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5100 Marlborough Dr.
San Diego, CA 92116
(619) 567-7399

Disclosure Statement & Agreement for Services

Introduction

This document is intended to provide [name of patient] _____ (herein "Patient") with important information regarding the practices, policies and procedures of Achieve Your True Potential "Therapist" (herein referred to as Therapist), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents prior to signing it.

Information 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, certifications, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

Therapist Identification

The name of this practice is: ACHIEVE YOUR TRUE POTENTIAL
The therapists and counselors who operate this practice are:

_____	ESMERALDA S. CHRISTENSEN, LMFT, LPCC Name of Therapist/License Type	45349, 1568 License Number
_____	HEIDI K. BECKENBACH, LPCC Name of Therapist/License Type	2767 License Number
_____	ANNA DOWD, LMFT, Name of Therapist/License Type	90465 License Number
_____	SHANE PADAMADA, PCC Intern Name of Therapist/License Type	1796 License Number

Registered Professional Counselling Intern under the direction and supervision of a Licensed Marriage and Family Therapist or Licensed Professional Clinical Counselor.

Risks and Benefits of Therapy

Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient 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 Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist.

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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 Patient, 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, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, 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. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Patient's perceptions and assumptions, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient.

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. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Patient.

Records and Record Keeping

Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient. Should Patient request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient with a treatment summary in lieu of actual records. 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. Therapist will maintain Patient's records for ten years following termination of therapy.However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

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Electronic Communications

Achieve Your True Potential cannot ensure the confidentiality of any form of communication through electronic media. You are also advised that any email sent to us via computer in a work-place environment is legally accessible by an employer. If you prefer to communicate via email for issues regarding scheduling or cancellations, we will do so. Please do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Friending

Achieve Your True Potential Therapists do not accept friend or contact requests from current or former patients on any social networking site (Facebook, LinkedIn, etc). Adding current or former patients as friends or contacts on these sites can compromise confidentiality and respective privacy. It may also blur the boundaries of the therapeutic relationship. If you have questions about this, please bring them up with your therapist when you meet so you can talk more about it. We do have a business Facebook page that you can find at https://www.facebook.com/Achieve-Your-True-Potential-349653232462/

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment.

If you participate in therapy/counseling, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy. This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask your therapist about his or her "no secrets" policy and how it may apply to you.

There are exceptions to confidentiality. For example, 1) therapists are required to report instances of suspected child or elder abuse, to the appropriate state agencies. 2) Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. 3) In addition, 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 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.

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients

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who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Therapist-Patient Privilege

The information disclosed by Patient, as well as any records created, is subject to the therapist-patient privilege.The therapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-patient privilege or the doctor-patient privilege. Typically, the patient is the holder of the therapist-patient privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the therapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by Patient or Patient's representative. Patient should be aware that he/she might be waiving the therapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient should address any concerns he/she might have regarding the therapist-patient privilege with his/her attorney.

Fees

The fee for service is $150 per individual/conjoint (marital /family) counseling session.
The fee for service is $40 per group counseling session.
Low fee counseling is $80 per individual/conjoint (marital /family) counseling session.

Individual Sessions and conjoint (marital /family) sessions are approximately 50 minutes in length.
Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure. There is a sliding scale.

The agreed upon fee between Therapist and Patient is $ _____. Therapist reserves the right to periodically adjust fee. Patient will be notified of any fee adjustment in advance.

From time-to-time, Therapist may engage in telephone contact with Patient for purposes other than scheduling sessions. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at Patient's request and with Patient's advance written authorization. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.

Patients are expected to pay for services at the time services are rendered. Therapist accepts cash, checks, and major credit cards, including Health Flex cards.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hrs. in advance of your appointment. If you do not provide your therapist with at least 24 hours notice in advance, you are

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responsible for the full payment of the missed session or a minimum of $60. Please understand that your insurance company will not pay for missed or cancelled sessions.

Insurance

Please inform your therapist if you wish to utilize health insurance to pay for services. If your therapist is a contracted provider for your insurance company, your therapist will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with your therapist.

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist immediately. Your therapist will help you to consider any options that may be available to you at that time.

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), 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. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance or go to the nearest emergency room. You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call.

You should be aware that your therapist is generally available to return phone calls within approximately 24 hours. Your therapist is not able to return phone calls after 9 P.M. Your therapist is not available to return phone calls on Sundays. 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 message.

