

Jacinda Mitchell, LMFT

Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

(Last) (First) (Middle Initial)

Birth Date: ____ / ____ / ____ Age: _____ Gender: Male Female Non-Binary

Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: (_____) May we leave a message? Yes No

Cell/Other Phone: (_____) May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact: _____ Phone _____

Relationship: _____

Marital Status:

- Never Married Domestic Partnership Married Separated
 Divorced Widowed

Please list any children/age: _____
Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

- No
 Yes, previous therapist/practitioner: _____
-

Are you currently taking any prescription medication?

- Yes
 No

Please list: _____

Have you ever been prescribed psychiatric medication?

- Yes
 No

Please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

- How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

- How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

- Please list any difficulties you experience with your appetite or eating patterns.

- Are you currently experiencing overwhelming sadness, grief or depression?

- No
- Yes

If yes, for approximately how long? _____

- Are you currently experiencing anxiety, panic attacks or have any phobias?

- No
- Yes

If yes, when did you begin experiencing this? _____

- Are you currently experiencing any chronic pain?

- No
- Yes

If yes, please describe? _____

- Do you drink alcohol more than once a week? No Yes
- How often do you engage in recreational drug use? Daily Weekly Monthly
 Infrequently Never What types: _____
- Are you currently in a romantic relationship? No Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

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

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

- Please Circle List Family Member

Alcohol/Substance Abuse yes/no _____

Anxiety yes/no _____

Depression yes/no _____

Domestic Violence yes/no _____

Eating Disorders yes/no _____

Obesity yes/no _____

Obsessive Compulsive Behavior yes/no _____

Schizophrenia yes/no _____

Suicide Attempts yes/no _____

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 weaknesses?

- What would you like to accomplish out of your time in therapy?

- Is there any additional information you think would be helpful to share?

**Jacinda Mitchell, LMFT 959 E. Walnut ST #214 Pasadena, CA 91106
702-340-5232**

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GENERAL INFORMATION & POLICIES

Confidentiality

Information revealed within sessions will remain confidential unless disclosure is required by law. Disclosure may be required in the following circumstances:

Where there is a reasonable suspicion of child or elder abuse or neglect; Where a client presents a danger to him/herself or to others, or is gravely disabled; When the court has ordered the assessment.

If there is an emergency during our work together, or in the future after termination, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I am obliged to do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the personal information sheet.

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client's) nor your attorney/s, nor anyone else acting on your behalf will call on me to testify in court or at any other proceedings, nor will disclosure of the psychotherapy records be requested.

Case material may be discussed by me in consultation with a professional colleague or in the context of ongoing education and teaching activities, but only when personal information regarding you is so altered as to render you unidentifiable.

Disclosure of confidential information may be required by your health insurance carrier or Victims of Crimes (VOC) in order to process the claims. Only the minimum necessary information will be communicated to the carrier or VOC. I have no control or knowledge over what insurance companies do with the information submitted.

As a client, you have the right to review or receive a summary of your records at any time, except when it is assessed that releasing such information might be harmful in any way. In such a case, the records may be provided to an appropriate and legitimate mental health professional of your choice.

Considering all the above exclusions, if it is still appropriate, upon your request, I will release information to any agency/person you specify.

Contacting the Therapist

I can be reached by calling 702-340-5232. Messages are checked once a day, seven days a week and will be returned between 10 am – 8 pm Tuesday through Saturday. In the unlikely event that you cannot reach me in a timely manner, and your call is urgent, please contact your family physician or your local Emergency Room and ask for the psychologist or psychiatrist on call. You will be given the name of a professional colleague for you to contact, if necessary when I am unavailable for any extended period of time.

Phone Consultations

I will return telephone messages as soon as possible. Time spent with you on the telephone is given the same consideration as time spent with you in the office and fees will be assessed according to the time spent, unless we have agreed upon other arrangements.

Social Media Policy

Jacinda Mitchell, LMFT participates in social media through the website, blog, and various other platforms. These platforms are used to share and post blogs as well as psychological news. Please note that comments will be turned off, and should you choose to follow or “like” Jacinda Mitchell, LMFT, posts or blogs, it may impact your confidentiality.

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Please do not use messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

Appointments

Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required for rescheduling or canceling an appointment. Unless we reach a different agreement, __\$ 100 will be charged for sessions missed without such notification. Insurance companies do not reimburse for

missed sessions. The standard appointment is 55 minutes. Even if you are late for the session, the appointment will end at the scheduled time.

Professional Documentation

Both law and the standards of my profession require that I keep appropriate records of services provided. The confidentiality of these records is closely safeguarded. The records are kept in a locked filing cabinet behind two locked doors.

Release of Information

Should I be required to communicate with a third party regarding the confidential treatment relationship, i.e. a psychiatrist, agency, school, or other institution, a separate “Release of Information” form will be provided and signed by you before any such exchange of information occurs.

