Negar Taslimi, PsyD
Licensed #PSY29115
(949) 478-5763

NEGAR TASLIMI, PSYD

CLIENT INTAKE FORM (ADULT)

(Please Print)

Today's date:

1. IDENTIFICATION

Client's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: ☐Sing/☐Mar/☐Div/☐Sep/☐Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:

P.O. box:	City:	State:	ZIP Code:
Home phone no.: ( )	May I leave you a message? ☐Yes ☐ No May I identify myself by name? ☐Yes ☐ No	Cell phone no.: ( )	May I leave you a message and send text messages? ☐Yes ☐ No May I identify myself by name? ☐Yes ☐ No

I give you permission to mail me a termination letter at the aforementioned address. ☐Yes ☐ No

Occupation:	Employer:	Employer phone no.: ( )
Primary Care Physician:		PCP Phone no.: ( )

Referred by (please check one box): ☐ Dr. _____ ☐ Insurance Plan ☐ Hospital
☐ Family ☐ Friend ☐ Close to home/work ☐ Internet/Social Media ☐ Other

List of people living in your home (Name, Age, Relation):

Ethnic identification (optional):

Religious/spiritual background (optional):

EMERGENCY CONTACT

Name of local friend or relative (not living at same address):	Relationship to client:	Home phone no.: ( )	Work phone no.: ( )

By providing this information, you are authorizing **Negar Taslimi, PsyD** to contact this person in the case of an emergency.

_____ _____

Client/Guardian signature *Date*

2. PRESENTING PROBLEM

What are the main problems, symptoms and current stressors that you seek treatment for?

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When did the issues arise? Was there an event that made these issues surface?

Degree problem(s) has affected your life:	☐ Low	☐ Moderate	☐ High	☐ Extreme
Rate your social/economic status: ☐ Poverty	☐ Lower-Middle	☐ Middle	☐ Upper-Middle	☐ Upper
Is your financial situation stressful?	☐ Low	☐ Moderate	☐ High	☐ Extreme

What do you expect to achieve from therapy/ what are your goals?

3. MEDICAL HEALTH HISTORY

Do you have a balanced diet? ☐Yes ☐ No	Do you exercise regularly? ☐Yes ☐ No
Has there been any change in your weight recently? ☐Yes ☐ No	If so, how much weight have you increased or decreased?
When did a physician last examine you?	What were the findings?

If applicable, please provide a list of any medications you are currently taking:

List any serious injuries, surgeries, hospitalizations, major medical issues you have had with their dates:

Which of the following conditions have you, previously or currently, been diagnosed with?

☐ Headaches	☐ Seizures or convulsions	☐ Ulcers	☐ Hypoglycemia (low blood sugar)
☐ Dizziness	☐ Memory loss	☐ High blood pressure	☐ Heart disease
☐ Fainting spells/blackouts	☐ Allergies	☐ Thyroid difficulties	☐ Other heart condition
☐ Severe or prolonged nausea	☐ Asthma	☐ Diabetes	☐ Other

4. MENTAL HEALTH HISTORY

Are you currently or have you ever received psychological or psychiatric treatment of any kind? ☐Yes ☐ No	If so, please specify the dates and duration you received the service(s):
Do you currently consider yourself suicidal? ☐Yes ☐ No	
Have you ever been suicidal? ☐Yes ☐ No	If yes, when?

Which of the following problems do you currently have or have you previously experienced?

☐ Depression/Sadness	☐ Lonely	☐ Gambling
☐ Suicidal ideas	☐ Excessive worry	☐ Unusual thoughts or beliefs
☐ Always sleepy/tired	☐ Shy with people	☐ Poor living conditions
☐ Sleep difficulties	☐ Can't make friends	☐ Insomnia
☐ Self-inflicted pain or injury	☐ Flashbacks/intrusive recollections	☐ Recurrent dreams
☐ Lacks motivation/energy	☐ Panic attacks	☐ Nightmares
☐ Unable to have a good time	☐ Eating disorder	☐ Sexual problems

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☐ Extreme mood swings	☐ No appetite	☐ Learning disability
☐ Feel hopeless	☐ Over-eating	☐ Over-ambitious
☐ Anxiety/Nervousness	☐ Inferiority feelings	☐ Occupational problems
☐ Unable to relax	☐ Feel worthless	☐ Relational problems
☐ Feel tense	☐ Aggression/violence	☐ Behavioral difficulties
☐ Fears and phobias	☐ Criminal behavior	☐ Difficulty focusing/paying attention
☐ Can't make decisions	☐ Recurrent conflicts with others	
☐ Obsessions	☐ Hallucinations	

Which of the following symptoms has any member of **your family** experienced?

