CONSENT TO TREAT A MINOR

I/We ____, parent(s) or legal guardian(s)
(parent / guardian)

of ____, a minor, hereby consent to
(minor)

counseling services of said minor by Elena Dasgupta-Tsinikas, LCSW. I/We understand that children are entitled to a confidential relationship with their therapist, and I/we will respect that confidentiality.

____
Name (PRINT)

____
Signature Date

____
Indicate Relationship to Minor (e.g. Mother, Father, Legal Guardian)

____
Name (PRINT)

____
Signature Date

____
Indicate Relationship to Minor (e.g. Mother, Father, Legal Guardian)

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3840 Woodruff Avenue, Suite 108, Long Beach, California 90808
Tel: (562) 270-4057

EVIDENCE OF CUSTODY STATUS

Divorced parents of minors are required to show evidence of their custody status prior to commencement of counseling services. A copy of the court document will be placed in the minor's file. If joint legal custody is specified, then both parents must give written consent for the minor to receive counseling services by Elena Dasgupta-Tsinikas, LCSW.

By signing below, I acknowledge that I have read and fully understand the above statement.

____
Parent Name (PRINT)

____
Signature of Parent Date

____
Parent Name (PRINT)

____
Signature of Parent Date

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NEW CLIENT INFORMATION SHEET
(MINOR)

General/Contact Information:

Minor's Legal Name: ______________________ Today's Date: ____________________

Minor's Preferred Name: ______________________ Gender: ______________________

Address: ______________________________ Date of Birth: _______ Age: ________

______________________________ Grade: ______ Special Ed? ________

SSN: ______________________________ Home Phone: ____________________

Ok to leave voicemail: Y □ N □

Referred by: ____

Parent #1: ______________________ Parent #2: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Cell Phone: ______________________ Cell Phone: ______________________

Ok to leave voicemail: Y □ N □ *Ok to leave voicemail*: Y □ N □

Ok to send text? Y □ N □ *Ok to send text?* Y □ N □

Work Phone: ______________________ Work Phone: ______________________

Ok to leave voicemail: Y □ N □ *Ok to leave voicemail*: Y □ N □

Occupation: ______________________ Occupation: ______________________

E-mail: ______________________ Email: ______________________

Parents' Relationship Status: ____

*Emergency Contact: ____

(*Name, Relation & Phone Number) *By providing this information you are authorizing therapist to contact this person in case of emergency.*

Others living in your home: ____

(*Names, ages, and relation*ship to minor)

____

Primary Insurance Information (if applicable):

Insurance Company: ________________ ID Number: ______________________

Group Number: ________________ Telephone Number: ____________________

Insured Name: ________________ Mental Health Plan: ____________________

Insured SSN: ________________ Auth #: ______________________

Insured Birth Date: ________________ Insured Employer: ____________________

Relationship to Insured: ______________ Co-Pay: ______________________

Areas of Concern:

Please describe your reasons for seeking treatment: ______________________________________

____

____

When did the issue arise? Was there an event that made these issues surface? ______________

____

What do you expect from therapy? ____

____

Please indicate and rate the issues you would like to work on in treatment:

1=Not an Issue **2=Mild Issue** **3=Moderate Issue** **4=Severe Issue**

__Depression	__Divorce	__Sexual Abuse
__Anxiety	__Adoption	__Traumatic event(s)
__Stress	__Behavioral Problems	__Learning Disabilities
__Anger	__Drugs/Alcohol	__Hyperactivity/Inattention
__Loss of Loved One	__Lack of Friends	__Nightmares
__Problems at School	__Loneliness	__Bed Wetting
__Problems at Work	__Self-harm	__Obsessions/Compulsions
__Relationship Issues	__Problems Coping	__School Fears/Bullying
__Sexuality/Sexual Issues	__Verbal Abuse	__Legal Matters:
__Family Conflict	__Physical Abuse	__Other:

Personal Medical History:

Primary Care Physician: ____

Phone: ______________________________ Fax: ______________________________

Allergies (including food/medication): ____

Current Medications: ____

____

Past Hospitalizations/Surgeries/Major Medical Issues: ____________________________________

