

WELCOME...

Today's Date _____

Please complete as much of the information for the primary person(s) receiving therapy. We will review the forms with you and answer any questions during your initial session.

NAME _____ Date of Birth _____

NAME _____ Date of Birth _____

ADDRESS _____ City _____

Zip code _____

EMPLOYER _____ HOW LONG? _____

CIVIL STATUS

Single__ Engaged__ Living Together__ Married__ Separated__ Divorced__ Widowed__

EMPLOYMENT STATUS

Student__ Student and Employed__ Employed__ Unemployed__ Stay Home__ Disabled__ Retired__

PRIMARY CARE PHYSICIAN _____ PHONE _____

HOW WERE YOU REFERRED TO US? (Please be as specific possible)

In case of emergency, whom may we contact:

NAME _____ RELATIONSHIP _____ PHONE _____

REQUEST FOR INFORMATION FOR METHOD OF CONFIDENTIAL COMMUNICATIONS

In the section below, you may request to receive confidential communications of your protected health information ("PHI") from me by alternative means or at alternative addresses. For example, you may not want your appointment notices or your bill to go to your home where a family member might see it. I cannot ask you the reason for your request, and I will accommodate all reasonable requests that you make. If you make a special request, you must give me an alternative address or other method of contacting you (phone number, email address, etc.). Please indicate next to the information below if I may contact you there.

ADDRESS _____ City _____, Zip code _____

Can we contact here? Yes__ No__

E-MAIL _____ Can we contact here? Yes__ No__

HOME PHONE _____ Can we contact here? Yes__ No__

WORK PHONE _____ Can we contact here? Yes__ No__

OTHER PHONE _____ Can we contact here? Yes__ No__

(NOTE TO THERAPIST: REVIEW PREFERRED METHOD OF COMMUNICATION AND CIRCLE.)

INSURANCE INFORMATION

NAME OF INSURED _____ DATE OF BIRTH _____

SSN _____ EMPLOYER _____

INSURANCE COMPANY _____

Policy group number (if available) _____

SUBSCRIBER IDENTIFICATION NUMBER * _____

PATIENT IDENTIFICATION NUMBER (IF DIFFERENT)* _____

AUTHORIZATION NUMBER(S) (IF APPLICABLE) _____

Authorization: Start date _____, End date _____, Number of visits _____

Is the patient covered by any other insurance plan? Yes ___ No ___

* PLEASE BE SURE THERAPIST RECEIVES A COPY OF YOUR INSURANCE CARD(S).

FEE AGREEMENT

I understand that unless other arrangements are made, fees are due as stated and are payable at the start of each session. Although my insurance may be billed, the final responsibility for payment remains with me.

The fee is \$_____ per 45-50 minutes for an Individual, Couple or Family session. This fee may represent a discounted contract rate between the therapist and the insurance company and not the therapist's regular fee.

The deductible is \$ _____. Once the deductible is met, my insurance is expected to pay \$_____ per session for _____ sessions. The insurance MAY or MAY NOT authorize additional sessions.

The co-payment amount is \$_____ per session. I understand that insurance plans vary and mine may deny payment for service at their discretion. I have read and understand that I am assuming responsibility for payment of services provided to me by Doreen Van Leeuwen, LMFT. (Client initials indicate acceptance _____.)

ASSIGNMENT OF BENEFITS

I hereby authorize _____ to make direct payment to Doreen Van Leeuwen
(Insurance company)

for any and all insurance benefits due for services rendered to me. A copy of this assignment shall be valid as an original.

RESCHEDULING AND CANCELLATION

I UNDERSTAND THAT my appointment time is especially reserved for me, and that I must notify Doreen of any cancellation at least 48 hours in advance. IF I FAIL TO DO THIS, I WILL BE CHARGED A \$25 FEE FOR LATE CANCELLATION (late is less than 48 hours prior to the appointment time). At any time, I may leave a message on Doreen's confidential voice-mail at 951-847-7742 or 951-347-1837 if she is unable to answer when I call.

