NEW CLIENT INTAKE FORM

Today's Date: _____

Identifying Information:

Last Name:_____ First:_____ Middle Initial: _____

Age:____Date of Birth:_____Gender:_____ Religion/Spiritual Preference: _____

Address: _____
Street City Zip code

Preferred Phone Number
_____**(Cell / H / W)**
OK to leave message? □ yes □ no

Backup Phone Number
_____**(Cell / H / W)**
OK to leave message? □ yes □ no

Are you employed: □ Yes □ No □ F/T □ P/T Occupation:_____

Employer:_____ How long with this employer? _____

Are you in school: □ Yes □ No □ F/T □ P/T Do you enjoy your work/school? □ Yes □ No

Highest Level of Education: _____

Current Relationship Status: (circle and add date of event where applicable)

Single Dating since_____ Married since_____ 1st - 2nd - 3rd Marriage Separated since _____

Dom. Partnership since_____ Widowed since_____ Divorced since_____ Engaged since _____

Relationship Satisfaction (please circle): Poor --- Unsatisfactory --- Satisfactory --- Good --- Excellent

Emergency Contact:_____/_____
Name / Relationship Telephone [Circle Home / Cell / Work]

Do you have children? □ Yes □ No How many?____ Ages: _____ _____ _____ _____

Who lives in your home (family members or others)?

Name	Relationship to you	Age	Date of Birth	Gender

Secure Online Client Portal.

New focus has a secure online patient portal. You can access the client portal via https://www.newfocusmfc.com/PatientPortal.en.html. You can use the portal to make, reschedule or cancel appointments, to receive appointment reminders via e-mail and/or text message, to access your billing account, to open superbills (to submit to your insurance), as well as to make a payment online. Lastly, you can send and receive HIPPA-compliant, secure e-mail via the patient portal to communicate with your therapist. To participate in this service, please register at the website above or provide an:

Email: _____ **Username** **(min 8, max 15 chars; letters & numbers only):** _____

Temp Password (8-35 letters, letters and numbers, no special characters): _____

Appointment reminders (if you sign up for the patient portal): □ Text □ Email □ None

Would you like your therapist to send you electronic handouts via email? □ yes □ no Initial _____

Would you like your therapist to send you text messages: □ yes □ no Initial _____

Primary Care Physician:_____Phone:_____Date of last exam? _____

Current physical health, (circle): Robust---Healthy---Pain---Infection---Chronic Illness---Cancer---Cold/Flu--Sensory Deficit

Do you have concerns about your physical health**?** _____

Current Psychiatrist:_____Phone:_____Last visit? _____

Are you currently under medical or psychiatric care? ☐ Yes ☐ No If yes, please indicate with whom and the reason(s): _____

_____

List prescribed medication(s). **Use reverse of paper if necessary.**

Medication	Dose	Reason for taking

Mediation use:

☐ Overuse ☐ As prescribed ☐ Forgetful ☐ Inconsistent ☐ Resistant ☐ Dissatisfied ☐ Inconsistent ☐ Discontinued

List any over the counter medications you currently take, including vitamins and supplements:
***Use reverse of paper if necessary.**

Over The Counter Vitamin/Supplement/Medicine	Dose	Reason for taking

Alcohol use: ☐ In recovery ☐ Non-drinker ☐ Occasional ☐ Social ☐ Regular ☐ Heavy use ☐ Alcoholic

Tobacco use: ☐ Non-user ☐ Occasional ☐ Social ☐ Regular ☐ Heavy use ☐ Cigars ☐ Chews

Unprescribed substance use: ☐ In recovery ☐ Non-user ☐ Occasional ☐ Social ☐ Regular ☐ Heavy use ☐ Addicted

Problematic sexual behaviors: ☐ In recovery ☐ None ☐ Occasional ☐ Regularly ☐ Heavily ☐ Addicted

Problematic gambling: ☐ In recovery ☐ None ☐ Occasional ☐ Regular ☐ Heavily ☐ Addicted

Problems with food: ☐ Overeat ☐ Binge ☐ Purge ☐ Starving self ☐ Use of laxatives/exercise to control weight

Problematic shopping: ☐ Yes ☐ No

Problematic overspending: ☐ Yes ☐ No **Problematic underspending:** ☐ Yes ☐ No

Problematic overachieving: ☐ Yes ☐ No **Problematic underachieving:** ☐ Yes ☐ No

List alcohol and/or street drugs that you **currently use**, or have **a history of using** recreationally.

