Anna B. Alcalá, M.S.
Marriage and Family Therapist
CA License # LMFT 84636
(805) 628-2204

PROFESSIONAL POLICY

Welcome clients!

I would like to clearly communicate to you my policies about my psychotherapy practice. Your and/or your family member's participation in psychotherapy can result in many benefits to you. These may include a better understanding of your personal goals, values, thoughts, and feelings, as well as improved relationships, changed behavior, and resolution of the specific concerns that bring you here. This all requires effort on your part, which may also involve emotional discomfort. Change occurs differently and uniquely for each person and is often slow and sometimes frustrating. To assist you I use many techniques as part of my practice including talk therapy, visualization exercises, play, art, music, and other standard psychotherapeutic methods. I welcome any questions you may have about the therapy process and practices, so please feel free to discuss these and any other questions with me.

IMPORTANT INFORMATION

Private Practice:
I am an independent/sole proprietor, which means I am in business for myself not engaged in a partnership, joint venture, professional corporation, or any other form of business organization with any other practitioners.

Office Hours:
I provide in-person appointments on Monday thru Friday in the evenings and Saturdays. My policy is to return phone calls within 24 hours. If I cannot be reached, nor do I respond, and you feel you are having a life-threatening emergency please go to the nearest emergency room or call 911.

Therapy Time and Standard Fee:
1. Sessions are generally 50-60 minutes in length.
2. IF YOU NEED TO CANCEL AN APPOINTMENT, please remember **I require 24-hour notice,** otherwise **there will be a charge for your missed session** (charged to you, not your insurance company). **You will be charged my standard fee of $175** or the *contracted rate* (NOT your co-pay of your insurance) whichever applies_____ (initial here). You can leave a message on my voice mail 24 hours a day, 7 days a week.
3. **If you are late**, we will meet for the remainder of your scheduled session. If you are more than 15 minutes late and I have not heard from you, I will assume you are not coming and may leave the office.
4. Telehealth and telephonic sessions are provided, when appropriate, and billed in accordance with service provided.

PHI USE AND DISCLOSURE POLICY

1. Your client record or PHI (Personal Health Information) is confidential. Client information can only be released pursuant to a signed release, a court order, or if one of the exceptions to confidentiality discussed below applies. If you are in individual therapy and are an adult, I will generally not release any PHI except pursuant to your written authorization, a subpoena, a court order, or one of the exceptions to confidentiality discussed below. If you are in conjoint therapy, then I will not release information about any participant in therapy without the written consent of <u>all</u> the participants, unless one of the exceptions to confidentiality set out below applies.

   If a minor child is my client, generally I will require the signature of the parent or parents who have legal custody of the child. Depending on the child's age, I may also obtain a release from the child. If a minor's counsel has been appointed for the child, then under California Family Code §3151, only the minor's counsel can release the child's privilege. Under California Health and Safety Code §123115, I may withhold information or records if I determine producing them would have a detrimental effect on my relationship with the child or would have a detrimental effect on the child's physical safety or psychological wellbeing. In such a circumstance, I will use my clinical judgment to protect your child's therapeutic interests.

2. If you have insurance which is being billed for our professional services, some information regarding you may be requested by the carrier. The amount of information varies depending upon the kind of plan you have. (HMOs for example often want periodic written reports and will contact the providers directly.) Insurance plans may make use of and/or require electronic communications by fax or computer. While I will make every reasonable effort to protect your privacy, I have no control of, and am not responsible for, any problems which occur once the information has left my practice. If you have any questions about this or your insurance plan, please contact me to discuss it.

3. In most instances, I use an electronic device to store most clinical files. This device is protected by encryption software and several levels of passcodes and has a regular backup procedure. I do not allow third parties to have access to this computer. In addition, I maintain some patient files in locked storage cabinets.

4. I am legally required to protect the privacy of your PHI. This includes information that can be used to identify you that I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment for this healthcare. I am required to provide you with this notice about my privacy practices which explains how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, and analyze such information within my practice. A disclosure of PHI happens when it is released, transferred, is given to, or is otherwise divulged to a third party who is outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is reasonably necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this notice.

