MARCIA HOFFMANN, L.C.S.W.
4930 CAMPUS DRIVE • NEWPORT BEACH, CA. 92660 • PHONE: 949) 836-1866

NEW CLIENT INFORMATION

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

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

HOME ADDRESS:_____ **CITY / SATE / ZIP:** _____

EMAIL: _____ **BUSINESS PHONE:** _____

HOME PHONE:_____ **STUDENT STATUS:** ☐ **NONE** ☐ **FULL TIME** ☐ **PART TIME**

CELL PHONE:_____ **REFERRED BY:**_____

TEXTING?: ☐ **YES** ☐ **NO**

NOTE: The office line 949 - 836 - 1866 is able to receive and send text messages. Many clients choose to communicate that way. If you DO NOT want to communicate via text for confidentiality reasons, please make sure that "NO" is checked above.

Please be aware that text messages cannot be accessed remotely and may not get to me immediately.

What Is the Relationship of Person Filling out this Form to Patient: _____

Person Financially Responsible for Payment of Services and /or Subscriber of the Primary Insurance Plan:

Subscriber:_____ City/State/Zip:_____

Home Address:_____ Business Phone: _____

Home Phone: _____ Employed By:_____

Occupation/Title:_____ Policy ID Number :_____

Subscriber Date of Birth:_____ Phone Number:_____

Insurance Company:_____ FAX Number_____

Insurance Address:_____ Plan Name/ Group Number:_____

City/State/Zip:_____ IPA/HMO Name:_____

Subscriber Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Dependent

Employment: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Unknown ☐ Retired

- - - - - - - - - - - - Office Use Only - - - - - - - - - - - -

Copay _____

Diagnosis: Code_____

Diagnosis: Code_____

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What are the concerns that brought you here? _____

_____

_____

_____

_____

Was there a specific event that caused these problems? ☐ **Yes** ☐ **No**
If yes, please describe: _____

_____

_____

_____

Have you ever had any previous counseling or therapy? ☐ **Yes** ☐ **No**

With whom_____ From_____ To_____

For what reason? _____

_____

_____

Have you ever been hospitalized for psychiatric or behavioral health treatment?

☐ **Yes** ☐ **No** If yes, then please explain? _____

_____

_____

Do you have a history of suicidal thoughts or attempts? ☐ **Yes** ☐ **No**
If yes, please explain circumstances and at what age this occurred : _____

_____

_____

Has any member of your family ever suffered from anything which could be described as an "emotional" or "psychological" problem? ☐ **Yes** ☐ **No**
If yes, please explain: _____

_____

_____

Has there ever been any domestic violence or child abuse in your family? ☐ **Yes** ☐ **No**
If yes, please explain: _____

_____

_____

Continue on next page...

Do you or have you used any recreational or illegal drugs? ☐ **Yes** ☐ **No**

Which Ones:	How Often:	Age Started:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you or have you abused or over used any prescription medication? □ Yes □ No

Which Ones:	How Often:	Age Started:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol? □ Yes □ No

If yes, when and how much? _____

Is your drinking of concern to you? □ **Yes** □ **No**

What would you like to accomplish through counseling? (State your goals for therapy)

_____

_____

_____

_____

_____

_____

Please read and initial the following:

_____ **Canceled / Missed Appointments:** A scheduled appointment means that time is reserved specifically for you. If an appointment is missed, or canceled with less than 24 hours notice, you will be billed the full amount of the missed session. This fee will be due at the time of your next appointment or before . I will also keep a record of your credit card on file in case of outstanding balances. Frequent cancellations may result in the termination of your treatment: your compliance in keeping appointments is vital in the treatment process.

_____**Emergencies:** If you are in imminent danger call 911 or go to the nearest emergency room. Calls to my voicemail will be returned within a 24 hour period during the week and a 48 hour period over the weekends.

_____**In an effort to fully respect your confidentiality, should we inadvertently meet in public I will not acknowledge you unless you indicate that this is appropriate.**

Client Signature _____ **Date** _____

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FEE AGREEMENT For Insurance Clients only

During initial sessions, copay amounts may not be known until insurance verification can be done. Until such time as the exact co pay can be determined, I will charge and collect a copay fee of $30.00 for each session. If this amount exceeds your copay as determined by the insurance plan, the difference will be either credited or refunded to you. If this amount is less than your determined copay the difference will be charged to your account.

All fees are to be paid at the time of the service.

A fee of one and a half percent per month will be added to all outstanding accounts in excess of 30 days. You will also be responsible for paying any deductibles your insurance carrier has determined.

CANCELED / MISSED APPOINTMENTS

Sessions are normally scheduled for 50-60 minutes. A scheduled appointment means that time is reserved specifically for you. If an appointment is missed, or is canceled with less than 24 hours notice, you will be billed the full amount of the session fee - *not just the copay in case of insurance coverage* - for the missed session. This amount is your responsibility. This fee will be due at the time of your next appointment or immediately after your missed session. I will keep a copy of a credit card on file in case of outstanding balances.
Frequent cancellations may result in the termination of your treatment: your compliance in keeping appointments is vital in the treatment process.

_____ Please initial here that you have read and agreed to this condition, including authorization to charge your credit card for any balances that you may owe.

If accounts become delinquent my office will begin collection procedures. I will attempt to contact you directly. If your account remains delinquent an outside agency may be used or small claims court action taken. You will be responsible for all court and legal fees incurred if above action is necessary.

EMERGENCIES

If there is an emergency, contact your therapist directly by calling the number provided to you on the cards. **However, always, in the event of a life threatening situation, first call the police or paramedics by dialing 911.**

I have read, understand and agree to the above conditions.

Client Signature _____ **Date** _____
(□ if guardian signature)

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OFFICE POLICIES AND GENERAL INFORMATION AGREEMENT TO PROVIDE MENTAL HEALTH SERVICES

Confidentiality

All written or spoken materials from any and all sessions, including psychological testing, will be considered confidential with the following exceptions:

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 abuse/neglect is 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.

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

Health Insurance: The disclosure of confidential Information may be required by your health insurance carrier or HMOs, PPOs, MCO's, or EAPs in order to process the claims. Your therapist has no control over or knowledge of what an insurance company does with the information submitted or who has access to this information.

Litigation Limitation: due to the nature of the therapeutic process and the fact 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 (client's) nor your attorney's nor anyone else acting on your behalf will call on your therapist or agent of this office to testify in court or at any of the proceedings, nor will the disclosure of the psychotherapy records be requested.

Mediation and Arbitration

All disputes arising out of or in relation to this agreement to provide Psychological /Psychiatric / Mental Health Services shall first be referred to mediation, before, and as a precondition 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 County's in accordance with the rules of the American Arbitration Association which are in effect at the time of 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, your therapist can use legal means (court, a collection agencies, etc. ...) to obtain payment. The prevailing party and arbitration or collection proceedings shall be entitled to recover a reasonable sum and attorney fees. In the case of arbitration, the sum will be determined by the arbitrator.

Consent for treatment

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 the purpose of these procedures will be explained to me upon my request and subject to agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

Termination

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

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 have read, I understand, and I agree to all of the above information and conditions.
Initial

Client Name _____
(Neatly Printed)

Client Signature _____ **Date** _____