____

Is your child currently being treated for medical issues? ___________________________________

____

Does your child have a history of blackouts, seizures, or withdrawals? (if yes, please describe): __

____

____

<u>Psychiatric History</u>:

Has your child ever received mental health treatment before? ____________________________

Provider Name	*Year(s)*	*# of Sessions*	*medication (if applicable)*

Has your child ever been hospitalized for a psychological problem? ________________________

If so, why was he/she hospitalized? ____

Hospital: ____________________________________ Year: _____________ # of days: __________

Has your child ever been diagnosed with a mental illness? (if so, what?) _____________________

____

Has your child ever attempted suicide? (if so, when?) _________________________________

Describe the circumstances that led to the attempt(s): ________________________________

____

____

Is your child currently having any suicidal thoughts that you know of? (if so, please describe): ___

____

____

Family History:

Please indicate which is true for your child or any other family members:

	Child	Mother	Father	Sibling	Grandparent
Depression					
Anxiety					
Suicide Attempts					
Alcohol Problems					
Drug Problems					
Emotional Problems					
Serious Medical Illness					
Violent Behavior					

Comments: ____

____

Lifestyle/Habits:

	Amount Currently Using	*Most Ever Used*	*When*
Coffee / Caffeine	____________	____________	________
Cigarettes/Vaping:	____________	____________	________
Alcohol:	____________	____________	________
Drugs (specify):	____________	____________	________

	Type(s)	*Frequency*
Current Exercise:	____________________	________________
Current Hobbies:	____________________	________________

Does your child have a friend/family member they talk to about their concerns? If so, who?____

____

Does your child participate in any regular social or community activities? If so, what? _________

____

What are some of your child's strengths/positive qualities? ______________________________

____

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OFFICE POLICIES & INFORMED CONSENT

This document is intended to provide you with important information regarding my practices, policies, and procedures, and to clarify the terms of the professional therapeutic relationship between therapist and client. Please read this document carefully, and initial after each section in order to indicate your understanding and agreement.

INFORMATION ABOUT YOUR THERAPIST

The name of this practice is Elena Dasgupta-Tsinikas, LCSW. I am a Licensed Clinical Social Worker (CA License # LCSW69299) and an independent provider of psychotherapy for individuals, couples, and families. Although I do share office space with other independently licensed providers, I am not an employee of or a partner in a group practice. I operate my private practice independently as a sole proprietor.

______Initial

RISKS & BENEFITS OF THERAPY

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

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times when I will challenge your perceptions and assumptions, and offer different perspectives. The issues that you present as my client may result in unintended outcomes, including changes in personal relationships. The client is responsible for any decision(s) on the status of his/her relationships.

During the course of therapy, many clients find that they feel worse before they begin to 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. We will keep working together as you go through the therapeutic process to meet your goals.

______Initial

CONFIDENTIALITY

Discussions between a therapist and client are confidential. Both ethical practice and California law protect your confidentiality, and no information can be released without your signed consent/authorization. However, certain conditions under California law do require confidentiality to be breached. A therapist is mandated to report to the appropriate agencies whenever s/he has knowledge of, or reasonably suspects, that a minor/child or elder has been physically abused,

sexually abused, severely emotionally abused, or that the minor/child's or elder's health is endangered due to lack of medical care, food, clothing, shelter or supervision. Elder abuse also includes financial abuse and restriction of physical freedom. Child abuse also includes a client owning, using, or in any way engaging in child pornography.

It has also been legally mandated that if an individual intends to take harmful or dangerous action against another, it is the therapist's duty to warn the person and/or the family of the person who is likely to suffer the results of harmful behaviors; as well as to notify the police.

Communications between therapists and clients who are minors (under the age of 18) are also confidential. However, as parents and other guardians who provide authorization for their child's treatment are often involved in said treatment, I may exercise my professional judgement in discussing the treatment progress of a minor client with the parent or caregiver, as appropriate.

______Initial

FINANCIAL ARRANGEMENTS

My fee for service is **$220.00** for an initial (90-minute) individual or family intake appointment. Thereafter, the rate for a standard 50-minute follow-up session is **$160.00**. Couples therapy sessions regularly take up to 90 minutes per session, and are therefore set at the flat rate of **$220.00** per session (regardless of whether the session is an intake or a follow-up appointment). Payment is due at the beginning of each session.

