Michelle Hill, LMFT
Licensed Marriage & Family Therapist 113458
242 W. Main St. #104, Tustin, CA 92780
(949) 359-1353

LIFE HISTORY QUESTIONNAIRE: ADULT

Name: ____ Date of Birth: _________________ Age: ________

Address: ____

Home Phone: __________________________________ ok to leave message? ☐ No ☐ Yes

Work phone: ___________________________________ ok to leave message? ☐ No ☐ Yes

Cell phone: ____________________________________ ok to leave message? ☐ No ☐ Yes

Email: ____ ok to leave message? ☐ No ☐ Yes

Emergency contact name & number: ____

NAME & AGES OF CHILDREN

Name: ____ Age: ______________________________________

Name: ____ Age: ______________________________________

Name: ____ Age: ______________________________________

Name: ____ Age: ______________________________________

What is the main reason that brought you in? ____

____

____

When did the problem start? ____

____

____

Can you recall any life circumstances or change that occurred around the time the problem(s) started? ___________

____

____

What solutions have been attempted? When is the problem better? ______________________________________

____

RELATIONSHIPS

Arguments per week: _______________ Do arguments get physical? ☐ No ☐ Yes

Please check all that apply:

Hitting:	☐ No	☐ Yes	How many times: _____________
Slapping:	☐ No	☐ Yes	How many times: _____________
Choking:	☐ No	☐ Yes	How many times: _____________
Pushing:	☐ No	☐ Yes	How many times: _____________
Forced Sex:	☐ No	☐ Yes	How many times: _____________

Verbal threats (by partner) to hurt self or others: ☐ No ☐ Yes How many times: _______________________

Have police been called to the home? ☐ No ☐ Yes (specify) _______________________________________

____

TREATMENT HISTORY

Have you received previous therapy? ☐ No ☐ Yes

Name(s)	Address/Phone	Dates of Service

Describe the effectiveness of these services and your satisfaction with them: __________________________

____

Have you been hospitalized for psychological reasons? ☐ No ☐ Yes

Hospital(s)	Address	Dates

MEDICAL HISTORY

If your medical history included any of the following, please note the age when the incident or illness occurred and any other pertinent information:

Childhood diseases: ☐ No ☐ Yes (specify) ______________________________

Operations: ☐ No ☐ Yes (specify) ______________________________

Hospitalizations: ☐ No ☐ Yes (specify) ______________________________

Head injuries: ☐ No ☐ Yes (specify) ____________ Unconscious? __________

Convulsions: ☐ No ☐ Yes (specify) ______________________________

Your overall rating of your health:
☐ Good ☐ Moderate ☐ Poor

Date of last exam? ______________________________

Name of Physician: ______________________________

Physician Address: ______________________________

Physician Number: ______________________________

Present illness(es) being treated for: ______________________________

Medications you are taking on regular basis: ______________________________

____

FAMILY PSYCHIATRIC HISTORY

Please indicate which of the following is true for yourself or any family member:

	Self	Mother	Father	Sibling	Grandparent	Aunt	Uncle
Depression							
Bipolar Disorder							
Suicide Attempts							
Anxiety							
Drug/Alcohol							

ADULT INFORMED CONSENT

TREATMENT INFORMATION AND AUTHORIZATION

I authorize treatment and assume financial responsibility for such treatment. I understand that it is customary to pay for professional services at the time they are tendered, unless prior arrangements have been agreed upon. I understand that the responsibility for payment remains with me regardless of my insurance coverage. In the event of my default; I also agree to pay for collection costs and reasonable attorney's fees that may be required to effect collection of default and that I will be informed prior to my account being turned over for collection.

I understand that my appointment times have been reserved for me, which prevents others from reserving that time and if I cancel the same day as my appointment I am responsible for a $75 cancellation fee.

GENERAL INFORMATION REGARDING THERAPY

Your visits are confidential and will remain so except for the following conditions mandated by law; information regarding suspected child abuse, elder abuse or dependent adult abuse, and threats of physical violence towards another, and threats of suicide must be reported immediately; privileged doctor/patient communication is waived if you bring the facts of your visit into a court; there may be no confidentiality for you if you become a danger to yourself or others; and your insurance company or managed care company may require information necessary to process your claim and for quality assurance reviews. A release of information signed by you will be necessary for our office to discuss your case of even acknowledge your visits at this office with others except as noted above. Furthermore, it is my policy regarding couples or family therapy to make the clinical determination of what information will be revealed from individual sessions between family members when more that one person is the client. Parents of children and adolescents have a right to be informed of the progress of their child; at the same time it is necessary to recognize with an adolescent the therapeutic importance to maintain a responsible level of doctor/patient confidentiality.

Therapy sessions are normally 50 minutes. On some occasions a double session or other time period may be discussed and arranged in advance. Same day cancellation will result in a fee of $75 dollars.

I have received, read and understand this policy/intake form.

______________________	______________________	______________
Client Name	Client Signature	Date

HIPAA 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. **IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).**

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice. Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. **HOW I WILL USE AND DISCLOSE YOUR PHI.**

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples. A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may 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, including discussing or sharing your PHI with my trainees and interns. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.
2. **For health care operations.** I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
3. **To obtain payment for treatment.** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
4. **Other disclosures.** Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.
5. **Certain Other Uses and Disclosures Do Not Require Your Consent.** I may use and/or disclose your PHI without your consent or authorization for the following reasons:
    a) When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
    b) If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
    c) If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
    d) If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
    e) To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).

f) If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
g) If disclosure is mandated by the California Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.
h) If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
i) If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
j) For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
k) For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
l) For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
m) For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
n) For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.
o) Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.
p) If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
q) If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
r) If disclosure is otherwise specifically required by law.

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: Michelle Hill at (949) 359-1353

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003. I acknowledge receipt of this notice

______________________	______________________	______________________
Name	Signature	Date

AUTHORIZATION TO BILL CREDIT CARD FOR SERVICES

To Our Clients,

In our efforts to continuously improve our patients service and office efficiency, you will be asked for a credit card number at the time of check in. that information will be held securely until your insurance has paid their portion and have notified both you and us of how much, if any, is your portion. A statement will be mailed to you regarding any remaining balance. If a balance becomes delinquent, the credit card will then be charged to avoid the collections process.

This will be advantage to you because you will no longer have to write out and mail us a check. It will be an advantage to us as well because it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody to keep down the cost of health care.

Much like when you check into a hotel or rent a car, you are asked for a credit card, which is imprinted and later used to pay your bill.

This will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, please do not hesitate to ask.

Sincerely,
Michelle Hill

Full Name on Credit Card (Please Print): ____

Card Billing Address: ____
(Street # and Name) (City) (State) (Zip Code)

Type of Credit Card: ____
(Visa, MasterCard, American Express, Discover)

Card Number: ____ Expiration Date: __________
(Month/Year)

CSC: ____________ For American Express, it's the four digits on the front of the card. For MasterCard, Visa or Discover, it's the last three digits in the signature area of the back of your card.

Client Signature: ____ Date: ______________

For client convenience if you would like to authorize Michelle Hill to charge your card at the time of service, (Initial here): __________