South Coast Psychological Services

INFORMED CONSENT AND SERVICES AGREEMENT

Take the time to read the following information. If you are unclear about any portion of, or have any questions about the information provided, please talk about it with Dr Takos.

CONFIDENTIALITY: All information disclosed in sessions and the written records pertaining to said sessions are confidential and may not be revealed to anyone without your written permission, except when required by law.

When Disclosure Is Required By Law: Disclosure is required by law when there is a reasonable suspicion of child, dependent or elder abuse or neglect. It is also required when a client presents a danger to themselves, to others, to property or is gravely disabled or when clients' family members communicate to the therapist that the client presents a danger to others.

When Disclosure May Be Required: Disclosure may be required in a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Dr. Takos. Additionally, in couples and family therapy, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Dr. Takos will not release records to any outside party unless authorized to do so by all adult family members who were part of the treatment. In all these situations, Dr. Takos will use her clinical judgment when revealing such information.

Emergencies: If there is an emergency during your work in therapy, where Dr. Takos becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychological care, Dr. Takos will do whatever she 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, Dr. Takos may also contact the person whose name you have provided on the biographical sheet.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or PPO/EAP in order to process claims. If you instruct Dr. Takos, only the minimum necessary information will be communicated to the carrier. Dr. Takos has no control or knowledge over what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has also been reported to be legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position.

E-MAILS, CELL PHONES, COMPUTERS AND FAXES: It is very important to be aware that computers, e-mail, texts, and fax communication (which are part of the clinical records) can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such

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communication. Emails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all emails, texts, and e-faxes that go through them. Emails, texts, and e-faxes are not encrypted and it is always a possibility that email, texts, and e-faxes can be sent erroneously to the wrong address and computers. Dr. Takos' computer is equipped with a virus protection and a password. All confidential information is stored on an encrypted flash-drive. The flash-drives are stored securely. Please notify Dr. Takos if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phone calls, phone messages, or e-faxes. Please do not use e-mail, texts, voicemail, or faxes for emergencies.

LITIGATION LIMITATION: 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) nor your attorney, nor anyone else acting on your behalf will call on Dr. Takos to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. If this litigation limitation agreement is violated, fees to assert privileged communication, preparation/review/stand-by status, and/or to testify in court or for a deposition are $850.00 per hour with a minimal charge of a half day when compliance entails travel.

RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards of Dr. Takos' profession require that she keep treatment records for a minimum of seven years from the client's discharge date or seven years after a minor client reaches the age of 18. Please note that clinically relevant information from emails, texts, and faxes are part of the clinical records. Unless otherwise agreed to be necessary, Dr. Takos retains clinical records only as long as is mandated by California law. If you have concerns regarding the treatment records, please discuss them with Dr. Takos. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Dr. Takos assesses that releasing such information might be harmful in any way. In such a case, Dr. Takos will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, Dr. Takos will release information to any agency/person you specify unless Dr. Takos assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, Dr. Takos will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

MEDIATION & ARBITRATION: All disputes arising out of, or in relation to these psychotherapy services shall first be referred to mediation, before, and as a pre-condition to the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Dr. Takos and you, the client. The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement shall be submitted to and settled by binding arbitration in Orange County, CA in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Again, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, your therapist can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum as and for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

CONSULTATION: Dr. Takos consults regularly with other professionals regarding her clients; however, client's identity remains completely anonymous and confidentiality is fully maintained.

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TERMINATION: Dr. Takos has a responsibility to determine whether or not she can be help to you and will not accept clients whose therapeutic needs she cannot meet. In such a case you will be given a number of referrals. If at any point during psychotherapy Dr. Takos assesses that she is not effective in helping you reach your therapeutic goals, she is obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case you will receive a number of referrals that may be of help. If you request it and authorize it in writing, she will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional opinion or wish to consult with another therapist, Dr. Takos will assist you in finding someone qualified, and with your written consent, will provide them with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, Dr. Takos will offer to provide you with names of other qualified professionals whose services you might prefer.

