

PATIENT INFORMATION SHEET

Trinity Ministries Group

4034 S. Demaree, Visalia CA 93277 / (559) 738-0700 / Fax: (559) 738-0710

PATIENT: (personal information)

Name: _____

Today's Date: _____ Referred by: _____

Home Address: _____ City/State/Zip: _____

Date of Birth: _____ Age: _____ SS No.: _____

Telephone: (home) _____ (work) _____

(cell) _____ (email) _____

Marital Status: Single _____ Married _____ Widowed _____ Seperated _____ Divorced _____

If married, how long: _____ If widowed, how long: _____

If seperated, how long: _____ If divorced, how long: _____

Spouse Name: _____

MESSAGES: (Please indicate if messages can be left or mail sent)

Phone messages: Home yes no Work yes no Cell yes no

Mailings: Home yes no

EDUCATION: (Check highest level completed)

Grade School High School College Graduate Graduate Degree

Other: _____

FAMILY:

Do you have children at home? Yes No (If yes list)

<u>Name</u>	<u>Age</u>	<u>Date of Birth</u>	<u>Sex (M/F)</u>
_____	_____	____/____/____	____
_____	_____	____/____/____	____
_____	_____	____/____/____	____
_____	_____	____/____/____	____

THERAPY:

Have you had previous Therapy: Yes No (If yes list)

Therapists Name: _____ Length of Treatment: _____

May we contact this Therapist?: Yes No Last appointment date: _____

Purpose of Treatment: _____

PATIENT INFORMATION SHEET Continued

Name: _____

HOSPITALIZATION: Have you had previous Psychiatric Hospitalizations?: Yes No (If yes list)

Hospital Name: _____ Date Hospitalized: _____

Hospital Name: _____ Date Hospitalized: _____

May we contact the Hospital?: Yes No

PHYSICIAN:

PCP Name: _____ Date of last Exam: _____

May we contact this Doctor?: Yes No

PATIENT EMPLOYER:

Employer Name: _____ Occupation: _____

Employer Address: _____ City/State/Zip: _____

INSURANCE:

If Mental Health benefits are available, do you want your Insurance billed?: Yes No

Primary Policy

Insurance Co.: _____ ID No.: _____

Name of Insured: _____ Group No.: _____

Insured's DOB: _____ Phone No.: _____

Insured's Employer: _____

Secondary Policy

Insurance Co.: _____ ID No.: _____

Name of Insured: _____ Group No.: _____

Insured's DOB: _____ Phone No.: _____

Insured's Employer: _____

EMERGENCY CONTACT: (In case of emergency contact)

Contact Name: _____ Phone No.: _____

Relationship: _____

Address: _____ City/State/Zip: _____

PATIENT QUESTIONNAIRE

Trinity Ministries Group
 4034 S. Demaree, Visalia CA 93277 / (559) 738-0700 / Fax: (559) 738-0710

Name: _____

Date: _____

This questionnaire is designed to help you indicate in what ways you might want some assistance.
 Please check the appropriate response, or fill in the answer. **YOUR RESPONSES ARE CONFIDENTIAL**

Brief description of the problem: _____

How long has it been a problem for you? _____

Have you previously sought help for this problem? Yes No
 (If yes with who?) _____ Therapist _____ Physician _____ Church/Pastor

Using the scale below, (5-Significant problem; 3-Some concern; 1-Does not apply), please circle the response that best describes problems you may have in the following areas

Marriage/Partner?	5	4	3	2	1
Family?	5	4	3	2	1
Child Rearing?	5	4	3	2	1
Job/School Performance?	5	4	3	2	1
Relationships?	5	4	3	2	1
Anxiety Level/Nerves?	5	4	3	2	1
Mood/Depressed?	5	4	3	2	1
General Health?	5	4	3	2	1
Eating Habits?	5	4	3	2	1
Sleeping Habits?	5	4	3	2	1
Ability to Concentrate?	5	4	3	2	1
Ability to Control Temper?	5	4	3	2	1

Financial Situation?	5	4	3	2	1
Legal Situation?	5	4	3	2	1
Alcohol Use?	5	4	3	2	1
Drug Use?	5	4	3	2	1
Spirituality?	5	4	3	2	1
Other (explain?)	5	4	3	2	1