IF I FAIL TO SHOW UP FOR MY APPOINTMENT, I will be charged \$ _____. The insurance will not pay for late cancels or missed appointments. (Client initials indicate acceptance _____.)

URGENT AND EMERGENCY ACCESS

If you need to reach Doreen after hours, you may contact her at 951-347-1837, her cell-phone. However, please ask yourself first if your concern can reasonably wait until the next business day before calling. IF SOMEONE IS IN IMMEDIATE PHYSICAL DANGER TO ONESELF OR OTHERS, DIAL 911 OR GO TO YOUR NEAREST EMERGENCY ROOM. Doreen will make every effort to return your phone call within 24 hours.

PROCEDURES TO FOLLOW IN THE ABSENCE OF MY REGULAR THERAPIST

I understand that if Doreen needs to cancel one of my office visits, she will make every effort to contact me and reschedule my appointment. If she needs to be away from her office for an extended period of time, she will tell me the identity of an on-call therapist - from list below - who will have access to my chart and who could best assist me, or she will negotiate with me for a delay in my sessions with her. If I repeatedly try to reach Doreen and cannot for period of over 72 hours, then I understand that I should contact one of the therapists from the list below for assistance.

AUTHORIZATION FOR RELEASE OF INFORMATION IN THE ABSENCE OF MY REGULAR THERAPIST

I authorize my therapist, Doreen Van Leeuwen, LMFT, to release information to the on-call therapists indicated here in order to assist me in her absence. This authorization will be valid for one year from the date of my signature or upon my request to revoke it.

_____ (Client initials indicate acceptance.)



LIST OF ON-CALL THERAPISTS

- * Alejandrina Flores Burrell, LMFT 951-371-8527 Laurie K. Lee, LMFT 951-808-7577
- * Sara Fernandez, LMFT 951-907-3710 Susan Seidman, LMFT 951-317-1267
- * Holly Gil-Khan, LCSW 951-818-4560 Catherine M. Zych, LMFT 909-263-5040
- *Hablan espanol Susan Kleszewski, LCSW 909-947-4357

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of a *Notice of Privacy Practices* that Doreen has given to you. Her *Notice of Privacy Practices* provides information about how she may use and disclose your protected health information. She encourages you to read it in full.

The *Notice of Privacy Practices* is subject to change. You may obtain a copy of the most recent notice by contacting Doreen at 951-847-7742.

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

1128 E. 6th ST, Suite 7, Corona, CA 92879.

I acknowledge receipt of the *Notice of Privacy Practices* of Doreen Van Leeuwen, LMFT.

Signature
(patient/parent/conservator/guardian)

Date

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HOUSEHOLD: THOSE LIVING WITH YOU, INCLUDING CHILDREN

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Credit Card Payment Consent Form

Patient Name (printed) _____
First (MI) Last

Name on card (if different from above) _____

Phone Number _____ Email to send receipt to (if desired) _____

I authorize A Better Way Center for Wellness, and ProfessionalCharges.com, to charge my credit/debit card for professional services as follows:

Initial

_____ This visit only, for the amount of \$ _____.

_____ All visits in the next 12 months, beginning ____ / ____ / ____,
not to exceed \$ _____ total.

_____ Recurring charges, date(s) of service ____ / ____ / ____ to
____ / ____ / ____, not to exceed \$ _____,
____ monthly, ____ semimonthly, ____ weekly, ____ per visit.

_____ **To charge my card for the balance of fees not paid by my insurance company within 90 days, as indicated above.**

Type of Card: Visa, MasterCard, Discover, Medical Savings/Expense

Credit Card Number _____ - _____ - _____ - _____, CVV Number _____

Expiration Date _____ A 3-digit number in reverse italics on the **back** of the credit card

Card Holder's Billing Address for Credit Card Statements

_____ Street
City State Zip

Card Holder Signature _____, Date ____ / ____ / ____

Charges will appear on your credit card statement as **ProfessionalCharges.com**

or some abbreviation of it.

ProfessionalCharges.com

Phone: 818-206-2126

1530 E. Chevy Chase Dr., Suite 209

E-mail: admin@ProfessionalCharges.com

Glendale, CA 91206