PAYMENTS & INSURANCE REIMBURSEMENT: Dr. Takos is a an out-of-network provider for most PPO insurance plans. The fee for the Intake Evaluation is $250. Subsequent sessions or the standard rate for therapy is $225.00 per 50-minute session. Full payment for services is due when services are rendered. Please notify Dr. Takos if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance, with the exception of Medicare, should remember that professional services are rendered and charged to the client and not to the insurance company. Unless agreed upon differently, Dr. Takos will provide you with a superbill, which you can then submit to your insurance company for reimbursement, if you choose. As was indicated in the section *Health Insurance & Confidentiality of Records*, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems dealt with in psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, Dr. Takos can use legal or other means (courts, collection agencies, etc.) to obtain payment. Should you elect to pay by check, you are responsible to ensure that sufficient funds are available to cover the expense. Should a check be returned as unpayable due to insufficient funds, or any other reason, you are responsible for any fee charged to the account by the banking institution as well as the cost of the initial service. In addition, a $25.00 fee will be charged on all returned checks.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact Dr. Takos between sessions, please leave a message on her confidential voicemail and your call will be returned as soon as possible. Every effort will be made to return your call the same day, with the exception of weekends and holidays. If you are difficult to reach, please leave times that you are likely available to be reached and the phone number to use. If you cannot reach Dr. Takos and feel you cannot wait for her to return your call, you should call your family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call. If you are unsuccessful in reaching one of the above, and you feel it is an emergency, call 911. Please do not use e-mail, texts, or faxes for emergencies.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE:
Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. Dr. Takos will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts

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can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Dr. Takos may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, Dr. Takos is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his/her assessment of what will best benefit you. Dr. Takos provides neither custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within her scope of practice.

AUDIO OR VIDEO RECORDING: Unless otherwise agreed to by all parties beforehand, there shall be no audio or video recording of therapy sessions, phone calls, or any other services provided by Dr. Takos.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours' notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.
By signing this document, I acknowledge that I have read the above Informed Consent carefully; that I understand it and agree to comply with it:

_____	_____	_____
Signature Responsible Party	Print Name	Date
_____	_____	_____
Signature Responsible Party	Print Name	Date
_____	_____	_____
Signature Psychotherapist's Name	Print Name	Date

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HIPAA Notice of Privacy Practices Statement

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

All information describing your mental health treatment and related health care services ("mental health information") is personal, and we are committed to protecting the privacy of the personal and mental health information you disclose to us. I am required by law to maintain the confidentiality of information that identifies you and the care you receive. When I disclose information to other persons and companies to perform services for us, I require them to protect your privacy, too. This Notice applies to your counselor, psychotherapist, psychiatrist and other health care professionals who provide care to you. I must also provide certain protections for information related to your medical diagnosis and treatment, including HIV/AIDs, and information about alcohol and other substance abuse. I am required to give you this Notice about our privacy practices, your rights and our legal responsibilities.

I MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION:
For TREATMENT for example, I may give information about your psychological condition to other health care providers to facilitate your treatment, referrals or consultations.

For PAYMENT for example, I may contact your insurer to verify what benefits you are eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.

For APPOINTMENTS AND SERVICES to remind you of an appointment, or tell you about treatment alternatives or health related benefits or services.

WITH YOUR WRITTEN AUTHORIZATION I may use or disclose mental health information for purposes not described in this Notice only with your written authorization.

I MAY USE YOUR MENTAL HEALTH INFORMATION FOR OTHER PURPOSES WITHOUT YOUR WRITTEN AUTHORIZATION

As REQUIRED BY LAW when required or authorized by other laws, such as the reporting of child abuse, elder abuse or dependent adult abuse.

For HEALTH OVERSIGHT ACTIVITIES to governmental, licensing, auditing, and accrediting agencies as authorized or required by law including audits; civil, administrative or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.

In JUDICIAL PROCEEDINGS in response to court/administrative orders, subpoenas, discovery requests or other legal process.