***Please use the back of the sheet if you need more room.**

Substance	Alcohol	How much in one sitting?	How often per day, week or month?	Current	Past

Physical health: ☐ Robust ☐ Healthy ☐ Pain ☐ Infection ☐ Chronic illness ☐ Cancer ☐ Sensory deficit ☐ Cold/flu

Physical activity: ☐ Regular exercise ☐ Active. ☐ Fit ☐ Average ☐ Inactive ☐ Lethargic

Sleep: Any changes in your usual sleeping patterns in the past three months? Yes ☐ No ☐

If yes, ☐ Night time waking ☐ Sleeping too much ☐ Insomnia ☐ Waking in the night and can't go back to sleep. ☐ Other, please describe: _____

Any changes with **appetite or in eating patterns** over past 2 weeks? Yes ☐ No ☐

If yes, describe: _____

Are you **experiencing sadness, grief, depression, tearfulness** over past 2 weeks? Yes ☐ No ☐

If yes, describe: _____

Are you experiencing **anxiety, panic, panic attacks, phobias/fears**? Yes ☐ No ☐

If yes, describe: _____

Are you suffering with **chronic pain**? Yes ☐ No ☐ If yes, please describe:

_____

Adult Trauma History. Have you experienced abuse/trauma in your adult life, such as domestic violence, accident, rape?

Please **circle** all that apply:

physical emotional verbal sexual mental neglect other (explain below)

_____

Childhood Trauma History. Have you experienced abuse in childhood? Please **circle** all that apply: physical emotional verbal sexual mental neglect abandonment bullied other _____

Do you currently, or have you ever physically harmed another person? Yes ☐ No ☐

If yes, please describe: _____

Are you currently involved in legal proceedings? Yes ☐ No ☐ If yes, please explain:

_____

Do you ever see or hear things that other people say they can't see or hear? If yes, please explain:

_____

Have you experienced significant life changes or stressful events recently? If yes, please explain

_____

Have you previously seen a counselor/therapist/psychologist/coach/psychiatrist? Yes ☐ No ☐

Names/Reasons/date ranges/locations: _____

_____

_____

Please check items listed below if you or a family member have a current diagnosis, or a history of any of the following conditions. List family member affected, (i.e. father, mother, brother, sister, etc.).

CONDITION	Self ✓	Family Member ✓
Alcohol Abuse or Dependence		
Substance Abuse or Dependence		
Anxiety		
Depression		
Domestic Violence		
Eating Disorder		
Obsessive Compulsive Disorder		
Schizophrenia		
Bipolar Disorder		
ADHD		
Learning Difference		
Phobia		
Other		

Other significant medical, family or psychological history you would like your therapist to know:

_____

Have you ever attempted suicide? Yes ☐ No ☐ If yes, when? _____

Do you currently have suicidal thoughts? Yes ☐ No ☐

Suicide & Crisis Hotline: (650-494-8420 or 408-279-3312)

Has a family member attempted suicide? Yes ☐ No ☐ If yes, who _____

when?_____Was the suicide attempt completed? Yes ☐ No ☐

Do you now, or have you ever harmed yourself, such as cutting, scratching, burning, hitting?

Yes ☐ No ☐ If yes, in what manner? _____

Have you ever been hospitalized for psychologically related reasons? Yes ☐ No ☐ If yes, please explain **when/where/why**:

_____

_____

Reason you are seeking counseling today, include symptoms?

_____

_____

Date symptoms first began. _____

How do you hope counseling will help? _____

What have you tried to resolve the problem up to now? What has helped? What made it worse?

_____

Is there anything else you feel it is important for your therapist to know?

_____

How to did you hear about us? (Who referred you?):

□ Friend/relative □ Court/Social Services □ Doctor/Therapist _____

□ Other/ Specify_____

□ Internet: □ Goodtherapy □ Sexhelp.com □ Google □ NewFocusMFC.com
□ Janetakyol.com □ Theravive
□ Networktherapy □ Psychologytoday □ Yahoo

Would you like a statement to submit to your insurance company (known as a Superbill)?