☐ Anxiety	☐ Unusual thoughts or beliefs	☐ Criminal behavior/incarcerated
☐ Depression	☐ Attention deficit hyperactivity disorder	☐ Aggression/violence
☐ Extreme mood swings	☐ Developmental delays	☐ Learning disability
☐ Alcohol or drug abuse	☐ Suicide	☐ Other

Has any member of your family sought out psychological or psychiatric treatment? ☐Yes ☐ No
If so, please explain:

5. DEVELOPMENTAL HISTORY

Where were you born?

How many siblings do you have? Sisters (include age) Brothers (include age)

What is your birth order?

Mother: ☐ Living ☐ Deceased Age:

Father: ☐ Living ☐ Deceased Age:

Who was your primary caretaker?

How were you disciplined as a child and by whom?

How would you describe your childhood?

Describe your parents' relationship:

Were there any significant events or circumstances, which influenced your childhood (many moves, illness, death of a loved one, traumatic injuries or accidents, physical abuse, verbal abuse, sexual abuse, emotional abuse, etc.)? ☐Yes ☐ No
If yes, please describe:

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6. SUBSTANCE USE HISTORY

	Frequency	Amount	Date Last Used
Caffeine(coffee, tea, sodas)			
Alcohol			
Drugs (include type)			
Sedatives (tranquilizers, sleeping pills)			

Have you ever been diagnosed or treated for substance abuse or addiction? ☐Yes ☐ No
If yes, where and when?

Was any member in your family using or abusing drugs or alcohol in your childhood home or in your current household? ☐Yes ☐ No
If yes, please describe their relationship to you and what substance(s) they were using:

7. EDUCATION, EMPLOYMENT AND MILTARY HISTORY

What is the highest level of education you completed?

☐ Elementary School
☐ Middle School
☐ High School or received G.E.D
☐ Vocational/technical training
☐ Some college
☐ BA/BS
☐ MA
☐ Ph.D. or M.D.

How long have you been working at your present job?

How many hours per week do you work?

Do you find work to be: ☐ Enjoyable ☐ Neutral ☐ Unpleasant

Do you have any problems at work? ☐Yes ☐ No

Were you in the military? ☐Yes ☐ No

8. LEGAL HISTORY

Are you currently involved in a civil or legal litigation? ☐Yes ☐ No
If so, please explain:

Have you ever been arrested? ☐Yes ☐ No
If so, please explain:

Have you been court ordered for therapy? ☐Yes ☐ No

If there is any other important information that you would like to add that can be helpful in aiding your treatment, please provide it here:

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PSYCHOLOGIST-CLIENT SERVICE AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undergo treatment. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, resolutions to specific problems and improved self-confidence. However, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first few sessions will involve a comprehensive evaluation of your needs. I will then be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for treatment.

CANCELLATION POLICY

The time scheduled for your appointment is assigned to you. If you need to cancel or reschedule a session, I ask that you provide me with a 24-hour notice. If you miss a session without canceling, or cancel with less than 24 hours of notice, my policy is to collect the full amount of your payment.

It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

The standard fee for service is $____ per 50 minute session. Sessions longer than 50 minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Client will be notified of any

fee adjustment in advance. Payment must be made by check, cash, or credit card. Any checks returned to my office are subject to an additional fee of up to $25 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. You are expected to pay for services at the time services are rendered.

