Ava Shokoufi, Intern MFT #82721
Supervisor: Johanna Jones, LMFT # 48902

Client Intake Form - Child/Adolescent

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 of Child/ Adolescent: _____
(Last) (First) (Middle Initial)

Insurance Company: _____ Group #: _____

Policy#: _____ Phone: _____

Social Security Number: _____

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

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: _____

Parent/Guardian 1:

Name:_____ Birth Date: _____ /_____ /_____ Age:_____

Relationship to child: _____ Biological Parent _____ Step Parent _____ Adoptive/Foster Parent

_____ Relative _____ Other, Please list _____

Address:_____ Phone:_____

Parent/Guardian 2:

Name:_____ Birth Date: _____ /_____ /_____ Age:_____

Relationship to child: _____ Biological Parent _____ Step Parent _____ Adoptive/Foster Parent

_____ Relative _____ Other, Please list _____

Address:_____ Phone:_____

Marital status of parents: ____ Married ____ Domestic Partnership ____ Separated ____ Divorced

____ Deceased ____ Live in

Custody Status? _____

Living Arrangements: Is there currently a custody dispute? _____ Yes _____ No _____ Possibly

Are there weekend visitations with a non-custodial parent? _____ Yes _____ No

Has your child recently moved? _____ Yes _____ No Number of moves in child's life _____

Who makes the decisions regarding the household money, discipline, and routine?

_____

What is your major form of discipline? (Example: grounding, spanking, taking away TV, etc.)

_____

Who is the major disciplinarian? _____

Please list brothers and sister with age: (specify if they are step-brothers or step-sister)

_____

_____

Are there any current concerns regarding siblings? Please list :

_____

Others living at home:_____

Has the child ever been exposed to domestic violence? _____ Yes _____ No

Traumas or Losses (please indicate the loss or trauma and the age of the child at time of loss of trauma)

_____

Has the child previously received any type of mental health services like psychotherapy or psychiatric services? _____ Yes _____ No

If the child is currently under the care of a psychiatrist, please give psychiatrist's name and phone

number: _____

Is your child currently taking any prescription medication? _____ Yes _____ No

Please list and provide medication dosage & frequency: _____

Has your child ever been prescribed psychiatric medication? _____ Yes _____ No

Please list and provide dates: _____

Has your child ever been hospitalized? If so please explain.

_____

Present Problem (s) for Caregiver/Parent: Please circle stressors you have had in recent months

____ Marital Issues ____ Health Issues ____ Job Issues ____ Financial Issues

____ Parent/Child Issues ____Issues in the Past Other: _____

Child's Presenting Problem(s) Please circle all that apply:

____ Sexual Abuse	____ Physical Abuse	____ Neglect	____ Health Issues
____ Nightmares	____ Sleeping Problems	____ Change in Appetite	____ Concentration
____ Anxiety	____ Shyness	____ Withdrawn	____ Academic Problems
____ Peer Conflict	____ Fearful	____ Crying	____ Suicidal Thoughts
____ Bed Wetting	____ Clinging behavior	____ Impulsivity	____ Temper Outbursts
____ Lying	____ Drug use	____ Alcohol use	____ Legal Trouble
____ Strange Thoughts	____ Stubborn	____ Overactive	____ Delinquent Behavior
____ Harming Self	____ Head banging	____ Skipping School	____ Running Away
____ Sexual problems	____ Sexually Acting Out	____ Missing School	____ Stealing

Other problems and/or concerns: _____

_____

How long have these problems been occurring (number of weeks, months, or years)

_____

Current Family Situation List the Occupants in the Home (even if temporary)

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your child's current physical health?

____ Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very good ___ Excellent

Does your child have any significant physical problems? ____ Yes _____ No

If yes, please explain:_____

_____

2. How would you rate your child's current sleeping habits?

____ Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very good ___ Excellent

Please list any specific sleep problems he/she is currently experiencing:

_____

3. How many times per week does your child generally exercise? _____

What types of exercise does he/she participate in _____

4. Please list any difficulties your child experiences with appetite or eating patterns

_____

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 (parent, grandparent, aunt, uncle, etc.).

List Family Member: _____

___ Y ___ N Alcohol/Substance Abuse ___ Y ___ N Anxiety ___ Y ___ N Depression

___ Y ___ N Domestic Violence ___ Y ___ N Obesity ___ Y ___ N Suicide

___ Y ___ N Obsessive Compulsive Behavior ___ Y ___ N Schizophrenia

Developmental History Prenatal: Please list any problems or complications during pregnancy or delivery

_____

Developmental Milestones (Referring to age when the child walked, talked, potty trained, etc.)

_____

_____

Educational History:

Name of child's school _____ Grade _____

Teacher's name (s)_____ Average Grades_____

Concerns regarding school academics or behavior

_____

_____

Have there been any significant changes or problems in school behavior or grades?

_____

_____

Child's best subject _____ Child's most challenging subject _____

Please check the following according to your child: Learning disabilities ___ Yes ___ No

If yes, please explain: _____

Gifted program ___ Yes ___ No ADD ___ Yes ___ No ADHD ___ Yes ___ No

Participation in extracurricular activities? ___ Yes ___ No If yes, please explain. _____

_____

Social History:

In school how many friends does your child have: _____ Many _____A Few _____None

How much time does your child spend with other children outside of school during the week?

0-1 day _____ 2-3 days_____ 4-5 days_____ more than 5 days_____

Please list child's special interests, hobbies, skills.

_____

_____

With whom does your child spend most of his/her time with?

_____

How does your child get along with: Peers, Adults, Teachers, Parents, and Others your family is connected with including any groups, churches, or religious organizations? _____

_____

Has your child ever had difficulty with the police? ___ Yes ___ No

If yes, please explain. _____

_____

Has your child ever been on probation? ___ Yes ___ No

Is your child employed? ___ Yes ___ No

Additional comments, questions, or concerns:

_____

Who does your child turn to for support in your family?

_____

_____

What has brought you to therapy at this time and what goals would you 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 name:_____

Parent name:_____ Signature:_____

Phone # :_____ Date:_____

Parent name:_____ Signature:_____

Phone # :_____ Date:_____

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

Informed Consent for Psychotherapy - Minors

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.

Minors:

Minor seeking therapy services should know that parents may have access to treatment records by law. This is important that parents and minors come to an agreement about what information teen would prefer to keep private. Although, it is necessary for children and teens to develop sense of independency, autonomy and freedom to discuses personal matters; if I ever believe that your child is in serious risk of harming self or others I will inform you. your child may relives sensitive information regard sexual contact, alcohol and drug use or other potentially problematic behavior in the session. It could be within the normal range of adolescent experimentation, but in other times they may need parental involvement. In this case, I encourage you to carefully and directly discuses your feelings and opinion about the acceptable behavior.

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 45-50 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- Child

_____ _____
Signature Date

_____
Print Name- Parent

_____ _____
Signature Date

_____
Print Name- Parent

_____ _____
Signature Date

Ava Shokoufi, MFTI # 82721
280 E. Thousand Oaks Blvd. Thousand Oaks, CA 91360
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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