Yes ☐ **No** ☐

If you would like a Superbill to submit to your insurance company, please fill out the following, which I may need if your insurance contacts me:

Primary Insurance Company Name:
_____

Primary Insurance Phone #:
_____

Insurance I.D. #: _____

Insurance Group Number (or None): _____

Primary Insured Person if not client: _____

Effective Date: _____

NEW FOCUS
Marriage & Family Counseling Inc

AGREEMENT FOR SERVICES & DISCLOSURE STATEMENT

Introduction

This document is intended to provide you with important information regarding your treatment at New Focus Marriage & Family Counseling Inc., owned by Janet E. Akyol, LMFT, CSAT. This document informs you of the practices, policies and procedures of New Focus Marriage & Family Counseling Inc., and the Licensed Marriage & Family Therapists, [herein called "Therapist"], and pre-licensed therapists, Associate Marriage & Family Therapists and/or Associate Professional Clinical Counselor, [herein called "Associate"], and it clarifies the terms of the professional therapeutic relationship between the Therapist or Associate and you, [herein called the "Client" or "Responsible Party"]. Please read the entire document carefully and be sure to ask your therapist any questions or concerns you have regarding the contents prior to signing it.

About Your Therapist

At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/her experience, education, special interests, and professional orientation. A summary of the training and professional experience of each therapist employed by New Focus is also available on the website www.newfocusmfc.com. You are also free to ask questions at any time about your Therapist's or Associate's professional background, experience and professional orientation. Licensed Marriage & Family Therapists have undergone the state's licensing requirements and continue to attend continuing education in order to maintain a license in good standing. Associates are Masters level graduates who have provided clinical services under the supervision of a licensed clinician, both in practicum as a Trainee during their Masters degree and post Masters degree as Associates registered with the California Board of Behavioral Science. They continue to work as pre-licensed therapists under the license of a licensed clinical supervisor until they have acquired a minimum of 3000 supervised hours, which qualifies them to sit two state licensing exams. Associates working at New Focus Marriage & Family Counseling Inc., are supervised by Janet E. Akyol, MFT, CSAT, Clinical Supervisor, License # MFC 51250. When Ms. Akyol is unavailable, Associates will be supervised by an on-call Licensed Clinical Supervisor.

Fees

Fees are due at the time of service:

- Licensed Marriage & Family Therapist:
  - $150.00 per 50 minute individual session.
  - $180.00 per 60 minute couples, family or individual session.
  - $40.00 per group session.

- Rarely, additional sessions may be advisable or requested on occasion and are at the standard hourly rate.

- If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist as soon as possible. Your therapist will help you to consider options available to you.

- There is a charge of $35.00 for returned checks.

- Fees will be reviewed annually and may be periodically adjusted with a 30 day notice period.

Insurance

The Therapist/Associates are usually not contracted providers with any insurance company or managed care organization. Associates may be providers to certain EAP organizations. Therefore, **payment is required at the time of service**. The client may choose to attempt to claim reimbursement from his/her insurance provider, and a Statement of Services, called a Superbill, will be provided which you can submit to the third-party of your choice to seek reimbursement of fees already paid. The Client/Responsible Party is responsible for verifying and understanding the limits of his/her benefits/coverage, and is advised to do so prior to the commencement of treatment.

Scheduling Appointments

Individual, couples, family and group sessions are typically scheduled to occur once per week at the same time and day, whenever possible. On occasion due to holidays, session may miss a week or two or may be rescheduled to a different day by Client/Therapist mutual agreement. Clients may schedule appointments via telephone with office admin staff at 408-412-8439, with their therapist or online at www.newfocusmf.com under the Schedule tab.

Cancellation Policy

Your standard fee will be charged for late cancellations and missed sessions, unless **48 hours notice** is given prior to the session. Please understand that your insurance company will not pay for missed or late canceled sessions. You will be requested to keep a credit card on file for missed appointment charges. You may also make payments online via your patient portal account.

Telephone Availability & Emergencies

Brief phone calls between office visits are welcome. However, your therapist will attempt to keep these contacts brief due to her/his belief that important issues are better addressed within regularly scheduled sessions, and within the confidential confines of the therapy office. You may contact your therapist by telephone and leave a message for him or her. You may also contact your therapist via the TherapyAppointment Patient Portal. **Your therapist will not be able to respond to texts or emails outside of the secure HIPPA system in a meaningful way**. In addition, it is important to be aware that contact by email or cell phone cannot be guaranteed as secure/confidential, therefore New Focus Marriage & Family Counseling Inc., recommends limiting information shared in the aforementioned manner. Clients will be charged for phone calls of 15 minutes or longer, and the fee will be calculated according to the Client's regular hourly fee, pro-rated. You may leave a message for your therapist at any time onhis/her

confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), even if you believe the therapist has it. Also leave a couple of good times to reach you, along with a brief message concerning the nature of your call. **Non-urgent phone calls** are returned during normal workdays, (Monday through Friday), within 24 hours. If you have an **urgent need** to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail that may pertain to out-of-office status, such as vacations, and emergencies. You can contact your therapist for urgent matters on 408-504-5707.

