A STEP FORWARD
PSYCHOTHERAPY & FORENSIC SERVICES
925-685-9670 • Fax 925-685-1528 • support@astepforwardinc.com
2827 Concord Blvd., Concord, CA 94519

CONFIDENTIAL INFORMATION

Date: _____

Patient's Name: _____ DOB: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Names of Parent(s) or Guardian(s) if patient is a minor: _____

Hm Phone: _____ Cell Phone: _____

Email address _____

Please answer the following, if applicable.

School (if minor): _____ Phone #: _____ Grade: _____

Social Worker: _____ Phone #: _____

Pediatrician: _____ Phone #: _____

Who resides in household at present?

Name	Age	Relationship to Patient	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Briefly describe why you are seeking therapy.

Have you been in therapy before? For how long?_____

Any relevant personal history? (i.e. – birth of new child; death in the family; illness; etc.) _____

Do you or does anyone in your family have a problem with drugs or alcohol? Yes [ ] No [×]

If "yes", please explain:

Have you or anyone in your family made a suicide attempt? Yes ☐ No ☐

Or you or anyone in your family having thoughts of suicide? Yes ☐ No ☐
If "yes, please explain:

Have you or anyone in your family ever been convicted of a serious crime? Yes ☐ No ☐
If "yes, please explain:

Has anyone in your family ever had:

1. In-patient treatment for substance abuse ☐ or mental health issues ☐

Which family member(s)? _____

Explain:

2. Outpatient treatment for substance abuse ☐ or mental health issues ☐

Which family member(s)? _____

Explain:

3. Outpatient treatment for psychological/psychiatric problems ☐

Which family member(s)? _____

Explain:

4. Medication ☐

Which family member(s)? _____

Explain:

5. Custody evaluation(s) ☐

Which family member(s)? _____

Explain:

A STEP FORWARD
PSYCHOTHERAPY & FORENSIC SERVICES

925-685-9670 • Fax 925-685-1528 • support@astepforwardinc.com
2827 Concord Blvd., Concord, CA 94519

NOTICE OF PRIVACY PRACTICES

The Federal Government now requires that patients receive this Notice pursuant to HIPAA Regulations.

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

II. **I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).**
I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been give to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office. You can also request a copy of this Notice from me, or you can view a copy of it in my office.

III. **HOW I MAY USE AND DISCLOSE YOUR PHI.**
I will use your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. **Uses And Disclosures Relating To Treatment, Payment, Or Health Care Operations Do Not Require Your Prior Written Consent.** I can use and disclose your PHI without your consent for the following reasons:

1. **For treatment.** I will use and disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist in order to coordinate your care.

2. **To obtain payment for 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 or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. **For health care operations.** I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountants, attorneys, consultants, and others to make sure I am complying with applicable laws.

4. **Other disclosures.** I may also disclose your PHI to others without your consent in certain situations. For example, your consent is not required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, of if I try to get your consent but you are unable to communicate with me (for

example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. **Certain Uses And Disclosures Do Not Require Your Consent.** I can use and disclose your PHI without your consent or authorization for the following reasons:

1. **When federal, state, or local law; judicial or administrative proceedings; or, law enforcement requires disclosure.** For example, I may make a disclosure to applicable officials when a law required me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.

2. **For public health activities.** For example, I may have to report information about you to the county coroner.

3. **For health oversight activities.** For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a healthcare provider or organization.

4. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.

5. **To avoid harm.** In order to avoid a serious threat to my health or safety of a person or the public, I may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

6. **For specific government functions.** I may disclose PHI of military personnel and veterans in certain situations. I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.

7. **For workers' compensation purposes.** I may provide PHI in order to comply with workers' compensation laws.

8. **Appointment reminders and health related benefits or services.** I may use PHI to provide appointment reminders or give information about treatment alternatives, or other healthcare services or benefits I offer.

C. **Certain Uses And Disclosures Require You 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 of your healthcare, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. **Other Uses And Disclosures Require Your Prior Written Authorization.** In any other situation not described in sections III, A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

IV. **WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.**
You have the following rights with respect to your PHI:

A. **The Right To Request Limits On Uses And Disclosures Of Your PHI.** You have the right to ask that I limit how I use and disclose your PHI. I will cons ider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required to make.

B. **The Right To Choose How I Send PHI To You.** You have the right to ask that I send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by

alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as I can easily provide your PHI to you in the format requested.

