Sarah Kirk, MS, MFT
Telehealth Therapist
License No.: LMFT38467
Mailing address: 3553 Atlantic Avenue, #1162
Long Beach, Ca 90807
714-816-4421

Welcome to my practice. We have established the following policies and procedures to avoid misunderstandings and to provide you with quality services.

1. The standard fee is $250.00 per 50 minute session for an individual which is to be paid at the time the service is rendered. There are circumstances in which I have agreed to take third-party payments. Should your third-party refuse to pay for services, you are responsible for services provided.

2. If your medical insurance covers mental health benefits, we will provide you with an invoice on a monthly basis. We will not bill your insurance. You may want to contact your insurance provider to discuss any limits on your policy.

3. According to the commonly accepted practice in the mental health profession, a "therapeutic hour" is 50 minutes for an individual session.

4. Every effort will be made to arrange appointments as conveniently as possible. However, in order that your therapist may reschedule his or her time, **cancellations must be made 24 hours in advance**. Otherwise, you will be billed for the missed session.

5. For emergent care needs, call 911. Otherwise, you may call (714) 816-4421 and your call will be returned by the next business day.

6. Your therapist will contact you by cell phone or email, as well as voicemail messages and text messages, on an as needed basis. Your therapist will use her name unless you have provided written notice to use a pseudonym as a means of identification.

7. We are required by law to report, to the proper authorities, suspected child abuse or threats by any client to harm him/herself or to do physical harm to a particular victim, including staff.

____________________________________ ______________________
Signature Date

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CLIENT INFORMATION SHEET

Today's Date: ______________

Last Name: ____________________________________ First Name: _________________ MI:

Date of Birth:_ Age:

Home Address:____

City:______________________________________ State:_______________ Zip Code:____________________

Home Phone:( )_______________ Work Phone:( )_______________ Cell Phone:( )_______________

OK to leave a voicemail at any of these numbers? Yes No Preference: Home Work Cell

Confidential Email Address: ____

Marital Status: S☐ M☐ D☐ W☐ Separated☐ Spouse's Name:___________________________

Employer:_______________________ Employer's Address:____

Occupation:____

Spouse's Employer:______________________ Spouse's Employer Address:____________________________

Person to Notify in Emergency:____

Home Phone:( )_______________ Work Phone:( )_______________ Cell Phone:( )_______________

Name of Current Physician:____ Phone:( )_________________

Who Referred You?:____

If Someone Other Than Patient Is Responsible For Payment, Please Complete This Section

Responsible Party:

Last Name:_________________________________ First Name:___________________________MI:______

Home Address:____

City:______________________________________ State:____________ Zip Code:___________________

Home Phone:(   )______________ Work Phone:(   )______________ Cell Phone:(   )______________

Employer:______________________ Employer's Address:_______________________________________

Occupation:____

MEDICAL HISTORY

List any major health problems for which you currently receive treatment: ____________________________

____

____

List any medications (prescriptions) you are now taking:

____

____

Have your ever been hospitalized? Yes/No If yes, please give approximate dates and reasons:

____

____

____

Do your usually sleep well? ______ Are you sleeping well now? _____ How many hours do you sleep? ____

Do you fall asleep easily? _______ Awaken during the night and have difficulty falling back asleep?_______

Significant weight loss or gain over last year? _____ Do you exercise regularly? _______________________

Drug usage:	Never	Occasionally	Often	Daily	In Past
Vitamins					
Stimulants					
Sleeping Pills					
Tranquilizers					
Appetite Suppressants					
Antidepressants					
Alcohol					
Street Drugs”					______

Do you smoke? ______ If so, how much? ____

EDUCATIONAL/OCCUPATIONAL/RECREATIONAL HISTORY

Please check highest level of education: High school College Advanced degree

How many hours a day do you work? ______Do you like your job? ______Explain: ___________________

____

____

Do you participate in sports or hobbies? _____If so, what? ____

____

How many hours per week? ______

Do you watch TV? _______Hours per day: ______ Do you read for enjoyment? _____Hours per day _____

Do your take vacations? ________Weeks per year: _____

Do you feel you have lived a happy life? Explain:

____

____

____

PAST AND CURRENT MENTAL HEALTH ISSUES

Are you now or have you ever received therapy/counseling? Yes/No If yes, please give approximate dates, reasons and with whom?

