708 Alhambra Blvd., Suite 100
Sacramento, CA 95816
Phone: (916) 492-9007
MiddleWayHealth.com

Intake Questionnaire

Name(s)_____Date_____

Dependents/Minors Names (if in treatment)_____Age_____

_____Age_____ _____Age_____

Address_____City_____Zip_____

Home Phone_____ Work Phone_____ Fax_____

E-mail_____ Cell Phone _____

Date of Birth_____ Social Security #_____-_____-_____ Marital status_____

Education: High School Trade School Jr. College College Graduate Degree

Training/Skills_____

Employer_____ Job_____

Emergency contact information_____Phone_____

Would you like to be contacted for upcoming groups, classes and workshops? Yes___ No___

Method of Payment:

How do you intend to pay for treatment? Cash Check Credit Card EAP Insurance

EAP Provider _____ Intake/Authorization#_____

If planning to use health insurance:

Name of Insurance company_____ Policy #_____

Group # _____ Telephone # _____

Subscriber # _____(From Card) Authorization #_____

Areas of Concern:

What issues/concerns caused you to seek counseling? Please describe:_____

_____

_____

What are your specific goals with regard to your counseling? _____

_____

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Client Information and Office Policy Statement:

Informed Consent

New Client: Welcome!

Thank you for choosing me as your psychotherapist. This is an opportunity to acquaint you with information relevant to psychotherapy, confidentiality and office policies. I will be glad to answer any questions you have regarding any of these policies.

I. Aims and Goals:

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with internal conflicts in order to achieve more satisfying personal and interpersonal relationships. This purpose is accomplished by:

1. Increasing personal awareness of obstacles and strengths.
2. Taking personal responsibility to make the changes necessary to attain your goals.
3. Identifying specific psychotherapy goals.
4. Utilizing all available community, medical and self-help resources.

II. Appointments:

Appointments are usually scheduled for 45-50 minutes. It is important to schedule your appointments 2-3 weeks in advance, if possible. Clients are generally seen weekly or more/less frequently as acuity dictates and you and I agree.

III. Emergency:

In the event of an emergency, it is possible to leave a voicemail 24 hours per day – 916-492-9007. Messages left after business hours will be returned the following business day. If you are unable to reach your psychiatrist, therapist, or primary care physician, please call 911 or go to the local emergency room, or call the crisis hotline 24 hours a day: 916-368-3111.

IV. Confidentiality:

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include:

1. Suspected abuse or neglect of a child, elderly person or a disabled person.
2. When I believe you are in danger of harming yourself or another person or you are unable to care for yourself.
3. If you report that you intend to physically injure someone, the law requires me to inform that person as well as the
4. legal authorities.
5. If I am ordered by a court to release information as part of a legal involvement.
6. When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc.
7. In natural disasters whereby protected records may become exposed.
8. As required by the Patriot Act.
9. For the purposes of supervision and/or consultation with another mental health professional.
10. When otherwise required by law.

You may be asked to sign a Release of Information so that I may speak with other healthcare professionals or to family members. I also reserve the right to contact your emergency contact if you do not contact me following a missed appointment.

V. Communication

Each provider has his or her own confidential voicemail box. Detailed messages can be left specifically for your provider. Each provider also has his or her own email address. Please be aware email is not a HIPAA approved form of communication amd your privacy cannot be guaranteed. Information can also be faxed to 916-492-9396.

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VI. Record Keeping:

A clinical chart is maintained describing your counseling goals and progress, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above. Records are locked and kept on site.

VII. Fees:

Fees are always agreed upon prior to service. Fees may be renegotiated thereafter by either party. Legal services that include talking with an attorney, writing reports and/or court time may be billed per hour at double the standard fee.

VIII. Payments:

Payments, including co-payments where applicable, are due at the beginning of the session unless other arrangements have been made. Payments are accepted in the form of cash, check, or credit card via paypal. You may also make payments through the website at MiddleWayHealth.com/schedule-a-payment

If I am an in-network provider, I will file your insurance claim, but you are responsible for deductibles, co-insurance, and co-payments. If your insurance claim is rejected and we have entered treatment, you are responsible for payment.
If I am an out-of-network provider, you must pay the full fee for session, and I will provide you with a statement at the end of each month, which you can then use to receive reimbursement through your insurance carrier if your benefits include out-of-network providers.

It is your responsibility to familiarize yourself with your insurance benefits and to call your insurance company to have the authorization for your sessions sent to this office, or to submit for reimbursement if out-of-network.

IX. Telephonic Consultations:

Sometimes, having a face-to-face meeting is not always possible. As such, with enough advance notice, I can and will facilitate a counseling session with you over the phone. The charge for this is the same as it would be if you came into the office. A full hour with me on the phone may not be necessary. You can also have a phone consultation with me that is prorated for the time we do spend on the phone based on your regular hourly rate.

X. Cancellations and Missed Appointments:

You will be billed for any sessions that you cancel with less than 48 hours' notice. You may leave messages 24 hours per day. You will be billed full fee – not just a co-payment. Insurance companies generally do not reimburse for failed appointments. I will only wait 15 minutes past our start time if you are late.

XI. Complaints:

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, please inform me immediately and discuss the situation.

XII. Treatment Agreement:

It's important that we develop a treatment plan so that both parties know what we are working on and with whom we are working. Usually our first three sessions are understood as assessment sessions during which time we mutually decide on how we are going to work together. We need to decide what is the issue or diagnosis we are working with and what kind of interventions or treatment modalities will be best for you. A referral to an outside support group or treatment program may be suggested or required. For example, a referral to a substance abuse recovery group, a grieving support group or a parenting group may be a necessary part of your treatment plan.