C. **The Right to See and Get Copies Of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I do not have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will not charge you more than twenty-five cents ($.25) for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. **The Right To Get A List Of The Disclosures I Have Made.** You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made *for* treatment, payment, or healthcare operations, directly to you, or to your family. The list also will not include uses and disclosures made *for* national security purposes, to correction or law enforcement personnel, *or* disclosures made before April 15, 2003.

I will respond to your request for an accounting of disclosures within sixty (60) days of receiving your request. The list I will give you will include disclosures made in the last six (6) years, unless you request a shorter time. The list will include the date of the disclosure, to whom your PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. 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.

E. **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, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reasons for the request in writing. I will respond to your request within sixty (60) days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (1) correct and complete, (2) not created by me, (3) not allowed to be disclosed, or (4) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file a disagreement, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, notify you that I have change your PHI, and notify others that need to know about the change to your PHI.

F. **The Right To Get This Notice By E-mail.** You have the right to get a copy of this Notice by e-mail. Even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy.

V. **HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES.** If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. **PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES.** If you have any questions about this Notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact:

NAME: **Diana Jones, Administrative Director**
ADDRESS: **2827 Concord Boulevard, Concord, CA 94519**
TELEPHONE NO.: **(925) 685-9670 x101**

I ACKNOWLEDGE RECEIPT OF THIS NOTICE.

NAME: _____ SIGNATURE: _____ DATE:_____

NAME: _____ SIGNATURE: _____ DATE:_____

A STEP FORWARD
PSYCHOTHERAPY & FORENSIC SERVICES
925-685-9670 • Fax 925-685-1528 • support@astepforwardinc.com
2827 Concord Blvd., Concord, CA 94519

AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL INFORMATION

This is an authorization for disclosure of confidential information concerning the following patient(s):

NAME(S):_____

DOB: _____

By signing this document, I (print patient or guardian name)_____ hereby authorize _____(hereinafter "Provider") and A Step Forward Team to disclose mental health treatment information and records obtained in the course of Provider's treatment of Patient, including, but not limited to Provider's diagnosis of Patient, to:

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time, unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider at Provider's address to be effective.

The disclosure of information and records authorized by Patient is required for the following purpose:

The specific uses and limitations of the types of medical information to be discussed are as follows:

_____

Such disclosure shall be limited to the following specific types of information:

_____

Provider shall not condition treatment upon patient signing this authorization.
Patient has the right to refuse to sign this form.
Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rule, although such information may be protected by applicable California Law.

This authorization shall remain valid for:

☐ One year

☐ The durations of treatment with provider

☐ Until specific date _____

A copy of this original signed authorization shall be as effective and valid as the original.

_____	_____	_____
PRINT - Patient or Guardian Name	Date	Signature

_____	_____	_____
PRINT - Patient or Guardian Name	Date	Signature

A STEP FORWARD
PSYCHOTHERAPY & FORENSIC SERVICES

925-685-9670 • Fax 925-685-1528 • support@astepforwardinc.com
2827 Concord Blvd., Concord, CA 94519

OFFICE POLICIES & GENERAL INFORMATION AGREEMENT FOR INDIVIDUAL PSYCHOTHERAPY SERVICES

CONFIDENTIALITY

All information disclosed within your sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure are described to you in the lengthy Notice of Privacy Practices that you will receive with this form.

The short version of Exceptions to Confidentiality and additional information is as follows:

- If there is "reasonable suspicion" that a child or elderly adult (over 65) has been abused, or if you are in danger of hurting yourself or another person.
- The Administrative Director, Bookkeeper or A Step Forward Team may have access to limited confidential information if he/she is asked to type letters or invoices. He/she has signed an agreement of confidentiality.
- I consult regularly with other professionals regarding my clients; however, clients' names or other identifying information is never mentioned. Clients' identities remain anonymous, and confidentiality is fully maintained.
- I am healthy and do not foresee any problems; however, in the event that I suffer a personal emergency, a representative from A Step Forward would notify you and would be responsible for all of my confidential written records.

TELEPHONE CALLS & EMERGENCY PROCEDURES

My voice mail is available to you at all times. I check my voice mail every day during the workweek. Return calls exceeding 10 minutes will be charged my hourly fee, pro-rated. All non-emergency weekend calls will be returned on the following Monday. I encourage parents to leave a "child update" before appointments if you have important information about the child's week. In an emergency, you may call the 24-hour crisis line for Contra Costa County at 925-472-0999, for Alameda County at (800) 309-2131, or go to a hospital, or call the police (911).

