Safe Harbor

Darlene Joy Manick, LMFT #32565
20301 Ventura Blvd. Suite 336
Woodland Hills, CA, 91364

OFFICE USE ONLY
DX: _____________
Primary Therapist: _____________
Fee/Co-pay: _____________
Insurance/Cash _____________

CLIENT INFORMATION

Name: ____ **Date:**

Address: ____

City: ________________________ **State:** __________________ **Zip:** ______________

Email: ________________________ **Cell Phone:** ______________ **Home Phone:** ____________

Birth Date: ________ **Sex: M☐ F☐ Legal Gaurdian (if applicable)** ______________________

Social Security: ___________ **Marital Status:** __________ **Driver's License:** _______________

Employer or School: ________________________________ **Work Phone:** ___________________

Employer Address: ___________________________ **City:** ___________________ **State:** _______

Responsible Financial Party: ____

Email: ________________________________ **Cell Phone:** ________ **Home Phone:** __________

Address: ____________________________ **City:** _______________________ **State:** ______

Employer: _________________________________ **Work Phone:** _________________________

Employer Address: ____________________ **City:** ________________________ **State:** _______

Health Insurance Carrier: ____________________ **Policy:** _______________________________

Name of Insured: _______________ **Relationship:** ______ **Insurance Phone:** _______________

Primary Care Physician: ____

Address: ____________________________ **City:** ___________ **State:** _______ **Zip:** _______

Phone: _______________________________ **Fax:** ___________________________________

In case of emergency, notify: _______________________ **Relationship:** ___________________

Email: ________________________ **Cell Phone:** _____________ **Home Phone:** ____________

Address: ____________________________ **City:** ___________ **State:** _______ **Zip:** _______

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ADULT INFORMATION FORM

Name____ Date of 1st Appointment___________ Therapist ___________________________

Date of Birth __________________________ Age __________ Gender: Male ______ Female _______

Spiritual/Religious Affiliation____

MEDICAL HISTORY

Name of Primary Care Physician: ____

Physician's Address:____Physician's Phone: _____________________________

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer:____

Date of last medical evaluation:______________________ Date of next appointment:________________________________

Current medications being taken:

1)_______________________ Dosage/Freq___________ Start Date:__________Purpose______________________________

2)_______________________ Dosage/Freq ___________ Start Date___________Purpose______________________________

3)_______________________ Dosage/Freq ___________ Start Date___________Purpose______________________________

4)_______________________ Dosage/Freq ___________ Start Date___________Purpose______________________________

Prescribed by: ____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
___________________________________	__________	____
___________________________________	__________	____
___________________________________	__________	____

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop? _______________________________

Type of Drug	How much	How often
______________________________________	______________	____
______________________________________	______________	____
______________________________________	______________	____

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list:

Type of Alcohol	How much	How often
______________________________________	______________	____
_____________________________________	______________	____

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind? ______________________________________

Describe any important medical history, chronic ailments, or other health problems you experience:________________________

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: ____

____

____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: ____

____

____

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain:____

____

What was the last year of school you completed? ___________ If you did not complete high school, please explain:

____

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s)____ Year(s)_______________________________________

(2) School(s)____ Year(s)_______________________________________

(3) School(s)____ Year(s)_______________________________________

How would you describe your current support network? (friends, relatives, etc.): ____

____

Please check all information which applies to your biological parents:

MOTHER		FATHER	
	____ living		____ living
	____ deceased		____ deceased
	____ married		____ married
	____ divorced		____ divorced
	____ remarried ____# of times		____ remarried ____# of times

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Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?
____
___

Where do your parents live? Mother
____

Father
____

Describe your relationship with your mother while growing up:____
____
___

Currently:
____
____
___

Describe your relationship with your father while growing up:
____
____
___

Currently:
____
____
___

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)

Describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse:
____
____
___
____
___

Sexual/physical/emotional abuse:____
____
___

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____
___

MARITAL HISTORY

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when were you married? ________________ If living w/someone, how long? _______________________

Please list your children:

Name	Age	Relationship (biological/step)	Lives with
______________________________	______	____________________________	______________________________________
______________________________	______	____________________________	______________________________________
______________________________	______	____________________________	______________________________________
______________________________	______	____________________________	______________________________________

LEGAL ASSESSMENT

Please list any current or previous legal issues:

____
____
____
____

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ____aggressive ___resentful
____worthless ___tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ____helpless

Describe any other feelings you have had:____
____
___

What activities or hobbies do you participate in? ____
____
___

Do you participate in regular exercise? (Circle One) YES NO

Describe:____

Describe your current working environment:____
____
___

Have you had any change in sleeping habits? (Circle One) YES NO

Describe:____

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____
___

Have you had any change in eating habits? (Circle One) YES NO Describe:
____
____
___

