

Jessica St.Clair, MS MFT
License: MFT 33138

5001 Birch Street, Suite 123, Newport Beach, CA 92660
714-568-1111 office, 741-227-2420, cell
Fax: 714-242-7381, stclair5681111@gmail.com

Dear New Client(s),

Welcome! To begin our work together, I request that you complete, read, and sign the attached forms as appropriate and bring them to our first meeting. Filling them out before our meeting will insure that the time we spend will get to the heart of your needs more directly. I am happy to discuss any questions you have about the forms at our meeting.

The forms needing your attention are as follows:

- The *Office Policies & Informed Consent* is required by law when we begin our professional relationship.
- The *Consent Agreement for Treatment of a Minor* is required when I am treating a child who is 17 years of age or younger. If there has been a divorce and custody has been awarded, please provide a copy of the custody order. I need signatures of both custodial parents on this form.
- The *Client Billing Information form* provides the information needed to bill and obtain payment from you and your insurance company. I need each person who will be participating in treatment (or the parent of that person) to fill out this form. If your insurance changes at any time during your treatment, I request that you complete a new *Client Billing Information Form*.
- The *Treatment, Payment, and Health Care Operations (TPO) Consent* form is standard for any health care provider and is required by HIPPA law. It also has a place for you to acknowledge receiving the HIPPA Leaflet (below).
- The *HIPPA Leaflet* (separate download document) is yours to have as future reference of your privacy rights.

All information is strictly confidential and is filed in a locked file cabinet.

Thank you and welcome,

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OFFICE POLICIES & INFORMED CONSENT AGREEMENT FOR PSYCHOTHERAPY SERVICES

This form provides you with information that is in addition to that detailed in the Notice of Privacy Practices.

CONFIDENTIALITY: All information disclosed within 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 were described to you in the *Notice of Privacy Practices* leaflet that you received with this form.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; and where a client presents a danger to others (See also *Notice of Privacy Practices*).

When Disclosure May Be Required: Disclosure may be allowed when a client presents a danger to self, to property, or is gravely disabled. Disclosure may be required pursuant to a legal proceeding. 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 from me. In couple/family therapy, or when different family members are seen individually, confidentiality may not apply. I will use my clinical judgment to support the disclosure of such information. I will not release records to any outside party unless I am authorized to do so by **all** adult family members who were part of the treatment.

Emergencies: If there is an emergency where I become concerned about your personal safety, I will do whatever I can within the limits of the law, to prevent you from injuring yourself and to ensure that you receive the proper medical care. For this purpose, I may contact the emergency person whose name you have provided on the *Client Information Sheet*, or other such documentation.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier/HMO/EAP in order to process the claims. Only the minimum necessary information will be communicated to the carrier. You must be aware that submitting an invoice for reimbursement can entail some risk to confidentiality, privacy, or future eligibility to obtain health or life insurance. Mental health information is entered into insurance companies' computers and soon will be reported to the congress-approved National Medical Data Bank. Computers are vulnerable to break-ins and unauthorized access; therefore, you could be in a vulnerable position.

Confidentiality of E-mail, Cell Phone and Faxes Communication: It is very important to be aware that e-mail and cell phone communication can be accessed by unauthorized people; hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to unauthorized access. Faxes can easily be sent erroneously to the wrong address. Please notify me at the beginning of treatment if you decide to avoid or limit the use of the above-mentioned communication devices. Please **DO NOT** use e-mail or faxes for emergencies.

Consultation: I consult regularly with other professionals regarding my clients; however, names or other identifying information are never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

* **Considering all of the above exclusions, if it is still appropriate, upon your request I will release information to any agency/person you specify unless I conclude that releasing such information might be harmful in any way.**

TELEPHONE POLICY & EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave a message on my voice mail and your call will be returned as soon as possible. I check my messages a few times a day, unless I am out of town. At times, phone support between sessions may be honored. However, those calls will be billed accordingly: at one-half the client's rate after 15 minutes and at the full rate after 30 minutes. If an emergency arises, please indicate it clearly in your message. If you need to talk to someone right away, please call the Police (911).

PAYMENTS: Fees are agreed upon by therapist and client by the first session. Clients are expected to pay at the end of the first session and at the beginning of subsequent sessions unless agreed otherwise. Individual sessions are 45-50 minutes long; double-sessions are 1½ hours in length. Telephone conversations, report writing, consultation with other professionals, releases, longer sessions, travel time, etc. will be charged at the same rate, unless other arrangements are made. **All bounced checks will incur an extra charge of \$20.00.** Please notify me if any problem arises regarding your ability to make timely payments.