PAYMENTS AND INSURANCE REIMBURSEMENT

My fee is $_____ per session. Payment is made each session. To save time, please have your check ready prior to the session. If you have insurance, you must still pay for the session and you will be given a monthly statement to send to your insurance company at the end of every month. Any reimbursement will go directly to you. We will discuss details or alternate arrangements in session. You

must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are the focus of psychotherapy, are reimbursed by insurance companies. They do require me to provide a diagnosis. It is your responsibility to verify the specifics of your coverage. If you request that I write a report, discuss your case at length with another professional, schedule a telephone session or anything else that requires time outside of your therapy session, there will be a charge based on the time it takes for me to complete the work (based on my session rate).

THE PROCESS OF THERAPY/EVALUATION

Change in therapy will sometimes be easy and swift, but can also be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, I am likely to draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what might benefit you. These approaches include cognitive-behavioral, psychodynamic, somatic/emotional, family systems, developmental, or psycho-educational.

CANCELLATIONS

Our work requires commitment, consistency, and responsibility. When you make an appointment, you are reserving a specific time with me and this time will be yours. If you cancel anytime less than 24 hours (one working day), before your scheduled session, you will be charged for the session, unless we are able to reschedule the appointment within the same week. If you do not call or come to a scheduled session, you will be charged the full fee. Most insurance companies do not reimburse for missed sessions.

The California State Department of Consumer Affairs, Board of Quality Medical Assurance, and the Code of Ethics of the American Psychological Association prohibit any and all sexual acts between therapists and clients. If you are aware of any violations of this rule of conduct, then you should report it immediately to the Department of Consumer Affairs, 1422 Howe Avenue, Sacramento, CA 95825, 1-866-503-3221.

I read, understand, and agree to comply with the above office policies and conditions:

Client Name or Guardian (print)	Date	Signature
Client Name or Guardian (print)	Date	Signature

A STEP FORWARD
PSYCHOTHERAPY & FORENSIC SERVICES
925-685-9670 • Fax 925-685-1528 • support@astepforwardinc.com
2827 Concord Blvd., Concord, CA 94519

OFFICE RULES

The following is a list of rules we ask you to read and sign. These rules are to ensure the safety and consideration of all our clients.

- We ask that children under the age of twelve be accompanied at all times by an adult (parent or guardian) whether inside or outside of the building.
- There is ample street parking and clients are asked to use only that area. The parking area in the rear of the building is for staff use only.
- The rest room is located at the top of the stairs. An adult must accompany young children. Cups will be provided in the upstairs bathroom for drinks of water.
- Please do not bring food or drinks into the Waiting Room.

Signature_____Date_____

Rev. 05-02-17

A STEP FORWARD
PSYCHOTHERAPY & FORENSIC SERVICES
925-685-9670 • Fax 925-685-1528 • support@astepforwardinc.com
2827 Concord Blvd., Concord, CA 94519

POLICIES FOR INSURANCE REIMBURSEMENT CLAIM FORMS

A Step Forward does not accept medical insurance of any kind. Some individual carriers will reimburse their patient for a portion or all of their "out-of-network" treatment fees. We recommend that you contact your insurance company to discuss what kind of coverage you have.

If you would like, we are happy to provide a monthly 'super' claim form for you to submit to your insurance company for reimbursement. Please make your request by signing the bottom portion of this notice and returning it to your therapist or Main Office.

A Step Forward cannot guarantee that your insurance company will approve your reimbursement request; however, we will do what we can to assist you in the process.

If you have any questions, please contact Diana Jones, Administrative Director, at 925-685-9670 x 101.

I have read the "Policies For Insurance Reimbursement Claim Forms." I agree with these policies, and I understand that I will only receive claim forms from the date this agreement was signed and ongoing throughout treatment.

Patient's Name _____ Date _____

Patient's Signature (or parent for minors) _____

Name of Treating Therapist _____

A STEP FORWARD
PSYCHOTHERAPY & FORENSIC SERVICES
925-685-9670 • Fax 925-685-1528 • support@astepforwardinc.com
2827 Concord Blvd., Concord, CA 94519

CONSENT TO TREAT A MINOR

I_____ as the parent/guardian (circle one)

of_____ give permission to _____ to provide treatment which may include group and/or individual therapy or psychological assessment for my child. I understand that _____ will keep me informed of the progress my child makes or of any new issues that arise during treatment.

_____
Parent/Guardian Signature

_____
Date

_____
Witness

A STEP FORWARD
PSYCHOTHERAPY & FORENSIC SERVICES
925-685-9670 • Fax 925-685-1528 • support@astepforwardinc.com
2827 Concord Blvd., Concord, CA 94519

ACE Childhood History and Current Medical Status

History of patient before the age of 18

1. Were you physically abused by a family member or friend as a child? ☐ Yes ☐ No
   If no, go to the next question.

If yes, can you briefly describe what happened to you, by whom and at roughly what ages the abuse occurred.