In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance, or go to the nearest emergency room. You should

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also be aware of the following resources that are available in the local community to assist individuals who are in crisis:

Crisis Hotline: (888) 724-7240

Therapist Communications

Your therapist may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

__ My therapist may call me at my home. My home phone number: ( ) _____

__My therapist may call me on my cell phone. My cell phone number: ( ) _____

__My therapist may send mail to me at my home address: _____

__My therapist may communicate with me by email. My email address: _____

__My therapist may send a fax to me. My fax number is: ( ) _____

Emergency Contact

_____ _____ ( )_____
Name Relationship Phone #

Notice of Privacy Practices

I have received a copy of the HIPPA Notice of Privacy Practices _____ _____
Date **Initials**

Termination of Therapy/Counseling

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

Therapist reserves the right to terminate therapy at his/her 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, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to

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reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient.

Acknowledgement

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____ _____

Name of Patient Name of Patient

_____ _____

Signature of Patient (Parent or Representative) Signature of Patient (Parent or Representative)

Date: _____ Date: _____

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

_____

Name of Responsible Party (Please print)

_____

Signature of Responsible Party Date

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Financial Agreement

PATIENT NAME:_____ **DOB:**_____

The following information is provided to explain AYTP's payment policy and to avoid any misunderstanding or disagreement concerning payment for professional services. Our policies apply to unaccompanied minors, therefore parents/guardians must plan ahead for prompt payment. It is the policy of this office that payment in full is expected at the time services are rendered if any of the following circumstances apply:

- You are a self-pay patient. (You have no medical insurance)
- Your therapist is not a participating provider with your insurance/managed care plan.
- You do not wish to have your insurance billed or you have not given us all of the current/correct information required to file an insurance claim.
- Your insurance benefits do not cover the service rendered.
- Your insurance company denied authorization of your therapists recommended testing or treatment plan and you elect to self-pay and proceed with the recommended testing/treatment. I hereby assume financial responsibility for and agree to make payment in full to Achieve Your True Potential for any and all charges for services received by me and/or any dependents not otherwise authorized or paid by my insurance carrier. Deductibles and/or co-payments are required at the time services are rendered unless payment arrangements are made with a representative of Achieve Your True Potential; prior to the time services are rendered. I certify that the financial information given is true, accurate, and complete to the best of my knowledge, and further authorize, Achieve Your True Potential to investigate any and all financial information given concerning this or related claims. I understand and agree to inform AYTP of changes in my insurance at the time of service so that claims can be filed within the insurance carrier's deadline and I will be responsible for the full fee for services rendered but not covered by my insurance carrier. I further understand that Achieve Your True Potential reserves the right to charge interest and/or pursue delinquent accounts via third party collection agencies or attorneys and that I am responsible for any fees and/or court costs incurred by Achieve Your True Potential during the collections process.
- I understand that my insurance claims will be sent electronically via computer modem to the medical payment Systems Incorporated offices. Medical payments systems will direct the insurance claim to my insurance company electronically, where it will be reviewed by any insurance company staff assigned to review claims. I understand that my insurance company will obtain information listed on the insurance claim about my diagnosis and the dates of my mental health treatment sessions. By my signature below and as recorded on the HIPPA consent form, I am giving Achieve Your True Potential permission to release all data necessary to my insurance company to determine eligibility and to process my insurance claim electronically. I realize that my insurance company may choose to make this information available to other entities, including other insurance companies.
- I understand that I will be charged the full fee for all missed appointments. A missed appointment is an appointment not cancelled PRIOR to 24 hours before the scheduled appointment time, or in the case of

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a Monday appointment, not cancelled by the corresponding appointment time of the preceding Friday. If the office is closed you may leave notice on our message system.

- I assume financial responsibility for additional services such as phone calls, letter writing, completion of forms and administrative meetings in or out of the office. I understand that claims for these services will be billed at the therapist's usual rate, will not be billed to my insurance carrier and remain my obligation to pay.
- In the event of a check returned, unpaid from the bank, I acknowledge that a service charge of $35.00 will be incurred for each incidence.
- In the event that a lawsuit is filed to collect my debt, I expressly waive privileges concerning disclosure of all information necessary to proceed with collection activities and acknowledge that an itemized account history, setting forth services rendered, fees charged and payments received shall be filed as an exhibit.
- I agree to notify AYTP of any changes in my billing address or telephone and/or my health insurance carrier information as they occur. This entire authorization is valid for all episodes of care rendered by all providers associated with Achieve Your True Potential. I permit a copy of this authorization and agreement to be used in place of the original.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE OF SIGNATURE

For those who will be using insurance, please complete the section below:

Name of insurance: _____ Insured's ID # _____

Employer's name: _____ Group or FECA # _____

Relation to Insured: _____ Insured's DOB: _____

Number listed for providers to call: _____

We strongly believe that a good therapist/patient relationship is based upon understanding and open communication. We have instructed our staff to make every effort to clarify any question or misunderstanding you have concerning your account. We hope to avoid any disagreement over payments for professional services.