INSURANCE REIMBURSEMENT: Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, I will provide you with a receipt on a monthly basis, which you can then submit to your insurance company for reimbursement. Not all issues which are the focus of psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. As indicated above in *Health Insurance & Confidentiality of Records*, you must be aware that submitting a mental health invoice for reimbursement carries some risk.

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THE PROCESS OF THERAPY/EVALUATION: Participating in therapy can result in numerous benefits, including improving interpersonal relationships and resolving the concerns that led you to seek therapy. Working toward these benefits, however, requires active involvement, honesty, and openness on your part. Moreover, while therapy is effective for many people and often leads to significant and lasting changes, there are some risks involved. Many people report discomfort during therapy, since strong and sometimes undesirable feelings can emerge as one considers unpleasant or embarrassing subjects. I may challenge some of your assumptions, or, propose different ways of handling situations that may trigger upset for you. Attempting to resolve tensions between yourself and others (such as a partner, child or family member) may lead to changes that were not originally intended. Moreover, a decision that is positive for one person can be viewed quite negatively by another. Change can be easy and swift; but more often it can be slow, and even frustrating. For some people, problems may get worse before they get better. It is also possible that therapy does not work. Even so, many people find that therapy is worth the difficulty it may entail.

Discussion of Treatment: Within a reasonable time after initiating treatment, I will discuss with you (client) my understanding of the therapeutic issues and objectives, and my view of the possible modalities and outcomes of treatment. During the course of therapy, I am likely to draw on various psychological approaches that include, but may not be limited to behavioral, cognitive-behavioral, transpersonal, psychodynamic, existential, system/family, developmental (adult, child, family), or psycho-educational. If you have any questions about any of the procedures used in the course of your therapy, please ask and you will be answered fully. You also have the right to ask about other treatments and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining that treatment.

Termination: After the first couple of meetings, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals that you can contact. In addition, if I assess that I am not effective in helping you reach the therapeutic goals, I am obliged to discuss it with you, and, if appropriate, to terminate treatment. Likewise, I would give you a number of referrals that may be of help to you. If at any time you want another professional's opinion, I will assist you in finding someone qualified; and, with your written consent, I will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, I will provide you with names of other qualified professionals whose services you might prefer.

Dual Relationships: Not all dual relationships are unethical or avoidable. However, therapy never involves sexual or any other dual relationship that impairs the therapist's objectivity, clinical judgment, or therapeutic effectiveness or can be exploitative in nature. I will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. Out in the community I will never acknowledge working therapeutically with anyone without your written permission. Many clients choose me as their therapist because they know me through group situations or a referral. Some clients know each other. Consequently, you may bump into someone you know in the waiting room. Also, while dual relationships can enhance therapeutic effectiveness, they can also detract from it; and, often it is impossible to know that ahead of time. It is your, the client's, responsibility to communicate to me if the dual relationship becomes uncomfortable for you. I will always listen carefully and respond accordingly to your feedback. I will discontinue the dual relationship if I find it interfering with the effectiveness of the therapeutic process or your welfare; and, of course, you can do the same at any time.

CANCELLATION: You are responsible for remembering the date, location, and time of appointments. While we try to send out reminders, we cannot always honor that courtesy. Since 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.

I have read the above Office Policies and Informed Consent Agreement carefully. I understand them and agree to comply with them.

| | | |
|---------------------|------|-----------|
| Client name (print) | Date | Signature |
|---------------------|------|-----------|

| | | |
|---------------------|------|-----------|
| Client name (print) | Date | Signature |
|---------------------|------|-----------|

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| | | |
|--|------|-----------|
| | Date | Signature |
|--|------|-----------|

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CONSENT AGREEMENT FOR TREATMENT OF A MINOR

CONSENT FOR TREATMENT OF MINOR for (please print minor's name): _____

1. It is understood that Jessica St.Clair, MS, MFT is a Marriage & Family Therapist properly licensed by the California Board of Behavioral Science Examiners (License # MFC 33138).

2. Therapy sessions with a minor child are confidential according to the laws of the State of California. All legal and ethical standards concerning confidentiality will be maintained by my therapist with the exceptions as outlined in # 3-5 below.

3. If there is reasonable suspicion of child abuse, neglect, or endangerment, the therapist is legally mandated to notify the appropriate authorities. If in the therapist's best clinical judgment it is decided that the client presents a clear danger to others, confidentiality will be breached.