Can you briefly say how this affected you as a child and how you feel it affects you now as an adult?

2. Were you subject to recurrent Emotional abuse by a family member or friend as a child? ☐ Yes ☐ No
   If no, please go to the next question.

If yes, can you briefly describe what happened to you, by whom and at roughly what ages the abuse occurred.

Can you briefly say how this affected you as a child and how you feel it affects you now as an adult?

3. Were you sexually abused by a family member or friend as a child? ☐ Yes ☐ No
   If no, please go onto the next question.

If yes, can you describe what happened to you and by whom and at roughly what ages the abuse occurred.

Can you briefly say how this affected you as a child and how you feel it affects you now as an adult?

4. Did you grow up in a home where someone was in prison? ☐ Yes ☐ No
   If no, please go onto the next questions.

If yes, can you briefly describe who it was that was in prison?

Can you briefly say how this affected you as a child and how you feel it affects you now as an adult

---

5. Did you grow up in a home where your mother or stepmother was treated violently? ☐ Yes ☐ No
   If no, please go to the next question.

If yes, can you briefly describe what happened?

Can you briefly say how this affected you as a child and how you feel it affects you now as an adult?

6. Did you grow up in a home where someone was an alcoholic or a drug user? ☐ Yes ☐ No
   If no, please go to the next question.

If yes, can you briefly describe who had the problem and what they used?

Can you briefly say how this affected you as a child and how you feel it affects you now as an adult?

7. Did you grow up in a home where someone was chronically depressed, mentally ill or suicidal? ☐ Yes ☐ No
   If no, please go to the next question.

If yes, can you briefly describe who had the problem and what it was?

Can you briefly say how this affected you as a child and how you feel it affects you now as an adult?

8. Did you grow up in a home where at least one biological parent was lost to you regardless of the cause (death, prison, disappeared after a divorce, never there) during your childhood? ☐ Yes ☐ No
   If no, please go to the next section.

If yes, can you briefly describe who you lost and how?

Can you briefly say how this affected you as a child and how you feel it affects you now as an adult?

Current Medical Conditions:

1._____

2._____

3_____

4._____

5._____

Current Medications:

1._____ 2._____

3._____ 4._____

5._____ 6._____

Patient Name Date

A STEP FORWARD
PSYCHOTHERAPY & FORENSIC SERVICES
925-685-9670 • Fax 925-685-1528 • support@astepforwardinc.com
2827 Concord Blvd., Concord, CA 94519

INFORMED CONSENT FOR TELE-HEALTH SERVICES

This Informed Consent for Telehealth services contains important information focusing on providing healthcare services using the phone or the Internet. Please read this carefully and let me know if you have any questions.

Benefits & Risks of Telehealth

Telehealth refers to providing mental health services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits to telehealth is that the patient and clinician can engage in services without being in the same physical location. This can be helpful, particularly during the Coronavirus (COVID-19) pandemic, in ensuring continuity of care, as the patient and clinician likely are in different locations or are otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telehealth, however, requires technical competence on both our parts to be helpful. Although there are benefits of telehealth, there are some differences between in-person treatment and telehealth, as well as some risks. For example:

> **Risks to Confidentiality**: As telehealth sessions take place outside of our office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end, I will take reasonable steps to ensure your privacy. It is important; however, for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our sessions on you cell phone and other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.
>
> **Issues Related to Technology**: There are many ways that technology issues might impact telehealth. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of telehealth services. The nature of electronic communications technologies, however, is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communication may be compromised, unsecured, or accessed by others.

Records
The telehealth sessions shall not be recorded in any way, unless agreed to in writing by mutual consent, prior to recording the session. I will maintain a record of our sessions in the same way I maintain records of in-person sessions, in accordance with my policies.

PATIENT CONSENT TO THE USE OF TELEHEALTH
This agreement is intended as a supplement to the general informed consent that we agreed to at the onset of our treatment together and does not amend any of the terms of that agreement.

I have read and understand the information provided above regarding telehealth, have discussed it with my therapist and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my behavioral health care.

_____	_____	_____
Patient's Name	Patient's Signature	Date
_____	_____	_____
Parent's (or Legal Guardian's) Name	Parent's (or Legal Guardian's) Signature	Date
_____	_____	_____
Therapist's Name	Therapist's Signature	Date