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To PUBLIC HEALTH AUTHORITIES to prevent or control communicable disease, injury or disability, or ensure the safety of drugs and medical devices.

To LAW ENFORCEMENT for example, to assist in an involuntary hospitalization process.

To THE STATE LEGISLATIVE SENATE OR ASSEMBLY RULES COMMITTEES for legislative investigations.

For RESEARCH PURPOSES subject to a special review process and the confidentiality requirements of state and federal law.

To PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY of an individual. I may notify the person, tell someone who could prevent the harm, or tell law enforcement officials.

To PROTECT CERTAIN ELECTIVE OFFICERS including the President, by notifying law enforcement officers of potential harm.

As required by the USA PATRIOT ACT to prevent future acts of terrorism, whereby FBI subpoenas can require access to any requested records, and the subject of the investigation, (i.e., the client) may not be notified.

YOU HAVE THE FOLLOWING RIGHTS:

To Receive a Copy of this Notice when you obtain care.

To Request Restrictions. You have the right to request a restriction or limitation on the mental health information I disclose about you for treatment, payment or health care operations. You must put your request in writing. I am not required to agree with your request. If I do agree with the request, I will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment.

To Inspect and Request a Copy of Your Mental Health Record except in limited circumstances. A fee will be charged to copy your record. You must put your request for a copy of your records in writing. If you are denied access to your mental health record for certain reasons, we will tell you why and what your rights are to challenge that denial.

To Request an Amendment and/or Addendum to your Mental Health Record. If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record) of no longer than 250 words for each inaccuracy. Your request for amendment and/or addendum must be in writing and give a reason for the request. I may deny your request for an amendment if the information was not created by us, is not a part of the information which you would be permitted to inspect and copy, or if the information is already

accurate and complete. Even if I accept your request, I do not delete any information already in your records.

To Receive an Accounting of Certain Disclosures I have made of your mental health information.

You must put your request for an accounting in writing.

To Request That We Contact You By Alternate Means (e.g., fax versus mail) or at alternate locations. Your request must be in writing, and we must honor reasonable requests.

CHANGES TO THIS NOTICE. I reserve the right to change this Notice. I reserve the right to make the revised or changed Notice effective for information I already have about you as well as any information I receive in the future.

CONTACT INFORMATION: If you have any questions about this Notice or believe your privacy rights have been violated, you may contact: The Secretary of the Department of Health and Human Services.

Contact the Office for Civil Rights 1-866-627-7748, 1-800-537-7697 (TTY)
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Filing a complaint will not affect the services you receive from Dr. Takos. By law, Dr. Dimitra Takos is required to follow the terms in this privacy notice. Dr. Takos has the right to change the way your personal health information is used and given out. If Dr. Takos makes any changes to the way your personal health information is used and given out while you are a current client of Dr. Takos, you will get a new notice, directly or by mail, within 60 days of the change.

PLEASE KEEP FOR YOUR RECORDS

South Coast Psychological Services

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I _____, acknowledge that I have received a copy of the California HIPAA Notice Form for South Coast Psychological Services.

_____	_____	_____
Signature of Responsible Party	Print Name	Date

This form will be retained in your medical record.

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South Coast Psychological Services

Parent/Legal Guardian Consent to Treat Minors

I hereby authorize Dr. Dimitra Takos, Licensed Clinical Psychologist PSY 29103, to provide services to my child _____

(Print Minor's Full Name) (Date of Birth)

Provided services include psychological treatment as directed by Dr. Takos. This form is an addendum to the Informed Consent and Services Agreement form, to authorize treatment of your child. In the case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept Dr. Takos' judgment regarding releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the client's wellbeing.

I, the undersigned, am legally authorized to provide consent.

_____

Signature of Parent/Legal Guardian Date

_____

Relationship to Child

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Adolescent Intake Form

Please fill out this biographical background form for your child as completely as possible. It will help me in our work together. Information is confidential as outlined in the Informed Consent Form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please bring it with you to the first session.