4. Should it be decided in the therapist's best clinical judgment that there is suicidal intent, other self-endangering behaviors, or a danger to property, confidentiality may be breached.

5. Other than these legally required exceptions, the therapist will not release any information about my child or me to any person or agency without my written permission.

6. While therapy is effective for many people and often leads to significant and lasting changes, there are some risks involved. Many people report discomfort during therapy. Strong and sometimes undesirable feelings can emerge as one considers unpleasant or embarrassing subjects. Attempting to resolve tensions between you and others, such as a spouse, partner, child, or family member may lead to changes that were not originally intended. It is also possible that therapy may not work. And, for a small number of people, problems may get worse. Even so, many people find that therapy is worth the difficulty it may entail.

7. Individual sessions are 45-50 minutes in duration. Family sessions are also 45-50 minutes, but may be scheduled as needed for 1½ hours -- or a double session.

8. I am responsible for remembering the date, location, and time of appointments. Reminders are not sent out. If I find that I need to reschedule, I will give at least 24 hours notice. Missed appointments with less than 24 hours notice will be charged at the client's regular rate. Sessions conducted over the phone will be charged at the client's regular rate. Occasional phone support between sessions will be honored. However, phone calls will be billed accordingly: at one half the client's rate after 15 minutes and at the full rate after 30 minutes.

9. Fees are due and payable at the end of the first session and at the beginning of each session thereafter. The fee is agreed upon between my therapist and me by the end of the first session. It may be adjusted for changes in circumstances.

10. Phone messages may be left on my therapist's voice mail at 714 227-2420. My therapist will make reasonable attempts to return phone calls. However, I understand that in the case of an emergency and inability to reach my therapist, I can always call 911; furthermore, I accept that responsibility.

I understand all of the above and agree to enter into a counseling relationship with Jessica St.Clair, MA, MFT.

Parent / Guardian Signature: _____ **Date:** _____

Client Signature: _____ **Date:** _____

CONSENT TO TREAT A MINOR:

I am the legal guardian of the minor child (please print child's name): _____

By signing I am giving my consent for treatment of the above named minor child. (Both parents must sign in the case of joint custody.)

Parent of Guardian Name (please print): _____

Parent or Guardian Signature: _____

Parent of Guardian Name (please print): _____

Parent or Guardian Signature: _____

CLIENT BILLING INFORMATION FORM

Patient Info:

Patient Name: _____ Date of Birth: _____
Patient's I.D. Number: _____ SSN #: _____
Relationship to Insured: _____
Address: _____ Marital Status: _____
Home Phone #: _____ OK to call? Y N Cell Phone #: _____
Work Phone #: _____ OK to call? Y N
E-Mail: _____
Employer: _____ Occupation: _____

Insured Info (If different from patient info):

Name: _____ Date of Birth: _____
Insured's I.D. Number: _____ SSN #: _____
Address: _____
Phone #: _____ Other Phone #: _____
E-Mail: _____
Employer: _____ Occupation: _____

Insurance Info:

Insurance Company: _____ Insurance Type (HMO, PPO): _____

Authorization # (if applicable): _____

- Please bring your insurance card with you to the first appointment. Please call your insurance company to obtain any required authorizations.
- We will bill your insurance company according to the information provided by you. If the fees are not paid, we will then turn to you for payment and you may work with your insurance company directly for reimbursement.
- I Authorize Jessica St. Clair MFT to bill my insurance for services rendered and to accept reimbursement from my insurance company. I agree to pay any co-pays and amounts charged to satisfy my deductible.

Signature of Patient/Parent/Guardian: _____ **Date:** _____

Credit Card Payment Information:

For credit card payments we use PayPal, an easy and convenient online payment service. If you prefer to pay with credit, we will send invoices to your email address. Please note: all credit card payments have a 4% convenience fee added to the total amount.

We appreciate payment for services within 30 days. If we do not receive payment with cash or check for any outstanding balance more than 30 days old, we will automatically bill you using PayPal.