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Credit Card Authorization Form

I authorize ACHIEVE YOUR TRUE POTENTIAL to keep my signature on file and charge my debit or credit card:

Charge of $_____ per psychotherapy/hypnotherapy session:

□ Check here if the charges are recurring
□ Check here if the credit card should be kept on file
□ Check here if you would prefer to be billed via invoice

□ email: _____

I understand this form will be valid for one year unless I cancel the authorization in writing. I agree not to dispute charges ("charge back") for sessions that I have received or for fees where I have not cancelled 24 hours prior to a scheduled session. I further authorize Achieve Your True Potential to disclose information about my attendance/cancellation to my credit card issuer should I dispute a charge.

Client Name:

_____

Card Holder Name: _____ Relationship to Client: _____

Billing Address:

_____

_____ Telephone: _____

Email: _____

Card Type: **Visa** **MasterCard** **Discover** **American Express**

Card Number: _____

Expiration Date: _____ CVC Code: _____ Zip Code: _____

_____ _____

Card Holder Signature: **Date:**

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Telemedicine Informed Consent Form

I _____(patient's name) hereby consent to engaging in telemedicine with _____ 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 or outside of California.

Because of recent advances in communication technology, the field of tele-therapy has evolved. It has allowed individuals who may not have local access to a mental health professional to use electronic means to receive services. Because it is relatively new, there is not a lot of research indicating that it is an effective means of receiving therapy. An important part of therapy is sitting face to face with an individual, where non-verbal communication (body signals) are readily available to both therapist and patient. Without this information, tele-therapy may be slower to progress or less effective. With the telephone, the patient's tone of voice, pauses and choice of words become especially important and therefore an important focus of the sessions. With, therapy via email, the written word is the exclusive focus. What is important here is that you are aware that tele-therapy may or may not be as effective as in-person therapy and therefore we must pay close attention to your progress and periodically evaluate the effectiveness of this form of therapy.

Because I may not have met you in person, I may request that you be interviewed by a professional in your area and allow me to talk to that individual before proceeding with therapy.

With tele-therapy, there is the question of where is the therapy occurring – at the therapist's office or the location of the patient? The law has not yet clarified this issue, therefore it is my policy to inform patients that they are receiving services from the State of California. These laws are primarily related to confidentiality as outlined in this form and my disclosure form.

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.

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(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 therapist, 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 therapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a therapist who can provide such services in my area. 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 therapist, my condition may not be 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.

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

Agreement

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

Signature of patient/parent/guardian/conservator. If signed by other than patient indicate relationship

_____

Print Patient Name

_____ _____

Signature Date

_____ _____

Representative Name Relationship

_____ _____

Signature Date

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Intake Form

Name: _____ Date: _____

Address: _____

Home phone _____ Cell phone _____

E-mail _____

Referred by: _____

Age _____ Date of birth _____

Marital status _____ Occupation _____

Emergency Contact 1 (name and number)

_____

Emergency Contact 2 (name and number)

_____

Psychological History

Have you ever received counseling before? No Yes

If yes, when and for how long?

_____

What was the focus of treatment?

_____

What did you like most of treatment?

_____

What did you like least of treatment?

_____

Name of treating therapist(s) and telephone number(s):

_____

_____

Have you ever been hospitalized for mental or emotional problems? No Yes

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If yes, when and for how long?

_____

Why were you hospitalized?

_____

Have you ever attempted suicide? No Yes

If yes, please list the approximate date, method, and outcome of attempt of each attempt:

_____

_____

_____

Are you currently having any suicidal thoughts? No Yes

Do you have any plans or intent to harm yourself? No Yes

If you answered yes to either of the 2 questions above, please bring this to your therapist's attention immediately.

Have you ever been diagnosed with a serious illness? No Yes

If yes, please describe:

_____

Are you currently taking any prescription medication? No Yes

If yes, please describe:

_____

Have you ever been prescribed psychiatric medication? No Yes

If yes, please describe:

_____

Are you currently experiencing any chronic pain? No Yes

If yes, please describe:

_____

How would you rate your current physical health? (please circle)

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Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

How often do you drink alcohol? (please circle)

Never Daily Weekly Monthly Infrequently Socially

_____

How often do you engage recreational drug use? (please circle)

Never Daily Weekly Monthly Infrequently Socially

Additional Information

Are you currently employed? No Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

Do you consider yourself to be spiritual or religious? No Yes

If yes, describe your faith or belief:

_____

_____

What do you consider to be some of your strengths?

