MICHAEL A. JONES
LICENSED CLINICAL SOCIAL WORKER

Michael A. Jones, LCSW 3511 Camino Del Rio South Suite 500 San Diego, California 92108 619-297-0010
LCSW22452 www.michaelajoneslcsw.com askmike@michaelajoneslcsw.com

CLIENT INFORMATION

Your Name: _____ First Appointment Date:_____

Client Name (if different) :_____ Date of Birth:_____

For Minor Clients:

What is your relationship to the minor? *(check all that apply)*

☐ *Parent* ☐ *Legal Guardian* ☐ *Foster Parent* ☐ *Self* ☐ *Other, (specify):* _____

Do you hold the legal privilege for this minor? ☐ *No* ☐ *Yes*

If no, who holds the legal privilege for this minor?

☐ *Parent* ☐ *Legal Guardian* ☐ *Court* ☐ *Minor* ☐ *Other, (specify):*_____

Address: _____ City: _____ ZIP:_____

Home # ( ) _____-_____ Work # ( ) _____-_____ Other # ( ) _____-_____

Emergency Contact: _____ Relationship: _____Telephone# ( )_____-_____

School/Employer:_____ Grade:_____ Contact:_____ Telephone:_____

Agency/Case Manager/Referral Source: _____Telephone: _____

E-Mail_____

Payment Information:

Name of Insurance Company: _____ Telephone# _____

Member ID: _____Group ID: _____Plan ID: _____

Authorization to see Michael A. Jones, LCSW_____ CoPay per visit: _____

☐ Provided Mental Health Services Information ☐ Provided Grievance and Appeal Procedures

Please list the names of the people (and/or pets!) who live in your home:

Name	Age	Their Relationship to you
1.		
2.		
3.		
4.		
5.		

Briefly, why are you seeking my services at this time ?

Medical History – Yours (client's), and biological relatives (as far as you know)

Check all those that apply	Client	Relatives	DESCRIBE (use back page for detail)
Injuries to head			
Thyroid problems			
Diabetes or blood sugar issues			
Sexually transmitted disease			
Fainting/ loss of consciousness			
Allergies			
Physical impairment or handicap			
Menses – difficulties or irregular			**Age of onset**
Aches/pains (head, stomach, etc.)			
Medical Hospitalization			
Other Diseases			

Mental Health History - Yours (client's), and biological relatives (as far as you know)

	Client	Relatives	DESCRIBE
Depression			
Mania			
Risk Taking Behaviors			
Mental Health Hospitalization			
Therapy or Other Treatment			

Current Medications/Dosages: _____
Supplements/Vitamins: _____
Over the Counter Medications: _____
Most recent Medical Exam: _____ **Recommendations:** _____
Physician's Name: _____ **Telephone #:** _____

Previous or Current Mental Health or Other Treatment Providers with Whom to Consult or Collaborate:

Dates Attended	Name of Provider Address/Telephone	Topics of Treatment	Level of Satisfaction

Life Stages History – Family History

In each section, please list the members of the household during that period in your life, and any events or experiences that you feel were significant, or impacted you positively or negatively, including any traumatic events. Please do not feel pressured to write down things that you do not wish to write about.

Client's mother's pregnancy history *(If you know anything about the mother's life experiences during her pregnancy, positive or negative, including her health and relationship with the father, please include it here.)*

_____

_____

Early Developmental Details **(***ages 0-5 – ex: learning to talk, walk, use the bathroom, etc.***)**

_____

_____

Childhood *(ages 6-12)*

_____

_____

Adolescence *(age 12 to 17)*

_____

_____

Young Adulthood *(ages 18 - 22)*

_____

_____

Adulthood *(ages 23 to present)*

_____

_____

_____

Educational History

Schools Attended

Academic Performance (include special needs)

Friendships/ Peer Relationships in School

Spiritual/Cultural History

Legal History

(Ex: Arrests, Restraining Orders, Charges, Convictions, Sentences, Jail/Prison, Court Cases, Divorce, Child Custody)

Current Symptoms – Please check, describe and rate level of concern 0-10.

PHYSICAL SYMPTOMS		Rating	Description	Ending Rating
Sleeping Patterns				
Appetite				
Weight Change				
Elimination Concerns				
Fatigue				
Crying				
Sexual Energy Changes				
Aches and Pains				
Aggression				
Stealing				
Arguing/Rages				
Manipulation				

EMOTIONAL SYMPTOMS		Rating	Description	Ending Rating
Hopelessness				
Decrease in Enjoyment/Interests				
Sadness				
Anger				
Fear				
Loneliness				

Preoccupation with Death				
Thoughts of Suicide				

COGNITIVE SYMPTOMS		**Rating**	**Description**	**Ending Rating**
Traumatic memories				
Intrusive thoughts				
Flashbacks				
Dwelling or Daydreaming				
Self-blaming thoughts				
Worries interfere with life				
Ability to make decisions				
Ability to concentrate				

