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
20301 Ventura Blvd. #336
Woodland Hills, Ca 91364
(818) 713-1312

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☐

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 ○ Social Isolation ○ Self-Harming Behavior(e.g.cutting) ○ Perfectionism ○ Body Dissatisfaction	○ Hair Pulling (facial or body hair) ○ Tic Disorder ○ Obsessive Compulsive Disorder ○ Stealing or shoplifting ○ Difficulty Concentrating
○ Problems with Sleep	○ Sexual Compulsivity	○ Memory Problems
○ Anger Management	○ Lack of Sexual Desire ○ Problems with hoarding	○ Trouble with work ○ 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

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: ____

____

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:____

____

____

____

____

Safe Harbor

Darlene Joy Manick, LMFT #32565
20301 Ventura Blvd. Suite 336
Woodland Hills, CA, 91364
818-713-1312

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

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

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

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.

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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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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: ______________________________

Parent/Guardian Signature: _____________________________

Safe Harbor

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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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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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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

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.

Safe Harbor

Darlene Joy Manick, LMFT #32565
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 ☐ American Express

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:________________________