My Medicare Provider Status

Please be aware that I am an Opted-Out provider. This means I am not contracted with Medicare. Medicare will not reimburse you for the cost of my services. If you are a Medicare beneficiary, we will need to enter into a private contract for therapy services for me to treat you.

Your Medicare Coverage Status

Are you a Medicare beneficiary?

Yes No

If so, which plan(s) are you under:

- Original Medicare
- Original Medicare + MediGap
- Medicare Advantage

Please provide the following information from your Medicare card:

Name on Card:

Medicare Number:

Entitled to (e.g. Medicare Part A, Part B, both, etc.):_____

Coverage Start Date:

Do you receive medical benefits through any other health plan (e.g. private insurance, Medi-Cal, etc.), including a spouse or partner’s health plan?

Yes No

If yes, what additional health plan are you covered under?

Name of Subscriber: _____

Policy Number: _____ Group Number: _____

Is the additional health plan you listed above your primary or secondary source of coverage?

Primary Secondary

Is your Medicare plan your primary or secondary source of coverage?

Primary Secondary

Payment for Services

The fee for psychotherapy is \$ 175 per session. Payment is expected at the end of each session. Bank charges on returned checks are your responsibility. Delinquent payments will be discussed and arrangements for a payment schedule made, if necessary.

Clients are personally responsible for all fees. You are responsible for submitting insurance forms for reimbursement. However, I will provide whatever other assistance is required to obtain reimbursement from the insurance company.

Nature of Services

I, _____ understand that I am consulting with Jacinda Mitchell, LMFT, for provision of individual psychological services. I understand that these services are intended to reduce or eliminate psychological symptoms and improve occupational and social functioning. There are other forms of treatment available, including the provision of medications, the performance of certain forms of physical exercise, and other interventions that may be helpful in alleviating psychological stress. This psychological intervention often leads to substantial improvement but the process itself may be uncomfortable at times, i.e., experiences of painful feelings, decisions made to change relationships or occupational situations, etc. I am well aware of these potential benefits and risks and consent to treatment.

Client Acknowledgment

I hereby acknowledge that Jacinda Mitchell, LMFT discussed this information sheet with me as well as elaborated further on her business policies, limits of confidentiality, and nature of the treatment process. I have received a copy of the Notice of Privacy Practices. I have read the above policies carefully. I understand them and agree to comply with them, and also have been provided with a copy of this document.

Print Name Date Signature

Print Name Date Signature

Therapist Date Signature

TELEHEALTH CONSENT FORM

I, _____ (Patient) hereby consent to engage in Telehealth with Jacinda Mitchell, LMFT #99700 (Therapist).

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:**
- 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 or Statement of Disclosures] I received from my therapist also apply to my Telehealth services.
 - 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.
 - I understand that miscommunication between myself and my therapist may occur via Telehealth.
 - 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.
 - I understand that at the beginning of each Telehealth session, my therapist is required to verify my full name and current location. I am aware that traveling outside of the state may impact my ability to receive services and agree to inform my therapist if I am outside of the state during a session.
 - 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.

- 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.
- 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.
- I have discussed the fees charged for Telehealth with my therapist and agree to them [or for insurance patients: I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments)], and I have been provided with this information in the [Informed Consent Form or Name of Payment Agreement Form].
- 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.

[For conjoint or family therapy, patients may sign individual consent forms or sign the same form.]

Patient's Signature

Date

Patient's Printed Name

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.

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 get 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.

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.

1. 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.

YOUR RIGHTS YOUR REGARDING YOUR PHI

You have the following rights with respect to your PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask 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, and my address and phone number are:

_____.

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 September 20, 2013.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have given to you. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at (702) 340-5232.

If you have any questions about my *Notice of Privacy Practices*, please contact me at: 1101 Fremont Ave #101, South Pasadena, CA 91030 (702) 340-5232.

I acknowledge receipt of the *Notice of Privacy Practices* of Jacinda Mitchell, LMFT.

Signature: _____

Date: _____

(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patients acknowledgment of his or her receipt of my Notice of Privacy Practices, including_____. However, because of_____ I was unable to obtain my patient’s acknowledgement.

Signature of Provider: _____

Date: _____

Authorization to Release Confidential Information

I, [Name of Patient]

_____ (“Patient”) hereby
authorize [Name of
Provider] _____ (“Provider”) to release
confidential information obtained during the course of my treatment to
[name or function of the person(s) or entities to whom information is to be
released] _____
 (“Recipient”).

This Authorization permits the release of the following information:

- Diagnosis
- Treatment Plan
- Progress to Date
- Prognosis
- Clinical Test Results
- Dates of Treatment
- Any and All Information Necessary
- Other (specify)

I authorize the release of the information described above for the following
purpose(s):

The specific uses and limitations on the types of information to be released
are as follows:

The specific uses and limitations on the use of the information by Recipient

are as follows:

I understand that I have a right to receive a copy of this Authorization and that any modification or revocation of this Authorization must be in writing.

The Authorization shall remain valid until: (“Expiration Date”)

By: Date: (Patient or Patient’s Representative)