SALLIE A. HUNT, L.M.F.T. Licensed Marriage and Family Therapist

PATIENT INFORMATION **Date:**

Patient_____
Last Name First Name Middle Name
Address: _____
Street
_____
City State Zip
Telephone: (H)_____(W)_____Cell_____
Area Code Number Area Code Number Area Code Number
Is it OK to Phone at Home?_____Work?_____Cell?_____
Date of Birth: _____Age: _____Sex: M ___F ____ Soc. Sec.# _____

Present Employment/Educational Status: Employed_____Unemployed_____Student_____
Employer:_____Position:_____
Address:_____Unemployed/how long?_____
If student, what school?_____Grade?_____
Highest Education Level completed: Elementary_____HS_____ GED_____College_____Graduate_____
Race (*optional)* African American____Asian_____Caucasian____Latino____Native American____Other_____
Household/Family Members: Live In/Out
of Home Age Relationship
_____ _____ _____
_____
_____ _____ _____
_____
_____ _____ _____
_____
_____ _____ _____
_____

Medical Information:

Physicians Name:_____Telephone:_____
Address:_____
Street City State Zip
Current medications and dosage levels:

Medical or psychiatric conditions/diagnoses:

Financial Information:

Name of Person Responsible for Payment of Services:
Complete the following only if you are seeking insurance billing/reimbursement for these services:
Insured's Name:_____DOB_____SS#_____
Insurance Company_____ Policy #_____
Insurance Billing Address_____Authorization #_____
Insurance Phone: ( )_____Employer/Group#_____

AUTHORIZATION FOR RELEASE OF INFORMATION FOR BILLING/COLLECTION PURPOSES:

I authorize the release of information to process claims for services rendered by Sallie Hunt, LMFT, DAPA Licensed Marriage and Family Therapist MFC 30923

_____
Patient Signature Date:

SALLIE A. HUNT, L.M.F.T. Licensed Marriage and Family Therapist

Agreement to Pay for Professional Services

I, the client (or person acting for the client), request that the therapist named below provide professional

services to me or to _____ , who is my _____, and I

agree to pay this therapist's fee of $ _____ per session for these services.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

_____

Signature of client (or person acting for client) Date

_____

Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____

Signature of therapist Date

Assignment of benefits

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

_____ _____

Client's (or parent/guardian's) signature, indicating agreement to all of the statements above

Date

_____

Printed name

NO-SHOW AND LATE CANCELATION POLICY

Due to the high number of clients not giving me the required **48 hour** policy to cancel or reschedule an appointment I'm immediately implementing a new policy. ***If a 48 hour notice is not given or you no-show on your schedule appointment my full $100.00 fee will be charged immediately.*** The only exception to this new policy is if you are very ill and or contagious. If this is the case then a doctor's note will be required to wave my $100.00 fee.

Please sign this form and date it. Thank you for your understanding and acceptance of my new policy.

Sallie A. Hunt, LMFT, FAPA

Print Your Name _____ Signature_____ Date:_____

SALLIE A. HUNT, L.M.F.T. Licensed Marriage and Family Therapist

Consent to Treatment

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

Confidentiality: I have the right to confidentiality. Information revealed by me will remain within this professional setting. There are, however, legal exceptions to this right: information must be divulged when ordered by the court, or when your therapist determines that I present a threat to myself or others. Further, California law requires the report of any known or suspected instance of child, dependent adult or elder abuse or neglect to the appropriate authorities.