5. I reserve the right to change the terms of this notice and my privacy policies at any time and any such changes will apply to PHI which is on file with me already. If I change this notice, I will post a new one on my website. You can request a copy of this notice from me or obtain it from the website.

6. I keep treatment notes in client files. These are generally not disclosed directly to clients to protect their best interests and the integrity of the psychotherapeutic relationship which is intended to provide a safe-holding environment. A summary can be provided, or with client authorization these can be shared with a qualified medical or psychological professional deemed by the client and/or legal representative.

6A. USES AND DISCLOSURES RELATING TO TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Uses and disclosures relating to treatment, payment, or healthcare operations do not require your prior written consent. I can use and disclose your PHI without your consent for the following reasons:

1) **For treatment**. I can disclose your PHI to licensed health care providers who provide you with healthcare services or are involved in your care. For example, if you are being treated by a psychiatrist, I can disclose your PHI to your psychiatrist to coordinate your care. However, I would not be able to disclose your PHI to a healthcare provider who is not involved in providing care to you.
2) **To obtain payment for treatment**. I can use and disclose your PHI to bill and collect payment for treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to either get paid for the health care services or have you reimburse for health care services that I have provided to you. I may also provide your PHI to my business associates such as billing companies or others that help process my claims for care provided to you.
3) **For health care operations.** I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of another health care professional who provided services to you in our office. I may also provide your PHI to our accountants, attorneys, or consultants to make sure that I am complying with the laws that are applicable.
4) **Other disclosures**. I may also disclose your PHI to others without your consent in certain situations. For example, if you need emergency treatment or you are unable to communicate with me due to being unconscious or in severe pain and I think it is likely that you would consent to treatment if you were able to do so.

6B. USE AND DISCLOSURES THAT DO NOT REQUIRE YOUR CONSENT

There are certain circumstances where I can use and disclose your PHI without your consent because of federal or state law which authorizes such disclosures to be made or requires them to be made.

1) **Child or elder abuse reporting**. If you report information to me that gives me a reasonable suspicion that child abuse, elder abuse or abuse of a dependent adult has occurred, then I am required by law to report such abuse to the appropriate governmental agency. This reporting will be by telephone and in writing and, in addition, I may be required to have discussions with government employees who are investigating the abuse report.

2) **Threats.** If you make a threat that I believe to be a serious threat of bodily harm or death to another person, or if I am advised that you have made such a threat by a member of your family or a significant other, I am required by law to notify the person who you have expressed the threat regarding and law enforcement.

3) **Danger to Self.** If I determine that you pose an imminent risk of harm to yourself, I may disclose information to the necessary authorities to try and protect you from harming yourself.

4) **Subpoenas.** If I receive a subpoena from a Federal or State court or an administrative agency concerning you, then I may be required to disclose PHI in response to the subpoena. If I do receive such a subpoena, I will make reasonable efforts to

notify you in advance to discuss it. Under California law, if a subpoena is served for psychotherapy records, the person issuing the subpoena is required to give you notice that your records are being sought and you have the opportunity to both object and file a motion to prevent the disclosure. The issuance of a subpoena by itself is not sufficient to compel me to disclose information about you without your consent. Of course, if you choose to consent to comply with the subpoena and provide me with an appropriate written release, I will comply with the subpoena.

5) **Minors.** As noted above with regards to patients who are minors, generally the consent of both parents will be required before I can release information, records or testify. In some instances, the court will have appointed a minor's counsel who by operation of law is the sole person who can make decisions on the child's privilege.

6) **Health oversight activities.** I may have to provide information to governmental agencies when investigating or inspecting of health care provider organization.

7) **For specific government functions.** I may disclose PHI of military personnel and veterans in certain situations as required by law. I may disclose PHI for national security purposes such as protecting the President of the United States or conducting intelligence operations.