____

____

In your own words, please describe the problems you wish to address in therapy: ______________________

____

____

____

____

Please check any of the following that pertain to you:

Nervous	Legal Matters	Unhappiness	Shyness	Alcohol Use	Work
Separation	Self Control	Tiredness	Drug Use	Stress	Ambition
Anger	Education	Depression	Fears	Stomach Trouble	Energy
Sleep	Anxiety	Inferiority	Sexual Problems	My Thoughts	Headaches
Relaxation	Bowel Troubles	Career Choices	Making Decisions	Relationships	Appetite
Divorce	Finances	Nightmares	Concentration	Children	Friends

Other:

____

Is there anything else you would like to add:

____

____

____

____

Signature: ____ Date: ______________

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THE PROCESS OF THERAPY INFORMED CONSENT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and write down any questions you might have so we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

- Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and the patient, and the particular problems you bring forward. There are many different methods that I may use to deal with the problems you bring forward. Psychotherapy is not like a medical doctor's visit. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

- Participating in therapy can result in a number of benefits to you, including improving interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working towards these benefits, however, requires effort on your part, to change your thought, feelings or behavior. Additionally, I will ask for your feedback and your views on your therapy, the efforts and progress we are making, and other aspects. Your therapy will progress better if you can be open about these.

- Change may at times be easy and swift, more often it will be slow and frustrating. Remembering or talking about unpleasant feelings, thoughts or even during therapy can result in you experiencing considerable discomfort or strong feelings of anger, sadness, fear, or experiencing anxiety, depression insomnia, nightmares, etc. Attempting to resolve an issue that brought you to therapy in the first place, such as, personal or interpersonal relationships may result in addressing issues and making changes that were not originally intended. However, there are no guarantees of what you will experience.

- During the course of therapy, I am likely to draw on various psychological approaches according in part, to the problem that is being treated. These approaches may include psychodynamic, system/family, development, psycho-educational, cognitive-behavioral, behavioral, dream or existential, and life coaching. If you have any unanswered questions about any of the procedures used in the course of your therapy, their risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You have also their right to ask about

other treatments and the risks and benefits. If you could benefit from any treatments I cannot provide, I have an ethical obligation (and heartfelt willingness) to assist you in obtaining those treatments.

- At the end of the first or second meeting I will ask if I can be of benefit to you. I will not take clients, whom in my opinion, I cannot help. In such a case, at the end of the first or second meeting, I will give you a number of referrals that you can contact.

Initial ____________

- Therapy *never* involves multiple relationships (e.g., business or sexual) with the therapist.

- Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many different matters which may be of a confidential nature, I agree that should there be legal proceedings, neither I nor my attorney, not anyone else acting on my behalf will call Sarah Kirk, MFT to testify in court or at any other proceedings nor will a disclosure of the psychotherapy records be requested.

Initial ____________

- I understand that my therapist does not consider it professional for personal growth workshops (such as LifeSpring, EST Seminars, etc.) to request any therapist to sign an authorization or release of any kind for any client to participate, as this situation contaminates the therapeutic relationship. While my therapist encourages me to freely discuss my wishes and my decision regarding such workshops, my decision to participate will be solely between the seminar presenters and me.

Please read the following carefully. You have been given two copies to sign and execute. Retain one copy and return the second executed copy to me for your file.

GUIDELINES FOR OUR WORK TOGETHER

CONFIDENTIALITY: Information shared, including that of minors, is kept strictly confidential except when the following legal limitations apply. In general, the law protects the privacy of all communications between a patient and a professional (i.e., licensed clinical social worker), and I can only release information about our work to others with your written permission. But there are a few exceptions.

1. There are some situations in which I am legally obligated to take actions to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person or a disabled person is being abused, I must file a report with the appropriate state agency.

2. If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contracting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I am obligated to seek hospitalization for him/her or to contact family members or others to help provide protection.

3. When information is required by law or ordered by court. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines the issues demand it.

   These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

4. I may occasionally find it helpful to consult other professionals about a case. During consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

LENGTH OF SESSIONS: Our time is set for 50 minutes.

FEES: My fee is $250.00 for individuals (50 minutes). We have agreed upon your fee. I charge this amount for other professional services you may need, though I will decrease the hourly cost if I work for periods of less than 50 minutes. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professions you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me within my scope of practice. If you become involved in a legal proceeding that requires my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $250.00 per hour for preparation and attendance at any legal proceeding. This is a *fee for service* profession, payment is due at the end of each session unless otherwise arranged. In circumstances of unusual financial hardship, I may be willing to negotiate a payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of the services provided and the amount due.