SOCIAL SYMPTOMS		**Rating**	**Description**	**Ending Rating**
Isolation				
Easily irritated				
Decrease in friendships				
Conflict with family members				
Employment issues				
Financial Issues				
Legal Issues				

RISK ASSESSMENT	**Yes**	**No**	**Explain: Frequency, Severity, Consequences, Treatment**
Do you intend to hurt yourself?			
Do you have a plan?			
Do you have means?			
Have you attempted self-harm?			
Do you intend to harm anyone?			
Have you identified that person?			
Do you have a plan?			
Do you have a means?			
Attempted to harm others?			
Alcohol/legal/illegal drug use?			
Age of first use?			
Date of last use?			
Frequency of use?			
Amount of last use?			
Duration of use?			
Difficulty stopping ?			
Concern about use?			
Consequences if use?			
Sought treatment?			
Relationship violence?			
Child abuse?			
Elder abuse?			
Disabled abuse?			
Animal abuse?			

INFORMED CONSENT and CONFIDENTIALITY AGREEMENT

Introduction

This agreement is intended to provide _____(***Client***) with important information regarding the practice policies and procedures of Michael A. Jones, LCSW (***Therapist***) and to clarify the terms of the professional therapeutic relationship between Client and Therapist. The Health Insurance Portability and Accountability Act of 1996 (***HIPPA***) requires that Client is provided with a Notice of Privacy Protection which is attached to this agreement. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Therapist Education, Training, Experience, Theoretical Orientation, and Treatment Approaches

Therapist earned a master's degree (***MSW***) and has been licensed by the Board of Behavioral Sciences in California as a clinical social worker (***LCSW***) since December 15, 2004. Therapist participates in a minimum of 18 hours of continuing education every two years. Therapist has experience working with children, adolescents, adults, couples, families, groups and supervisees. Therapist employs treatment modalities based in attachment, developmental, psychodynamic, and cognitive-behavioral theories. In approaches targeting the parent-child relationship therapist may demonstrate, teach, and encourage the use of appropriate safe touch in care, nurturing, and play with children and adolescents. Therapy approaches with children, adolescents, couples and families most often require the participation of all parties in treatment. Therapist employs a time-limited approach based on diagnosis, prognosis, and mutually agreed upon modalities, established treatment goals, and behaviorally measurable progress. Therapist also employs a crisis management model including immediate assessment, referral, and possible ethical, legal, and medical coordination when immediate risk supersedes current treatment.

Benefits and Risks of Therapy

Psychotherapy is a process in which Client and Therapist explore and discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Client can experience his/her life more fully. Psychotherapy is a joint effort between Client and Therapist. Progress and success may vary depending upon several factors, including but not limited to the types of issues or problems being explored and addressed, Client's personal history, Client's resources and support systems, and Client's level of motivation.

Participating in therapy may result in a number of benefits to Client, including, but not limited to, a reduction in stress, anxiety, and depression, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Client, including an active participation in the therapeutic process, honesty, and a willingness to change thoughts, feelings, and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, guilt, anger, frustration, fear, loneliness, helplessness, and hopelessness. There may be times in which Therapist will challenge Client's perceptions and assumptions, and offer different perspectives. The issues presented by Client may

result in unintended outcomes, including changes in personal relationships. Client should be aware that any decision on the status of his/her personal relationships is the responsibility of Client.

During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Client should address any concerns he/she has regarding his/her progress in therapy with Therapist.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Client.

Records and Record Keeping

Therapist may take notes during session, and will also produce other notes and records regarding Client's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter normal record keeping process at the request of any Client. Should Client request a copy of Therapist's records; such a request must be made in writing. Therapist reserves the right, under California law, to provide Client with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Client's records for ten years following termination of therapy. However, after ten years, Client's records will be destroyed in a manner that preserves Client's confidentiality.

Confidentiality

The information disclosed by Client is generally confidential and will not be released to any third party without written authorization from Client, except when required or permitted by law. Exceptions to confidentiality include, but are not limited to, the ***suspected abuse*** of children (including by relationship violence), dependent adults, the elderly, and animals. Exceptions to confidentiality also include serious risk of ***self injury*** including suicide, the use of dangerous substances, and untreated medical conditions that could cause imminent death. Therapist also has a legal duty to warn the identified victim and report to police ***intended harm*** to persons and property. Therapist will work with Client to facilitate joint report when possible and to maintain the therapeutic relationship while providing only the information necessary to meet legal and ethical mandated reporting requirements.

When parents and children, couples, or families participate in therapy, the parent-child, couple, or family is the treatment unit. Therapist will maintain the confidentiality of each individual but cannot guarantee that all parties in the treatment unit will maintain confidentiality for the others. Therapist may meet with a smaller part of the treatment unit but uses his best clinical judgment to determine whether, when, and how to make disclosures of information learned in the separate session to the rest of the treatment unit, usually encouraging and facilitating the smaller unit to communicate the information to the rest of the treatment unit. If you feel it necessary to talk about matters you do not want to share with the rest of the treatment team, you may consider individual therapy. The addition of other parties to the treatment process will require each individual Client or Client representative to sign an Authorization for the Release of Protected Health Information or a renegotiation of the psychotherapy contract.