PATIENT QUESTIONNAIRE Continued

Name: _____

HEALTH SUMMARY:

Current Medical Problems: _____

Current Medications:
(please list)

Medication name

Dosage

Frequency

_____ / _____ /
_____ / _____ /
_____ / _____ /
_____ / _____ /

Allergies to Medications:

Yes No (If yes list)

_____ / _____ /
_____ / _____ /

Primary Care Physician: _____

Date of last appointment: _____

May we contact this Doctor?: Yes No

Smoker?:

Yes No If yes, number of packs per day: _____ for _____ years
 If quite - year stopped: _____

Caffeine Drinks:

Coffee Tea Cola Other _____
 How many caffeine drinks per day?: _____

Alcohol:

_____ Beer _____ Wine _____ Other
 Amount per day/week: _____ (d / w) _____ (d / w) _____ (d / w)

If now a non-drinker, year stopped: _____

Drugs (list):

Amount per day/week: _____ If now a non-user, year stopped: _____

Family History (Has any blood relative ever had any of the following?)

	Yes	No
High blood pressure		
Cancer		
Diabetes		
Heart Trouble		

	Yes	No
Depression		
Anxiety		
Alcohol abuse		
Drug abuse		

Other (not listed above): _____

Other Concerns: _____

INFORMED CONSENT FOR TREATMENT

Trinity Ministries Group

4034 S. Demaree, Visalia CA 93277 / (559) 738-0700 / Fax: (559) 738-0710

Daniel S. Holford, LMFT	Jennifer Kramer, LMFT	Donald K. Weintz, LMFT	Kathie Mittman, LMFT
Timothy Hochhalter, LMFT	Rose Churchill, LMFT	Joy Rauch, LMFT	Richard Meyer, CATC
Cathy Humerickhouse, MFT Intern		Nagwa S. Maksy, MFT Intern	

Name: _____

Date _____

Consent for Treatment:

I authorize and request my practitioner to carry out psychological and/or psychiatric exams, treatment and/or diagnostic procedures which now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. **Initial here** _____

Confidentiality:

All communications made by you in the context of a therapeutic session are held in the strictest of confidence. Members of groups will be informed that they must be in agreement to participate. In order for information to be released to outside parties, you must sign a release of information. However, there are exceptions to confidentiality.

Exceptions to Confidentiality:

- 1) **Danger to self or others.** When information is communicated to a therapist that an individual intends to harm him/herself, or intends to harm another person(s), California law **mandates** that action must be taken to prevent harm. In the case of harm to self, such actions may include notifying family, the police, and/or psychiatric emergency teams from the county or psychiatric hospitals. In the case of harm to others, an attempt must be made to notify the intended victim and the police.

- 2) **Child Abuse/Elder Abuse/Abuse of Handicapped.** California law **mandates** that when a therapist (or other mandated reporter) receives information which creates a reasonable suspicion of:
 - a) child abuse or neglect (under 18 year of age)
 - b) elder abuse (over 65 years of age)
 - c) abuse of physically or mentally handicapped adults

information about the suspected abuse must be turned over to the appropriate governmental agency (i.e. child protective services, adult protective services).

Examples of child abuse can include, but are not limited to: slapping the child in the face, hitting in such a manner as to leave a mark on the child's body, punishment which results in physical injury or which psychologically traumatizes the child. Abuse also includes reasonable suspicion of sexual molestation. Neglect includes acts (or absence of acts) which could be reasonably construed as dangerous to the child's safety and well being.

INFORMED CONSENT FOR TREATMENT Continued

Name: _____

Please note: State law requires that the therapist report such abusive situations even when the abuse was in the past, if there is reasonable suspicion that the child, elder, or handicapped individual is still in the situation where the abuse occurred, or if the abuser has direct access to their children, elders, or handicapped individuals. For example: If an adult states that he/she was abused as a child by a parent, and if that parent still has charge over the children, the situation must be reported.

- 3) **Escaping Prosecution.** When a client attempts to use therapy as a means of escaping prosecution for the commission of a crime.
- 4) **Insanity Plea.** When a client makes an “insanity plea” as a defense in criminal proceedings.
- 5) **Court order:** When a court orders a psychological evaluation as part of legal proceeding, or your medical record is subpoenaed by the court, all information provided is accessible to the court.
- 6) **Minors.** While it is useful for minors to have confidentiality during therapy, except in cases specified by law, the parents have a right to information provided by the minor in the course of therapy.