8) **For workers compensation purposes.** I may provide PHI in order to comply with Workers Compensation laws and orders from the Workers Compensation Appeals Board.

9) **Appointment reminders and health related benefits of services.** I may use PHI to provide appointment reminders or give you information about treatment alternatives or other health care services or benefits I offer.

6. C. USES AND DISCLOSURES WHICH REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT

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 full or in part. The opportunity to consent may be obtained retroactivity in after an emergency.

6. D. MINIMUM NECESSARY DISCLOSURES

When using or disclosing PHI and was requesting PHI from another therapist, hospital or facility, I will make reasonable efforts to use, disclosure or request the minimum amount of PHI reasonably necessary to accomplish the intended purpose of the use, disclosure, or request. Minimum necessary standard for uses, disclosures, and requests does not apply to the following:

1) Disclosures to a request by a healthcare provider for treatment purposes.
2) Disclosures to you as the patient who is the subject of the information.
3) Uses or disclosures made pursuant to a valid authorization signed by you.
4) Uses or disclosures that are required for compliance with the HIPPA privacy standards.
5) Disclosures to the Department of Health and Human Services when for compliance and enforcement purposes.
6) Uses or disclosures that are otherwise required by law.

7. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. **The right to request limits on uses and disclosures of your PHI.** You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures in ways that prevent me from doing things I am legally required to do or allowed to do.

B. **The right to choose how I send PHI to you.** You have the right to ask that I send information to you at an alternate address. For example, sending information to your work address rather than your home address or by alternate means. For example, email instead of regular mail. I must agree with your request if I can easily provide the PHI to you in the format you requested.

C. **The right to see and get copies of your PHI.** In most cases, you have the right to look at or get copies of your PHI that I have but you must make the request in writing. Depending on whether your request is made under federal or state law, the length of time in which I must respond will vary. I will respond to you within the period the law allows me to respond. In some situations, I may be required, and in use of my clinical judgment, to deny your request. If I do, I will explain in writing my reasons for the denial and your right to have my denial reviewed. The amount of costs you can be charged for copying a PHI is governed by different statutes and I will charge you the statutorily set rate for such copies. I may elect to provide you with a summary or explanation of the PHI.

D. **The right to get a list of disclosures I have made.** You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as, those made for treatment, payment, or health care operations, directly to you or to your family. The list also will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel. 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. The list will include the date of disclosure, to whom PHI was disclosed, including their address if known, a description of the information disclosed and the reason for the disclosure. 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 for the additional request.

E. **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, you have the right to update or correct information. You must provide the request and the reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing. PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my record. My written denial will state the reason for the denial; explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your response to my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, I will tell you I have done it, and tell others that need to know about the change to your PHI.

F. **The right to get this notice by email.** You have the right to get a copy of this notice by email. Even if you have agreed to receive notice by email, you also have the right to request a paper copy of it.

G. **How to complain about my privacy practices.** If you think I may have violated your privacy rights or you disagree with the decision I have made about access to your PHI, you may file a complaint with the Secretary of the Department of Health and Human Services at 200 Independence Avenue, Southwest Washington D.C. 20201. I will not take any retaliatory action against you if you file a complaint about my privacy practice.

H. **Notification of breach of unsecured PHI.** You will receive notification of any breach of unsecured PHI.

I. **Clients have the right** to restrict disclosures of PHI to health plans for certain payment or health care operations purposes, assuming the PHI pertains solely to a health care item or service that clients have paid for out-of-pocket in full.

J. **PHI will not be sold** without client authorization.

K. **PHI will not** be disclosed for marketing purposes.

8. PATIENT CONSENT and/or Parent/Guardian Signature(s): ****ALL* LEGAL PARENTS** and **Adults** Participating in Treatment **MUST SIGN***

I consent to the use or disclosure of my protected health information by Anna B. Alcalá, M.S. for the purpose of diagnosing or providing psychotherapeutic services to me and/or my child, obtaining payment for my health care bills, or to conduct health operations of Anna B. Alcalá, LMFT.

Name	Signature	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

MORE IMPORTANT INFORMATION

Emergencies and Contacting Me: I utilize a Google phone number which can be accessed 24 hours a day, 7 days a week. My policy is to return calls within 24 hours. In case of a crisis or urgent matter call me and please specify you need a response quickly. If I cannot be reached, nor do I respond, and you feel you are having a life-threatening emergency please go to the nearest emergency room or call 911.

Vacations etc.: I will let you know in advance when possible when I will be unavailable. If you have an emergency when I am gone you may call 911, contact your primary physician or psychiatrist, or ask to speak with a designated colleague who will cover for me in my absence.

Termination: Termination from therapy is an important process which can be of benefit to clients and therapist. This is an important opportunity to reflect on progress, or lack of, and the process of where you are now and where you hope to be going. I encourage my clients to partake with me in this process of finding out what was helpful and what could have been more helpful. It is your right to

terminate therapy at any time. If you choose to terminate, I will be glad to provide referrals to qualified professionals. As your therapist, I have the right and duty to terminate therapy under the following circumstances: when I assess that treatment is no longer helpful or beneficial to you, if I determine that another professional would better serve your needs, if you have not paid for the last two sessions (unless a special arrangement has been made), or if you have failed to show up for your last two sessions without the required 24 hour notice of cancellation. In all cases I will be happy to provide you with resources and referrals as necessary.

Financial Policy: My standard fee is **$175.00 per hour**. Contracts with insurance companies may apply.

1. Fees can be paid in the following manner:
   A. You pay in full each session; you may send my bill to your insurance (does not apply to HMO and managed care).
   B. You pay fees in full monthly immediately upon receipt of your billing statement**. If your payment is not received by the 20th of the month, a service charge of $50 each month** will be added.
   C. You pay your assigned co-payment required by your insurance company and I bill your insurance for balance (you may still be liable for balance if insurance does not pay).
   D. **Credit/Debit Card**/PayPal can be made in the office or through www.annaalcala.com
2. Physician referral may be required by your insurance company for mental health benefits. If required, please obtain this promptly as you will be responsible for all charges until you do.
3. **Secondary insurance**: I can, upon request, provide a billing statement which you can submit to your secondary carrier for reimbursement to you, or as a courtesy I will send a bill. **I do not**, however, **wait for secondary insurance payments**.
4. A charge will be assessed for extensive reports requested by the client(s) (for court, attorneys, work etc.), see below.
5. **A $35.00 late fee** is assessed on overdue accounts for each month delinquent.
6. **Please remember, all charges are your responsibility. It is your responsibility to maintain insurance coverage, update therapist upon any changes, and keep informed as to deductibles or changes in co-payments. In cases where children have divorced parents, EACH PARENT is 100% responsible for any balance.**

Additional Charges: Additional charges may be incurred for the following: letter writing at client request, court reports or documentation requested by attorneys (authorized by the client), sessions which take place at someplace other than this office, special meetings. Time outside this office is usually charged door to door at a separate rate. Any additional charges will be discussed in advance and agreed upon. I charge for extensive telephone calls (see above). These charges are calculated at my regular hourly fee of $150.00/hr, and in *most cases not covered by insurance*.

***Note:** Children under the age of 18 years **must have the consent of all parents/guardians who hold "legal custody."** **I will not treat children without this written consent**. I prefer to involve all parents/guardians as much as is therapeutically appropriate. I will be glad to discuss how, when, and if this can be accomplished in your case.