Forms, letters, reports, or similar inquiries involving my time will require a charge to be determined based upon the time necessary for the completion of the request.

Although you will be charged for the first session, keep in mind that the first session is an evaluation session, after which I will determine whether it is appropriate to begin treatment or refer you to a more appropriate therapist or another venue of care.

______Initial

INSURANCE

If you choose to use your insurance, it is your responsibility to check your benefits. I will make every effort to check your benefits, however benefits are often quoted incorrectly over the phone. Benefits will not be known fully until an Explanation of Benefits (EOB) is received. In the event that benefits are quoted incorrectly or insurance does not reimburse for sessions, the financial responsibility is on the client and the client will be billed for the balance.

______Initial

RELEASE OF INFORMATION FOR CLAIMS

Client or Authorized Representative, ____________________________________, authorizes therapist Elena Dasgupta-Tsinikas, LCSW, to release the necessary information to client's insurance provider in order to bill for sessions and authorize continued sessions.

______Initial

APPOINTMENTS & CANCELLATION POLICY

Therapy sessions generally occur weekly or more/less frequently as acuity dictates and you and I agree. If you are unable to attend a scheduled appointment, please give me as much notice as possible. ***I require 24-hour notice to cancel an appointment. Without 24-hour notice, you will be charged the full fee for your missed appointment.***

______Initial

COMMUNICATION

To contact me between sessions, please call and leave a message on my confidential voicemail. Email may be used, however, please limit email communication to scheduling issues, as I cannot guarantee your confidentiality via email. Your call/email will be returned within 24 hours. ***If you are experiencing a life-threatening emergency, please call 911 immediately.*** Please also note: therapy is a professional relationship and I will not associate with clients via social media.

______Initial

DUAL RELATIONSHIPS

Therapy never involves sexual or any other dual relationship that would impair my objectivity, my clinical judgment, or that would be exploitative in nature. Due to the confidential nature of our work together, it is my policy that if I were to see you out in the community, I would not acknowledge our relationship. This is intended to protect your privacy.

______Initial

CLIENT LITIGATION

Please be aware that I will not voluntarily participate in any litigation or custody dispute in which a client and another individual, or entity, are parties. I have a policy of not communicating with clients' attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in a client's legal matters. I will also generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving a client, the client agrees to reimburse me for any time spent for preparation, travel, or other time in which I make myself available for such an appearance at my usual and customary hourly rate of $160.00.

_____Initial

PROFESSIONAL CONSULTATION

Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. Please rest assured that during such consultations, I do not reveal any personally identifying information regarding my clients.

______Initial

RECORDS

The laws and ethical standards of my profession require that I keep treatment records; these records are locked and remain confidential. If you would like to request a copy of your records, such a request

must be made in writing. I reserve the right, under California law, to provide my clients with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. I will maintain client records for ten years following termination of therapy. After ten years, each client's records will be destroyed in a manner that preserves client confidentiality.

______Initial

TERMINATION OF THERAPY

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. Together we will plan for your termination as you approach the completion of your treatment goals.

Please be aware that, as your therapist, I reserve the right to terminate therapy at my discretion. Reasons for termination may include, but are not limited to: (1) untimely payment of fees, (2) failure to comply with treatment recommendations, (3) conflicts of interest, (4) failure to participate in therapy, (5) client needs that are outside of my scope of competence or practice, or (6) inadequate progress in therapy. You also have the right to discontinue therapy at any time.

Upon either party's decision to terminate therapy, I will generally recommend that you participate in at least one termination session. This is intended to facilitate a positive termination experience and to give us an opportunity to reflect on the work that has been done. I will also attempt to ensure a smooth transition to another therapist by providing you with referrals for other qualified professionals that I believe may be of help to you.