Other circumstances when confidentiality may be broken:

- 1) **Client’s choice.** If the client chooses to have a therapist release information to another individual(s) (i.e. medical doctor, new therapist, family member, clergy, etc.) he/she may do so by signing consent from which lists the person(s) or agency to receive the information, the type of information which will be released, and the duration for which the consent is valid.
- 2) **Insurance.** Confidentiality may be broken in order to provide the necessary information for processing insurance claims for reimbursement of clinical services. The client must consent to this release of information. The client’s refusal to allow the release of such information to an insurance carrier places the client at full financial responsibility for the consequences which may result.

This information is provided so that the client of psychotherapy can understand the legal and voluntary limits of confidentiality. It is not intended to discourage someone from disclosing a problem where a problem exists. If a problem, such as outlined above exists, it is best to acknowledge it and seek help from the appropriate agency.

I have read and understand the “Informed Consent for Treatment”.

Signature:

(Client/Parent/Guardian/Conservator)

Date

Your Relationship to the Client

(Client/Parent/Guardian/Conservator)

Date

Your Relationship to the Client

INFORMED CONSENT FOR TREATMENT-SUPPLEMENT (Assessment)

Trinity Ministries Group

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Timothy Hochhalter, LMFT	Rose Churchill, LMFT	Joy Rauch, LMFT	Richard Meyer, CATC
Nagwa S. Maksy, MFT Intern	Cathy Humerickhouse, MFT Intern		

Name: _____

Date: _____

I give consent for evaluation and treatment to be provided for myself/my child

by: _____

I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.

The risks, benefits, side effects, and consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.

I understand that I need to provide accurate information about myself to my provider so that I will receive effective treatment. I also agree to play an active role in my treatment process.

I understand that I may terminate treatment at any time.

My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

Signature of Client or Parent/Guardian

Date

Printed Name

Relationship to Client (if applicable)

Witness Signature

Date

FINANCIAL POLICY & FEE SCHEDULE

Trinity Ministries Group

4034 S. Demaree, Visalia CA 93277 / (559) 738-0700 / Fax: (559) 738-0710

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Timothy Hochhalter, LMFT	Rose Churchill, LMFT	Joy Rauch, LMFT	Richard Meyer, CATC
Nagwa S. Maksy, MFT Intern	Cathy Humerickhouse, MFT Intern		

Name: _____

Date: _____

This statement is issued so you may understand the financial policies for the clinical services provided by Trinity Ministries Incorporated. **Payment in full for services provided is expected to take place at the time of the appointment.** All other payment arrangements must be made prior to any services being rendered.

Insurance: If you plan to use Insurance to pay for services, TMi will, to the best of their ability, help you receive maximum benefits. **However, you, not your insurance company, are responsible for full payment of services.** We will bill your insurance directly leaving you responsible for your co-payment, deductible, and charges not covered by the Insurance. In some cases pre-certification with your insurance company is necessary prior to sessions. If you have further questions please do not

Payment for services: Trinity Ministries Group will accept cash, check, and money orders. For a nominal fee you may also use a debit card, or credit card for payment of services rendered. Checks may be made payable to TMi or Trinity Ministries Group.

Current Fees: Unless otherwise documented by therapist.

	<u>Other</u>	<u>LMFT</u>	<u>PSY</u>	<u>CATC</u>	
_____	_____	\$110.00	\$125.00	\$65.00	for 50 minute history & evaluation
Therapist Initials	_____	\$90.00	\$125.00	\$65.00	for 50 minute individual psychotherapy
	_____	\$100.00	\$125.00		for 50 minute family therapy
	_____	\$100.00	\$110.00		for 50 minute conjoint therapy
_____	_____	\$60.00	\$75.00	\$60.00	per hour for reports
Client Initials	_____	\$35.00	\$50.00	\$45.00	for 1 hour group psychotherapy
	_____	\$110.00	\$150.00		hourly service other than office

Your session time is very important to TMI. Streamlining payment conditions frees our counseling staff to concentrate on you and your issues when you arrive for your sessions. Therefore, TMI asks you to take the time to make your check out prior to your appointment so that it is ready before your session begins. You may prefer to make your payment in cash, which is also acceptable, and you should have that amount prepared prior to the session if you choose that form of payment.