CLIENT INFORMATION AND HISTORY FORM

Please state your reason for seeking counseling:

Please check any areas where you are experiencing challenges:

| | | | | | |
|-------------------------------|-----|--|-----|------------------------------------|-----|
| Grief, death, illness | ___ | Financial stressors | ___ | Legal issues | ___ |
| Work, profession | ___ | Family stressors | ___ | Health, sleep, physical challenges | ___ |
| School | ___ | Change in residence | ___ | Other loss: _____ | ___ |
| Relationships | ___ | Loss / promotion of a job | ___ | Other big change: _____ | ___ |
| Marriage, separation, divorce | ___ | Pregnancy, miscarriage birth, abortion | ___ | Other _____ | ___ |

Have you experienced any of the following in the past year?

| | | | | | |
|--------------------|-----|-------------------------|-----|--------------------------------------|-----|
| Fatigue | ___ | Mood swings | ___ | Isolation / loneliness | ___ |
| Intrusive thoughts | ___ | Decreased concentration | ___ | Loss of interest in daily activities | ___ |
| Panic / anxiety | ___ | Memory loss | ___ | Feelings of guilt, worthlessness | ___ |
| Depression | ___ | Weight gain / loss | ___ | Other: _____ | ___ |
| Physical violence | ___ | Sleep disturbances | ___ | Other _____ | ___ |

What role (if any) does spirituality or religion play in your life? _____

How will you know when you overcome your challenges? What will be different? _____

Relationships:

Relationship / Marital History (Give names, Ages & Duration): _____

Children (Give names & DOB): _____

Family of Origin (Give names & DOB): _____

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Support Systems:

Coping Skills / Self Care: _____

Education / Degrees: _____

Friendships: _____

Work / Hobbies / Interests: _____

Medical & Mental Health History:

Medical History: _____

Current MD: _____ Date of Last Visit: _____

Current Psychiatrist: _____ Date of Last Visit: _____

Current Medications & Dosages: _____

Previous Counselor: _____ Date of Last Visit: _____

Previous counseling for: _____

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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Client Name(s) (print): _____

Federal regulations (HIPAA) allow me as your service-provider to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The *Notice of Privacy Practices* leaflet describes these disclosures in more detail. You have the right to review the *Notice of Privacy Practices* before signing this consent.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken regarding the PHI prior to the date of revocation.

This consent is voluntary; you may refuse to sign it. However, I reserve the right to deny treatment if this consent is not granted, or if the consent is later revoked.

I (client) hereby consent to the use or disclosure of my Protected Health Information as specified above.

Signature of Client/Parent/Guardian: _____ Date: _____

Signature of Client/Parent/Guardian: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this section, you (the client) acknowledge receipt of the *Notice of Privacy Practices* leaflet that I have given to you. The *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information (PHI). I encourage you to read it in full. If you have any questions about the *Notice*, please contact me.

A current copy of *Notice* may be obtained by contacting me at:

5001 Birch St., Newport Beach, CA 92660, 714-568-1111 (office) or 714-227-2420 (cell).

I (client) acknowledge receipt of the *Notice of Privacy Practices* of Jessica St.Clair, MA, MFT.

Signature of Client/Parent/Guardian: _____ Date: _____

Signature of Client/Parent/Guardian: _____ Date: _____

Office use only

Good faith effort to obtain consent (describe)

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I (name of client) _____ hereby authorize **Jessica St.Clair, MS, MFT**

("Provider") to consult with or disclose to _____ ("Recipient": name, function,
and address of the person or entity to whom disclosure is to be made) the following protected health
information:

- | | | |
|--|----------------------------------|------------------------------------|
| _____ Entire File | _____ Symptoms | _____ Prognosis |
| _____ Dates of Treatment | _____ Psychotherapy Notes | _____ Clinical Test Results |
| _____ Session Start/Stop Times | _____ Treatment Plan | _____ Other _____ |
| _____ Diagnosis | _____ Progress to Date | |
| _____ Modalities & Frequencies of Treatment Furnished | | |

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it 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: **5001 Birch St., Office, Newport Beach, CA 92660** to be effective.

I authorize the disclosure of the health information described above for the following purpose:

- | | |
|--|--|
| _____ Provider Tx Planning and/or Tx | _____ Recipient Tx Planning and/or Tx |
| _____ To coordinate Tx between Provider & Recipient | _____ Other _____ |

The specific uses and limitations on the uses of my health information by Recipient are as follows:

- | | |
|---|--|
| _____ Minimum disclosure to facilitate Tx Planning and/or Tx | _____ Other _____ |
| _____ Minimum disclosure to coordinate Tx | _____ Minimum disclosure to: _____ |

I understand that Provider cannot condition treatment upon me signing this authorization. I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re-disclosure of such information may be protected by applicable California law. Provider is authorized to disclose the protected health information specifically listed above until:

Authorization Expiration Date
(typically a year from the current date).

Signed By: _____ **Date:** _____ *If signed by other than Patient,
please indicate the relationship of Representative to the Patient:
