Dr. Larry Lachman
Licensed Clinical Psychologist
(PSY 18627)

Phone: 831-915-6466
drlarrypsychologist@gmail.com

INTAKE QUESTIONNAIRE

Name_____ Date_____

Home Ph_____ Work Ph_____

Address_____

Age_____ DOB_____ Sex_____ SS#_____

Marital Status_____ Educational Status_____ Occupation_____

Presenting Problem - What Brings You Into Therapy?_____

_____

_____

_____

_____

Previous Counseling/Therapy/Hospitalization_____

_____

Medical Illnesses/Surgeries/Medications Taking_____

_____

_____

Alcohol Use: ☐ *None* ☐ *Social Use* ☐ *Problem Use*

Drug Use: ☐ *None* ☐ *Social Use* ☐ *Problem Use*

Suicidal/Homicidal Thoughts: ☐ *None* ☐ *Plans* ☐ *Past Attempt* Describe:_____

_____

_____

_____

_____

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INTAKE QUESTIONNAIRE (Continued)

Legal Problems: ☐ *None* Describe:

_____

_____

_____

Work/School Problems: ☐ *None* Describe:_____

_____

_____

Current Living Situation:_____

_____

Support Network:_____

_____

Major Issue/Challenge To Treat In Therapy: _____

Eight Problems Stemming from Major Issue:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Your Strengths and Positive Traits That Have Gotten You Through Tough Time In The Past:

_____

_____

_____

_____

_____

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INTAKE QUESTIONNAIRE (Continued)

Terms of Therapy and Confidentiality:

Everything discussed in therapy is confidential or private except for:

Child Abuse

Elder Abuse

Suicide

or Homicide

Your therapist is required by law to break confidentiality in these cases or face incarceration in jail and punitive fines.

In addition, records of therapy sessions may be turned over for court proceedings in response to an order of a judge who finds exception to privilege or confidentiality.

Also, you have the legal right to submit in writing a request to inspect your records (within 5 days), get a copy of your records (within 15 days) or a written summary of your records (within 10 days).

Therapy is usually conducted once a week for a 50 minute session.

If for whatever reason your insurance company does not submit payment, then by signing this page, you agree that you will be responsible for paying any outstanding amounts. Any outstanding payments not paid may be subject to collection agency referral with patient name, address, date of service and amount owed provided. If you need to cancel an appointment, please notify the therapist by phone no later than 24 hours before the appointment is scheduled to avoid being charged for a missed appointment. Thank you for your understanding.

_____ _____

Signature Date

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SLIDING SCALE THERAPY FEES

Household Gross Monthly Income:

$0 - 2,000/Month — $95/Per Session

$2,001 - 3,000/Month — $125/Per Session

$3,001 - $4,000/Month — $145/Per Session

$4,001 - $5,000/Month — $165/Per Session

$5,000+/Month — $185/Per Session

DISABILITY/WORKER'S COMP/PSYCH EVALUATION FEE

$180

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NO SELF-HARM / NO SUICIDE CONTRACT

I _____ agree to not hurt myself, harm myself, injure myself, or try to kill myself or commit suicide from the following date:

_____

to the following date:

_____

so my therapist and I can work on constructive life affirming ways to cope with emotional/physical/social/family/or spiritual pain and/or medical conditions, instead of me having to die.

I willfully and willingly abide by this no harm/no suicide contract.

_____ _____
Client Date

_____
Therapist

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AUTHORIZATION FOR THE RELEASE OF CLIENT RECORD INFORMATION

Regarding Records of: ___Psychiatric/Medical ___Drug/Alcohol

Client's Full Name:_____

Social Security Number:_____ DOB:_____

Dates of Treatment:_____

Information to be released ( ) From ( ) To

Name and Address:_____

_____

Phone/Fax Numbers: _____ / _____

Information to be released ( ) From ( ) To

Name and Address:_____

_____

Phone/Fax Numbers:_____ / _____

This authorization is effective immediately. This authorization expires **one year** from date of signing unless otherwise stated*. (*Expires:_____)

I realize this is a required consent if I wish my records to be released and that I voluntarily and knowingly sign this authorization BEFORE any records can be released. I understand I have a right to receive a copy of this release.