Returned Items (NSF): If a payment is returned by the bank there will be a \$25.00 service fee in addition to the original amount of the check presented for payment. _____ **Client Initials**

Collections: If your account becomes 90 or more days delinquent and you have not contacted our office to make payment arrangements your account will be sent to collections. This will be done at the discretion of your therapist.

FINANCIAL POLICY & FEE SCHEDULE Continued

Name: _____

Cancellation/No Show Policy: If you need to cancel or reschedule your appointment you must do so at least 24 hours or more in advance, otherwise you will still be responsible to pay the full payment. If you do not show for your scheduled appointment you will be billed the full amount as well. Cancellation and no show charges are **NOT** covered by Insurance, County and Victims Witness. _____ **Client Initials**

I have read and understand the “Financial Policy and Fee Schedule,” and agree to the following:

- a. the fee for each session is: _____(Individual) / _____(Conjoint)
- b. payment/co-payment is due in full at the time of service
- c. I am financially responsible to pay for any sessions cancelled less than 24 hours in advance of my scheduled appointment
- d. I am financially responsible for any “no-show” sessions
- e. To best utilize my session time of 50 minutes, I am to have my check or cash payment for sessions ready prior to my appointment

Appeals and Grievances-For Insured Clients _____ **N/A**

I acknowledge my right to request reconsideration (an Appeal) in the case that outpatient care is not certified. I understand that I can request an Appeal directly through my Health Plan and that I risk nothing in exercising this right.

I also understand that I may submit a Grievance to my Practitioner at any time to register a complaint about my care or I may send the complaint directly to my Health Plan. My practitioner has access to information and forms to facilitate this.

I understand that the California Department of Corporations (DOC) is responsible for regulating health care services. The California ODC has a toll-free telephone number (800-400-0815) to receive complaints regarding health care plans. If I have a grievance I can contact my insurer and use the appeal and grievance process. If I need the DOC’s help with a complaint involving an emergency appeal or with an appeal that has not been satisfactorily resolved by the plan, I can call the DOC’s toll free

Signature:

(Client/Parent/Guardian/Conservator)

(Client/Parent/Guardian/Conservator)

Date

Date

Your Relationship to the Client

Your Relationship to the Client

NOTICE OF PRIVACY PRACTICES (MENTAL HEALTH)

Trinity Ministries Group

4034 S. Demaree, Visalia CA 93277 / (559) 738-0700 / Fax: (559) 738-0710

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Name: _____

Date: _____

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable mental health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your mental health information is used. "HIPAA" provides penalties for covered

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your mental health information and how we may use and disclose your health information.

We may use and disclose your mental health records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing mental health care and related services by one or more mental health care providers.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit
- **Health care operations** include the business aspects of funding our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected mental health related information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosure of protected mental health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

NOTICE OF PRIVACY PRACTICES (MENTAL HEALTH) Continued

Name: _____

- The right to reasonable requests to receive confidential communications or protected mental health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected mental health information.
- The right to amend your protected mental health information.
- The right to receive an accounting of disclosures of protected mental health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected mental health information and to provide you with notice of our legal duties and privacy practices with respect to protected mental health information.

This notice is effective as of _____, 20_____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S. W.
Washington, D. C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Signature:

(Client/Parent/Guardian/Conservator)

Date: _____

Your Relationship to the Client:

(Client/Parent/Guardian/Conservator)

Date: _____

Your Relationship to the Client:

AUTHORIZATION for DISCLOSURE of CONFIDENTIAL MENTAL HEALTH INFORMATION (HIPAA)

Trinity Ministries Group

4034 S. Demaree, Visalia CA 93277 / (559) 738-0700 / Fax: (559) 738-0710

Daniel S. Holford, LMFT	Jennifer Kramer, LMFT	Donald K. Weintz, LMFT	Kathie Mittman, LMFT
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Cathy Humerickhouse, MFT Intern	Nagwa Maksy, MFT Intern		

Name: _____

Today's Date: _____

Date of Birth: _____

My therapist; _____

is authorized to release and disclose information to:

(Name of Person or Organization)

(If applicable) _____ (Name of Person or Organization)

is authorized to release and disclose information to my therapist; (Name of Therapist)

Specific Information to be Released/Obtained (Please select only one):

- All health/mental health information including diagnosis and treatment received.
- Only the following records or type of information:

Please specify if any information is to be excluded:

This disclosure of information authorized by Client is required for the following purpose:

This authorization shall become effective on: _____/_____/_____ and will expire in one year.

