



## Client Information Sheet

|   |                                       |
|---|---------------------------------------|
| <b>Client Information</b>   | Date: _____                           |
| Client Name: _____  |                                       |
| Address: _____  |                                       |
| City: _____   | State: _____ Zip: _____               |
| Phone Numbers: Home: (____) _____   | Work: (____) _____ Cell: (____) _____ |
| Email: _____  | Birth date: _____                     |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other |                                       |
| Work Status: <input type="checkbox"/> Employed <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student <input type="checkbox"/> Other   |                                       |
| Primary Care Physician: _____   | Phone: (____) _____                   |
| Emergency Contact: _____  | Phone: (____) _____                   |
| Who referred you: _____   |                                       |
| <input type="checkbox"/> Please add me to your email list for upcoming workshops, presentations, and "thought for the week."  |                                       |

|   |
|---|
| <b>If client is a minor or someone else is responsible for payment.</b> |
| Additional Responsible Party (1) – Name: _____                          |
| Address: _____  |
| City: _____ State: _____ Zip: _____                                     |
| Phone Numbers: Home: (____) _____ Work: (____) _____ Cell: (____) _____ |
| Email: _____ Birth date: _____  |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female   |
| Additional Responsible Party (2) – Name: _____                          |
| Address: _____  |
| City: _____ State: _____ Zip: _____                                     |
| Phone Numbers: Home: (____) _____ Work: (____) _____ Cell: (____) _____ |
| Email: _____ Birth date: _____  |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female   |

**History, Concerns, Goals**

Current symptoms and/or concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of your last doctor appointment: \_\_\_\_\_

Major Medical Injuries, Illnesses, or Surgeries: \_\_\_\_\_  
\_\_\_\_\_

Current medication you are taking (name, dosage, prescribing MD, start date): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Psychiatric medications you have take in the past (name, dosage, prescribing MD, start date, end date):  
\_\_\_\_\_  
\_\_\_\_\_

Please list any substances you use (alcohol, marijuana, caffeine, tobacco, heroin, psychedelics, methamphetamine, etc.): \_\_\_\_\_  
\_\_\_\_\_

Please list past therapists you have seen and/or psychiatric hospitalizations: \_\_\_\_\_  
\_\_\_\_\_

Psychiatric disorders in immediate or extended family: \_\_\_\_\_  
\_\_\_\_\_

Describe your current support system (family, friends, organizations, etc.): \_\_\_\_\_  
\_\_\_\_\_

Do you have thoughts about hurting yourself or other? yes no  
Please describe: \_\_\_\_\_  
\_\_\_\_\_

What information would you like to get from testing:  
1) \_\_\_\_\_  
2) \_\_\_\_\_  
3) \_\_\_\_\_



## Office Policies

The following policies are described to ensure that you are aware of your rights and responsibilities.

### **Legal and Ethical**

- It is without coercion that the client/guardian consents to psychological testing.
- The client/guardian is entitled to receive information from Timothy D. Stein, MFT about the assessments being given, reasonable expectations for results, and the fee structure. Please ask if you would like to receive this information.
- All information disclosed in sessions and assessment and the written records pertaining to those sessions and assessments are confidential and may not be revealed to anyone without my, the client/guardian's, written permission, except where disclosure is required by law.
- The reporting of information disclosed in session or on assessments is *required by law* under the following circumstances:
  - If a client presents an imminent danger to self or is gravely disabled (severely disoriented or in danger due to a psychiatric condition) authorities must be notified.
  - If a client expresses a serious threat of harm to an identifiable person, that person must be warned and the police must be notified.
  - If there is *reasonable suspicion* of child, dependent, or elder abuse or neglect, authorities must be notified.
- The reporting of information disclosed in session or on assessments *may be required*:
  - If the client's mental status is placed at issue in litigation initiated by me, the client/guardian.
  - In the event of a court order or subpoena. Information, records, or testimony about the client may have to be produced.
- The client/guardian has the right to review and/or receive a copy of the client's protected health information. If I, Timothy D. Stein, MFT, deem that releasing such information might be harmful in any way, I will either deny your request or offer to provide the records to an appropriate and licensed mental health professional of the client/guardian's choice.
- The client/guardian may terminate assessment services at any time.
- The client/guardian authorizes that in the event of Timothy D. Stein, MFT's death or grave disability, one or more of Timothy D. Stein, MFT's selected colleagues may review confidential information that Timothy D. Stein, MFT has collected about the client in order to advise the client/guardian of options.