_____

_____

_____

What do you consider to be some of your weakness?

_____

_____

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Treatment Goals

What significant life changes or stressful events have you experienced recently:

_____

_____

_____

_____

What issues/concerns are you hoping to work on in therapy? Please describe.

_____

_____

_____

_____

Do you have any specific goals with regard to your treatment?

_____

_____

_____

_____

Do you have any particular concerns/fears with regard to treatment?

_____

_____

_____

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Please check the boxes that match your experience of the symptoms listed below.

Symptom	With the last 30 days	Historically
Sadness		
Tearfulness		
Feelings of hopelessness		
Feelings of worthlessness		
Loss of interest		
Loss of motivation		
Fatigue		
Changes in appetite		
Anxiety		
Worry		
Racing thoughts		
Difficulty with sleep		
Inability to concentrate		
Cutting, burning or biting self		
Thoughts of harming self		
Irritability		
Problems at work		
Problems at home		
Problems with relationships		

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Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often…Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____
2. Did a parent or other adult in the household often …Push, grab, slap, or throw something at you?
or Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you ever…Touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you?
Yes No If yes enter 1 _____
4. Did you often feel that …No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____
5. Did you often feel that …You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____
6. Were your parents ever separated or divorced?
Yes No If yes enter 1 _____
7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
Yes No If yes enter 1 _____
10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

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5100 Marlborough Dr.
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(619) 567-7399

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: September 20, 2013.

I understand that your health/mental health information is personal and I am committed to protecting this information. I am required by applicable federal and state law to maintain the privacy of your health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), also requires that I give you this Notice about my legal duties, my privacy practices, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect.

Individually identifiable information about your past, present, or future health/mental health or condition, the provision of health/mental health care to you, or payment for the health/mental health care is considered "ProtectedHealth Information (PHI)." Whenever possible, the PHI contained in your record remains private. In some circumstances, it is necessary for me to share some of the PHI contained in your record (or your child's record). In all but certain specified circumstances, I will share only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

I reserve the right to change this notice and to make changes in my privacy practices. Any changes will be effective for all PHI that I maintain, including health/mental health information created or received before I made the changes. I will post a copy of the current notice in my reception area and on my website (if applicable). You may also request a current copy of this notice from me. For more information about my privacy practices, please contact me at the number listed at the end of this notice.

How I May Use and Disclose Health/Mental Health Information About You:
The following categories describe different ways that I use and disclose your PHI. For each category, I explain what I mean, and offer an example. In some instances a written authorization signed by you is required in order for me to use or disclose your PHI; in others it is not. I have tried to identify which instancesdo not require your signed authorization and which do.

Uses and Disclosures of PHI For Which No Signed Authorization is Required:

- **For Treatment:** I may use/disclose your PHI (or your child) to provide you with mental health treatment or services. For example, I can disclose your PHI to physicians, psychiatrists, and other licensed health care providers who provide you with health care services or are involved in your care. If a psychiatrist is treating you, I can disclose your PHI to your psychiatrist in order to coordinate your care.
- **For Payment:** I may use/disclose your (or your child's) PHI in order to bill and collect payment (from you, your insurance company, or another third party) for services provided by me. For example, I may send your PHI to your insurance company to get paid for the services we provided to you or to determine eligibility for coverage.
- **For Health Care Operations:** I may use/disclose your (or your child's) PHI to your health care service plan or insurance company for purposes of administering the plan, such as case management and care coordination.
- **Appointment Reminders or Changes in Appointments:** I may use/disclose your (or your child's) PHI to contact you as a reminder that you have an appointment. I may also contact you to notify you of a

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change in your appointment. For example, if I am ill, I may have someone in my office contact you to notifying you that the appointment is cancelled. If you do not wish me to contact you for appointment reminders or changes inappointment times, please provide me with alternative instructions (in writing).