A photocopy or facsimile of this form is to be considered as valid as the original.

Please note: If you have authorized the disclosure of your mental health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written and verbal authorization or as specifically required or permitted by law.

AUTHORIZATION for DISCLOSURE of CONFIDENTIAL MENTAL HEALTH INFORMATION (HIPAA) Continued

Name: _____

Your Rights:

- You may refuse to sign this Authorization.
- You may revoke this Authorization only by delivering your revocation in writing to your therapist. Your revocation will be
- You have the right to receive a copy of this Authorization.
- You may inspect or obtain a copy of your mental health information, within the limits of California and federal laws.
- Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on your providing or refusing to

Signature:

(Client/Parent/Guardian/Conservator)

Date: _____

Your Relationship to the Client:

(Client/Parent/Guardian/Conservator)

Date: _____

Your Relationship to the Client:

AUTHORIZATION FOR THE REQUEST, RELEASE, OR EXCHANGE OF INFORMATION

Trinity Ministries Group

4034 S. Demaree, Visalia CA 93277 / (559) 738-0700 / Fax: (559) 738-0710

Daniel S. Holford, LMFT	Jennifer Kramer, LMFT	Donald K. Weintz, LMFT	Kathie Mittman, LMFT
Timothy Hochhalter, LMFT	Rose Churchill, LMFT	Joy Rauch, LMFT	Richard Meyer, CATC
Nagwa Maksy, MFT Intern	Cathy Humerickhouse, MFT Intern		

Name: _____

Date: _____

Information requested/released/exchanged:

Name/Agency _____

Address: _____

Information requested/released/exchanged:

_____ Psychiatric evaluation	_____ Insurance Information for	_____ Judicial documents
_____ Psychological tests/results	_____ claims for payment of services	_____ Consultation reports
_____ Progress Notes	_____ Dates of hospitalization	_____ All educational records
_____ Medication plans	_____ Chemical recovery reports	_____ Education tests/reports
_____ Treatment plans	_____ Diagnoses	
_____ Other (specify): _____		

Purpose for release/exchange:

_____ Diagnoses and treatment	_____ Insurance purposes
_____ Other (specify): _____	

This information may be communicated in the following manner:

_____ All means listed	_____ Oral and written/photocopies	_____ FAX
_____ Oral	_____ Written/photocopies	

Authorization For The Request, Release, Or Exchange Of Information

The authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, this authorization expires one year from the date of signing. I am aware or have been advised of the provisions of state and federal statues, rules and regulations which provide for my right to confidentiality of the information in these records. I realize that this is a voluntary consent and I must willingly and knowingly sign this authorization before any records can be released. I may refuse to sign, but in that event the records cannot and will not be released/exchanged. I realize the quality of my care may be affected by failure to secure these records. Failure to sign this for purposes of insurance reimbursement may jeopardize financial reimbursement by the insurance company.

Signature of client/parent/guardian/conservator

Date

Relationship to client

Signature of TMI staff and/or supervisor

Information released by

Date

To parties receiving this document: A photocopy or FAX of this release is as valid as the original.

EMERGENCY ACCESS PROCEDURE

Trinity Ministries Group

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Nagwa Maksy, MFT Intern	Cathy Humerickhouse, MFT Intern		

Name: _____

Date: _____

Emergency Access:

If you have an emergency, after regular office hours, you should call the main office number (738-0700) to access your therapist personal voice mail extension and from there you will be instructed on how to reach your therapist or how to leave your therapist a message. If this is an extreme emergency and you are unable to leave a message or wait for your therapist to call you back please hang up and call 911 or proceed to the nearest Emergency room. You can also contact Tulare County Mental Health at 1-800-320-1616.

I have read and understand the above statement.

Signature:

(Client/Parent/Guardian/Conservator)

Date: _____

Your Relationship to the Client:

(Client/Parent/Guardian/Conservator)

Date: _____

Your Relationship to the Client:

NOTE: Give client a copy of these instructions