The Therapist and the Associates employed by New Focus Marriage & Family Counseling Inc., are outpatient providers of non-emergency psychotherapy services. Therefore, in the event of a medical or psychiatric emergency, or an emergency involving a threat to your safety, the safety of others, or their property, please attempt to reach your primary medical provider, your psychiatrist and/or call 911to request emergency assistance, or go to the nearest emergency room. If you are in group therapy the group therapist is not your primary therapist. Therefore, please contact your primary therapist for urgent matters. In addition, you may contact the following crisis phone numbers for urgent assistance:

- Suicide and Crisis Service: 1-855-278-4204 (Toll-free).
- Next Door Hotline for Battered Women: 408-279-2962 or 408-501-7550
- Parent Outreach: 1-800-901-4565
- Child Protective Services: 408-299-2071
- Gateway (Drug & Alcohol information/referrals): 800-488-9919
- Emergency Psychiatric Services 408-885-6100
- EMQ (child and teen mobile crisis unit) 408-379-9085

Therapist's Communication With Clients

Your therapist may need to communicate with you from time to time. Please inform the therapist by which means you prefer to be contacted. Please indicate your preference for allowed contact by checking ALL of your preferred contact choices listed below:

Home Phone ____ **Cell Phone** ____ **Work Phone** ____ **Patient Portal** ____

Text (limited) ____ **US Mail** ____ **Email(limited)** ____

Confidentiality

The Therapist/Associates observe the standards of their profession regarding confidentiality, and will only reveal information disclosed in the course of treatment outside the practice in the following cases:

1. The Client(s) provides consent in writing, signing an Authorization to Release/Exchange confidential information.
2. For family or marital therapy, all participants must sign an Authorization to Release/Exchange Confidential Information form, before any disclosure canbe made.

There are exceptions to confidentiality:

1. A therapist is mandated to make a report to an appropriate entity if there is reasonable suspicion of abuse of a child, elder or dependent adult.
2. The therapist is permitted to break confidentiality if there is a clear and immediate danger to the client, another person or property, in order to gather support services, to provide an appropriate level of care.
3. There is an order by a judge.
4. A federal law, known as The Patriot Act of 2001, requires therapists and others in certain circumstances, to provide FBI agents with books, records, papers, documents and other items, and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

Group Confidentiality

In group therapy, it is of utmost important that all members maintain confidentiality and neither disclose the content of sessions, nor the identity of fellow group members. However, you can discuss your own process with whomever you choose. It is highly recommended that any meaningful exchange that you may want to have outside of the group about the group or its members, is better discussed in the group. In group therapy, the other members of the group are not therapists, and as such they are not regulated by the same ethics and laws that bind the group facilitator. The limits of confidentiality and the reporting laws have been outlined earlier in this document. While the expectation is that all group members will maintain confidentiality, neither you nor the Therapist(s) can be certain that others will always keep what you say confidential. You are ultimately responsible for what you say and what you think, feel, or do with the feedback you receive in the group. The therapist recommends sharing only what you feel comfortable sharing and proceeding slowly, with caution, until trust is built, as with any other relationships.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapists and Associates regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, the Therapist may discuss certain details about your case, but will not reveal any identifying information regarding the Client or the Client's family members or caregivers. The Associates employed by New Focus Marriage & Family Counseling Inc., attend weekly clinical supervision meetings with Janet E. Akyol, MFT, CSAT. During those meetings, Associates present clinical information about their cases, treatment plans, interventions and etc. Legally, the clients of Associates are under the care and responsibility of the Licensed Clinical Supervisor.