Insurance Benefits: I will provide treatment within the limits of your insurance. I will discuss with you at the onset of treatment a reasonable treatment plan that includes a general estimate of the length of treatment. Mental health treatment often requires considerable length of time to achieve optimal results. Should your insurance benefits terminate prior to the completion of treatment private-pay fees can be discussed. There are risks should this occur that include: the continuity of care will be disrupted, and the therapeutic relationship may be affected. Difficult emotions may arise from such a situation and I will attempt to appropriately explore the impact of such a decision, but the client (or legal parents) is ultimately the one to make the final decision regarding this issue. Remember* that whoever is legally responsible you/parent(s) are the ones ultimately responsible for payment. **If insurance does not pay you are responsible.**

Technology/Social Media Policy: In an age of fast changing technology, it is important to understand the risks and benefits involved in any communication, especially of a private nature such as in therapy. I take reasonable steps to protect your privacy, however, it is important to understand and accept the risks to privacy by using these methods of communication. If you provide your email address, I will presume you have granted me permission to use this method of communication. **If you do NOT want me to contact you via email/text etc**. please specify here_____. Please limit tech communications to non-urgent matters that are not critical or private as there can be a delay in my receipt and/or response using such methods. If you have any questions about how best to communicate with me, I encourage you to talk about it when we meet. Please note that any communication between a client and therapist can be part of the clinical record.

I have a professional website at www.annaalcala.com that may serve for informational purposes and as a way to contact me. I also do not accept friend or contact requests from current/ former clients on any social networking site. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Family/Couple Therapy:
If multiple members of the same family are being seen each adult member of the family must authorize participation in treatment. At times, it may be appropriate to see individual family members or a grouping of members. Confidentiality for all is to be maintained, however the therapist is not responsible for holding "secrets," but will assist, when necessary and appropriate, members to find optimal ways of sharing with one another.

If you would like a copy of this document, please ask

I have read, understand, and agree to the professional policy for Anna B. Alcalá, M.S., LMFT

Client(s) Signature

Name	Signature	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent(s)/Guardian(s) Signature (if client is under 18 years of age)

Name	Signature	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Anna B. Alcalá, M.S.

Marriage and Family Therapist
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TELEHEALTH CONSENT FORM

I, _____ hereby consent to engage in Telehealth with Anna B. Alcala, LMFT.
I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality regarding my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the [Informed Consent Form or Statement of Disclosures] I received from my therapist also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.
6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.
9. I have discussed the fees charged for Telehealth with my therapist and agree to them. For insurance patients: I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments), and I have been provided with this information in the Informed Consent Form.
10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction. For conjoint or family therapy, patients may sign individual consent forms or sign the same form.

_____	_____	_____
Patient's Printed Name	Patient's Signature	Date

Verbal Consent Obtained
Therapist reviewed Telehealth Consent Form with Patient, Patient understands and agrees to the above advisements, and Patient has verbally consented to receiving psychotherapy services from Therapist via Telehealth.

_____	_____
Therapist's Signature	Date

Anna B. Alcalá, LMFT 84636
155 Granada St. Suite E
Camarillo, CA 93010
(805) 628 -2204

Office Safety Precautions in Effect During the Pandemic

My office is taking the following precautions to protect our clients and help slow the spread of the coronavirus.

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1. Office seating in the waiting room and in therapy/testing rooms has been arranged for appropriate physical distancing.
2. We wear masks.
3. We maintain safe distancing.
4. Restroom soap dispensers are maintained, and everyone is encouraged to wash their hands.
5. Hand sanitizer that contains at least 60% alcohol is available in the therapy room and in the waiting room.
6. I schedule appointments at specific intervals to minimize the number of people in the waiting room.
7. We ask all patients to wait in their cars or outside until no earlier than 5 minutes before their appointment times.
8. I conduct contactless temperature checks.
9. Credit card pads, pens, and other areas that are commonly touched are thoroughly sanitized after each use.
10. Physical contact is not permitted.
11. Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
12. Common areas are thoroughly disinfected at the end of each day.

