Ava Shokoufi, Intern MFT #82721
280 E. Thousand Oaks Blvd. Thousand Oaks, CA 91360
Supervisor: Johanna Jones, LMFT # 48902

Client Intake Form- Adult

Please provide the following information below and bring the form to your first session. All information will be held confidential in your client file.

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

Insurance Company: _____ Group #: _____

Policy#: _____ Phone: _____

Social Security Number: _____

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Marital Status: ____Never Married ____Domestic Partnership ____Married ____Separated ____Divorced ____Widowed

Occupation: _____ Education Level: _____

Partner/Spouse Name:_____ Age:_____ Occupation:_____

Please list any children/age:_____

_____

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:_____
Name Relation Phone

Referred source: _____ How did you find out about us: _____

Have you previously received any type of mental health services like psychotherapy or psychiatric services? ____Yes ____No

If you are currently under the care of a psychiatrist, please give psychiatrist's name and phone number:

_____

Are you currently taking any prescription medication? ____Yes ____No

Please list and provide medication dosage & frequency:_____

Have you ever been prescribed psychiatric medication? ____Yes ____No

Please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?

___Poor ___ Unsatisfactory ___Satisfactory ___Good ___Very good ___Excellent

2. Do you have any significant physical problems? ____Yes _____No If yes, please explain:

If yes, please explain:_____

_____

3. How would you rate your current sleeping habits?

____Poor ___ Unsatisfactory ___Satisfactory ___Good ___Very good ___Excellent

Please list any specific sleep problems you are currently experiencing:

_____

4. How many times per week do you generally exercise? _____

What types of exercise to you participate in _____

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

_____

6. Are you currently experiencing overwhelming sadness, grief or depression? ___Yes ___No

If yes, for approximately how long? _____

7. Are you currently experiencing anxiety, panic attacks or have any phobias? ___Yes ___No

If yes, when did you begin experiencing this? _____

8. Are you currently experiencing any chronic pain? ___Yes ___No

If yes, please describe :

_____

9. Do you drink alcohol more than once a week? ____Yes ____No

10. How often do you engage recreational drug use? ___Daily ___Weekly ___Monthly
___ Infrequently ___Never

11. Have you, any of your family members or significant other attempted suicide? ____Yes ____No

If yes, please explain:_____

12. 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.).

List Family Member: _____

yes/no Alcohol/Substance Abuse yes/no Anxiety yes/no Depression

yes/no Domestic Violence yes/no Obsessive Compulsive Behavior

yes/no Schizophrenia yes/no Obesity yes/no Eating Disorders

ADDITIONAL INFORMATION:

1. Are you currently employed? ____Yes ____No

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

2. Do you consider yourself to be spiritual or religious? ____Yes ____No

If yes, describe your faith or belief:

_____

3. Are you currently in a romantic relationship? ____Yes ____No

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

4. Do you have any sibling? Please list with age: _____

_____

5. Who you turn to for support in your family?

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

6. What do you consider to be some of your strengths?

_____

_____

7. What do you consider to be some of your weakness?

_____

_____

8. What has brought you to therapy and what goals you would like to accomplish in therapy?

_____

_____

_____

I have received and understand the office policies, informed consent, confidentiality, no secret policy, and HIPPA, regulation in a verbal and written format. Please sign below and initial each previous page to verify that this is your information:

Client Signature:_____ Date:_____

Ava Shokoufi, MFTI # 82721
280 E. Thousand Oaks Blvd. Thousand Oaks, CA 91360
Supervisor: Johanna Jones, LMFT # 48902

Informed Consent for Psychotherapy

New Client

Welcome! Thank you for choosing me as your psychotherapist. This document contains important information about my professional services and office policies. Please read it carefully and I will be glad to answer any questions you may have regarding any of these policies in our next meeting.

About Therapy

Psychotherapy is a process of healing, growth, and change. I am committed to providing a safe emotional presence that allows you to explore issues and relationships from the past and present in order to gain insight and continue to grow and thrive. It is a journey we will travel together that will lead to many personal benefits including but not limited to: improved interpersonal relationships and deeper self awareness; reduced stress and anxiety; decrease in negative thoughts and self-sabotaging behaviors; increased self-confidence and self acceptance; a better communication with loved ones; increased capacity for intimacy; increased comfort in social, work, and family settings; greater ability to experience life more fully; and have more balance in life. Therapy works best when you are an active partner in the process and willing to change as needed.