Records and Record Keeping

Therapists and Associates will produce notes and records regarding the Client's treatment. These notes, called case notes or progress notes, constitute the Therapist's clinical and business records, which by law, the Therapist is required to maintain. Such records are the sole property of New Focus Marriage & Family Counseling Inc. Therapist and Associates will not alter his/her normal record keeping process at the request of any Client or representative. Should the Client or representative request a copy of the Therapist's records, such a request must be made in writing. The Therapist reserves the right, under California law, to provide the Client,or Representative, with a treatment summary in lieu of actual records. The Therapist also

reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Representative will generally have the right to access the records regarding the Client. However, this right is subject to certain exceptions set forth in California law.
Should Representative request access to Therapist's records, such a request will be responded to in accordance with California law. A fee of $35 will be charged for a photocopy of the record. The Therapist will maintain Client's records for seven years following the termination of therapy, or until the Client is 21 years of age, whichever is longer. However, after seven years, the Client's records will be destroyed in a manner that preserves the Client's confidentiality.

About The Therapy Process

It is the Therapist's and Intern's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to the Therapist/Associate, and the specifics of your situation, the Therapist/Associate will provide recommendations to you regarding your treatment. The Therapist/Associate and Client are partners in the therapeutic process. You have the right to agree or disagree with the Therapist's/Associate's recommendations. The Therapist/Associate will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion. Due to the varying nature and severity of issues and the individuality of each Client, the Therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Risks & Benefits Of Therapy

Psychotherapy is a process in which the Therapist/Associate and Client discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so the Client can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties the Client may be experiencing. Psychotherapy is a joint effort between Client and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Participating in therapy may result in a number of benefits to the Client, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits usually require substantial effort on the part of the Client, as well as his/her caregivers and/or family members, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above. Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which the Therapist will challenge the perceptions and assumptions of the Client or other family members, and offer different, alternate perspectives. The issues presented by the Client may result in unintended outcomes, including changes in personal relationships. During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. The client should address any concerns regarding progress in therapy with the Therapist. Your input is valued and always welcomed.

Dual Relationships

In order to maintain the integrity of the therapeutic relationship, your therapist is restricted from socializing with any client outside of sessions for purposes of business or pleasure. Part of what makes the therapeutic relationship safe is that your therapist is outside of your circle of contacts. A secondary relationship can compromise the therapeutic relationship. In addition, all clients should be informed that professional therapy never includes sex. If a therapist has ever made sexual comments or flirtatious advances, initiated a sexual relationship of any kind, or responded to a sexual relationship that you initiated, this constitutes unethical, illegal behavior and your rights as a client have been violated. Tell your current therapist, who will provide you with a copy of the State of California Consumer Affairs brochure, 'Professional Therapy Never Includes Sex.' This will notify you of your rights as a consumer. Gift giving also comes under the umbrella of dual relationships, and it is the preference of New Focus Marriage & Family Counseling Inc., that gift giving does not take place between therapist and client. While a card or small, inexpensive token, such as a flower from your yard, may be given, it is preferable that gift giving to your therapist be limited. Your therapist understands that culturally it is important for some clients to provide a gift. This should be discussed with your therapist in terms of it's therapeutic relevance to your treatment. Owing money to your therapist also creates a dual relationship, therefore, your therapist will endeavor to not allow a balance to accrue.

Termination Of Therapy

Terminating therapy is preferably planned ahead of time and with enough time for the Client to process with the Therapist/Associate. However, You or your Therapist/Associate may discontinue therapy at any time. If you or your Therapist/Associate determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referrals, changing your treatment plan, or terminating therapy. The Therapist/Associate reserves the right to terminate therapy at her/his discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Client needs that are outside of the Therapist's scope of competence or practice, or the Client is not making adequate progress in therapy and the Therapist feels a referral is warranted. The termination of group therapy is pre-determined by the length of group, which will be outlined at the beginning of therapy; typically 10-12 weeks. A continuation group may be offered and will be announced should you wish to continue. Groups are not drop in groups, therefore you are requested to make a 12 week commitment and to attend regularly. However, you or your therapist may discontinue group therapy at any time. If you or your therapist determines that you are not benefiting from group treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating therapy.

Other Practice Policies

All clients are prohibited from:

1. Attending therapy sessions while under the influence of non-prescribed drugs or alcohol.
2. Engaging in any potentially dangerous or threatening behaviors.
3. Leaving young children unattended in the waiting area.

Patient Litigation

The Therapist or Associate will not voluntarily participate in any litigation or custody disputes in which the Client, or Representative, and another individual, or entity, are parties. The

Therapists and Associates are not trained in Custody Evaluations, visitation issues or mediation, and therefore cannot make recommendations in these areas. Thus, the Therapists/ Associates will make efforts to be uninvolved in any custody dispute. The Therapist and Associates have a policy of not communicating with Client's/Representative's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Client's, or Representative's, legal matter(s). Therapist will generally not provide records or testimony unless compelled to do so by the court. Should Therapists/Associates be subpoenaed, or ordered by a court of law to appear as a witness in an action involving Client, Client or Representative agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made herself/himself available for such an appearance at Therapist's usual andcustomary hourly rate.

Please review the following illness agreement and initial:

If I am ill with a head cold, flu, lice, virus, chicken pox, pink eye, scabies, or any other potentially contagious illness at any stage **no matter how mild** that would potentially expose my therapist or others in the therapy office, I agree to alert my New Focus Marriage & Family Counseling Inc therapist, and either reschedule my session by the **48-hour cancellation time period**, or agree to conduct my individual therapy session via telemedicine if I am ill, feel as if I am becoming ill, or am at the end of a flu virus. _____ (Initial here) HIPPA-compliant telemedicine can be accessed via the website: www.newfocusmfc.com under the Telemedicine tab. Please sign the telemedicine informed consent.

I understand that my therapist may, on the rare occasion, ask that my session be conducted via telemedicine if she is ill or recovering from a contagious illness . _____ (Initial here)

If I am seeing a New Focus Marriage & Family Counseling Inc therapist for couple's therapy, I agree to cancel the session by 48 hours if my spouse or I am ill, and we can both opt for telemedicine. _____ (Initial here)

I agree not to bring in sick family members or children to the office setting if they are experiencing any stage of illness or flu. I understand I will be asked to leave the office if I choose to do this. _____ (Initial here)

If I am participating in Group Therapy, I agree to forgo attending group that week if I am feeling ill, am sick with the a contagious illness. I understand I will be asked to excuse myself from group if I arrive at any stage of illness. _____ (Initial here)

I understand that if I choose to show up for my therapy session, couples session or group session at any stage of a contagious flu virus or other illness, my therapist will use discretion, will uphold safety boundaries, and will ask me to leave the office, conduct the session via telemedicine or phone from my car, or another area outside of the clinical office so as not to expose himself/herself, colleagues, or other clients to the illness at any stage. _____ (Initial here)

I understand that my fee will apply to all sessions that are not canceled by 48 hours prior to my scheduled session. On the rare occasion that an emergency or grave illness occurs that does not allow me to give 48 hours notice, special consideration will be extended. Otherwise the session will be conducted via telemedicine or phone and the fee will stand _____ (Initial here)

Acknowledgment

I understand that fees are due at the time of service and the established fees are as follows:

Janet E. Akyol, LMFT:

- A 50 minute individual session with a Licensed MFT in person or via telemedicine is $150.00 [Initial] _____
- A 60 minute couples, family or individual session with a Licensed MFT in person or via telemedicine is $180.00 [Initial] _____
- A 60 minute group session in person or via telemedicine is $45.00. [Initial] _____

My signature indicates that I have read this document carefully and understand and accept its contents and conditions.

Please ask your therapist to address any questions or concerns that you have about this information before you sign!

Please take a copy of this agreement for your records.

_____/_____/ _____

[Print] Client Name or Responsible Party's Name / Relationship to Client | Signature of Client or Responsible Party | Date

Janet E. Akyol, LMFT, CSAT. Lic# MFC 51250 /_____/ _____

Therapist Name / License Type | Therapist Signature | Date

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.

New Focus Marriage & Family Counseling Inc., and all employees are required, by law, to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). We must abide by the terms of this Notice, and must notify you if a breach of your unsecured PHI occurs. We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

Except for the specific purposes set forth below, we will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving us written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. We can use and disclose your PHI without your Authorization for the following reasons:

1. **For your treatment**. New Focus Marriage & Family Counseling Inc., can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, we can disclose your PHI to him or her to help coordinate your care, although our preference and company policy is for you to give us an Authorization to do so.
2. **To obtain payment for your treatment**. New Focus Marriage & Family Counseling Inc., can use and disclose your PHI to bill and collect payment for the treatment and services provided by us to you. For example, we might send your PHI to your insurance company to get paid for the health care services that we have provided to you, although our preference is for you to give us an Authorization to do so.
3. **For health care operations**. New Focus Marriage & Family Counseling Inc., can use and disclose your PHI for purposes of conducting health care operations pertaining to our practice, including contacting you when necessary. For example, we may need to disclose your PHI to an attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization.

