Sue M. Bushrow LMFT#97127
Licensed Marriage & Family Therapist
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43385 Business Park Dr. Suite 100
Temecula Ca. 92590
PH 951.249.3774/ Fax 951.693.3366

CLIENT INTAKE FORM

Patient Information

Patient's Name: _____

DOB: _____ **Age:** _____ **Sex:** Male Female

Marital Status: Single Married Separated Divorced Widowed Long Term Relationship

Parent/Guardian Name(s), if patient is a minor:

_____

Home Address: _____

Home Phone: (___)_____ **Cell Phone:** (___)_____

E-mail Address: _____

What is your preferred method of contact? _____

If I call, may I identify who I am? _____ **If I call, may I leave a message?** _____

Emergency Contact Name, Phone and Relationship: _____

Employer (School/Grade, if student): _____ **Work/School Phone:** (___)_____

Employer/School Address: _____

Responsible Party / Subscriber, Parent or Spouse

Name: _____ **Relationship to Patient:** _____

DOB: _____-____ **Age:** _____ **Sex:** Male Female

Home Address: _____

Home Phone: (___)_____ **Occupation:** _____

Employer: _____ **Work Phone:** (___)_____

Employer Address: _____

Health Insurance Provider: _____ **Policy#:** _____

Primary Care Physician

Name: _____

Phone # _____ **Fax #** _____

Referred by: _____

Patient Name:_____

Intake Questionnaire

In order for me to be able to fully evaluate you, please fill out the following intake questions to the best of your ability. I realize there is a lot of information and you may not remember or have access to all of it; do the best you can. Thank you!

Main Purpose of Consultation (please give a brief summary of the main problems and how long you have been experiencing them)

Why are you seeking treatment at this time?

Have you sought previous treatment for this issue? YES NO (if yes, please indicate what and with whom below)

Current Life Stressors (please include anything that is currently stressful for you, examples include relationships, job, school, finances, children, etc.)

What would successful treatment results look like? (what are your treatment goals)

Who Currently Lives In Your Household? (please list names , relationship and ages of everyone currently living in your household)

Patient Name:_____

Medical History

Do you have any current or past medical conditions that I should be aware of? Yes No (if yes, please explain)

_____

_____

Medications (please list past and current medications along with their dosage, date of initial prescription, purpose, results, and prescribing doctor)

_____

_____

Regular Doctor or Clinic (please list your primary care physician as well as any other doctor or psychiatrist that you have seen in the last year)

_____

_____

History of suicidal thoughts, homicidal thoughts, or self harming thoughts or activities? Yes No (if yes, please explain)

_____

History of Hallucinations? Yes No (if yes, please list any past and current, and include if auditory, visual, tactile and/or olfactory)

_____

History of Head Trauma? Yes No (if yes, please describe what happened and when)

_____

History of Seizures of Seizure Like Activity? Yes No (if yes, please include periods of spaciness, confusion, lost time, etc.)

_____

Victim of Abuse (physical, sexual, emotional, domestic violence)? Yes No (if yes, please explain)

_____

Prior Hospitalizations and/or Surgeries? Yes No (if yes, please indicate date, place, cause and outcome)

_____

Prior Abnormal Lab Tests, X-rays, EEG, etc.? Yes No (if yes, please describe what and when)

_____

Allergies and/or Drug Intolerances? Yes No (if yes, please describe)

_____

Please indicate if you use any of the following:

Alcohol: Yes No If yes, amount and frequency _____

Tobacco: Yes No If yes, amount and frequency _____

Caffeine: Yes No If yes, amount and frequency _____

Drugs: Yes No If yes, types(s), amount and frequency _____

Present Height _____ **Present Weight** _____

Patient Name:_____

Please check off any symptoms you are currently experiencing and how often they occur. Use initials if filling out as a couple.