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO
If so, please give a brief description with
dates:____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO
If so, please give a brief description with
dates:____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO
If so, please give a brief description with
dates:____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO
If yes, please
explain:____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO
If yes, please
explain:____

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.):
____
____
___

THOUGHTS: Please check any of the following that apply to you:

_____I sometimes hear voices even though no one nearby is talking to me.
_____I sometimes feel that forces outside of me control me.
_____I sometimes feel that other people control my thoughts.
_____I sometimes have the same thought over and over and cannot control it.
_____I sometimes feel that someone is out to hurt me or do something against me.
_____I am sometimes unable to control my behavior. Please
explain:____
____
____

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Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

____
___
____
___

Please list your therapy goals:

____
___
____
___

THANK YOU!

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Assessment Information

Name: ___________________________________ Date:_________________________

Birthdate:______________________ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Ethnicity:_______________________ Religion:_________ Practicing ☐ Non-Practicing ☐

Height: _____________ Current Weight: ____________ Desired Weight:______________

Cardio(hours/wk): __________ Weight Training(hours/wk):__________ Sports(hours/wk):____________

Please describe why you want therapy at this time: ____
____

Please briefly describe your goals for recovery and your level of motivation for change:
____
____
____
____

ACTIVE PROBLEMS: (Check all that apply)

○ Extreme rigidity in eating	○ Avoidance of fats	○ Avoidance of carbs
○ Hoarding of food or condiments	○ Avoidance of fluid	○ Eating less than 1000/day
○ Low Weight	○ Compulsive Exercise Frequency____________________ Type_________________________	○ Ammenorhea (absence of or infrequent menstrual periods
○ Appetite Suppressors: Date of last use__________ Dose__________________ Frequency______________ Side Effects______________________	○ Diuretics Date of last use__________ Dose__________________ Frequency______________ Side Effects____________________	○ Fat Absorbers Date of last use__________ Dose__________________ Frequency______________ Side Effects____________________
○ Laxatives Date of last use__________ Dose__________________ Frequency______________ Side Effects____________________	○ Vomiting Most recent episode ____________ Time of Day __________________ No. of times/day ______________ No. of purges/episode_________________ Location________________________	○ Binge Eating Most recent episode ____________ Frequency __________________ Duration of Binge ______________ Location________________________ Food Type: Carbs ☐ Sweets ☐ Meat ☐ Crunchy ☐ Salty ☐

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MEDICAL SIGNS/ COMPLICATIONS: (Check all that apply)

○ Constipation	○ Reflux/ heartburn	○ Edema (swelling)
○ Hair Loss	○ Lanugo (fine facial hair)	○ Fainting
○ Osteopenia, Osteoporosis (bone loss)	○ Bradycardia (slow pulse below 50 b/m)	○ Low Body Temp (below 97 degrees)
○ Night Sweats	○ Low Energy Level	○ Allergies
○ Weight loss Amount lost_______________ Since what date____________	○ Weight Gain Amount gained___________ Since what date____________	○ Panic Attacks ○ Other_____________
Adverse reactions to medications or other substances:		

OTHER COMMON PROBLEMS: (Check all that apply)

○ Depression	○ Manias/ Moodswings	○ Attention Deficit Disorder
○ Anxiety ○ Panic ○ Shyness ○ Avoidance ○ Worry/Guilt ○ Phobias ○ Fear ○ Paranoia	○ Past Suicide Attemps	○ Hair Pulling (facial or body hair)
	○ Social Isolation	○ Tic Disorder
	○ Self-Harming Behavior(e.g.cutting)	○ Obsessive Compulsive Disorder
	○ Perfectionism	○ Stealing or shoplifting
	○ Body Dissatisfaction	○ Difficulty Concentrating
○ Problems with Sleep	○ Sexual Compulsivity	○ Memory Problems
○ Anger Management	○ Lack of Sexual Desire	○ Trouble with work
	○ Problems with hoarding	○ Trouble with school

Suicidality:

▢ None Ideation ▢ Plan ▢ Intent w/out means ▢ Intent with means, how: ▢
Past attempts, how:

_________________ _________________

Homicidality:

▢ None Ideation ▢ Plan ▢ Intent w/out means ▢ Intent with means, how: ▢
Past attempts, how:

_________________ _________________

If risk exists- Client has contracted not to self harm: ▢ Self ▢ Others
Impulse Control: ▢ Sufficient ▢ Moderate ▢ Minimal ▢ Inconsistent ▢ Explosive

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ADDICTIVE BEHAVIOR:

○ Alcohol	○ Substance	○ Substance
• Quantity___________________	• Quantity___________________	• Quantity___________________
• Frequency_________________	• Frequency_________________	• Frequency_________________
• Date of last use_____________	• Date of last use_____________	• Date of last use_____________
• Duration of use_____________	• Duration of use_____________	• Duration of use_____________
• # of sobriety attempts_______	• # of sobriety attempts_______	• # of sobriety attempts_______

CURRENT/PAST TRAUMAS: (Check all that apply)

☐ Victim of Sexual Abuse ☐ Child Abuse or Neglect ☐ Elder Abuse or Neglect

If yes, client is ☐ Victim ☐ Perpetrator

Has the abuse been legally reported? ☐ Yes ☐ No

Is there any risk of further abuse by perpetrator? ☐ Yes ☐ No

If yes to any of the above, please explain: ____

____

☐ Bereavement ☐ Other: ____

PAST TREATMENTS:

Residential Centers (Places & Dates): ______________________________________

____

Inpatient Treatments (Places & Dates): ______________________________________

____

Day Treatments (Centers & Dates):____

____

Self Help Support Groups: ____

Psychotherapy: Describe past individual, group, and family treatments (Places & Dates)

____

____

____

Alternative Therapies:____

____

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CURRENT MEDICATIONS:
Name: ________________________Dose:_______Length of Time Taken:_______________.

Name: ________________________Dose:_______Length of Time Taken:_______________.

Name: ________________________Dose:_______Length of Time Taken:_______________.

Name: ________________________Dose:_______Length of Time Taken:_______________.

Over the counter medications:____

Birth Control Pills: ☐ Yes ☐ No

MEDICAL HISTORY (other medical problems):___________________________________

____

PREVIOUS MEDICAL & PSYCHIATRIC DIAGNOSIS, IF ANY:

____

DATE OF LAST:

___/___/___	___/___/___	___/___/___	___/___/___	___/___/_
Physical Exam	Menses	Pelvic Exam	Dental Exam	Dexa Bone Scan

☐ Abnormalities in sodium ☐ Abnormalities in potassium ☐ Abnormalities in phosphorus

CURRENT THERAPIST:	**PSYCHIATRIST:**	**INTERNIST:**
Name: ________________	Name: _______________________	Name: ____________________.
Phone: ________________	Phone: _______________________	Phone: ____________________.
Date last seen: __________	Date last seen:________________	Date last seen:_________________

Please describe anything that you know about yourself which may interfere with your ability to benefit from treatment:
____

____

Client's Signature: _____________________________________Date:______________________

Clinical Impressions:____

____

____

____

____

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EATING DISORDER QUESTIONNAIRE

Name:___________________________

1. Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight (whether or not you have succeeded)?

No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
◯	◯	◯	◯	◯	◯	◯

2. Have you gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your shape or weight?

No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
◯	◯	◯	◯	◯	◯	◯

3. Have you tried to exclude from your diet any foods that you like in order to influence your shape or weight (whether or not you have succeeded)?

No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
◯	◯	◯	◯	◯	◯	◯

4. Have you tried to follow definite rules regarding your eating (for example, a calorie limit) in order to influence your shape or weight (whether or not you have succeeded)?

No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
◯	◯	◯	◯	◯	◯	◯

5. Have you had a definite desire to have an empty stomach with the aim of influencing your shape or weight?

No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
◯	◯	◯	◯	◯	◯	◯

6. Have you had a definite desire to have a totally flat stomach?

No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
◯	◯	◯	◯	◯	◯	◯

7. Has thinking about food, eating or calories made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?

No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
◯	◯	◯	◯	◯	◯	◯

8. Has thinking about shape or weight made it very difficult to concentrate on things you are interested in (for example, working, following a conversation, or reading)?

No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
◯	◯	◯	◯	◯	◯	◯

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9.	Have you had a definite fear of losing control over eating?						
	No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day

10.	Have you had a definite fear that you might gain weight?						
	No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day

11.	Have you felt fat?						
	No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day

12.	Have you had a strong desire to lose weight?						
	No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day

Question 13 to 18: Please fill in the appropriate number in the boxes. Remember that the questions only refer to the past four weeks (28 days).Over the past four weeks (28 days) ...