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At times you will be asked to complete assignments outside of the therapy hour. These might include journaling, thought and behavior tracking logs, practicing stress reduction techniques, practicing assertive communication skills or attending various support groups. The outside assignments are essential aspects of your treatment and failure to follow through may seriously impair my

ability to be helpful to you. We will then have to reassess our treatment plan and decide if I can still be helpful to you. You are expected to take an active role in therapy, which includes regular feedback to your therapist or counselor as to your progress.

XIII. Psychotherapy with Stephen Bryant Walker, MA, LMFT or Colleen Tweed Wong, MA, LMFT:

Stephen B. Walker, M.A., LMFT is a Licensed Marriage and Family Therapist, license MFC36712, and provides psychotherapy utilizing qualified psychotherapy approaches to improve human relationships.

Colleen Tweed Wong, M.A., LMFT, is a licensed Marriage and Family Therapist, license MFC96875, and provides psychotherapy and mindfulness coaching as an employee of Middle Way Health.

XIV. Psychotherapy with Jesus S. Sanchez, MA, MFTI:

Jesus S. Sanchez, MFTI, Marriage and Family Therapist intern, registered with the California Board of Behavioral Sciences, IM787855. As an MFTI, Mr. Sanchez provides psychotherapy as an employee of Middle Way Health under the supervision of Stephen B. Walker, LMFT, license MFC36712. Mr. Sanchez discusses client cases with Mr. Walker for the purposes of supervision and consultation.

XV. Consent for Counseling:

When applicable, I authorize payment of medical benefits from my insurance company to the undersigned therapist for counseling sessions. I authorize the release of any medical or other information, including a mental health diagnosis, necessary to process claims from my insurance carrier. I also request payments of government benefits either to myself or to the party who accepts assignment below.

I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or counseling.

Client Name (please print): _____

Client Signature: _____ Date: _____

Therapist Signature: _____ Reg./Lic. #_____ 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 IT CAREFULLY.

I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of you PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice. However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office.

HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

For Treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

To Obtain Payment for 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 or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

For Health Care Operations. I can use and 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 the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operation.

Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.

When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.

When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

To avert a serious threat to health or safety. For example, I may have to use or disclose you PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

Certain Uses and Disclosures Require You to Have the Opportunity to Object.

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.

Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

The Right to Request Restrictions on My Uses and Disclosures. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to

me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

The Right to Choose How I Send PHI to You. You have the right to request that I send confidential 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, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

The Right to Inspect and Receive a Copy of Your PHI. In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary of explanation of the PHI as long as you agree to that and to the cost in advance.

The Right to Receive a List of the Disclosures I Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003. I will respond to your request for an Accounting of Disclosures within 60 days of receiving such 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 the disclosure was made, to whom the 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 may charge you a reasonable, cost-based fee for each additional request.

The Right to Amend 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 request that I correct the existing information or add the missing information. You must provide the request and your reason for 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 if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to you PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, you may file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services, 50 United Nations Plaza – Room 322, San Francisco, CA 94102, Voice Phone (415) 437-8310, FAX (415) 437-8329, TDD (415) 437-8311. A complaint must be submitted in writing. You will not be retaliated against or penalized for making a complaint.

middleway HEALTH

Notice of Privacy Practices

Your privacy is important to us

(916) 492-9007

EFFECTIVE DATE: APRIL 14, 2003

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Notice of Privacy Practices Acknowledgement of Receipt

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have received a copy of the Providers 'Notice of Privacy Practices'.

_____ _____
Signature of Patient (or Patient's Representative) Date

_____ _____
Print Name Relationship to Patient (if applicable)

_____
Interpreter (if applicable)

Written Acknowledgement Not Obtained

- ☐ Notice of Privacy Practices Given – Patient Unable to Sign
- ☐ Notice of Privacy Practices Given – Patient Declined to Sign
- ☐ Notice of Privacy Practices Mailed to Patient – Awaiting Signature
- ☐ Other Reason Patient Did Not Sign

_____

_____

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Authorization For Pre-Arranged Payments

This form authorizes Middle Way Health to charge your account using a valid Credit or Debit Card for services scheduled or rendered, pre-paid packages, long telephone consultations, any late cancellations, rescheduling or failure to show to appointments. Refunds are not given for services rendered. By signing this agreement, you agree not to dispute any charge that is conducted fairly by this office.

By signing your counseling agreement, you have agreed to pay for late cancellations or no-shows, and a missed appointment will be charged to your account within 48 hours of the scheduled date of service. Middle Way Health holds each account number in strict confidence.

PATIENT NAME		
CARDHOLDER BILLING ADDRESS		
CITY	**STATE**	**ZIP**
EMAIL ADDRESS		

CREDIT CARD TYPE: □ VISA □ MASTERCARD □ DISCOVER □ AMERICAN EXPRESS	
CREDIT CARD ACCOUNT NAME	
ACCOUNT #	
EXPIRATION DATE:	**3 DIGIT # ON BACK OF CARD:**
NAME ON CARD IF DIFFERENT FROM PATIENT	

CARDHOLDER SIGNATURE:	**DATE:**
NAME (PRINT):	
PATIENT SIGNATURE IF DIFFERENT FROM CARDHOLDER:	**DATE:**

By signing above, I authorize Middle Way Health to charge all subsequent account balances, minus any cash payments, to the identified Credit or Debit Card listed above, until all account balances are paid in full and agreement is rescinded in writing. I also agree that the office may keep this original form permanently on file. This office may disclose account information and attendance history to Credit Card companies or related business partner or associate for purposes of collection of payment.