Symptom	Never or Rarely	A Few Times per Month	Nearly Every Day	Symptom	Never or Rarely	A Few Times per Month	Nearly Every Day
Guilt Feelings				Hopeless About Future			
Worrying				Thoughts of Death			
Too Much Energy				Thoughts of Suicide			
Aggressive				Problems With Family			
Uncontrolled Temper				Brooding About Past			
Afraid of Work/School				Crying Excessively			
Afraid to Leave Home				Feeling Down/Sad			
Sleep Walking				Nightmares			
Problem Falling Asleep				Feeling Anxious			
Problem Staying Asleep				Feeling Panicky			
Memory Loss				Problems With Anger			
Trouble Making Decisions				Feeling Jealous			
Feeling Alone				Feeling Impatient			
Difficulty Concentrating				No Confidence in Self			
Sudden Mood changes				Shortness of Breath			
Restlessness				Fast Heart Beat			
Easily Distracted				Chest Pains			
Problems Getting Along with others				Feelings of Unreality			
Feeling Worthless				Lying			
Overly tired				Problems at Home			
Poor or No Appetite				Alcohol Use			
Over Eating				Drug Use			
Bingeing				Blackouts			
Food Preoccupation				Stomach Problems			
Vomiting				Uncontrolled Thoughts			
Sleeping Too Much				Uncontrolled Behavior			
Hearing Voices				Problem With Peers			
Problems at Work				Problem With Authority			
Problems at School				Other:			
Stealing				Other:			

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INFORMED CONSENT

Introduction

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents.

Information about Your Therapist

I, Sue Bushrow, am a Licensed Marriage and Family Therapist. I hold a B.S. Degree in Human Services and a Masters in Counseling. You are free to ask questions at any time about my experience, education and clinical background. I also am a Cardiovascular Interventional Radiology Technician and have spent the last 30 years working in the Medical Field performing Cardiac Catherization's.

The Therapy Process

Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part and may result in you experiencing considerable discomfort. Change will sometimes be easy and swift, but more often it will be slow and frustrating. Remembering unpleasant events and resolving them through therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended. When working with children, behavioral symptoms often increase before positive changes occur.

As part of the therapeutic process, I may use several techniques including journaling and homework assignments. It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my feedback. Due to the varying nature and severity of issues and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

Client's Rights and Confidentiality

You have the right to a confidential therapeutic relationship. Within certain legal limits (see #3 below), information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any person without your written permission.

1. You have the right to know the content of your records at any time and I have the responsiblity to provide you with the complete records or a summary of their content.

2. If you ask me, I can release any part of your records to any person you specify. I will tell you when you make your request whether or not releasing that information to that agency or person might be harmful to you at any time.

3. Under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:
   a. If you reveal information about active child abuse or neglect, elder abuse, or dependent physical abuse, I must make a report to protective services. When a perpetrator of child abuse is in contact with minors and there is a reasonable suspicion that he/she may still be abusing minors, I must also report that information.

b. If you seriously threaten harm or death to another person, I am required to warn the intended victim and notify the appropriate law enforcement agencies.
c. If you are in therapy or being tested due to an order of a court or lawyer, the result of the treatment or tests ordered must be revealed to that court or lawyer.
d. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena.
e. If you are in a lawsuit where emotional harm is being claimed, the opposing side may subpoena your therapy records.

4. Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding you or your family members or caregivers.

5. You have the right to ask questions about any of the procedures used in the course of your therapy. I will explain my customary approach and methods to you.

6. Communications between therapists and patients who are minors are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, I, in the exercise of my professional judgment, may discuss the treatment progress of a minor client with the parent or caretaker.

7. You have the right to choose NOT to receive therapy from me. If you choose this, I will provide you with names of other qualified professionals whose services you might prefer.

8. You have the right to terminate therapy at any time without any financial, legal, or moral obligations other than those you've already incurred.

9. I have the right to terminate therapy with you under the following conditions:
a. When I believe that therapy is no longer beneficial to you.
b. When I believe that you will be better served by another professional, whom I will recommend. If I determine during the first 3 sessions that I cannot help you, I will assist you in finding someone qualified. If I have written consent from you, I will provide that professional with the essential information he or she requires.
c. When you have not paid for the last two sessions, unless special arrangements have been made.
d. when you have failed to show up for your last two therapy sessions without a 24-hour notice.

If any of these situations apply, I will send you a certified letter to your address of record to inform you of the decision, and I will give you the names of several therapists for your future counseling needs.

Client Litigation

I will ***not voluntarily*** participate in any litigation or custody dispute that you or your minor child is a party to. I have a policy of not communicating with your attorney and I will not write or sign letters, reports or affidavits to be used in your legal matters. I will not provide records or testimony unless compelled to do so and I will not make any recommendation as to custody or visitation regarding a client. I will make every effort to be uninvolved in any custody matter involving a client. Should I be subpoenaed or ordered by a court of law to appear as a witness in an action involving you or a minor client, you agree to reimburse me at the rate of $200 per hour for time spent making phone calls, giving testimony or depositions, preparation time (including submission of records) and any attorney costs incurred by me as the result of the legal action. A $1500 retainer fee will be due prior to any scheduled court appearance. Even though you are responsible for my testimony fee, it does not mean that my testimony will be solely in your favor. I can only testify to the facts of the case and to my professional opinion.

Fees and Insurance

1. The standard fee for each session is $125, unless other arrangements have been made prior to the start of therapy. Sessions are approximately 45-55 minutes in length. Payment in the form of cash, check or credit card is required at the time of the therapy appointment, unless other arrangements have been made in advance. You may leave therapy at any time and are only contracting to pay for the completed therapy sessions or sessions missed without providing a 24-hour notice.

2. Every client must keep an updated Credit Card Authorization on file. The Credit Card Authorization will be utilized for cancellations with less than a 24-hour notice, appointments missed without any notice (no-shows), and insurance refusal to pay for services.

3. Please inform me if you wish to utilize health insurance to pay for services. If I am a contracted provider for your insurance company, your copayment will be due at the time of service. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. If reimbursement has not been received by your insurance company within 90 days of billing, you will be responsible for the full amount of the bill. This is typically due to a simple delay in processing by the insurance company, but it is ultimately your responsibility to handle any delays or denial of payments by your insurance company.

4. You should be aware that insurance plans generally limit coverage to certain diagnosable mental disorders. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you.

5. Out of network clients who have a PPO Insurance policy, may request from me a Superbill which may be self-submitted by you for reimbursement directly to your insurance company. In certain cases, I may be able to submit out of network claims on your behalf. However, you agree that you will pay the standard fees for each session, regardless of what reimbursement you may receive from your insurance company at a later date.

6. For some reason you find that you are unable to continue paying for your therapy, you should inform me. I will help you consider any options that may be available to you at that time, including a fee that is reasonable for both of us.

Dual Relationships

Therapy never involves sexual, business, or any other dual relationships that could impair my objectivity, clinical judgment or therapeutic effectiveness or could be exploitative in nature. Please discuss this with me if you have questions or concerns.

Clinical Records

1. **Records:** I am required to keep appropriate records of the psychological services that I provide. Although psychotherapy often includes discussions of sensitive and private information, normally very brief records are kept noting that you have been here, what was done in session, and a general mention of the topics discussed. You have the right to a copy or summary of your file at any time. You have the right to request that a copy of your file be made available to any other health care provider at your written request. Your records are maintained in a secure location according to HIPAA Standards.
2. **Letters or Documentation:** If you need a letter from me for school, work or any other reason, my fee is $50

General Office Policies

1. Payment for Services: You are expected to pay for services at the time they are rendered unless other arrangements have been made. I am able to accept payment in the form of cash, checks or credit card. Please notify me if any problem arises regarding your ability to make timely payments.

2. Cancellations: *Since an appointment reserves time especially for you; a minimum of 24 hours' notice is required for* rescheduling or cancellation of an appointment. A $85 cancellation fee will be charged for sessions missed without such notification and a Credit Card Authorization must be kept on file in order to process this fee should this occur. You may reschedule or cancel appointments by calling/texting (951) 249-3774 or emailing me at suebushrowmfti@gmail.com

3. Office Hours: My business hours are subject to change at any time. Generally, I have sessions three days a week; Monday through Friday from 10am-6pm.

4. Therapist Availability/Emergencies: Telephone communication between sessions is welcome; however, I will keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions. Any discussions lasting longer than 10 minutes will require a full session fee. You may leave a message for me at any time on my confidential voicemail. If you wish me to return your call, please be sure to leave your name and phone number, along with a brief message and whether or not it is okay to leave a voicemail message back to you should I be unable to reach you. Non-urgent phone calls are returned during normal work hours within 48 hours. If you have an urgent need to speak with me, please indicate that fact in your message and follow any instructions that are provided by my voicemail. In the event of an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance or in the case of a mental health crisis contact the Suicide Prevention Lifeline at 1-800-273-8255.

3. **Email/Text Communications:** You can have the confidence that your insights, vulnerable experiences, and feelings will not be repeated outside the therapeutic relationship established. By nature, email and text correspondence is NOT confidential. Though security measures can be effective, it is never 100% seal proof. My policy regarding email/text usage is as follows: Email/text correspondence with me is NOT secure. Email/text correspondence is NOT a substitute for person-to-person therapeutic treatment, unless discussed with me in advance and in person. Email/text correspondence should only be reserved for scheduling questions. Anything stated in an email/text from you will be discussed in session, and in session only. Email/text correspondence is NOT to be used in the case of an emergency to contact me. If you need to contact me with something that demands immediate attention, please do so by voicemail at the following number: (951)297-3688, call 911, or go to the emergency room. If it becomes necessary, I will terminate treatment if email/text usage is or becomes inappropriate.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives.

Acknowledgment

I have read this information fully and completely, I have discussed any questions I had about the information, and I understand the information. I acknowledge that it is my choice to participate in psychotherapy (or have my child participate). I realize that the outcome of therapy depends upon my personal investment in the therapy process. I have familiarized myself with the fees and charges for services.

_____ _____

Client Name Parent/Guardian Name (if applicable)

_____ _____

Client or Parent/Guardian's Signature Date

_____ _____Client/Parent/Guardian's Signature

Date

Adult Consent for Treatment

I _____ authorize and request Sue Bushrow LMFT, to carry out psychological examinations, diagnostic procedures, and/or treatments that are advisable now or during the course of my care as a patient. 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 Consent for Treatment Form.

_____ _____

Client Signature Date

Consent to Treat Minor

I require the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of a parent or caregiver to give consent for psychotherapy, I will require copies of supporting legal documentation, such as a custody order, prior to the commencement of services. When working with an individual child, I respect his/her right to confidentiality. I will consult with you about your child's progress. Both parents are entitled to know the nature and progress of the child's therapeutic services. If I am treating your child in individual sessions, I appreciate you telling me at the beginning of the session whether there have been any unusual happenings since our last session or issues of concern you wish to discuss prior to the child's session. This interchange must be brief so as not to interfere with the child's therapy session or please leave me a detailed message on my confidential voicemail at 951-249-3774 prior to our session. If more extended time is needed, please call for a separate appointment or request a telephone session (see section concerning phone calls). Some children need to know that their parent is present for them in the waiting room and sometimes we involve the parent in a special session. Please inform me where you plan to wait while your child is in session and if your child is under the age of 10, please remain on site during their session. If you do leave, please make sure you get back on time to pick up your child as I cannot be responsible for watching your child between sessions.

I _____ _____as parent/guardian of minor child named

_____ authorize and request Sue Bushrow LMFT to carry out psychological examinations, diagnostic procedures, and/or treatments that are advisable now or during the course of his/her care as a patient. 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 Consent for Treatment Form.

_____ _____

Parent/Guardian's Signature Date

_____ _____

Parent/Guardian's Signature Date

Consent for Couples or Family Therapy

As a couple, we agree to engage in therapy which will include both joint and individual sessions. I understand my right to confidentiality in individual sessions but am willing to waive that right so that information shared in individual sessions can be shared in joint session at the discretion of the therapist. I also understand that my therapist believes that couples' therapy is most successful when a family is willing to be completely honest with the therapist and with each other. For this reason, my therapist has explained that she is unwilling to collude with secrets. Where a family member shares information with the therapist, it will be discussed in joint sessions to maintain an atmosphere of openness and honesty. I authorize and request Sue Bushrow LMFT to carry out psychological examinations, diagnostic procedures, and/or treatments that are advisable now or during the course of my care as a patient. 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 Consent for Treatment Form.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, that provision of health care to you, or the payment of this health care. I must provide you with this notice about my privacy practices, and such notice must explain how, when and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice: PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this notice. However, I reserve the right to change the terms of this notice and my privacy policies at any time. Any changes will apply to the PHI on file with me already. Before I make any important changes to my policies, I will promptly change this notice and provide you with a new copy.

I. HOW MAY I USE AND DISCLOSE YOUR PHI?

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and disclosures relating to treatment, payment or health care operation do not require your written consent. I can use and disclose your PHI without your consent for the following reasons:

1. For treatment. I can use your PHI within my practice to provide you with mental health treatment. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

2. To obtain payment of treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. For health care operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

4. Patient incapacitation or emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain other uses and disclosures also do not require your consent or authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local law requires disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for worker's compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order, I may also have to use or disclose your PHI in response to a subpoena.

3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.

4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

5. When health oversight activities require disclosure. For example, I may have to use or disclose your PHI to assist the government in conducting an investigation or inspection of a health care provider or organization.

6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of yourself or others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

8. To remind you about appointments and to inform you of health related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health case services, or other health care benefits that I offer that may be of interest to you.

C. Certain uses and disclosures require you to have the opportunity to object.

1. Disclosures to family, friends or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

2. Other uses and disclosures require your prior written authorization. In any other situation not described in the above sections, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action to rely on such authorization) of your PHI by me.

II. WHAT RIGHT YOU HAVE REGARDING YOUR PHI:

You have the following rights with respect to your PHI:

A. The right to request restrictions on my uses and disclosures. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members, friends or to others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your request, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. The right to choose how I send PHI to you. You have the right to request that I send confidential information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, email instead of regular mail), I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communication will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications.

C. The right to inspect and copy your PHI. In most cases, you have the right to inspect and copy the PHI that I have for you, but you must make the request to inspect and copy such information in writing. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you no more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The right to receive a list of the disclosures I have made. You have the right to receive a list of instances, i.e., an accounting disclosure, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosed incidents to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel. I will respond to your request for an accounting of disclosures within 60 days of receiving such requests. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. The right to amend your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The right to receive a paper copy of this notice. You have the right to receive a copy of this notice.

III. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I have made about access to your PHI, you may file a complaint with the person listed in Section IV below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave, S. W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

IV. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at 951-249-3774.

I acknowledge receipt of the Notice of Privacy Practices.

Client's Name (Printed) Parent/Guardians Name and Relationship to Minor Client if Applicable (Printed)

Client or Parent/Guardian's Signature Date

Sue M. Bushrow LMFT#97127
Licensed Marriage & Family Therapist
suebushrowmfti@gmail.com/suebushrowcounseling.com

43385 Business Park Dr. Suite 100
Temecula Ca. 92590
PH 951.249.3774/ Fax 951.693.3366

AUTHORIZATION CONSENTING TO RELEASE OF INFORMATION

I, _____, Client or Parent/Guardian of Minor Client, hereby authorize Sue Bushrow, LMFT #97127 (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Client, including, but not limited to, therapist's diagnosis of Client, and to receive relevant information from the following person/organization:

Name: _____

Address: _____ Phone: _____ Fax: _____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider's office address to be effective.

This disclosure of information/records authorized is required for the following purpose:

_____Any and All Information Necessary	_____Diagnosis	_____Treatment Planning
_____Prognosis	_____Progress to Date	_____Clinical Test Results
_____Dates of Treatment	_____Patient Records	_____Summary of Treatment
_____Consultation/Evaluation	_____Other: _____	

I authorize the release of the information described above for the following purposes: _____

_____

Therapist shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid until: _____

_____
Client's Name (Printed)

_____
Parent/Guardian Name if Client is a Minor and Relationship to Minor (Printed)

_____
Client or Parent/Guardian's Signature Date

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Insurance Information

Insurance Carrier

Patient's Name_____DOB_____SSN_____
Insured's Name_____DOB_____SSN_____
Insured is the person who carries the insurance. If insured person is the same as patient, you may write "SAME"
Health Insurance Name _____PHONE_____
Policy#_____ Group/Plan#: _____
Do you have a deductible? Yes____ No____ Amount of your deductible $_____
Have you met your deductible for the year? Yes____ No____
Do you have a Co-Payment? Yes_____ No_____. Amount of your Co-Payment: $_____
Authorization Number_____

Assignment of Benefits

I hereby authorize payment directly to Sue Bushrow LMFT 97127, of the benefits otherwise payable to me under the terms and conditions of my health insurance. I understand I am financially responsible to the above provider for the charges not covered by my insurance. I understand and agree that all accounts are due and payable at the time of service and that insurance is being billed as a courtesy. In insurance assigned cases, Sue Bushrow LMFT agrees to accept the charge determination of the insurance carrier as the full charge and I am only responsible for the deductible, co-payment and non-covered services. If my insurance carrier denies payment for these services, I agree to be personally responsible for the payment.

_____

Client's Name (printed) Parent/Guardian's Name and Relationship to Minor(printed)

_____

Client or Parent/Guardian's Signature Date

Release of Information

I will authorize the release of any medical or other information necessary to process insurance claims to obtain additional/continued authorization for services. I understand that this release includes billing and clerical personnel who are also under legal obligation to maintain confidentiality.

_____

Client's Name (printed) Parent/Guardian's Name and Relationship to Minor(printed)

_____

Client or Parent/Guardian's Signature Date

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Notice for Contact

Sue Bushrow LMFT97127 will provide the option for clients to receive courtesy appointment reminder emails or text messages 24 hours before your scheduled appointment.

If you wish to receive electronic reminders about your appointments, please provide your email address or text message number.

Fees for receiving text messages or emails may apply from your service provider.

____Yes, please send appointment reminder information to the following:

Email Address: _____

-OR-

Text Message Number: _____

By signing this document, I am giving my permission to send only appointment date and time reminder information by email and/or text message. No other protected the health information will be sent. I am aware that text messages and email are not protected or secure methods of transmitting information. Others may be able to view the information and Sue Bushrow LMFT, once sent, cannot protect this information of scheduled appointments. I understand the potential risks and will hold harmless Sue Bushrow LMFT in the event others obtain access to the information of scheduled dates and times.

I have read the above, understand and agree to accept electronic reminders of appointment days and times.

Clients' Name (printed)_____

Clients' or Parent/Guardian Signature_____

Date_____

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CREDIT CARD AUTHORIZATION

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time. All clients are required to have a valid credit card authorization on file.

I, _____, authorize Sue Bushrow LMFT 97127 to charge my credit/debit card for professional services as follows: I understand and agree that my card will be charged the amount stated above should any of the following situations arise (please initial each item below):

_____ Cancellations with less than 24 hours' notice are subject to a $50 cancellation fee

_____ Appointments I miss without notice (no-shows) are subject to a $85 cancellation fee

_____ Insurance refusal to pay for services.

_____ All other fees agreed upon in the Informed Consent and Office Policy

Card Type: _____ Visa _____ MasterCard _____ Discover _____ American Express _____HCSA

Card #: _____Expiration Date: _____Security Code: _____

Name on Card: _____

Email Address: _____

Billing Address (Street, City, State & Zip):

_____

_____

_____

Clients or Parent/Guardian's Name and relationship to Minor Client (Printed)

_____Date: _____

Client's Signature/Guardian's Name and relationship to Minor Client

_____Date: _____