13.	**Over the past 28 days, how many times have you eaten what other people would regard as an unusually large amount of food (given the circumstances)?**	
		(Please fill in number, eg. 0,1,2,3)
14.	**On how many of these times did you have a sense of having lost control over your eating (at the time that you were eating)?**	
		(Please fill in number, eg. 0,1,2,3)
15.	**Over that past 28 days, on how many DAYS have such episodes of overeating occurred (i.e., you have eaten an unusually large amount of food and have had a sense of loss of control at the time)?**	
		(Please fill in number, eg. 0,1,2,3)
16.	**Over the past 28 days, how many times have you made yourself sick (vomit) as a means of controlling your shape or weight?**	
		(Please fill in number, eg. 0,1,2,3)
17.	**Over the past 28 days, how many times have you taken laxatives as a means of controlling your shape or weight?**	
		(Please fill in number, eg. 0,1,2,3)
18.	**Over the past 28 days, how many times have you exercised in a "driven" or "compulsive" way as a means of controlling your weight, shape or amount of fat, or to burn off calories?**	
		(Please fill in number, eg. 0,1,2,3)

Questions 19 to 21: Please select the appropriate answer. Please note that for these questions the

term "binge eating" means eating what others would regard as an unusually large amount of food for the circumstances, accompanied by a sense of having lost control over eating.

19. Over the past 28 days, on how many days have you eaten in secret (i.e., furtively)?
Do not count episodes of binge eating

No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day

20. On what proportion of the times that you have eaten have you felt guilty (felt that you¡¦ve done wrong) because of its effect on your shape or weight?
Do not count episodes of binge eating

None of the times	A few of the times	Less than half	Half of the times	More than half	Most of the time	Every time

21. Over the past 28 days, how concerned have you been about other people seeing you eat?
Do not count episodes of binge eating

Not at all — Slightly — Moderately — Markedly

Questions 22 to 28: Please select the appropriate answer. Remember that the questions only refer to the past four weeks (28 days).

22. Has your weight influenced how you think about (judge) yourself as a person?

Not at all — Slightly — Moderately — Markedly

23. Has your shape influenced how you think about (judge) yourself as a person?

Not at all — Slightly — Moderately — Markedly

24. How much would it have upset you if you had been asked to weigh yourself once a week (no more, or less, often) for the next four weeks?

Not at all — Slightly — Moderately — Markedly

25. How dissatisfied have you been with your weight?

Not at all		Slightly		Moderately		Markedly
○	○	○	○	○	○	○

26. How dissatisfied have you been with your shape?

Not at all		Slightly		Moderately		Markedly
○	○	●	○	○	○	○

27. How uncomfortable have you felt seeing your body (for example, seeing your shape in the mirror, in a shop window reflection, while undressing or taking a bath or shower)?

Not at all		Slightly		Moderately		Markedly
○	○	○	○	○	○	○

28. How uncomfortable have you felt about others seeing your shape or figure (for example, in communal changing rooms, when swimming, or wearing tight clothes)?

Not at all		Slightly		Moderately		Markedly
○	○	○	○	○	○	○

29. **What is your weight at present?** (Please give your best estimate.)

30. **What is your height?** (Please give your best estimate.)

31. **If female: Over the past three-to-four months have you missed any menstrual periods?**

32. **If so, how many?**

33. **Have you been taking the "pill"?**

THANK YOU

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PATIENT ALLERGIES AND/OR SERIOUS MEDICAL CONSIDERATIONS ALERT

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AGREEMENT FOR SERVICE / INFORMED CONSENT

Introduction

Welcome to Safe Harbor. This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by Safe Harbor for the Client. It is intended to provide important information regarding the practices, policies and procedures of this business and to clarify the terms of the professional therapeutic relationship between Therapist(s) and Client. Any questions or concerns regarding the contents of this Agreement should be discussed with the Therapist prior to signing it.

Risks and Benefits of Therapy

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Participating in therapy may result in a number of benefits to the Client, including, but not limited to, reduced stress and anxiety, 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 require substantial effort on the part of the Client, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts 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, anger, fear. There may be times in which the Therapist will challenge the Client's perceptions and assumptions, and offer different perspectives. The issues presented by the Client may result in unintended outcomes, including changes in personal relationships. The Client should be aware that any decision on the status of his/her personal relationships is the responsibility of the 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. The Client should address any concerns he/she has regarding his/her progress in therapy with Therapist.

Meetings and Fee Arrangements

Typically, an initial evaluation constitutes two to four sessions. During this time, we can both decide if your Safe Harbor Therapist is the best person to provide the services that you need in order to meet your treatment goals. For general outpatient psychotherapy, the standard of treatment is a minimum of one 45-50 minute session per week. Additional sessions may be longer or more frequent based on individual treatment needs. For intensive outpatient services, the standard of care may be two to three hours a day, up to seven days per week.

Once an appointment is scheduled, you will be expected to pay unless you provide at least **48 hours advanced notice of cancellation**. An exception would occur if we both agree you were unable to attend due to circumstances beyond your control. In addition, it is important to arrive to session on time. If you are late, your session will still end at the originally planned time.

