Cathy Chambliss

Licensed Marriage Family Therapist, MFC 39875
2615 Pacific Coast Hwy Suite 325
Hermosa Beach, CA 90254

Form to be completed by client (or parent/guardian if client is under 18)

Name: _____
Date of Birth: _____ Age: _____

Medication Allergies:
_____
_____
_____

Current medications:
_____
_____
_____
_____
_____

Physician diagnosed medical problems:
_____
_____
_____

Past surgeries:
_____
_____
_____

Personal and Family History:

1. Does your _____Father _____Mother _____Brother(s) _____Sister(s) have a history of alcohol or drug abuse? _____
2. Do you smoke? _____
3. Do you use alcohol? _____ If yes, would you describe your use as -- Minimal _____ Moderate _____ Heavy_____
4. Have you ever been treated or diagnosed with Alcoholism / Alcohol Abuse / Drug Addiction / Drug Abuse? _____
5. Do you think you are an alcoholic or a drug addict? _____

6. Have you abused prescription medications (your own or someone else's)? _____
   Type?
   _____
   _____

7. Have you been convicted of any type of drug or alcohol related crime within the past 10 years?
   _____

8. Household information: Please list any family members living in your home, including their names, age/birthdate and relationship to you.
   _____
   _____
   _____
   _____

9. Spouse/Significant Other information
   Name:_____Age:_____Sex:_____DOB_____
   Occupation:_____Employer/School:_____
   Phone number:_____Is it ok to leave a message?_____

10. Presenting Concerns:
    What circumstances or event caused you to seek therapy at this time?

_____
_____
_____

What specific goal would you like to accomplish in therapy?

_____
_____
_____

Current symptoms/behaviors (in your own words):

_____
_____
_____

What do you consider to be your strengths? What do you like most about yourself?

_____
_____
_____

Have you had previous experience with therapy or counseling of any kind? YES/NO
Was it beneficial? YES/NO
Briefly explain why.

_____
_____
_____

11. How were you referred to Cathy Chambliss, LMFT?

_____
_____
_____

12. Have you ever attempted suicide? YES/NO, if so, when?_____ Do you presently have suicidal thoughts? YES/NO

13. Do you have any history of physical or sexual abuse? YES/NO, if yes, please describe:

_____
_____
_____

14. Please describe any family history of psychological/psychiatric issues (include relationship to you, type of issue and whether treatment was received).

_____
_____
_____

_____ _____

Signature **Date**

Client Registration Form

Therapist: _____

Patient Demographic Information

Patient Name:	**Social Security # (optional):**
Street Address:	**Date of Birth:**
City, State, Zip Code:	**Home Phone:**
Gender:	**Work Phone:**
Email Address:	**Mobile Phone:**
Primary Physician:	**Psychiatrist (if any):**
Emergency Contact Person:	**Emergency Contact Phone:**
How did you hear about us?	**Marital Status:**

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)

Responsible Party:	**Home Phone:**
Street Address:	**Work Phone:**
City, State, Zip Code:	**Mobile Phone:**
Relationship to Patient:	**Responsible Party SSN (optional):**

No Show and Late Cancellation Policy

1. I understand that I will be charged a LATE CANCELLATION fee of $200 if I fail to give at least 24 hour notice prior to cancelling my appointment.

2. I understand that I will be charged a NO-SHOW fee of $200 if I fail to show for my appointment.

3. I understand that I will be charged a $10 service charge if I fail to make my payment at the time of my appointment.

4. I am an out of network provider but can give you a "superbill" which you can submit to your insurance for possible reimbursement.

5. I understand that the therapy session will last 50 minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

_____

Signature of Responsible Party

_____

Date

Emergencies

If you are in imminent danger, please call 911 or go to the nearest police department or emergency room.

Treatment Philosophy

I work with both couples and individuals to learn healthy ways to improve their self esteem, relationships, communication techniques, coping skills and both understanding/ managing emotions to improve both their relationships and quality of life. Sometimes people feel worse before they get better, but the goal is to always support you in your growth through a safe and compassionate experience . I used a variety of modalities to help you achieve your goals in counseling.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you, appointment reminder telephone calls, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal representative.

2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure increases risk of abuse, neglect, domestic violence and threats. Confidentiality is also broken in case of suspected child, elder or dependent adult abuse. If you are a danger to yourself, confidentiality will be broken to ensure your safety.

3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in Sections 1 and Sections 2.

4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at any time. Psychotherapy notes are part of your medical records.

5. You may request corrections to your records.

6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested in-

formation references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.

7. This agreement may be modified or amended as required by law or in the course of health care operations.

8. If you think I may have violated your privacy rights:
    a. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:
        i. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201
        ii. Calling 1-877-696-6775;
        iii. Visiting www.hhs.gov/orc/privacy/hipaa/complaints.

    I will not retaliate against you if you file a complaint about my privacy practices

I HAVE READ AND UNDERSTOOD THIS PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEATLH CARE INFORMATION.

_____ _____

Individual or Legal Representative (please print) Date

_____ _____

Signature of Individual or Legal Representative Date