I understand that all information disclosed within these sessions will otherwise be kept confidential and will not be released to anyone other than for professional consultation. If professional consultation is sought, it is also understood that my identity will be kept confidential by both parties.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 48 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

Release of Records: *I hereby consent to the exchange of information and/or medical records with past or current therapists or medical providers (MDs, Social Workers, Psychotherapists, Psychologists) for the purpose of gathering past history information and facilitating the continuance of the current treatment plan.*

DISCLAIMER (Updated 8/27/2011): Please be aware that certain insurance companies and third party providers demand more disclosure regarding your symptoms, history and my subsequent treatment plan. At times, this does not adequately protect your privacy. You may contest this but in most cases it results in the lack of payment for my services and the entire fee for my service in that case would now be your responsibility.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

Patient Litigation

As your therapist, I will not provide the following services, as they are most likely to be deemed "conflictual" by the courts:

- Custody dispute for a minor child
- Recommendation regarding custody or visitation regarding minor Patient.
- The signing of letters, reports, declarations or affidavits to be used in the Patient or Patients' Representative's legal matters.
- Providing records or testimony unless compelled to do so by subpoena
- If subpoenaed or ordered by the court to appear as a witness in an action involving a Patient, the Patient or Representative agrees to reimburse me for any time spent for preparation, travel or other time in which I have made myself available for such an appearance at my forensic fee of $250 an hour.
- Telephone conversations with Patient attorneys will also be billed at a prorated time of $250 an hour.

Consultations Outside of Scheduled Therapy Sessions

All telephone calls (emails and texts are unacceptable as they violate HIPAA regulations) that require any more time than would be needed to cancel or re-schedule an appointment will be billed at a rate of $62.50 per 15 minutes of time after the initial greeting. In most cases, insurance will not reimburse consultation calls. Exception: Some insurance policies will cover emergency calls that necessitate hospitalization. Check with your insurance provider for more information.

Your signature below indicates that you have read and understood all of the material presented on this page and that you agree to follow the protocols specified by said information.

Printer Name:_____ Signature:_____ Date: _____

SALLIE A. HUNT, L.M.F.T. Licensed Marriage and Family Therapist

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral health provider to share valuable information with your PCP. No information will be released without your signed authorization. Once completed and signed, please give this form to your behavioral health provider.

Section 1. The Patient

Last Name	First Name	Middle Initial

Subscriber Number From ID Card	Insurance Company Name	Date of Birth (MM/DD/YYYY)	Phone Number

I hereby authorize the disclosure of protected health information about the individual named above.

I am: ☐ the individual named above (complete Section 8 below to sign this form)
☐ a personal representative because the patient is a minor, incapacitated, or deceased (complete Section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

The following behavioral health provider may disclose the information:

Name (a person, or an organization if you are naming a facility)	Phone Number (if known)

Section 3. Who Will Be Receiving Information About the Individual?

The information may be disclosed to the following primary care physician:

Name (a person, or an organization if you are naming a practice)	Phone Number (if known)

Street Address (if known)	City, State and Zip Code (if known)

Section 4. What Information About the Individual Will Be Disclosed?

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

Section 5. The Purpose of the Disclosure

To release behavioral health evaluation and/or treatment information to the PCP to ensure quality and coordination of care.

Section 6. The Expiration Date or Event

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date.

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

Section 8. Signature of the Individual

Signature_____ Date (required) _____

Section 9. Signature of Personal Representative (if applicable)

Signature_____ Date (required) _____

Relationship to the individual (required): _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Last Updated: 09/20/06

SALLIE A. HUNT, L.M.F.T. Licensed Marriage and Family Therapist

Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- Ž I have no problem or concern bringing me here
- Ž Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- Ž Aggression, violence
- Ž Alcohol use
- Ž Anger, hostility, arguing, irritability
- Ž Anxiety, nervousness
- Ž Attention, concentration, distractibility
- Ž Career concerns, goals, and choices
- Ž Childhood issues (your own childhood)
- Ž Children, child management, child care, parenting
- Ž Codependence
- Ž Confusion
- Ž Compulsions
- Ž Custody of children
- Ž Decision making, indecision, mixed feelings, putting off decisions
- Ž Delusions (false ideas)
- Ž Dependence
- Ž Depression, low mood, sadness, crying
- Ž Divorce, separation
- Ž Drug use—prescription medications, over-the-counter medications, street drugs
- Ž Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- Ž Emptiness
- Ž Failure
- Ž Fatigue, tiredness, low energy
- Ž Fears, phobias
- Ž Financial or money troubles, debt, impulsive spending, low income
- Ž Friendships
- Ž Gambling
- Ž Grieving, mourning, deaths, losses, divorce
- Ž Guilt
- Ž Headaches, other kinds of pains

(cont.)