Client Litigation

Therapist will not voluntarily participate in any litigation, or custody dispute in which Client and another individual, or entity, are parties. Therapist has a policy of not communicating with Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Client's legal matters. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Client, Client agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist is available for such an appearance at Therapist's usual and customary hourly rate of **$120.00**.

Psychotherapist-Client Privilege

The information disclosed by Client, as well as any records created, is subject to the psychotherapist-client privilege. The psychotherapist-client privilege results from the special relationship between Therapist and Client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-client privilege on Client's behalf until instructed, in writing, to do otherwise by Client, Client's representative, or the Court. Client should be aware that he/she might be waiving the psychotherapist-client privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding including those against the Therapist. Client should address concerns he/she might have regarding the psychotherapist-client privilege with an attorney.

Fee and Fee Arrangements

The usual and customary fee for service is **$120.00** per 45-minute session. Sessions longer than 45-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Client will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with Therapist. Clients are expected to pay for services at the time services are rendered unless other arrangements are made in advance. Therapist accepts cash and personal checks. Client will be charged **$25.00** if a check is returned from the bank due to insufficient funds. Thereafter, Client will be required to pay by cash only.

From time-to time, Therapist may engage in telephone contact with Client for purposes other than scheduling sessions. Client is responsible for payment of the agreed upon fee at a pro rata basis for any telephone calls longer than ten minutes.

Insurance

Client is responsible for full payment of all fees. If Client intends to use benefits of his/her health insurance policy, this must be agreed upon in advance by Client and Therapist. If Therapist is a contracted provider for the Client's insurance plan, Therapist will submit claims and required paperwork to be reimbursed by the insurance company. Client is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles. Client is responsible to request initial authorization from his/her insurance plan. Client is responsible for payment of co-pays and deductibles at the time of the session. Use of the Client's insurance requires the signed Authorization for Release of Protected Health Information and Notice of Privacy Practices.

If Therapist is ***NOT*** a contracted provider for the Client's insurance plan, Client will be responsible for full payment at the time of the session. Client will be provided with a statement which Client can submit to his/her insurance company to seek reimbursement for fees already paid. Client agrees to inform Therapist in

advance of any changes related to insurance coverage. Therapist is a contracted provider with several companies and has agreed to specified fees.

Cancellation Policy

Client is responsible for payment of the full fee for any session(s) not cancelled within 24 hours. Cancellation notice should be left on Therapist's voice mail at **(619) 297-0010.** If Client does not call to cancel a session and does not arrive at the scheduled time, Therapist will wait for ***15 minutes***. At that time, if Client has not arrived or phoned to report a delay, the session will be considered non-attended and the fee will apply. In the event of a non-canceled and non-attended session, Client agrees to contact Therapist within seven days to schedule the next session. ***Please note: the same day and session time may not be available.*** If Client does not contact Therapist within seven days of a non-canceled and non-attended session, Therapist will assume that Client does not wish to continue therapy at that time. Client may contact Therapist to resume therapy if and when desired. When insurance prohibits late fees, Therapist will terminate service and provide referrals after two no show sessions.

Therapist Availability

Therapist's office is equipped with a confidential voice mail system that allows Client to leave a message at any time. Therapist will make every effort to return calls within 24 hour (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. ***In the event that Client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, the Access and Crisis Line at (800) 479-3339, or go to the nearest emergency room***. Therapist's outgoing message will provide these same instructions. Therapist is routinely in the office Monday through Friday. ***Sessions are by scheduled appointment only.*** Therapist will inform Client of changes to the routine schedule.

Termination of Therapy

Client and Therapist may agree to end therapy when treatment goals are met. Therapist reserves the right to terminate therapy at Therapist's discretion. Reasons for termination include nonattendance, untimely payment, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Client needs are outside the Therapist's scope of competence or practice, or Client is not making adequate progress in therapy. Client has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Client participate in at least one termination session. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work done and make appropriate recommendations. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals and making himself available for continuity of care. Therapist has made provisions for notifying clients, providing referrals, and maintaining client records in the event of Therapist death, disability, or business closure.

Acknowledgement

By signing below, Client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Client's satisfaction. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Client agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____
Client Name (please print)

_____ _____
Signature of Client (or authorized representative) Date

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

_____
Name of Responsible Party (please print)

_____ _____
Signature of Responsible Party Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order

- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer: Michael A. Jones, LCSW 3511 Camino Del Rio South Suite 500, San Diego, California 92108, 619-297-0010.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions. .** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257.

We will not retaliate against you for filing a complaint.

The effective date of this Notice is _____

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Client Name:_____

Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Privacy Practices of Michael A. Jones, LCSW.

I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer, Michael A. Jones, LCSW.

_____

Signature of Client

_____

Signature or Parent, Guardian or

Personal Representative*

_____

Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ Patient/Client Refuses to Acknowledge Receipt:

_____

Signature of Staff Member Date