Westlake Village Family Services
3625 E. Thousand Oaks Blvd. Suite 225
Westlake Village, CA. 91362

Checklist of Forms

_____Consent for Treatment-Adult / Minor

_____Fee Policy

_____Clients Rights

_____Notice of Privacy Practices & Acknowledgement of Receipt Form

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_____Signed limitations of confidentiality

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_____Nondiscrimination Policy

Westlake Village Family Services
3625 E. Thousand Oaks Blvd. Suite 225
Westlake Village, CA. 91362

CONSENT FOR TREATMENT-ADULT

I, _____________________________, HEREBY GIVE PERMISSION TO WESTLAKE VILLAGE FAMILY SERVICES TO EVALUATE AND IF DEEMED NECESSARY OR BENEFICIAL, PROVIDE ME WITH COUNSELING AND/OR CASE MANAGEMENT SERVICES.

I UNDERSTAND…

THAT AS PART OF THE AGENCY'S SERVICE DELIVERY SYSTEM, INFORMATION ON MY PROGRESS MAY BE SHARED WITH STAFF AT WESTLAKE VILLAGE FAMILY SERVICES;

THAT THE AGENCY MAY INCLUDE TRAINING FOR MENTAL HEALTH PROFESSIONALS AND I MAY BE SEEN BY A CLINICAL INTERN WHOSE WORK WILL BE SUPERVISED BY A LICENSED MENTAL HEALTH PROFESSIONAL; AND

THAT AS A PART OF THE AGENCY'S EVALUATION COMPONENT, YOU MAY BE CONTACTED AFTER TERMINATION BY AGENCY STAFF TO DETERMINE YOUR SATISFACTION WITH THE SERVICES RENDERED.

___________________________ ___________________________
SIGNATURE DATE

___________________________ ___________________________
WITNESS DATE

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CONSENT FOR TREATMENT-MINOR

I/WE ______________________________, THE PARENT(S)/GUARDIAN(S) OF

MINOR'S NAME__________________________, HEREBY GIVE PERMISSION TO

WESTLAKE VILLAGE FAMILY SERVICES TO EVALUATE AND IF DEEMED NECESSARY OR BENEFICIAL, PROVIDE MY CHILD WITH COUNSELING AND/OR CASE MANAGEMENT SERVICES.

I UNDERSTAND…

THAT AS PART OF THE AGENCY'S SERVICE DELIVERY SYSTEM, INFORMATION ON MY PROGRESS MAY BE SHARED WITH STAFF AT WESTLAKE VILLAGE FAMILY SERVICES;

THAT THE AGENCY MAY INCLUDE TRAINING FOR MENTAL HEALTH PROFESSIONAL AND I MAY BE SEEN BY A CLINICAL INTERN WHOSE WORK WILL BE SUPERVISED BY A LICENSED MENTAL HEALTH PROFESSIONAL; AND

THAT AS A PART OF THE AGENCY'S EVALUATION COMPONENT, YOU MAY BE CONTACTED AFTER TERMINATION BY AGENCY STAFF TO DETERMINE YOUR SATISFACTION WITH THE SERVICES RENDERED.

______________________________ ______________________________
SIGNATURE DATE

______________________________ ______________________________
SIGNATURE DATE

______________________________ ______________________________
WITNESS DATE

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FEE POLICY

$ ____ /per session is made payable to Westlake Village Family Services at the time of session, unless other arrangements are made at the onset of services. Westlake Village Family Services does not bill insurance, but can provide an invoice for you to provide to your insurance company, if needed.

CANCELLATION POLICY

There will be no charge for cancellations made at least 24 hours in advance of session.

______________________________	______________________________
SIGNATURE	DATE
______________________________	______________________________
SIGNATURE	DATE
______________________________	______________________________
WITNESS	DATE

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CLIENT'S RIGHTS

We are pleased that you have called upon Westlake Village Family Services for professional services. Westlake Village Family Services offers client's service regardless of their race, color, religion, national origin, gender, sexual orientation, age or disability. We will do our best to serve you well. As a client of Westlake Village Family Services, you are both entitled and welcome to:

1. Ask about professional qualifications.
2. Ask about and comment on agency policies and operations.
3. You have the right to participate in decisions regarding services provided to you or your family.
4. Know about our policies and procedures to protect your privacy.
5. Discuss any concerns with staff and, if you need further assistance, you may discuss your concerns with your therapist. Unsolved grievances or complaints may be taken to the Executive Director. All grievances will be responded to in writing within 30 days.
6. Refuse any service or treatment.

Under the laws of the State of California, this agency and its professionals employed by it are required to report information to police and/or various government social agencies in the following situations:

1. Reports of abuse to:
   - Children
   - Elderly
   - Dependent adults
2. Threats of violence
3. Threats of suicide

If you make statements to Westlake Village Family Services personnel concerning any of these categories, reports will be made by law. If you have any questions about these reporting requirements, please raise them.

Westlake Village Family Services reserves the right to terminate or not provide service at any time for such issues as: nonpayment of bills, in our professional judgment our services are not clinically appropriate or, in our professional judgment your behavior is threatening the well-being of our staff or clients.

Westlake Village Family Services will make every effort to provide service satisfactorily in all respects, and we welcome your suggestions and inquiries.

I have read the foregoing and understand it.

____________________________ ________________________

SIGNATURE DATE

____________________________ ________________________

WITNESS 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 THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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 (*insert website address, if applicable*).

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 written 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 use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physi-cians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

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 use and 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 my accountant, attorney, consultants, or others to further my health care operations.

4. Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. 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

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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 Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:
1. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.
2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.
3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.
4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.
5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.
6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.
7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.
8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

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 need your written authorization before using or disclos-ing 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 Restrictions on My Uses and Disclosures**. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to

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family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legal-ly required to make.