1. **Psychotherapy Notes**. New Focus Marriage & Family Counseling Inc., does keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

    a. For our use in treating you.

    b. For our use in training or supervising other mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

    c. For our use in defending the company in legal proceedings instituted by you.

    d. For use by the Secretary of Health and Human Services to investigate the company's compliance with HIPAA.

    e. Required by law, and the use or disclosure is limited to the requirements of such law.

    f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

    g. Required by a coroner who is performing duties authorized by law.

    h. Required to help avert a serious threat to the health and safety of others.

2. **Marketing Purposes**. As a psychotherapist, New Focus Marriage & Family Counseling Inc., and it's employees, will not use or disclose your PHI for marketing purposes**.**

3. **Sale of PHI**. New Focus Marriage & Family Counseling Inc., will not sell your PHI under any circumstances.

Certain Uses and Disclosures Do Not Require Your Authorization.
Subject to certain limitations in the law, New Focus Marriage & Family Counseling Inc., can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including**,** ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others.
New Focus Marriage & Family Counseling Inc., and it's employees, may provide your PHI to one or more of your family members, a 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.

YOUR RIGHTS YOUR REGARDING YOUR PHI
You have the following rights with respect to your PHI:

1. **The Right to Request Limits on Uses and Disclosures of Your PHI**. You have the right to ask us not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and we may say "no" if we believe it would affect your health care.

2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. **The Right to Choose How I Send PHI to You**. You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.

4. **The Right to See and Get Copies of Your PHI**. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other

information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost based fee for doing so.

5. **The Right to Get a List of the Disclosures We Have Made**. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided us with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost based administrative fee for each additional request.

6. **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 from your PHI, you have the right to request that we correct the existing information or add the missing information. We may say "no" to your request, but we will tell you why in writing within 60 days of receiving your request.

7. **The Right to Get a Paper or Electronic Copy of this Notice**. You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

H**OW TO MAKE A COMPLAINT ABOUT PRIVACY PRACTICES**

If you think an employee of New Focus Marriage & Family Counseling Inc. may have violated your privacy rights, you may file a complaint with the Privacy Officer for the practice, and my address and phone number are:

Janet E. Akyol, MFT
4950 Hamilton Ave, Suite 102
San Jose, CA 95032
408 504 5707

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;

2. Calling 1-877-696-6775; or,

3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

New Focus Marriage & Family Counseling Inc., will not retaliate against you if you file a complaint about their privacy practices.

EFFECTIVE DATE OF THIS NOTICE This notice went into effect on June 23rd, 2014.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices given to you by your Therapist: Janet E. Akyol, LMFT, CSAT. This Notice of Privacy Practices provides information about how your Therapist may use and disclose your protected health information. We encourage you to read it in full. This Notice of Privacy Practices is subject to change. If New Focus Marriage & Family Counseling Inc. changes the notice, you may obtain a copy of the revised notice by contacting the office at:

New Focus Marriage & Family Counseling Inc
4950 Hamilton Ave, Suite 102
San Jose, CA 95032
408 504 5707

If you have any questions about the Notice of Privacy Practices, please contact the offices of New Focus Marriage & Family Counseling Inc. at the phone number listed above.

I acknowledge receipt of the Notice of Privacy Practices of New Focus Marriage & Family Counseling Inc.

Patient Name (printed): _____

Signature: _____ Date: _____
(patient/parent/conservator/guardian- **please circle one**)

IF PATIENT DOES NOT SIGN -- INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, Therapist at New Focus Marriage & Family Counseling Inc., made good faith attempts to obtain my patient's acknowledgment of his or her receipt of our Notice of Privacy Practices, including _____

However, because of _____

I was unable to obtain my patient's acknowledgement.

Signature of Provider_____ Date: _____

NEW FOCUS
Marriage & Family Counseling Inc

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions at New Focus Marriage & Family Counseling Inc., are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities. Additionally, the mental health professional is mandated to report a person who knowingly develops, duplicates, prints, downloads, streams, accesses through any electronic or digital media, or exchanges a film, photograph, video, in which a child is engaged in an act of obscene sexual conduct.

Patriot Act

The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramification

Client Print Name	Signature (Client's Parent/Guardian if under 18)	Date

NEW FOCUS
Marriage & Family Counseling Inc

CANCELLATION POLICY

If you fail to cancel a scheduled appointment with your therapist at New Focus Marriage & Family Counseling Inc., within the 48 hour cancellation notice period, you will be billed for the entire cost of your missed appointment. This is because we have reserved this appointment time for you and are unable to fill the slot on short notice.

