CONSENT FOR TREATMENT

Tonya Meeks, LMFT 53591
1106 Second Street #250
Encinitas Ca 92024
415-571-0682

1. **SCHEDULED SESSIONS:** Our time together is 50 minutes for individual sessions and 90 minutes for group sessions. Tele Health Session and will review when in person session resume.

2. **FEE:** We have agreed on a per session fee of $200.00 only for private pay clients. If you cancel without 48 hours notice will be charged this fee. Sessions, when extended upon the agreed time, will be charged accordingly. I will accept Credit On File for Client Billing through Square. Additional fees will be charged to the client in the event of necessary legal work or hospital visits. You are responsible for all fees not covered by insurance. If fees for services are not paid in full, utilization of a collection agency may be necessary. Or you may pay with credit card in office or keep one on file.

3. Credit Card on File for Payment for private pay or cancellation less than 48 hours. Square Charges 3.5 percent and 1.50 per card.

   CC Number: ___________________________________

   Security Code: _________________________

   Exp Date: ______________________________

   Billing Zip Code: ________________________

4. **INSURANCE:** If you have health insurance please contact my billing person Pauline McKnight at 707-436-9393 for authorization and she will review insurance coverage.

5. **CANCELLATION:** The scheduling of an appointment involves the reservation specifically for you. Please inform me of your cancellation at least 48 hours in advance or you will be charged for the session.

6. **TELEPHONE CALLS/EMERGENCY PROCEDURES:** If you need to reach me between visits, please leave a message on my voice mail with your name, day and evening telephone numbers, and the best time to reach you. I will return our call as quickly as possible. There is no fee for the occasional brief telephone call. However, I will need to charge you at the regular rate for frequent conversations or those over 10 minutes, which will be considered, phone sessions. I will let you know when I will be out of town or unavailable and my voice mail message will inform you of how to contact the colleague who is on call for me. In the event of an emergency, contact 911 or go to the nearest hospital.

Read By: _______________________________________ Date: ________________

Client Information

Tonya Meeks, LMFT 53591
1106 Second Street #250
Encinitas Ca 92024
415-571-0682

Client Name: ____Marital Status:______________

Age: ___________Date of Birth: ________________Social Security Number: _________________

Address:____

Home ____________________Cell Phone: ___________________Work: ________________

Name and Ages of Children:____

Name of person to contact in case of emergency:____

Phone: ___________________________Relationship: ____________________________

Serious Illnesses, Accidents, Operation and Allergies: ____________________________________

____

Previous Psychiatric Treatment:____

What brings you here at this time? ____

____

Previous Therapy Experiences: _________no __________yes

Therapist: _______________________________________Amount of time:____________________

Psychiatric Hospitalization: ________no __________yes

Hospital: _______________________________________Amount of time:____________________

Family or Significant Other(s) Psychiatric Hospitalization: ________no ________yes

Hospital: _______________________________________Amount of time:_____________________

Use of Alcohol ________no _________yes

(if yes)Times per: _________day ________week: Type ______Amount________

Use of Drugs: _______no _______yes

(if yes) Times per: _________day ________week: Type ______Amount __________

Eating Disorder: __________no ___________yes

(if yes) Type ___________________For how long _________________

History of Sexual Abuse: ______no ______yes

______ sexual intrusion ______ molestation______ rape ______sexual harassment__________

______other

Gambling: ________no _________yes

(if yes) Type_______________________ for how long________________

Suicidal Tendency: ________no ________yes

(if yes) Explain____

Significant Other Suicidal Tendency: _________no ________yes

(if yes) Explain____

Additional Information: ____

Referred By____

Signature of Client: _______________________________Date: __________________________

Signature of Patient (if minor): _____________________Date: __________________________

CLIENT RIGHTS

Tonya Meeks, LMFT 53591
1106 Second Street#250
Encinitas Ca 92024
415-571-0682

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In The following circumstances, we ma disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For purpose of public health and safety;
- To government agencies for purpose of their audits, investigations, other oversight activities.
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and otherwise required by the law.

Clients Rights. As our client you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request what we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

Read By: ____ Date: ____________________