B. The Right to Choose How I Send PHI to You. You have the right to request that I send confidential 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 it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI. In most cases, you have the right to inspect and receive a copy of the PHI that I that I have on you, but you must make the request to inspect and receive a copy of such information 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 your request 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 Receive a List of the Disclosures I Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003.

I will respond to your request for an Accounting of Disclosures within 60 days of receiving such 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 the disclosure was made, to whom the 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 may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend 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 Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

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V. HOW TO COMPLAIN ABOUT OUR 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 Vl 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 complaints 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:

Michael Kaufman, M.F.T., Psy.D.
Westlake Village Family Services
3625 E. Thousand Oaks Ed. Suite 225 91362
818-730-2960

VlI. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have given to you. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at: 805-413-1130

If you have any questions about my *Notice of Privacy Practices,* please contact me at:
Westlake Village Family Services
3625 E. Thousand Oaks Blvd. Suite 225
Westlake Village, CA. 91362
1-818-730-2960

I acknowledge receipt of the *Notice of Privacy Practices* of Westlake Village Family Services.

Signature: ________________________________ Date:________________
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including [describe good faith attempts]. However, because of [*insert reasons why acknowledgement was not obtained*] I was unable to obtain my patient's acknowledgement.

Signature of Provider:________________________ Date: ________________

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Intake/Assessment

The following form was developed to make the intake process easier for clients. The questions are designed so that a minimum of writing is necessary; however, we ask you to elaborate on questions when requested. This form makes our work easier in that it standardizes the information we have on each of our clients. This form is part of your confidential file and it is available for your review at any time.

Name: ____
Last First Middle Initial

Name of parent/guardian (if under 18 years):

Name: ____
Last First Middle Initial

Birth Date: _______/________/_______ Age: _______ Gender: ____male _____female

Marital Status: ___ never married ___domestic partnership ___married ___ separated

___divorced ___widowed

Please list any children/ages:

____

____

Address: ____

Home Phone: __________________________ May we leave a message? ___yes ___no

Cell Phone: ____________________________ May we leave a message? ___yes ___no

Email: ________________________________ May we email you? ___yes ___no
*please note: email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): ____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

___yes, previous therapist/practitioner _______________________________
___no

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

How many times per week do you currently exercise? ___________________

What types of exercise do you participate in: __________________________

Please list any difficulties you experience with your appetite or eating patterns.

Are you currently experiencing overwhelming sadness, grief or depression?
___ No
___ Yes If yes, for approximately how long? ________________________

Are you currently experiencing anxiety, panic attacks or have any phobias?

___ No
___ Yes If yes, when did you begin experiencing this?
____

____

Are you currently experiencing any chronic pain?

___ No
___ Yes If yes, please describe?
____

____

Do you drink alcohol more than once a week?
___ No

___ Yes

How often do you engage recreational drug use?

____ Daily
____ Weekly
____ Monthly
____ Infrequently
____ Never

Are you currently in a romantic relationship?
___No
___Yes If yes, for how long? _________________

On a scale of 1-10, how would you rate your relationship? __________

What significant life changes or stressful events have you experienced recently?
____

____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

Are you currently employed?
__ No
___ Yes If yes, what is your current employment situation:
____
____

Do you enjoy your work? Is there anything stressful about your current work?____
____

What do you consider to be some of your strengths?
____
____

What do you consider to be some of your weakness?
____
____

What would you like to accomplish out of your time in therapy?
____

____

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Limitations of Confidentiality

I, ____________________________, understand that the staff of the Batterers' Treatment Program will report to the court, Probation Department and/or local law enforcement my participation in group, any threats to do bodily harm or kill another person, serious suicidal threats, violation of restraining orders, and violation of Program Rules. Suspected child abuse or neglect, will be reported to the Department of Children's Services and to the Court or Probation Department.

______________________ ______________
Client Signature Date

______________________ ______________
Staff Signature Date

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Unpaid Balances

In compliance with your signed contract, and the responsibility you have for your program fees, Westlake Village Family Services is issuing this policy.

If your current balance is zero, you will need to keep that balance current. If your balance becomes two payments behind, a violation will immediately be sent to court and/or probation and you may be terminated from the Program.

If you have a current balance, you must pay in addition to your fee each week until your balance is zero. If you fail to do this a violation will be sent to court and you may be terminated from the program.

I have read the foregoing and understand it.

______________________________ ______________________________
SIGNATURE DATE

______________________________ ______________________________
WITNESS DATE

Westlake Village Family Services
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Nondiscrimination Policy

Westlake Village Family Services in accordance with applicable Federal and State law does not discriminate in its employment practices and provision of benefits and services on the basis of race, color, national origin, religion, gender, gender identity, pregnancy, [1] disability, age, medical condition (cancer related), ancestry, marital status, citizenship, sexual orientation or status as a Vietnam-era veteran or special disabled veteran. Westlake Village Family Services also prohibits sexual harassment. This nondiscrimination policy covers admission, access, and treatment in Westlake Village Family Services programs and activities. This is pursuant to Title VI of the Civil Rights Act of 1964 (Section 2000d, Title 42, United States Code); the Rehabilitation Act of 1973 (Section 794, Title 29, United States Code); the Americans with Disabilities Act of 1990 (Section 12132, Title 42, United States Code); Section 11135 of the California Government Code; and Chapter 6 (commencing with Section 10800), Division 4, Title 9 of the California Code of Regulations.

Inquiries regarding Westlake Village Family Services nondiscrimination policies may be directed to Dr. Michael Kaufman, Executive Director of Westlake Village Family Services.

______________________ ______________
Client Signature Date

______________________ ______________
Staff Signature Date

[1] Pregnancy includes pregnancy, childbirth, and medical conditions related to pregnancy or childbirth.