______Initial

ACKNOWLEDGEMENT

By signing below, I acknowledge that I have reviewed and fully understand the terms and conditions of this Agreement. I have discussed such terms and conditions with my therapist, and I have had any related questions answered to my satisfaction. I agree to abide by the terms and conditions of this Agreement and I consent to participate in psychotherapy with Elena Dasgupta-Tsinikas, LCSW. I also understand that I am financially responsible to Elena Dasgupta-Tsinikas, LCSW for all charges, including unpaid charges by my insurance company or any other third-party payer. Moreover, I agree to hold Elena Dasgupta-Tsinikas, LCSW free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

____

Client Name (PRINT)

____

Signature of Client (or Authorized Representative) Date

____

Therapist Signature Date

NOTICE OF PRIVACY PRACTICES

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

II. LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
I am legally required to protect the privacy of your PHI, w hich 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 w ith this Notice about my privacy practices, and such Notice must explain how , when, and why I w ill "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information w ithin my practice. PHI is "disclosed" w hen it is released, transferred, has been given to, or is otherw ise 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 w hich the use or disclosure is made. I am legally required to follow the privacy practices described in this notice. How ever, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes w ill be made available to you by request.

III. HOW I MAY USE AND DISCLOSE YOUR PHI
I w ill use and disclose your PHI for many different reasons. For some of these uses or disclosures, I w ill need your prior authorization; for others, how ever, 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 w ithout your consent for the follow ing reasons:

i. *For treatment*. I can disclose your PHI to physicians, psychiatrists, psychologists and other licensed health care providers w ho 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.
ii. *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 PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
iii. *For health care operations*. I can disclose your PHI to operate my practice. For example, I may provide your PHI to accountants, attorneys, consultants, and others to make sure I'm complying w ith applicable law s.
iv. *Other disclosures*. I may also disclose your PHI to others w ithout 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 w ith me (for example, if you are unconscious or in severe pain) and I think that you w ould consent to such treatment if you w ere able to do so.

b. Certain uses and Disclosures Do Not Require Your Consent. I can use and disclose your PHI w ithout your consent or authorization for the follow ing reasons:

i. *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 w hen ordered in a judicial or administrative proceeding.
ii. *For public health activities*. For example, I may have to report information about you to the county coroner.
iii. *For health oversight activities*. For example, I may have to report information to assist the government w hen it conducts an investigation or inspection of a health provider or organization.
iv. *For research purposes*. In certain circumstances I may provide PHI in order to conduct medical research.
v. *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.
vi. *For specific government functions*. I may disclose PHI to 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.
vii. *For workers' compensation purpose*. I may provide PHI in order to comply w ith workers' compensation laws.
viii. *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.

i. *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 w ill 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 w riting 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 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. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI I collected in connection with a legal proceeding. 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 the denial reviewed. If you request copies of your PHI, I will charge you not more than $.45 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 named 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 February 12, 2017.

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 (a) Correct and complete, (b) not created by me, (c) not allowed to be disclosed, and/or (d) not a 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.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES
If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice. My address and telephone number are at bottom of this document. I will not retaliate against you if you file a complaint about my privacy practices.

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
2. Calling 1-877-696-6775; or,
3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

VI. EFFECTIVE DATE OF THIS NOTICE.
This notice went into effect on February 12, 2017.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
I hereby acknowledge that I have reviewed and received a copy of the *Notice of Privacy Practices*

*Print Name:*____

*Signature:*____

*Date:*______________________

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CANCELLATION POLICY & CREDIT CARD AUTHORIZATION

A scheduled appointment means that this time has been reserved especially for you. If an appointment is missed or cancelled less than 24 hours prior to your session time, you will be charged the full fee of the session.

A credit card will be held for payment in the case of a late cancel or no show. This is required for the following reasons:

- When an appointment time is reserved for you, it is not available for other clients.
- When an appointment time is reserved for you, your therapist prepares for your appointment and sets that time aside for you.

Credit Card Number: ________________________ Type: ______________________

Expiration Date: ____________________________ CCV Code: __________________

I authorize Elena Dasgupta-Tsinikas, LCSW to charge the above card for the full fee of my session ($160.00 for individual or family sessions; $220.00 for couples sessions) in the event of a missed or late canceled session.

____ ___________________

Signature Date

If you would also like to use the above card to cover your regular payment for sessions, please sign below:

____ ___________________

Signature Date