Hourly fees for outpatient services are arranged through our business office. In addition to weekly appointments,

the Client will be charged for other professional services including report writing, telephone conversations lasting longer than five minutes, consulting with other professional with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request. If you become involved in legal proceedings that require Therapist participation, you will be expected to pay for all professional time, including preparation and transportation costs, even if the Therapist is called to testify by another party. Because of the difficultly of legal involvement, the Therapist charges 3 times the hourly rate.

Most of the clients participating in our program will be seen by a post-masters trained MFT or psychology intern. All interns are under the rigorous supervision of Darlene Manick, LMFT. Ancillary licensed medical and mental health professionals may, on a case-by-case basis, be consulted when necessary. If this occurs, we will make every effort to maintain your confidentiality in the strictest manner.

Therapist Availability
Due to each Therapist's work schedule, we are often not immediately available by telephone. However, each Therapist monitors his/her voicemail frequently. Every effort will be made to return your phone call as soon as reasonable possible. If you are difficult to reach, please inform us of some times when you are available. If you are unable to reach your Therapist and feel as if you cannot wait for a return call, contact your family physician or the nearest emergency room and ask for the psychologist/psychiatrist on call, or contact your insurance provider for an interim provider referral.

Limits on Confidentiality
The law protects the privacy of all communications between a patient and a psychotherapist. In most situations, the Therapist can only release information about your treatment to others if you sign a written Authorization form that meets certain requirements imposed by state law and/or HIPAA. However, there are some situations where we are permitted and/or required to disclose information without your consent:

- We may occasionally find it helpful to consult with other mental health professionals about a case. During consultation, every effort is made to avoid revealing the identity of the Clients discussed. The other professionals are also legally bound to keep information confidential. All consultations will be noted in the Client's Clinical Record and will be kept on file.
- The information disclosed by a Client is subject to the psychotherapist-patient privilege, the special relationship between the Therapist and Client. If the Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, we will assert the psychotherapist-patient privilege on the Client's behalf until instructed, in writing, to do otherwise by the Client or his/her representative. You, the Client, should be aware that you might be waiving the psychotherapist-patient privilege if you make your mental or emotional state an issue in a legal proceeding. Any concerns regarding the psychotherapist-patient privilege should be discussed further with an attorney.

There are some situations in which we, the Therapists, are legally obligated to take actions believed to be necessary to protect others. These actions may include having to reveal some information about the Client's treatment. These situations include:

- Reporting suspected child, elder, and/or dependent adult abuse
- When the Client makes a serious threat of violence towards a reasonably identifiable victim
- When the Client is dangerous to him/herself or the person or property of another

If such a situation arises, the Therapist will make every effort to fully discuss it with you before taking any

action, and will limit our disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and in situations where specific advice is required, formal legal advice may be needed.

Records and Record Keeping

The laws and standards of our profession require that we keep clinical records of each Client. We will not alter the normal record keeping process at the request of any Client. If the Client requests a copy of the Therapist's records, this request must be made in writing. A copy of records will be given to the Client within 30 days of the written request. Under California law, we reserve the right to provide our Clients with a treatment summary in lieu of their actual records. A treatment summary will be given to the Client within 30 days of the written request. Please be aware that because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we strongly recommend the Client initially review them with the Therapist. We reserve the right to charge a minimal fee for the cost of locating and preparing these records. We maintain Client records for seven years following termination of therapy, after which we destroy them in a manner that preserves our Client's confidentiality.

Insurance

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can to help you receive the benefits to which you are entitled. However, you (not your insurance company) are responsible for full payment of our fees. For this reason, it is very important that you take the time to find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience, and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call your insurance company on your behalf.

We accept and are contracted with the following insurance companies:

Aetna
Anthem
Blue Cross (Blue Shield)
College Health (CHIPA)
Magellan
Optum Health
Pacificare
United Health Care
United Behavioral Health
Value Options

You should also be aware that your contract with your insurance company requires we provide information relevant to the services we provide to you. We are required to provide a clinical diagnosis and/or additional clinical information such as treatment plans or summaries. Before we can disclose information, the insurance company must provide us with a written notification stating what they are requesting, why they are requesting it, and what will be done with the information once they are finished with it. In these situations, we will make every effort to release only the minimum information that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. By signing this Agreement, you agree that we can provide requested information to your insurance company.

If you do not have insurance coverage, you will be expected to pay for each session at the time it is held, unless we make other agreed-upon arrangements. In circumstances of unusual financial hardships, we may be willing to negotiate a fee adjustment or payment installment plan.

Termination of Therapy

The therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Client needs that are outside of the Therapist's scope of competence, or inadequate progress in therapy. The Client also has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, the Therapist will generally recommend that the Client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. The therapist will also attempt to ensure a smooth transition to another Therapist by offering three referrals to the Client.