CLIENT LITIGATION

I will not voluntarily participate in any litigation or custody dispute. I generally will not write or sign letters, reports, declarations, or affidavits to be used in legal matter. I will generally not provide records or testimony unless compelled to do so. In the case that I am subpoenaed, or ordered by a court of law, to appear as a witness in action involving you, you are expected to pay me for any time spent preparing, traveling, or other time in which I make myself available at my usual rate of $____ per 50 minutes.

PSYCHOTHERAPITS-PATIENT PRIVILEGE

Typically, the client is the holder of the psychotherapist-patient privilege. If I am subpoenaed for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege until I am instructed to do otherwise in writing by you or your representative. You might be waiving the psychotherapist-patient privilege if you make your mental or emotional sate an issue in a legal proceeding. If you have any concerns in regards to the psychotherapist-patient privilege, you should discuss it with your attorney.

INSURANCE

Since I am currently not a participating provider for your insurance plan, I can provide you with a receipt of payment for services. You can submit the receipt to your insurance company for reimbursement. Please note that not all insurance companies provide reimbursement for fees already paid.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

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CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING ME

You may leave a message on my confidential voicemail and your call will be returned as soon as possible. It may take me one to two business days to return your call on non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice. The following resources are available in the local community for individuals in crisis:

Crisis Hotline: 877-727-4747

Youth Shelter: 949-494-4311

Domestic Violence Help: 800-799- 7233

Rape Crisis Hotline: 714-957-2737

Hospital: 714-771-8113

General Resources: 211

SOCIAL NETWORKING AND INTERNET SEARCHES

I do not accept requests to add current or former clients on social networking sites. Communicating via any interactive social networking websites or applications can potentially compromise your privacy and confidentiality. Thus, it is best to avoid such interactions.

THERAPEUTIC PROCESS

I intend to assist you in reaching your personal goals. I may provide treatment recommendations. Psychotherapy is most effective when the therapist and client work together and have open communication with one another. You have the right to disagree with any recommendations I make. I will periodically provide feedback in regards

to your progress. I cannot predict the length of treatment due to the varying nature and severity of problems and the individuality of each client. In addition, I cannot guarantee a specific outcome from treatment.

TERMINATION OF THERAPY

The length and eventual termination of treatment depends on your progress and the specifics of your treatment plan. It is recommended to plan for the termination of treatment with me. Treatment may be terminated for the following reasons: untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, your needs are outside of my scope of competence or practice, or you are not making adequate progress in therapy. It is recommended that you participate in at least one termination session in order to reflect on the work that has been done and to facilitate a positive termination. If it is needed or applicable, I will ensure a smooth transition to another therapist by providing you with referrals.

ACKNOWLEGEMENT

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms. You agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with me.

_____

Client Name (please print)

_____ _____

Signature of Client (or authorized representative) 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 payer.

By providing the information below, you authorize me to keep the following credit card information on file and to charge this credit card for payment of services rendered,, missed appointments or appointments canceled/rescheduled without a **24-hour notice**, copays, and outstanding balances.

Credit Card #: _____ Type: _____

Expiration Date: _____ Security Code: _____ Billing Zip Code: _____

_____

Name of Responsible Party (Please print)

_____ _____

Signature of Responsible Party Date

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NOTICE OF PRIVACY

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.

I am 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"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website. Except for the specific purposes set forth below, I 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 me 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. I can use and disclose your PHI without your Authorization for the following reasons:

1. For your treatment. I 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, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.
2. To obtain payment for your treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to be paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.
3. For health care operations. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization:

1. Psychotherapy Notes. I do 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 my use in treating you.
    b. 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.
    c. For my use in defending myself in legal proceedings instituted by you.
    d. For use by the Secretary of Health and Human Services to investigate my 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, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

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Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations in the law, I 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:

Disclosures to family, friends, or others. I may provide your PHI to a family member, 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.

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 me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I 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 me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I 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 I have about you. I 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 I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or

for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based 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 I correct the existing information or add the missing information. I may say "no" to your request, but I 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 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.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice. 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.

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on August 1, 2017.

I have read this NOTICE OF PRIVACY PRACTICES and have received a copy.

_____

Patient Name (please print)

_____

Signature of Patient (or authorized representative) Date