CANCELLATION AND RESCHEDULING: A missed appointment is a loss for everyone. To avoid being charged for the session, please call to inform me of your cancellations a full 24 hours in advance of your regular appointment. If feasible, I will reschedule a missed appointment or late cancellation. If for any reason rescheduling is not possible, and if a full 24 hours advance cancellation is not received, full payment for the session is due.

INSURANCE: As discussed, I do not bill for insurance reimbursement. The full fee is due at the time of service. It is your responsibility to contact your insurance provider to determine your mental health coverage. At your request, I will provide a super-bill at the end of each month, should you decide to process your insurance claim on your own.

CONTACTING ME: I am often not immediately available by telephone. I work part time at my practice. I use a cell phone to be available to my practice calls and clients, but I am usually unable to directly answer the phone, as I am frequently in session with other clients. Therefore, please leave a message and include where, when and how I can reach you in a timely manner. I will return your call within my next business day. If you are in crisis or if it is a life or death situation and you cannot wait for me to return your call, please go to an emergency room or call 911. If I am going to be out of the office, I will notify you and make plans for your care in my absence with another colleague who will cover my practice in my absence. Your care and safety is of primary concern to me so please be honest and direct in discussing your treatment needs.

Please be aware that I use a cell phone for client calls. In some circumstances privacy may be at risk. Therefore, if you are concerned about your confidentiality, please discuss this with me and other arrangements can be made.

If a situation occurs and I do not show for your appointment or I do not contact you for 48 hours after missing an appointment, something untimely or serious may have occurred. Under such circumstances, I have colleagues who will know what has happened and will review your file with the purpose of contacting you and assisting you with a referral to another therapist. Should an incident arise and you have concerns, please feel free to contact the professional listed below. They should aid you in any unforeseen yet necessary transition. As noted earlier, your care and comfort is a primary concern.

Laura Navarro Pickens, LCSW (562) 882-7901

PROFESSIONAL RECORDS: I am required to keep records of the professional service I provide during your treatment, and of our work together. Because these records contain information that can be misunderstood by someone who is not a mental health professional, it is my general policy that patients may not review them. However, I will provide at your request a treatment summary unless I believe that to do so would be emotionally damaging. If that is the case, I will be happy to send the summary to another mental health professional that is working with you. You should be aware that this will be treated in the same manner as any professional (clinical) service and you will be billed accordingly.

Minors: If you are under eighteen years of age, please be aware that the law may provide your parents their right to examine your treatment records. It is my policy to request an agreement for parents that they give up this right to access your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

While this written summary for exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. In other words, you wish to continue in treatment and you agree to its conditions and requirements.

I understand the legal limitations described above and I give Sarah Kirk, MFT, permission to provide psychotherapy to me.

Signature: ___________________________________ Date: _____________

Print Name: _________________________________

Parent/Legal Guardian: ________________________ Date: _____________

TELEHEALTH CONSENT FORM

I, _____________________ hereby consent to engage in Telehealth with Sarah Kirk, MFT.

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Informed Consent Form I received from my therapist also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that miscommunication between myself and my therapist may occur via Telehealth.

4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.

6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written

permission.

9. I have discussed the fees charged for Telehealth with my therapist and agree to them.

10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

____ ________
Patient's Signature Date

____
Patient's Printed Name

PROVIDER 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.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Protecting the Privacy of Patient's Health Information

Overview: The first-ever federal privacy standards to protect patient's medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. Developed by the Department of Health and Human Services (HHS), these new standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country. State laws providing additional protections to consumers are not affected by this rule.

Uses and Disclosures: Sarah Kirk uses information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Sarah Kirk uses or discloses identifiable health information about you without your authorization in several situations, but beyond those situations, she will ask for your written authorization before using or disclosing any identifiable health information about you.

Your Rights: In most cases you have the right to look at or get a copy of health information about you. If you request copies, Sarah Kirk will charge you only the normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that she has made. If you believe that the information in your record is incorrect, you have the right to request that Sarah Kirk correct the existing information.