Acknowledgement

By signing below, the Client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. The Client has discussed such terms and conditions with the Therapist, and has had any questions with regard to its terms and conditions answered to the Client's satisfaction. The Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with the Therapist. Moreover, the Client agrees to hold the 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. I also acknowledge I have seen and read Safe Harbor's California Notice of Psychotherapists' Policies and Practices to Protect the Privacy of Your Health (HIPPA). While this form is available to view in Safe Harbor's waiting room, I have also been offered a copy of this document for my own records.

Safe Harbor
Darlene Joy Manick, LMFT #32565
20301 Ventura Blvd. Suite 336
Woodland Hills, CA, 91364

AGREEMENT FOR SERVICE / INFORMED CONSENT

____
Client Name (please print)

____ __________________________
Signature of Client (or authorized representative) Date

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

____
Responsible Party (Please print)

____ __________________________
Signature of Responsible Party Date

Safe Harbor

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Safe Harbor is a facility that offers our community a variety of specialized services. Our professional staff is comprised of both licensed and post-masters level therapists.

IT IS OUR POLICY TO INFORM OUR CLIENTS WHEN THEY ARE RECEVING PSYCHOTHERAPY BY AN UNLICENSED CLINICIAN.

YOUR THERAPIST____________________________ IS A POST-MASTERS REGISTERED INTERN GAINING CLINICAL HOURS TOWARD LICENSURE UNDER REGULATED SUPERVISION BY DARLENE JOY MANICK M.A. LMFT LICENSE #32565.

ALL CLIENTS SEEN BY A REGISTERED INTERN ARE CLOSELY MONITORED AND DISCUSSED REGULARLY WITH DARLENE JOY MANICK IN ADDITION TO OUR WEEKLY CINICAL STAFF TREATMENT TEAM MEETINGS. TREATMENT TEAM MEETINGS MAY BE COMPRISED OF STAFF THERAPISTS OF SAFE HARBOR WHO ARE NOT DIRECTLY INVOLVED WITH YOUR TREATMENT PERSONALLY. PLEASE BE ADVISED THAT ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL PER HIPAA REGULATIONS AND DOES NOT LEAVE THE PREMISES OF SAFE HARBOR.

DARLENE JOY MANICK IS AVAILABLE FOR ADDITIONAL CONSULTATION AT ANY TIME FOR ANY REASON DURING THE COURSE OF YOUR TREATMENT WITH ANY OF OUR STAFF THERAPISTS.

IT IS YOUR RIGHT TO DISCUSS AND/OR CHANGE YOUR PSYCHOTHERAPY OPTIONS PRIOR TO CONTRACTING FOR SERVICES OR ANYTIME DURING THE COURSE OF YOUR TREATMENT WITH SAFE HARBOR AND ANY AGENTS OF DARLENE JOY MANICK M.A. LMFT LICENSE #32565.

YOUR SIGNATURE BELOW INDICATES YOU ARE FULLY AWARE OF AND IN AGREEMENT WITH SAFE HARBOR’S PSYCHOTHERAPY PRACTICES AND AGREE TO BE SEEN BY THE REGISTERED INTERN NAMED ABOVE AS YOUR THERAPIST.

Signature: ______________________________

Safe Harbor
Darlene Joy Manick, LMFT #32565
20301 Ventura Blvd. Suite 336
Woodland Hills, CA, 91364

Authorization to Release Confidential Information

I, [Name of Patient] ("Patient") ____________________________________hereby authorize [Name of Provider] ("Provider")____ to exchange confidential information obtained during the course of my treatment to [name or function of the person(s) or entities to whom information is to be released]______________________

____("Recipient") and agents of Safe Harbor.

This Authorization permits the release of the following information:

____ Diagnosis ____ Treatment Plan ____ Progress to Date

____ Prognosis ____ Clinical Test Results ____ Dates of Treatment

____ Any and All Information Necessary

____ Other (specify)

I authorize the release of the information described above for the following purpose(s):

____

____

The specific uses and limitations on the types of information to be released are as follows:

____

____

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.

The Authorization shall remain valid until: _______________________________ ("Expiration Date")

By: ___________________________________ Date: ___________________________________

(Patient or Patient's Representative)

*If signed by an individual other than Patient, please indicate relationship between Patient and his/her Representative____

*Agents of Safe Harbor include licensed clinicians, MFT Interns, dieticians, physicians, and psychiatrists associated with Safe Harbor and who are consulting as part of the treatment team.

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Billing Agreement - Important: Please read, initial, and sign

The patient agrees to pay at the time the services are rendered unless a payment arrangement is made in advance ___________

As a courtesy to the patient, we will call the insurance company for benefits in advance of services. It is the normal practice for the insurance company to quote that they will pay a certain percentage of an unknown "usual and customary" amount set by that particular insurance company.