- **When Disclosure is Required by state, federal or local law; judicial or administrative proceedings; or law enforcement:** I may use/disclose your (or your child's) PHI when a law requires that I report information about suspected child, elder or dependent adult abuse or neglect; or in response to a court order. I must also disclose information to authorities that monitor compliance with these privacy requirements.
- **To Avoid Harm:** I may use or disclose limited PHI about you when necessary to prevent or lessen a serious threat to your health or safety, or the health and safety of the public or another person. If I reasonably believe you pose a serious threat of harm to yourself, I may contact family members or others who can help protect you. If you communicate a serious threat of bodily harm to another, I will be required to notify law enforcement and the potential victim.
- **Law Enforcement Officials:** I may disclose your (or your child's) PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or grand jury or administrative subpoena.
- **For Health Oversight Activities:** I may disclose PHI to a health oversight agency for activities authorized by law. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
- **Specialized Government Functions:** I may disclose you (or your child's) PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.
- **Disclosure to Relatives, Close Friends and Other Caregivers:** I may use or disclose your PHI to a family member, other relative, a close personal friend or any other person that you indicate is involved in your care or the payment of your care unless you object in whole or in part. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, I may exercise my professional judgment to determine whether a disclosure is in your best interests. If I disclose PHI to a family member, other relative or a close personal friend, I would disclose only information that I believe is directly relevant to the person's involvement with your health care or payment related to your health care.
- **Workers' Compensation:** I may disclose your PHI as authorized by and to the extent necessary to comply with California law relating to workers' compensation or other similar programs.
- **As required by law:** I may use and disclose your (or your child's) PHI when required to do so by any other law not already referred to in the preceding categories.

Uses and Disclosures of PHI For Which a Signed Authorization is Required: For uses and disclosures of PHI beyond the areas noted above, I must obtain your written authorization. Authorizations can be revoked at any time in writing to stop future uses/disclosures (except to the extent that I have already acted upon your authorization).

- Psychotherapy Notes: I keep "psychotherapy notes" as that term is defined in 45 CFR Section 164.501, and any use or disclosure of such notes requires your authorization unless the use or disclosure is:
    1. For my use in treating you.
    2. For my use in training or supervising other mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
    3. For my use in defending myself in legal proceedings instituted by you.
    4. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

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5. Required by law, and the use or disclosure is limited to the requirements of such law.
6. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
7. Required by a coroner who is performing duties authorized by law.
8. Required to help avert a serious threat to the health and safety of others.

- Marketing Purposes: I will not use or disclose your PHI for marketing purposes.
- Sale of PHI: I will not sell your PHI in the regular course of my business.
- Fundraising Purposes: I will not contact you for fundraising purposes.

Your Rights Regarding Your (or Your Child's) PHI:

You have the following rights regarding PHI I maintain about you (or your child):

Right to Inspect and Copy: You have the right to inspect and copy your (or your child's) health/mental health information upon your written request. However, some mental health information may not be accessed for treatment reasons and for other reasons pertaining to California or federal law. I will respond to your written request to inspect records. A charge for copying, mailing and related expenses will apply.

If Your Request to Inspect and Copy is Denied, you may have the right to request to have this denial reviewed by a licensed health care professional who I designate to act as a reviewing official. The reviewing official will be an individual who did not participate in my determination to deny access. I will provide or deny access in accordance with the determination of the reviewing official.

Right to Request Restrictions: You have the right to ask that I limit how I use or disclose your PHI. I will consider your request, but I am not legally required to agree to the request. If I do agree to your request, I will put it into writing and comply with it except in emergency situations. I cannot agree to limit uses and/or disclosures that are required by law.

Right to Amend: If you believe that there is a mistake or missing information in my record of your health/mental health information, you may request, in writing, that I correct or add to the record. I will respond to your request within 60 days of receiving it. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request to amend information that: was not created by me, not part of my records, not part of the information that you would be permitted to inspect and copy or is accurate and complete.

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.

Right to an Accounting of Disclosures: You have a right to get a list of when, to whom, for what purpose, and what content of your (your child's) PHI has been disclosed. This applies to disclosures other than those made for purposes of treatment payment, or health care operations. Your request must be in writing and state a time period (which may not be longer than six [6] years and may not include dates before April 14, 2003). I will respond to your request within sixty (60) days of receiving it. The first list you request within a 12 month period will be free. There

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may be a charge for more frequent lists. In such a case, I will notify you of the cost involved and you may choose to change or withdraw your request before any costs are incurred.

Right to Request Confidential Communications: You have the right to request that I communicate with you about health/mental health matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail. To request confidential communications, you must make your request in writing. Please specify how or where you wish to be contacted. I will accommodate all reasonable requests.

Right to a Paper Copy of this Notice: You have a right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time.

Complaints:

If you think that your privacy rights have been violated you may contact me and file a complaint with me, as the Privacy Officer for my practice. My address, phone number and email address are: 5100 Marlborough Dr. San Diego, CA 92116, (619) 567-7399 ext. 1 or esmeralda@achieveyourtruepotential.com.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human by sending a letter to the following address:

Office of Civil Rights
90 7th Street, Suite 4-100
San Francisco, California 94103
(415) 437-8310
(415) 437-8329 fax

You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Client's Name: _____ Date of Birth: _____

Parent/Guardian's Name (if client is a minor): _____

By signing below, I hereby acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Signature of Client (Parent or Guardian if Client is a minor) Date