Anna B. Alcala, LMFT 84636
155 Granada St. Suite E
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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services considering the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face
We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, if it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus or other public health risk. This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, our families, and other clients) safer from exposure, sickness, and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

1. You will only keep your in-person appointment if you are symptom free. ___
2. You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I will not charge you our normal cancellation fee. ___
3. You will take your temperature when entering the waiting room and if it is elevated (100 Fahrenheit or more), please leave immediately and contact your therapist. ___
4. You will wait in your car or outside until no earlier than 5 minutes before our appointment time. ___
5. You will wash your hands or use alcohol-based hand sanitizer when you enter the office. ___
6. You will adhere to the safe distancing precautions we have set-up in the waiting room and therapy room. For example, you will not sit where we have signs asking you not to sit. ___
7. You will wear a mask in all areas of the office (I will too). ___
8. You will keep 6 feet apart and there will be no physical contact. For example, no shaking hands with me. ___
9. You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ___
10. If you are bringing your child, you will make sure that your child follows all these sanitation and distancing protocols. ___
11. You will take steps between appointments to minimize your exposure to COVID. ___
12. If you have a job that exposes you to other people who are infected, you will immediately let me know. ___
13. If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know. ___

14. If a resident of your home tests positive for the infection, you will immediately let me know and we will then resume treatment via telehealth. ___

I may change the above precautions if additional local, state, or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I must report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together. Your signature below shows that you agree to these terms and conditions.

_____	_____	_____
Client Name	Signature	Date

_____	_____
Psychotherapist: Anna B. Alcalá, LMFT84636	Date

INTAKE INFORMATION

Date of First Appointment:	*Therapist 's Name:* **Anna B. Alcalá, M.S., LMFT 84636**	
PRIMARY CLIENT's NAME:		
Primary Address:	Birth date: / /	
	Gender: Female Male	
Secondary Address *(please designate)*:	Relationship Status: Single Married Divorced Domestic Partner	
Home phone: Okay to leave a message? No Yes	Cell phone: Okay to leave a message? No Yes	E-mail: Okay to leave a message? No Yes
Client's Occupation:	Other:	
Employer Name or School (*include grade level*):	Work/School Phone:	Ext.
Who referred you? (*relationship)*		
Physician:	Physician's Phone:	Ext.
Date of Last Physical: / / Major Illness(es)	Medication Allergies? Non-medication Allergies?	
Medications:	Alcohol or Other Drug Use *(type, amount, frequency)*:	
Risk Assessment: ***Suicidal Ideation**:* Denies Intent Plan History	***Violence*:** Denies Intent Plan History	
Previous Psychotherapy? No Yes *(when and with whom?)*	Prior Diagnoses?	History of Trauma? No Yes
Client Strengths:		
Please list other family members: *(for children please list all parents/guardians)*		

Name	*Birth date*	*Relationship*	*Living at home* yes / no
			yes / no
			yes / no
			yes / no
			yes / no
			yes / no

Person(s) Legally Responsible and Relationship:	Phone: Okay to leave a message? No Yes	E-mail: Okay to leave a message? No Yes
Address *(if different from client's)*		
I AUTHORIZE TREATMENT FOR ME AND/OR THE MINOR CHILD(REN) UNDER MY CARE. *Signature* Date / /		
Thank you for your time!		

INSURED/INSURANCE INFORMATION

For Insurance Billing Only

(Please present your insurance card at your first visit)

PRIMARY INSURANCE: _____

Insured Person's Name: _____

Insurance Identification Number: _____

Gender: Female ☐ Male ☐

Address_____

Authorization No._____

Relationship to client: Self ☐ Spouse ☐ Other ☐

Insured Date of Birth: _____/_____/_____

Insured's Social Security: _____ - _____ - _____

SECONDARY INSURANCE: *for billing purposes (**therapist will not defer payment for receipt from a secondary insurer but will provide statement for you to submit to your secondary carrier)**

Who is the Insured: _____

Insurance Identification Number: _____

Gender: Female ☐ Male ☐

Address_____

Authorization No._____

Relationship to client: Self ☐ Spouse ☐ Other ☐

Insured Date of Birth: _____/_____/_____

Insured's Social Security: _____ - _____ - _____

*********NOTE: MUST BE SIGNED BELOW*********

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for services described on claims.

****Signature*** _____ Date _____/_____/_____