Legal Duty: Sarah Kirk is required by law to protect the privacy of your information, provide this notice about information practices, follow the information practices that are described in this notice and seek your acknowledgement of receipt of this notice. Before she makes a significant change in policy, she will change its notice and post the new notice in an easily accessible place. You can also request a copy of this notice at any time.

Complaints: If you are concerned that Sarah Kirk has violated your privacy rights, or you disagree with a decision she has made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:

Sarah Kirk, MS, MFT

714-816-4421

ACKNOWLEDGEMENT OF RECEIPT FOR THE COPY OF THE "PROVIDER NOTICE OF PRIVACY PRACTICES."

_______________________________________ _______________________________

Signature Date

Further Details:

1. Uses and Disclosures of Protected Health Information

Following are examples of types and uses and disclosures of your protected health care information that the provider is permitted to make. These examples are not meant to be exhaustive but to describe the types and uses of disclosures.

Treatment: I will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, your protected health information may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, in activities related to obtaining payment for your health care services. For example, obtaining approval for a hospital stay ma require that your relevant protected health information be disclosed to your health insurance company or governmental plan to obtain approval or the hospital admission.

Healthcare Operations: I may use or disclose, as needed, your protected health information in order to support my business activities. For example, when I review employee performance, may need to look at what an employee has documented in your medical record.

Business Associates: I may share your protected health information with third party "business associate" that performs various activities (e.g., billing, transcription services). Whenever an arrangement is made between me and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains the terms and will protect the privacy of your protected health information.

Marketing: I may use or disclose certain health information in the course of providing you with information about treatment alternatives, health related services, or fund-raising. You may contact me a request that these material not be sent to you.

Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization, at any time, in writing.

Opportunity to Object

I may use and disclose your protected health information in the following instances. You have the opportunity to object. If you are not present or able to object, then your provider may use professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Member of the clergy will be told your religious affiliation.

Other Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement with your health care.

Emergencies. In an emergency treatment situation, we will provide you with a Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.

Communication Barriers: I may use and disclose your protected health information if I have attempted to obtain acknowledgement from you of our Notice of Privacy Practices but have been unable to do so due to a substantial communication barrier and I determine, using professional judgment, that you would agree.

Without Opportunity to Object

I may use or disclose your protected health information in the following situations without your authorization or opportunity to object.

Public Health: For public health purposes to a public health authority or to a person who is at risk of contract or spreading your disease.

Health Oversight: To a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse and Neglect. To an appropriate authority to report child abuse or neglect, if I believe that you have been the victim of abuse, neglect, or domestic violence.

Food and Drug Administration: As required by the Food and Drug Administration to tract product.

Legal Proceedings: In the course of legal proceedings.

Law Enforcement: For law enforcement purposes, such as pertaining to victims of a crime or to prevent a crime.

Coroners, Funeral Directors, and Organ Donation: For the coroner, medical examiner, or funeral director to perform duties authorized by law and for organ donation purposes.

Research: To researchers when their research has been approved by an Institutional Review Board or Privacy Board.

Soldiers, Inmates, and National Security: To military supervisors of Armed Forces personnel or to the custodians of inmates, as necessary. Preserving national security may also necessitate disclosure of protected health information.

Workers' Compensation: To comply with workers' compensation laws.

Compliance: To the Department of Health and Human Services to investigate my compliance.

In general, I may use or disclose your protected health information as required by law and limited to the relevant requirements of the law.

2. Your Rights.

You have the right to:

Inspect and copy your protected health information. However, I may refuse to provide access to certain psychotherapy notes or information for a civil or criminal proceeding.

Request a restriction of your protected health information. You may ask me not to use or disclose operation. You may also request that information not be disclosed to family members or friends who may be involved with your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. I am not required to agree to a restriction that you may request, but if I do agree, then I must act accordingly.

Request to receive confidential communications from me by alternative means or at an alternative location. I will accommodate reasonable requests. I may also accommodate this condition by asking you for information as to how payment will be handled or specification of alternative address or other method of contact. I will not request an explanation from you as to the basis for the request.

Ask me to amend your protected health information. You may request an amendment of protected health information about you. If I deny your request for an amendment, you have the right to file a statement of disagreement with me, and your medical record will note the disputed information.

Receive an accounting of certain disclosures I may have made. This right applies to disclosure for purposes other than treatment, payment or healthcare operations. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice electronically.

END of Notice of Privacy Practices.