### **Emergency Procedures**

- The client/guardian can call Timothy D. Stein, MFT at (707) 888-9098 between sessions during the week. Timothy D. Stein, MFT will try to return the client/guardian's call the same day.
- If the client is a *danger to him/herself or others*, the client/guardian will call **Psychiatric Emergency Services**, the 24-hour crisis line for Sonoma County, at **(707) 576-8181** or the Police at **911**.

I have read the preceding information and understand my rights as a client/guardian. I also agree to receive services provided by Timothy D. Stein, MFT

\_\_\_\_\_  
Signature of Client/Legal Dependant

\_\_\_\_\_  
Client/Legal Dependant Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client/Legal Guardian

\_\_\_\_\_  
Client/Legal Guardian Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Timothy D. Stein, MFT

Timothy D. Stein, MFT

\_\_\_\_\_  
Date



## Financial Agreement

- The client/guardian assumes primary financial responsibility for all professional services rendered and understands that any balance due will be billed to the client/guardian directly.
- **Cancellation Policy**
  - If the client misses an appointment or cancels an appointment without giving at least 24 hours notice then the client/guardian will be charged at the rate of \$60 for each 30-minute session.
  - The charge for a late cancelled or missed appointment may be waived for emergency or illness reasons at the discretion of Timothy D. Stein, MFT.
- There are several options for financing the cost of assessment including spreading out your payments over time by using a credit card.
- I am happy to provide you with a simple billing statement that you may submit for 'out-of-network' insurance reimbursement and/or for tax purposes.

**Contract Agreement:** I, the client/guardian, agree that, in signing this Financial Agreement, I have read and fully understand the terms contained herein.

I am responsible for a fee of \$\_\_\_\_\_ for the agreed upon assessment.

\_\_\_\_\_  
Signature of Client/Legal Dependant

\_\_\_\_\_  
Client/Legal Dependant Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client/Legal Guardian

\_\_\_\_\_  
Client/Legal Guardian Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Timothy D. Stein, MFT

Timothy D. Stein, MFT

\_\_\_\_\_  
Date



## Notice of Privacy Practices

**I. 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.**

### **II. 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, the 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 PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website. You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at [www.TimSteinMFT.com](http://www.TimSteinMFT.com).

### **III. HOW I MAY 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 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 Operations Do Not Require Your Prior Written Consent.** I can use and disclose your PHI without your consent for the following reasons:

1. **For 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 in order to coordinate your care.
2. **To obtain payment for 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 may 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 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 our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws.
4. **Other disclosures.** I may also disclose your PHI to others without your consent in certain situations. 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 Uses and Disclosures Do Not Require Your Consent.** I can use and disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement.** For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. **For public health activities.** For example, I may have to report information about you to the county coroner.
3. **For health oversight activities.** For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
5. **To avoid harm.** In order to avoid a serious threat to the PHI to law enforcement personnel or persons able to prevent or lessen such harm.
6. **For specific government functions.** I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
7. **For workers' compensation purposes.** I may provide PHI in order to comply with workers' compensation laws.
8. **Appointment reminders and health related benefits or services.** I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

**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.

**D. Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described in sections III A, B, and C above, I will ask for 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 in reliance on such authorization) of your PHI by me.

#### **IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**

You have the following rights with respect to your PHI:

**A. The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

**B. The Right to Choose How I Send PHI to You.** You have the right to ask that I send information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.



**C. The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you 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 not 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 Get a List of the Disclosures I Have Made.**

You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. 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 of the disclosure, to whom 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 charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

**E. The Right to Correct or Update 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 Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

**V. 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 made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

**VI. 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: 1023 College Avenue, Santa Rosa, CA 95404, (707) 888-9098, [Tim@TimSteinMFT.com](mailto:Tim@TimSteinMFT.com)

**VII. EFFECTIVE DATE OF THIS NOTICE**

This notice went into effect on October 17, 2005.



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have given to you. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full. My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at (707) 888-9098 or checking my website [www.TimSteinMFT.com](http://www.TimSteinMFT.com).

If you have any questions about my *Notice of Privacy Practices*, please contact me at:

Timothy D. Stein, MFT  
1101 College Avenue, Suite 230  
Santa Rosa, CA 95404  
(707) 888-9098  
Tim@TimSteinMFT.com

I acknowledge receipt of the *Notice of Privacy Practices* of Timothy D. Stein, MFT.

\_\_\_\_\_  
Signature of Client/Guardian

\_\_\_\_\_  
Date

**INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including \_\_\_\_\_

\_\_\_\_\_

However, because of \_\_\_\_\_

\_\_\_\_\_

I was unable to obtain my patient's acknowledgement.

\_\_\_\_\_  
Signature of Timothy D. Stein, MFT

\_\_\_\_\_  
Date

