

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: _____

For your safety, videotaping is in progress in the waiting room only

CHILD INTAKE ASSESSMENT FORM

IDENTIFYING INFORMATION

Child's name: _____

Date of birth: _____ Age: _____ Grade: _____

Race/ethnicity: _____ Religious affiliation: _____

Social security number: _____

Person(s) completing this form: _____ Today's date: _____

Referred by: _____

Child's custodian/guardian(s) is/are: _____

Child's Home Address: _____

City _____ State _____ Zip Code _____

Home Telephone: _____ Other Phone (specify type): _____

Is it OK to contact you/child at home? yes no OK to leave a message? yes no
Special instructions? _____

Emergency Contact Name: _____ Relationship to Child: _____

Address: _____

City _____ State _____ Zip Code _____

Home Telephone: _____ Other Phone (specify type): _____

MOTHER'S INFORMATION

Mother's name: _____ Date of birth: _____ Home phone: _____

Address: _____

Race/ethnicity: _____ Religious affiliation: _____

Highest Grade Completed: _____

Marital/relationship status (Check one):

Married Live with partner Single Separated/Divorced Widowed or Other:

Employment status (Check all that apply):

employed retired disabled student homemaker unemployed

If/When employed, what type of work does mother do?

_____ Current employer is:
_____ Years on

Current Job: _____ Business Phone: _____

Is it OK to contact mother at work? yes no OK to leave a message? yes no

Special calling instructions?

FATHER'S INFORMATION

Father's name: _____ Date of birth: _____ Home phone:

Address: _____

Race/ethnicity: _____ Religious affiliation: _____

Highest Grade Completed: _____

Marital/relationship status (Check one):

Married Live with partner Single Separated/Divorced Widowed or Other:

_____ Employment status (Check all that apply):

employed retired disabled student homemaker unemployed

If/When employed, what type of work does father do?

Current employer is:

_____ Years on

Current Job: _____ Business Phone: _____

Is it OK to contact father at work? yes no OK to leave a message? yes no

Special calling instructions?

STEP-PARENT'S INFORMATION

Step-parent's name: _____ Date of birth: _____ Home phone:

Address: _____

Race/ethnicity: _____ Religious affiliation: _____

Highest Grade Completed: _____

Marital/relationship status (Check one):

Married Live with partner Single Separated/Divorced Widowed or Other:

_____ Employment status (Check all that apply):

employed retired disabled student homemaker unemployed

If/When employed, what type of work does father do?

Current employer is:

_____ Years on

Current Job: _____ Business Phone: _____

Is it OK to contact father at work? yes no OK to leave a message? yes no
Special calling instructions?

LEGAL ASSESSMENT

Please list any current or previous legal issues:

REASON FOR SEEKING TREATMENT:

Describe any traumatic event(s) and/or problems your child has experienced:

TREATMENT GOALS:

What are your treatment goals for your child or for yourself?:

What do you consider to be other stresses in your child's life?

HISTORY OF THE PROBLEM

When did your child first start experiencing the problem(s)?

How often does the problem occur?

How long does it last?

Does your child have any thoughts of harming him/herself? No Yes

Has your child ever attempted to harm him/herself? No Yes If yes, please explain:

Does your child have any thoughts of harming someone else? No Yes

Has your child ever attempted to harm someone else? No Yes If yes, please explain:

Has your child ever had previous therapy/counseling of any kind? No Yes

If yes, when and for how long?

What concerns were addressed in therapy?

Was this experience helpful (please explain)?

Has your child ever been hospitalized for emotional/behavioral problems? No Yes

If yes, when/where was this:

Has your child been prescribed medications to control emotional/behavioral problems? No

Yes

If yes, please list medications, when prescribed, and by whom:

To your knowledge, has your child experimented with alcohol/drugs? No Yes

Are you concerned that your child might have or be developing a problem with alcohol or drugs?