A full session fee is charged for missed appointments or cancellations with less than 48-hour notice, unless you let us know that it is due to illness or an emergency. Your credit card will be billed for the amount of your session on the day of the missed appointment. If for some reason the charge does not go through, a bill will be mailed directly to the client. Please note, that your insurance company will not reimburse for missed or late canceled session charges.

New Focus Marriage & Family Counseling Inc., does not want to waste your hard earned resource, your money. We prefer to provide you with quality service for our fee. Therefore, we urge you to please cancel in a timely fashion. We realize that life happens and things come up. Therefore, we encourage you to cancel your appointment Monday through Saturday either via phone, voicemail, or the patient portal.

Thank you for your consideration regarding this important matter.

_____	_____	_____
Client Print Name	Signature (Client's Parent/Guardian if under 18)	Date

4950 Hamilton Ave, Suite 102, San Jose, CA 95130
www.newfocusmfc.com

NEW FOCUS
Marriage & Family Counseling Inc

CREDIT CARD AUTHORIZATION & PERMISSION TO KEEP ON FILE

I , Responsible party:_____authorize New Focus Marriage & Family Therapy Inc., to keep my signature on file and to charge fees to my credit card account for services provided or for missed or late cancellations to:

Responsibility Party Name (print): _____

By paying via credit card, I acknowledge that the credit card information provided will be automatically kept on file via PCI-compliant encrypted code with the following credit card processor: First Data. According to Therapy Appointment, the electronic health record provider, **"Technically we don't store the card information itself, but a "token": a representation of the card that is useless if stolen. This keeps the system PCI compliant."** Once swiped or keyed in, New Focus Marriage & Family Counseling are only able to see the last four digits of your credit card number in your account profile online. This form would be kept in your chart.

I further understand and agree that the fee for services, and any balance, is my responsibility, and is due at the time of service. I understand and acknowledge that my fee for services rendered will be charged to the credit/debit card at the time of service. Additionally, I understand that I am responsible for payment in full for missed appointments, or appointments cancelled with less than 24 hour notice.

New Focus Marriage & Family Counseling Inc., will provide me with a credit card receipt and/or a superbill via encrypted email reflecting the charges applied to my credit card. I also understand that I may also receive my receipts in printed form, to be provided the following week in person or via US Mail service. I also understand that charges for missed or late cancellation appointments will not be reimbursed by my insurance provider.

By signing this form, I authorize New Focus Marriage & Family Counseling Inc., to keep my credit card on file and to charge my credit card for the session, at the fee agreed to in the financial agreement. Charges will be made on the day of the session. This agreement will be valid until canceled in writing. If you prefer not to write down your cc number, please sign and have card swiped.

Signature_____ Date_____

Patient Name if a minor: _____

Credit Card:_____/_____/_____/ ____ ____ ____ ____

Name on Card:_____Expiration Date:_____

CVV Code:_____ Zip code:_____

4950 Hamilton Ave, Suite 102, San Jose, CA 95130
www.newfocusmfc.com

NEW FOCUS
Marriage & Family Counseling Inc

Telemedicine Informed Consent Form

I [name of patient] _____ hereby consent to engaging in telemedicine with [name of psychotherapist] Janet E. Akyol, LMFT, CSAT, as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California.

I understand that I have the following rights with respect to telemedicine:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

2. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent. New Focus Marriage & Family Counseling does not and will not record sessions as a policy.

3. I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be advised to attend in-person session, unless the client or the therapist are ill. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse.

4. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

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Marriage & Family Counseling Inc

5. I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

6. I understand that my practitioner **cannot provide telemedicine when I am outside the state of California**, **or when my therapist is outside the state of California,** as my therapist is legally obliged to practice in the state in which s/he is licensed.

7. Your session fee will be charged at the time of service and requires a credit card payment be made. Your insurance provider may not pay for telemedicine sessions. To ascertain your benefits, please consult with your insurance provider if you submit claims for reimbursement.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

_____

Client name (print)

_____ _____

Signature of client/parent/guardian/conservator Date

Therapist name: Janet E. Akyol, LMFT, CSAT, Lic #: MFC 51250

_____ _____

Signature of psychotherapist Date

4950 Hamilton Ave, Suite 102, San Jose, CA
95130 Tel: 408-412-8439 Fax: 408-350-2015