DATE: _____ **REFERRAL SOURCE:** _____

NAME: _____
Last First Middle

DATE OF BIRTH: _____ **BIRTHPLACE:** _____**AGE:** _____

ADDRESS: _____

TELEPHONE: H: _____ Cell: _____Work _____
Please mark your preferred contact number

EMAIL: _____
Please do not indicate an email address if you do not wish to be contacted by email

PERSON & TELEPHONE NO. TO CONTACT IN EMERGENCY:

Name: _____ TELEPHONE NO: _____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you.):

_____

_____

_____

_____

_____

Estimate the severity of above problem: Mild ____ Moderate ____Severe ____Very severe ____

CURRENT GRADE: _____ **CURRENT SCHOOL:** _____

ACADEMIC PERFORMANCE: _____

_____

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PARENTS MARITAL STATUS: _____

PERSONS LIVING AT HOME WITH YOU: _____

_____ _____

_____ _____

PARENTS/STEPPARENTS (Name/age or year of death, occupation, personality, brief statement about the relationship with child):

Father: _____

_____

_____

Mother: _____

_____

_____

Step-parents: _____

_____

_____

SIBLINGS (name/age, if deceased: age and cause of death & brief statement about the relationship.):

1. _____
2. _____
3. _____
4. _____
5. _____

FAVORITE ACTIVITIES, SPORTS, EXTRACURRICULAR ACTIVITIES

_____

_____

_____

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BIRTH, EARLY DEVELOPMENT:

Pregnancy (complications) _____

_____

Complications during birth? _____

_____

Milestones (on time/delayed)? _____

_____

Temperament, frustration management? _____

_____

MEDICAL DOCTOR (S) (name/phone): _____

_____

_____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness, etc.):

Current: _____

_____

Past: _____

_____

CURRENT MEDICATION (doses and reasons for taking them):

_____

_____

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: e.g. cancer, epilepsy, etc.):

_____

_____

_____

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FAMILY HISTORY OF PSYCHIATRIC ISSUES

☐ Mood Disorder ☐ Anxiety ☐ Substance Abuse ☐ Psychotic Disorder

☐ Developmental Disorder ☐ Domestic Violence ☐ Physical Abuse ☐ Sexual Abuse

☐ Chaos/Instability ☐ Trauma ☐ Abandonment ☐ Other

Please explain below:

_____

_____

_____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

_____

_____

_____

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (describe: ages, reasons, circumstances, how, etc.)

_____

_____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY: (describe quality, frequency, activities, etc.)

_____

_____

PAST/PRESENT PSYCHOTHERAPY or HOSPITALIZATIONS (specify: month year(s) (beginning—end), estimated no. of sessions, name, degree, reason for therapy, Individual/Couple/Family):

_____

_____

_____

_____

USE OTHER SIDE OF PAGE TO ADD MORE INFORMATION, IF NEEDED.

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Please have your child complete this section. It will help me in our work together. Information is confidential as outlined in the Informed Consent Form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer."

SELF-CARE

Do you have problems with sleep? _____ (if you answer Yes, please explain):

_____

_____

How many hours of sleep do you need per night? _____

How many hours of sleep do you get per night? _____

Do you exercise? _____ (if you answer Yes, please state what you do and how often): _____

_____

Do you eat regular meals throughout the day? _____

Do you drink caffeine? _____

How many hours per day do you spend online? _____

What do you like to do online? _____

_____

SYMPTOMS (Please circle the following that are a problem for you):

☐ anger ☐ anxiety ☐ assertiveness ☐ conflict ☐ depression

☐ difficulty expressing emotions ☐ difficulty managing emotions ☐ mood swings

☐ fear ☐ guilt ☐ panic ☐ shame ☐ irritability

☐ school ☐ self-esteem ☐ social anxiety ☐ loss ☐ racing thoughts

☐ communication difficulties ☐ friends ☐ self-harm ☐ behavior

☐ nightmares ☐ flashbacks ☐ substance use ☐ disturbing thoughts

☐ obsessions ☐ impulses ☐ body image ☐ food ☐ trust

☐ concerns about your sexuality ☐ dating ☐ family ☐ parents

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