The patient is responsible for a minimum of 50% of the patient fees at the time services are rendered. Please be advised that insurance quotes are only an estimate of coverage and the patient/responsible party is ultimately responsible for payment of services in full if insurance denies payment. ___________

A full 48 hour advance notice is required for cancellations or full fee will be charged. No exceptions. ___________

Group therapy fees are payable in full at the beginning of each month. Your space in the group is reserved, and therefore there are no refunds for missed sessions. ___________

If a payment is not paid in full or the agreeable payment is not made 30 days after the receipt of our invoice, a 3% interest charge will be added to the patient's account. ___________

By initialing all places above, the patient/responsible party is in complete agreement of paying IOEDP/Safe Harbor in the time allowed. Missed payments may be subject to collections after two attempts by phone and 30 days following first notification.

Our purpose is to provide our patients with excellent treatment. We ask that the patient/responsible party assist us by making payments on time so that the patient's time can be focused on treatment versus financial matters.

Please refer to Psychotherapist-Patient Services Agreement for specific fees.

Patient Signature____Date:______________________

Printed Name ____

Responsible Party Signature _____________________________Date:______________________

Printed Name ____

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SCHEDULE OF FEES

Uninsured Patients:

Initial Assessment $____________________________

Individual therapy session 45-50 minutes $____________________________

Conjoint (marital/family) therapy session 60 minutes $____________________________

Group therapy session per week $____________________________

Therapy/Consultation phone calls over 10 minutes in length are considered individual therapy sessions. These phone sessions will be billed at the same rate of individual therapy session, pro-rated 15 minute intervals.

Insurance Reimbursement

Co-pays:

Assessment $____________________________

Individual 45-50 minutes $____________________________

Conjoint $____________________________

Group $____________________________

*IOP will be reimbursed at contracted rate per your insurance company.

*Benefits are not guaranteed. Please be advised this is an estimate of payment. Active benefit will be determined upon payment from insurance company.

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Intensive Outpatient Eating Disorder Programs
INITIAL AGREEMENT

As a patient of Safe Harbor, I ___________________________(name of patient) hereby agree to the following outpatient program as recommended by the treatment team on ________________ (date):

INITIAL PROGRAM REQUIREMENTS:	**# SESSIONS PER WEEK:**
☐ Individual Therapy Session	Per Week 1 2 3
☐ Coping Skills Group	Per Week 1 2 3
☐ Primary Group Session	1x per week
☐ 12 Step	1x per week __OA __NA __AA __AL ANON
☐ Family Conjoint Therapy/Education	1x per week (Sat) (Tues)
☐ Primary Care Physician's Authorization for Outpatient Treatment	

SUPPLEMENTARY TREATMENT AS RECOMMENDED BY TREATMENT TEAM:

NUTRITION:		
	☐ Assessment	☐ Family Meal
	☐ Individual Counseling	☐ Market Field Trip
	☐ Weekly Weigh-Ins	☐ Home Visit
	☐ Individual Meal	☐ Other

☐ Medical Evaluation Date: Name of Physician Have on file	Comments:
☐ Psychiatric Evaluation Date: Name of Physician Have on file	Comments:
☐ Blood Screenings Date: Have on file	_____ x per week
☐ Physical Fitness Training	Cardio ____ x per week Weight Training ____x per week Other ____x per week

This program shall be re-assessed and if necessary, amended on ________________ (date).

Patient's Signature: ____ Date ____________________

Printed Name: ____

Responsible Party/Legal Guardian: ______________________________ Date ____________________

Printed Name: ____

Dietician's Signature: ____ Date ____________________

Primary Care Physician's Signature: _____________________________ Date ____________________

Treatment Team: Date ____________________

____

____

____

Safe Harbor

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MEDICAL SCREENING AND AUTHORIZATION

Must be performed or reported within 2 weeks after____________________.

Name of Patient: _________________________________ Date:___________________

To the physician: The patient named above is applying for treatment with Safe Harbor, an intensive outpatient eating disorder program in Woodland Hills, California. Please fill out this form completely. When certifying the patient for treatment, please keep in mind that this is an outpatient, non-hospital based program (24 hour medical supervision is not available). Thank you for your time.

Date of most recent exam: _______________________.

Date began seeing patient: _______________________.

Initial Reason for visit: ____
____
____

Eating Disorder Diagnosis (if any):
Anorexia Nervosa ____ Bulimia Nervosa ____ Binge Eating Disorder ____
Purging Type ___ Non-purging type ___

Other ____

Other significant medical problems (including co-morbid conditions): _________________
____
____
Medications/Dosage/Prescribing/Physician: _______________________________________
____

I _______________________________ hereby authorize agents of Safe Harbor to exchange confidential information obtained during the course of my treatment with ________________________ for the purposes of treating my eating disorder.