SALLIE A. HUNT, L.M.F.T. Licensed Marriage and Family Therapist

SALLIE HUNT, L.M.F.T. Licensed Marriage Family Counselor

- Ž Health, illness, medical concerns, physical problems
- Ž Inferiority feelings
- Ž Interpersonal conflicts
- Ž Impulsiveness, loss of control, outbursts
- Ž Irresponsibility
- Ž Judgment problems, risk taking
- Ž Legal matters, charges, suits
- Ž Loneliness
- Ž Marital conflict, distance/coldness, infidelity/affairs, remarriage
- Ž Memory problems
- Ž Menstrual problems, PMS, menopause
- Ž Mood swings
- Ž Motivation, laziness
- Ž Nervousness, tension
- Ž Obsessions, compulsions (thoughts or actions that repeat themselves)
- Ž Oversensitivity to rejection
- Ž Panic or anxiety attacks
- Ž Perfectionism
- Ž Pessimism
- Ž Procrastination, work inhibitions, laziness
- Ž Relationship problems
- Ž School problems (see also "Career concerns . . .")
- Ž Self-centeredness
- Ž Self-esteem
- Ž Self-neglect, poor self-care
- Ž Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- Ž Shyness, over-sensitivity to criticism
- Ž Sleep problems—too much, too little, insomnia, nightmares
- Ž Smoking and tobacco use
- Ž Stress, relaxation, stress management, stress disorders, tension
- Ž Suspiciousness
- Ž Suicidal thoughts
- Ž Temper problems, self-control, low frustration tolerance
- Ž Thought disorganization and confusion
- Ž Threats, violence
- Ž Weight and diet issues
- Ž Withdrawal, isolating
- Ž Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues:

- Ž _____

- Ž _____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

_____

SALLIE A. HUNT, L.M.F.T. Licensed Marriage and Family Therapist

Please fill out about your biographical background as completely as possible. It will help me in our work together. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly.

PERSON & PHONE NO. TO CALL IN EMERGENCY:

_____

Who referred you to our office?_____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you…):

_____

_____

_____

_____

_____

_____

Estimate the severity of above problem: Mild-Moderate-Severe-Very severe

CURRENT: Marital status:___ **Live with someone:**___ **Name:** _____**Years:** _____

PAST & PRESENT MARRIAGE/S OR PARTNERS LIVING TOGETHER (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

_____

_____

_____

_____

_____

PRESENT SPOUSE/PARTNER: Education: _____**Occupation:** _____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)

1._____

_____

2._____

_____

3._____

_____**4.**_____

_____

5._____

_____

PARENTS/STEP-PARENT (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father:_____

_____

_____

_____

_____

_____

Mother:_____

_____

_____

_____

_____

_____

Step-parents_____

_____

_____

_____

_____**SIBLINGS** (name/age, if dead: age and cause of death & brief statement about the relationship):

1._____
2._____
3._____
4._____
5._____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments)**:**

SUICIDE ATTEMPT/S, SELF HARM (cutting)**, VIOLENT BEHAVIOR** (describe: ages, reasons, circumstances, how, etc)

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: cancer, epilepsy, heart disease, etc)**:**

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended)**:**

1.

2.

3.

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

IF PARENTS DIVORCED: Your age at the time: _____, Describe how it affected you at the time

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, psychiatric diagnoses,
depression, anxiety, hospitalizations in mental institutions, abuse, etc.):

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if Yes, please explain):

What gives you the most joy or pleasure in your life?

What are your main worries and fears?

What are your most important hopes or dreams?

Please add any other information you would like me to know about you and your situation. (You may write on the other side of the page.)

SALLIE A. HUNT, L.M.F.T. Licensed Marriage and Family Therapist

Abuse history: • I was not abused in any way. • I was abused. If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation, etc.

