educational, consultation and/or research purposes. In addition, in couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members.

Payment for Service: My fee is $200 per 50-minute session and you will be expected to pay for services at the time they are rendered, unless other arrangements have been made. Payment can be in cash or by check. If you pay by a check that is ever returned for insufficient funds, I will expect you to make good on the check and to pay me for any service charges levied by my bank. In general, large balances should not accrue, and we will work to prevent this from happening. *As a last resort, I reserve the right to use a collection agency if you do not pay a large balance.*

Managed Care: I do not accept managed care.

Health Insurance Reimbursement: If you carry insurance, please understand that my professional services are rendered and charged to *you*, not to the insurance company. If you request, I will provide you with a monthly statement which you can submit to your insurance company for reimbursement. This statement will include your diagnosis, the procedure code, the number of sessions, and the amount you have paid me. It will be your responsibility to contact your insurance company to determine if they will reimburse you under these terms, and, if so, what percentage of the fee they will cover. Be advised, however, that *your use of insurance severely jeopardizes the confidentiality of your treatment*. This office or your therapist has no control or knowledge over what insurance companies do with the information submitted or who has access to this information.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to 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 (clients) nor your attorneys, nor anyone else acting on your behalf will call on your therapist or agents of this office to testify in court or at any other proceedings, nor will a disclosure of the psychotherapy records be requested.

MEDIATION AND ARBITRATION

All disputes arising out of or in relation to this agreement to provide psychological services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement between you and your therapist. The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement shall be submitted to and settled by binding arbitration in Orange or Los Angeles Counties in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan and your therapist can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum as and for attorney fees. In the case of arbitration, that sum will be determined by the arbitrator.

CONSENT FOR TREATMENT

You should be aware that, although I anticipate otherwise, despite treatment you may not improve at all, you may not improve as quickly as you might like, or you may start to improve only after treatment has ended. You should also be aware that treatment is intended to induce change in your life, and that when this change occurs it may disrupt your accustomed manner of living and your relationships with others. Treatment can also provoke feelings of affection or anger for the psychotherapist that must be discussed in the treatment. In short, treatment may be emotionally painful at times. Such is the nature of growth.

I authorize and request that my therapist carry out psychological examinations, treatments, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

PROBLE LENGTH OF SERVICES AND TERMINATION

Although some clients elect to pursue long-term, open-ended treatment, many issues can be resolved in about 25 to 30 sessions, while some highly focused issues such as phobias can be resolved in about 12 sessions. Of course, the success of any treatment depends on the motivation and aptitude of the person being treated. For this reason, I can make no guarantees about treatment length or success.

If at any point your therapist determines that he/she is not able to provide the exact services you require, he/she will discuss this with you and, if appropriate, will terminate treatment. In such a case, you will receive a number of referrals which may be of help to you. If you request and authorize in writing, your therapist will talk to the provider of your choice in order to help with the transition. If at any time you want another professional's opinion or want to consult with another therapist, your therapist will assist you in finding someone qualified, and if he/she has your written consent, will provide him/her with the essential information. You have the right to terminate therapy at any time. If you choose to do so, your therapist will provide you with names of other professionals whose services your might prefer.

DUAL RELATIONSHIPS

Therapy never involves sexual or business relationships nor does it involve any other dual relationship that impairs your therapist's objectivity, clinical judgment, therapeutic effectiveness or can be exploitive in nature.

RELEASE OF INFORMATION

I authorize the release of information for claims, certification/case management, and other purposes related to the benefits of my Health Plan (If applicable).

NOTICE OF PRIVACY PRACTICES

A notice of privacy practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA), describing how information about you may be used and disclosed and how you can get access to this information is provided to you. Please review it carefully. I have received the Notice of Privacy Practices. I have been provided an opportunity to review it.

I understand and agree to all of the above information.

_____

PRINTED Patient (or Parent/Guardian) Name

_____ _____

SIGNATURE Patient (or Parent/Guardian) Name Date

_____ _____

SIGNATURE Witness (Therapist) Name Date