_________________________________ _________________________
Signature Date

Safe Harbor

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20301 Ventura Blvd. Suite 336
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Last date of menses: _______________________ Irregular ____ Last 3 cycles regular ____
Physical Exam: ___________________________
Height: ___________________________
Weight: ___________________________
Temperature: ___________________________
Pulse: ___________________________
Blood Pressure: ___________________________
BMI: ___________________________

Abnormal Findings on physical exam: ____
____
____

Concerns regarding suicide/homicide: ____

Any restrictions or concerns:

Exercise: ____

Dietary: ____

Social: ____

Other: ____

Certification: I have examined this patient and certify that he/she is medically stable to enter into treatment with Safe Harbor Programs. If at any time during my treatment of patient, I determine that patient needs alternative treatment or a higher level of care than Safe Harbor can provide, I agree to contact Darlene Manick, Executive Clinical Director of Safe Harbor, within 24 hours of such decision.

Signature: ______________________________ Date: ______________________________

Printed Name: ______________________________

Address: ______________________________

____

Phone #: _____________________ Emergency Phone#: ____________________________

License #: ______________________________

Safe Harbor

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20301 Ventura Blvd. Suite 336
Woodland Hills, CA, 91364

Electronic Payment Authorization

Please complete the following:

I, ______________________, give permission to have my credit card billed automatically for any outstanding payments over 30 days. I may choose to authorize Safe Harbor to bill me through my credit card for an ongoing basis.

Client Information

Name: ________________________________

Email: ________________________________

Zip Code: _____________________________

Telephone:_____________________________

Credit Card Information:

☐ Visa ☐ Master Card ☐ Discover

Credit Card #: _____________________________

Expiration Date:_____________________________

Security Code: _____________________________

I authorize charging my credit card for the following purposes.

☐ Use my credit card for unpaid amounts over 30 days.

☐ Use my credit card on an ongoing basis for all billing purposes.

☐ Late cancellations- less than 24 hours notice.

☐ No show to appointments.

Signature:____________________________ Date:________________________

Safe Harbor
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Woodland Hills, CA, 91364

Safe Harbor Financial Email Release

I agree and allow for any and all agents of Safe Harbor to send and receive any and all financial information relating to any of my, my spouse's, or my minor child's financial matters via email.

Printed Name___________________________________

Signature_______________________________________ Date________________

Safe Harbor
Darlene Joy Manick, LMFT #32565
20301 Ventura Blvd. Suite 336
Woodland Hills, CA, 91364

Please sign and acknowledge receipt of the following HIPAA (Health Insurance Portability and Accountability Act) policies:

Patient Signature: ________________________________Date:________________
Printed Name:____________________________________
Responsible Party Signature:_______________________ Date:________________
Printed Name:____________________________________

I. 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. (Please note that this particular provision must be set forth in your notice of privacy practices exactly as it is set forth here.)

II. 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 your 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 and on my website (if applicable). You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at www.safeharborprograms.com.

III. 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 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.

A. 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:

1. **For treatment**. 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 you're being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care. At certain times for best practices, it may necessary for our treatment team to communicate clinical information about our patients through text to our treatment team, which may include, but is not limited to any or all of Safe Harbor staff and necessary ancillary professionals involved in your treatment for any reason, and or email using minimally descriptive ID whenever possible. However, sometimes it may be necessary to use full names for clarity.
2. **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.
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 the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm com-plying with applicable laws.
4. Other disclosures. I may also disclose your PHI to others with-out your consent in certain situations. 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.

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

1. **When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement**. For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. **For public health activities**. For example, I may have to report information about you to the county coroner.
3. **For health oversight activities**. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. **For research purposes**. In certain circumstances, I may provide PHI in order to conduct medical research.
5. **To avoid harm**. In order to avoid a serious threat to the PHI to law enforcement personnel or persons able to prevent or lessen such harm.
6. **For specific government functions**. I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
7. **For workers' compensation purposes**. I may provide PHI in order to comply with workers' compensation laws.
8. **Appointment reminders and health related benefits or 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.

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

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health

care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. 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 ask for 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.

IV. WHAT RIGHTS YOU HAVE 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 that I am legally required or allowed to make.

B. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you to 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 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. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you 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 or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the 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 won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.

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 the 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 based fee for each 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 request that I correct the existing information or add the missing information. You must provide the request and your 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 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.

F. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made

about access to your 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.

VI. 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 com-plaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Darlene Joy LMFT 20301 Ventura Blvd. Ste 336 Woodland Hills CA 91364 8187131312 darlenejoy101@gmail.com

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.