No Yes If yes, please explain:

FAMILY

Has this child ever experienced any parental separations, divorces, or death? No Yes

If yes, when? _____ How old was the child at the time?

Please describe the circumstances.

If parents are separated or divorced, who has custody of this child? Legal: _____

Physical: _____

Do you have the court documents: Yes No If yes, please give therapist a copy of custody documents.

How often does the other parent see this child? ____ Weekly or more often

____ Once or twice a month

____ Few times a year
 ____ Never

Please list the age and sex for each sibling (including those deceased, and step-siblings):

Age	Sex	Relationship to Child	Living at home?
			No Yes
			No Yes
			No Yes
			No Yes
			No Yes
			No Yes

Other than any children already indicated above and parents, who else lives in the child's household?

Has anyone in the child's family had treatment for emotional problems? No Yes

If yes, please briefly explain (who/when):

_____ Has anyone in your family ever attempted or committed suicide? No Yes

If yes, please briefly explain (who/when):

FAMILY HEALTH

Describe father's present health:

_____ Describe mother's present health: _____ Have any

family members had any of the following (PLEASE CHECK IF YES)?

If yes, please specify family member's relationship to this child.

Cancer _____ Severe head injury _____

Tourette's syndrome _____ Cerebral palsy _____

Diabetes _____ Allergies _____

Heart disease _____ Alcohol/drug abuse _____

High blood pressure _____ Kidney disease _____

Behavior disorder _____ Migraine headaches _____

Depression _____ Multiple sclerosis _____

Mental Illness _____ Physical _____ disability

Mental retardation _____ Stroke _____

Nervousness _____ Tuberculosis _____

Seizures/epilepsy _____ Alzheimer's disease _____

Reading problem _____ Other Learning Problem _____

Speech/language problem _____ Sickle cell anemia _____

Attention Deficit/Hyperactivity Disorder _____

Sleep Difficulties _____ Tics _____

Anxiety _____ Bipolar Disorder _____

Other significant health or emotional problem:

What kinds of stressful events has your child experienced recently?

What kinds of stressful events have family members experienced recently?

CHILD'S EDUCATION

School (name, address)	Grade	Age	Teacher	Approx. Grades

Describe any difficulties or problems your child is having in school:

CHILD'S DEVELOPMENT

Pregnancy and delivery

Was this a planned pregnancy? No Yes

Was the mother under a doctor's care? No Yes

Number of previous pregnancies/miscarriages: _____

Describe any complications that occurred during the pregnancy:

What drugs/medications were used during the pregnancy?

At this child's birth, what was the mother's age? _____ Father's age? _____

Length of pregnancy: _____ weeks Birth weight: ____ lbs ____ oz.

Length of labor: _____

Child's condition at birth:

Mother's condition at birth:

_____ Length of stay in
hospital: Mother ____ days Child ____ days

Is this child adopted? No Yes If yes, please provide adoption history:

Was this child breast fed or bottle fed? No Yes If yes, when was she/he weaned?

At what age was this child toilet trained? Days: _____ Nights: _____

Did bed-wetting occur after toilet training? No Yes If yes, until what age: _____

Did soiling occur after toilet training? No Yes If yes, until what age: _____

Describe sleep routine/ patterns or problems:

Language difficulties? No Yes If yes, describe:

Delays with child's walking? No Yes If yes, describe:

As a young child, did your child have problems getting along with others? No Yes
If yes, describe:

Where there other problems experienced during the child's first year? No Yes
If yes, describe:

CHILD'S MEDICAL CARE

Child's physician: _____ Telephone: _____
Address: _____

How often does this child see a doctor? _____ Date of last visit: _____

Is this child currently on any medication? No Yes

If yes, indicate type and reason:

Does your child have any history of the following (please check all that apply):

hospitalizations surgeries high fevers serious accidents
eye, ear, nose & throat problems digestive disorder head injuries seizures
loss of consciousness serious illness allergies hyperactivity allergies:

Please list below details of any conditions you checked above, including any additional childhood illnesses and other medical conditions:

Condition/hospitalization	Age	Treated by whom?	Outcome of treatment

CHILD'S INTERESTS AND ACTIVITIES

Is this child involved in any extracurricular activities, such as school sports or music programs, clubs or religious organizations? No Yes If yes, please describe:

Please describe your child's strengths and positive characteristics:

Other information you feel is important and wasn't asked about:

Therapist's Signature: _____ (Date): _____

Supervisor's Signature: _____ (Date): _____

Safe Harbor
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PATIENT ALLERGIES AND/OR SERIOUS MEDICAL CONSIDERATIONS ALERT

AGREEMENT FOR SERVICE / INFORMED CONSENT FOR MINORS

Introduction

This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by Safe Harbor for the minor child(ren) _____ (herein "Patient") and is intended to provide _____ [name of parent(s)/legal guardian(s)] (herein "Representative(s)") with important information regarding the practices, policies and procedures of Safe Harbor (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Policy Regarding Consent for the Treatment of a Minor Child

Therapist generally requires the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for psychotherapy, Therapist will require that Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services.

Risks and Benefits of Therapy

A minor patient will benefit most from psychotherapy when his/her parents, guardians or other caregivers are supportive of the therapeutic process. Psychotherapy is a process in which Therapist and Patient, and sometimes other family members, discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to Patient, 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, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, as well as his/her caregivers and/or family members, 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. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge the perceptions and assumptions of the Patient or other family members, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships.

During the therapeutic process, many patients 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. Patient 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 Patient or Patient's family members or caregivers.

Records and Record Keeping

The laws and standards of our profession require that we keep clinical records of each patient. We will not alter the normal record keeping process at the request of any Patient or Representative. If Patient or Representative requests a copy of Therapist's records, this request must be made in writing. A copy of records will be given to Patient or Representative 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 Patient or Representative within 10 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 Patient or Representative initially review them with 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.

Confidentiality

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

Representative should be aware that Therapist is not a conduit of information from Patient. Psychotherapy can only be effective if there is a trusting a confidential relationship between Therapist and Patient. Although Representative can expect to be kept up to date as to Patient's progress in therapy, he/she will typically not be privy to detailed discussions between Therapist and Patient. However, Representative can expect to be informed in the event of any serious concerns Therapist might have regarding the safety or well-being of Patient, including suicidality.

Psychotherapist-Patient Privilege

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by a person with the authority to waive the privilege on Patient's behalf. When a patient is a minor child, the holder of the psychotherapist-patient privilege is either the minor, a court appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law. Representative

is encouraged to discuss any concerns regarding the psychotherapist-patient privilege with his/her attorney.

Patient, or Representative, should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient, or Representative, should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

Meetings and Fee Arrangements

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. Sessions are usually scheduled for 45-minutes once a week, although some sessions may be longer or more frequent based on individual treatment needs. 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.

The agreed upon hourly fee between Therapist and Client is \$_____. In addition to weekly appointments, this amount is charged for other professional services you may need, including report writing, telephone conversations lasting longer than 5 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.

Patient Litigation

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient, or Representative, and another individual, or entity, are parties. Therapist has a policy of not communicating with Representative's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's, or Representative's, legal matter. 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 Patient, Representative agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance. For these services, Therapist charges 3 times the hourly rate. In addition, Therapist will not make any recommendation as to custody or visitation regarding Patient. Therapist will make efforts to be uninvolved in any custody dispute between Patient's parents.

Insurance

If you have a health insurance policy, it may 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.

Safe Harbor

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We accept and are contracted with the following insurance companies:

Aetna
Anthem
Blue Cross
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

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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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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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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 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.

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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 RECEIVING 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: _____

Parent/Guardian Signature: _____

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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: _____

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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

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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

Safe Harbor

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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.
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:

Safe Harbor

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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

Safe Harbor

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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.

Safe Harbor

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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

Safe Harbor

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If you have any questions about this notice or any complaints 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.