Participating in therapy may include discussing difficult feelings and experiences and may result in uncomfortable and unanticipated strong emotions, like anger, sadness, and fear. It is important to recognize that it is not uncommon to feel worse initially before you begin to feel better. Process of growth and change may be easy and quick sometimes, while frustrating or slow at other times. Please be aware that all choices about your personal life and relationships are your responsibility.

Confidentiality:

Psychotherapy is a safe place for you to talk and explore your personal life and issues. Everything you share with me will be kept completely confidential, except:
a) You may sign a Release of Information so that I may speak with other healthcare professionals who provide you treatment or to family members.
b) You tell me something that I am legally required to report to others like suspected child, elder, or dependent adult abuse, or when a client poses a threat to self or others.
c) Sometimes I will seek consultation with other experienced therapists to be able to better help my clients. These consultants follow the same laws of confidentiality.

Fees: My fee is $100-$160.00 for a 50 minute office session payable at the beginning of each session by check, cash, or credit card, unless other arrangements have been made. There is no charge for brief phone calls (up to five minutes), but longer phone sessions with you or with any professionals or others you ask me to speak with on your behalf are subject to a charge based on the length of the call.

Cancellations: Your session time is specifically reserved for you, therefore, if you need to cancel an appointment, please let me know at least 24 hours in advance. Otherwise, I will have to charge you for the missed session, unless it is an emergency.

Telephone and Emergency Procedures: If you need to contact me between sessions, please leave a message on my voicemail and I will return your call within a 24 hour period. In case of an emergency, call 911 for immediate attention.

Completion of Therapy:
The length of therapy depends on your specifics situation and needs and the progress of the treatment. If you approach your goals, we will discuss a plan to end therapy in a smooth transition. If during therapy you feel that you are not satisfied with the process; or it becomes clear to me that you are not benefitting from our work together, I will stop treating you. In this case, I will provide you with referrals to other sources for therapy. You may discontinue therapy at any time, but I recommend to meet for at least one final visit to have the opportunity to reflect and review what we've done.

Questions/Concerns:
I encourage you to bring up any questions you may have about my policies, my practice, or psychotherapy in general, to my attention.

I/we have read, understand and agree to the information and policies described in the Informed Consent Form.

_____
Print Name

_____ _____
Signature Date

_____
Print Name

_____ _____
Signature Date

Ava Shokoufi, MFTI # 82721
280 E. Thousand Oaks Blvd. Thousand Oaks, CA 91360
Supervisor: Johanna Jones, LMFT # 48902

Credit/Debit Card Use Consent and Agreements

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request. I understand this form is valid for two years unless I cancel the authorization in writing.

I _____, authorize Ava Shokoufi, MFTI to use my debit/credit card information to charge my debit/credit card in the event that:

___I do not cancel my appointment at least 24 hours in advance

___A check is returned for any reason (additional $35 fee for returned checks)

___There is an outstanding balance including denial of insurance benefits/claims, deductibles not met or inaccurate co-pay amounts.

___I am electing to use this card for co-pay fees

Type of Card: ___VISA ___MasterCard ___American Express ___Discover

Name as Printed on Card: _____

Card Number: _____

Verification/ Security Code:_____ Exp. Date:_____/_____

Address of Cardholder:

_____

Client Signature _____ Date_____

Ava Shokoufi MFTI #82721 – (805) 372-1972
280 E. Thousand Oaks Blvd. Thousand Oaks, CA 91360
Supervisor: Johanna Jones, LMFT # 48902

NOTICE OF PRIVACY PRACTICES (HIPPA)

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:

a. 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.
b. 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.
c. For health oversight activities, including audits and investigations.
d. 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.
e. For law enforcement purposes, including reporting crimes occurring on my premises.
f. To coroners or medical examiners, when such individuals are performing duties authorized by law.
g. 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.
h. 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.

i. 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.

j. 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 : You have the following rights:

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.