Age	Kind of Abuse	By Whom	Effects on You	Whom did you tell	Consequences of telling

Legal history

1. Are you presently suing anyone or thinking of suing anyone? • No • Yes If yes, please explain:

_____

_____

2. Is your reason for coming to see me related to an accident or injury? • No • Yes If yes, please explain: _____

_____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment?

• No • Yes If yes, please explain: _____

_____

_____

4. List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones. Under "Jurisdiction," write in a letter: (F = federal, S = state, Co = county, Ci = city). Under "Sentence," write in the time and the type of sentence you served or have to serve (AR = accelerated or alternate resolution, CS = community service, F = fine, I = incarceration, Pr = probation, Po = parole, O = other, R = restitution).

Date	Charge	Jurisdiction (F, S, C, Ci)	Sentence (AR, I, Pr, Pa)	Probation/parole officer's name	Your attorney's name
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

5. Your current attorney's name: _____Phone: _____

6. Are there any other legal involvements I should know about? _____

_____

Health habits

1. What kinds of physical exercise do you get? _____

_____

_____

2. How much coffee, cola, tea, or other sources of caffeine do you consume each day?

_____

_____

3. Do you try to restrict your eating in any way? How? Why?

_____

_____

4. Do you have any problems getting enough sleep? _____

_____

_____

For women only

1. At what age did you start to menstruate (get your period):_____

2. Menstrual period experiences:

   a. How regular are they? _____

   b. How long do they last? _____

   c. How much pain do you have? _____

   d. How heavy are your periods? _____

   e. Other experiences during period? _____

3. Please list all of your pregnancies:

		What happened with with pregnancy?			
	Your age	Miscarriage	Abortion	Child born	Problems?
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

5. _____ _____ _____ _____ _____

6. _____ _____ _____ _____ _____

4. Menopause:
   a. If your menopause has started, at what age did it start? _____

   b. What signs or symptoms have you had? _____

   _____

Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

_____

_____

_____

Please do not write below this line.

Follow-up by clinician

Based on the responses above and on • interview data • records I reviewed • other information I have requested the client to complete and/or I have completed the following forms:

- Chemical use survey
- Suicide risk assessment summary and recommendations
- Mental status evaluation report

- Other: _____

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.

Uses and Disclosures

Treatment
Your health information may be used by designated staff members or may be disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members, this will only be done after you have signed a medical release form allowing us to do so.

Payment
Your health information may be used to seek payment from your health insurance plan, from other sources of coverage such as an automobile insurer, 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 services, that services provided, and the medical condition being treated.

Health care operations
Your health information may be used as necessary to support the day-to-day activities and management of Sallie Hunt LMFT DAPA. For example, information on the services you received may be used for necessary financial reporting, and activities to evaluate and promote quality.

Law enforcement
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. This will only be released after all legal authorization and signatures have been signed and verified.

Other uses and disclosures require your authorization
Disclosure of your 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 may 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.

Additional Uses of Information

Appointment reminders
Your health information will be used by my staff to send you appointment reminders.

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

- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information. Disclaimer: This is not done unless deemed necessary by the Board of Behavioral Sciences.

- 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.

Sallie Hunt LMFT DAPA Duties
I am required by law to maintain the privacy of you protected health information and to provide you with this notice of privacy practices. I have implemented privacy policies and procedures to comply with the standards, implementation specifications and other requirements of the, "Health Insurance Portability and Accounting Act" (HIPAA).

I also am required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, I reserve the right to amend or modify my privacy policies and practices. These changes in my policies and practices may be required by changes in federal and state laws and regulations. Upon request, I will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information I maintain.

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 me, Sallie Hunt. Your request will be reviewed and will generally be approved unless there are legal of medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about my privacy practices, or if you believe that your privacy rights have been violated, you may do so by sending a letter describing the cause of your concerns to: Sallie Hunt LMFT FAPA – 1495 W. Shaw, Fresno, CA 93711.

You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date
This notice is effective on or after July 10th, 2010.