_____ _____
Client Date

_____
If not client, relationship to client

_____
Therapist

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PATIENT EMERGENCY CONTACT INFORMATION 2019/2020

Patient Name_____ Date_____

Street Address_____

Mailing Address_____

Home Ph_____ Cell Ph_____

Work Ph_____. Which Can Leave Messages At:_____

Please Provide TWO Emergency Contacts. Names, Relationship, Home Numbers, Work Numbers and Cell Numbers:

Emergency Contact Person One: Name_____ Relationship_____

Home Number_____ Work Number_____

Cell Number_____

Emergency Contact Person Two: Name_____ Relationship_____

Home Number_____ Work Number_____

Cell Number_____

Patient Insurance Company _____

Patient Insurance Identification Number_____

Patient Allergies and Medications_____

Patient Family Physician Name and Phone Number_____

_____

Patient Blood Type_____

Thank you for providing this required additional information for Dr. Lachman and his services.

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Office Location
215 W Franklin Street, Ste 318
Monterey, CA 93940

Mailing Address
PO Box 1653
Monterey, CA 93942

Tele-mental Health Informed Consent (Phone or Zoom/Internet)

I, _____, hereby consent to participate in **tele-mental health** with,_____ , as part of my psychotherapy. I understand that tele-mental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to tele-mental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there **are risks, benefits, and consequences associated with tele-mental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.**

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele-mental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) **I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be**

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determined that tele-mental health services are not appropriate and a higher level of care is required.

6) I understand that during a tele-mental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at_____ to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency. **Emergency Protocols** : I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. In case of an emergency, my location is: _____ and my emergency contact person's name, address, phone: _____
_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian _____
Date _____

Signature of therapist _____
Date _____

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CALIFORNIA HIPAA NOTICE FORM

Notice of Mental Health Provider Policies and Practices to Protect the Privacy of Your Health Information
This Notice Describes How Psychological and Medical Information about You May Be Used and Disclosed and How You Can Get Access to this Information. Please Review it Carefully.

I. Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *Protected Health Information* (*PHI*), for certain *treatment, and health care operations* purposes without your *authorization*. In certain circumstances I can only do so when the person or business requesting your PHI gives me a written request that includes certain promises regarding protecting the confidentiality of your PHI. To help clarify these terms, here are some definitions:

"*HIPAA"* refers to Health Insurance Portability and Accountability Act, a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

"PHI" refers to information in your health record that could identify you. *"Treatment and Payment Operations"*

"Treatment" is when I provide, or another healthcare provider, diagnoses or treats you. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist, regarding your treatment.

"Health Care Operations" is when I disclose your PHI to your health care service plan (for example your health insurer), or to your other health care providers contracting with your plan, for administering the plan, such as case management and care coordination.

"*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. *"Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties. *"Authorization*" means written permission for specific uses or disclosures.

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II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment and payment operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI.

You may revoke or modify all such authorizations (of PHI or psychotherapy notes) at any time; however, the revocation or modification is not effective until I receive it.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: Whenever I, in my professional capacity, have knowledge of or observe a child I know or reasonably suspect, has been the victim of child abuse or neglect, I must immediately report such to a police department or sheriff's department, county probation department, or county welfare department. Also, if I have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well- being is endangered in any other way, I may report such to the above agencies.

Adult and Domestic Abuse: If I, in my professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these or if I reasonably suspect such, I must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency.

1) I have been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect;

2) I am not aware of any independent evidence that corroborates the statement that the abuse has occurred;

3) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and

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Health Oversight: If a complaint is filed against me with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.

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Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made about the professional services that I have provided you, I must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; or 3) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides me with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified me that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.

Serious Threat to Health or Safety: If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.

Worker's Compensation: If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of the your initial examination, and at subsequent intervals as may be required by the administrative director of the Worker's Compensation Commission in order to determine your eligibility for worker's compensation.

IV. Patient's Rights and Provider's Duties

Patient's Rights:

1. *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
2. *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)*
3. *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
4. *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
5. *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
6. *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

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Provider's Duties:

1. I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
2. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
3. If I revise my policies and procedures, I will notify you in writing by U.S. mail or in person.

V. Complaints If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the **Privacy Officer** of CTOC: Dr. Larry Lachman, PO Box 1653, Monterey, CA 93942.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.