Sync
Counseling Center, Inc

Section 1: Patient Information

Last Name_____ First Name:_____

Address _____ City_____State _____Zip_____

Age _____ Birthdate _____ Sex _____ Social Sec # _____

Home #_____ Cell # _____ Work #_____

Email #_____

Marital Status (circle) S M D W Who lives with you? _____

Employed? (circle) Yes / No Occupation_____ Net Monthly Income $_____

Employer Name/Address _____

Have you had previous psychological counseling? (circle) YES / NO Name of Therapist? _____

Do you now or have you ever had thoughts of harming yourself or others? (circle) YES / NO

Are you currently taking any medications? YES / NO If yes, please list_____

How did you hear about Sync? _____ Referring Physicians Name_____

Section 2: Areas of Concern

Please check the areas you feel you need help with:

☐ personal relationships	☐ legal/police	☐ marital	☐ drugs
☐ family	☐ drinking	☐ sexual	☐ parenting
☐ financial	☐ incest	☐ abuse	☐ other

Section 3: Communication Preferences

Please check which of the following ways you authorize your therapist to contact you. This may include the communication of confidential information. (you may check more than one box):

☐ home # ☐ cell # ☐ work # ☐ email

Thank you!

For Office Use Only

O/P: _____

Ins: _____

W/O: _____

Tel. 626-802-5490 Fax 626-921-0005 | www.sync.org

Counseling Center, Inc

Disclosure Statement & Consent for Treatment

Please read the following document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

About Your Therapist

Your therapist will discuss his/her professional background with you. Your therapist is a:

____Licensed Marriage and Family Therapist ____Licensed Clinical Social Worker ____Psychological Assistant

____Marriage/Family Therapist Registered Intern* (IMF#_____) _____ Marriage/Family Therapist Trainee

*If your therapist is a Marriage and Family Therapist Registered Intern, Marriage and Family Therapist Trainee, or Psychological Assistant his/her practice is conducted under the supervision of a licensed mental health professional.

Fees and Insurance

The fee for service is _____ per individual therapy session. Individual Sessions and conjoint (marital /family) sessions are approximately ____ minutes in length. Fees are payable at the time the services are rendered. Please inform your therapist if you wish to utilize health insurance to pay for services. You should be aware that you are responsible for verifying and understanding the limits of your insurance coverage. We are unable to guarantee whether your insurance will provide payment for the services provided to you.

Confidentiality | Minors & Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. *There are exceptions to confidentiality*. Therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker.

Appointment Scheduling | Cancellation Policies | Therapist Availability

Sessions are typically scheduled to occur one time per week at the same time and day if possible. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hrs in advance of your appointment. If you do not provide your therapist with at least 24 hours notice in advance, you are responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions. Non-urgent phone calls are returned during normal workdays within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that have been provided to you by your therapist. *In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.*

About the Therapy Process | Termination of Therapy

Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations and assist you in reaching your goals. We believe that therapists and patients are partners in the therapeutic process. Due to the varying nature of the therapeutic process your therapist is unable to predict duration or to guarantee a specific outcome of treatment. You may discontinue therapy at any time. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

Your signature indicates that you have read this agreement for services carefully and understand its contents.

Client Signature _____ Date_____

Parent/Guardian(If minor client) _____ Date_____

Therapist Signature_____ Date_____

Counseling Center, Inc

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)

Sync Counseling Center, Inc is legally required to protect the privacy of your PHI, which includes information that can be used to identify you that Sync Counseling Center, Inc 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. Sync Counseling Center, Inc must provide you with this Notice about our privacy practices, and such Notice must explain how, when, and why they will "use" and "disclose" your PHI. A "use" of PHI occurs when Sync Counseling Center, Inc shares, examines, utilizes, applies, or analyzes such information within their practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of the Sync Counseling Center, Inc practice. With some exceptions, Sync Counseling Center, Inc 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, Sync Counseling Center, Inc is legally required to follow the privacy practices described in this Notice.

However, Sync Counseling Center, Inc reserves the right to change the terms of this Notice and their privacy policies at any time. Any changes will apply to PHI on file with me already. Before Sync Counseling Center, Inc makes any important changes to their policies, I will promptly change this Notice and post a new copy of it in the office and on the website. You can also request a copy of this Notice from your therapist at Sync Counseling Center, Inc, or you can view a copy of it in the office or at at www.synctherapy.com

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

Sync Counseling Center, Inc will use and disclose your PHI for many different reasons. For some of these uses or disclosures, Sync Counseling Center, Inc will need your prior written authorization; for others, however, Sync does not. Listed below are the different categories of Sync Counseling Center, Inc 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. Sync Counseling Center, Inc can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. Sync Counseling Center, Inc 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. Sync Counseling Center, Inc can disclose your PHI to physicians, 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, Sync Counseling Center, Inc can disclose your PHI to your psychiatrist to coordinate your care.

2. To Obtain Payment for Treatment. Sync Counseling Center, Inc can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, Sync Counseling Center, Inc might send your PHI to your insurance company or health plan to get paid for the health care services that Sync Counseling Center, Inc have provided to you. Sync Counseling Center, Inc 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. Sync Counseling Center, Inc can use and disclose your PHI to operate my practice. For example, Sync Counseling Center, Inc 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. Sync Counseling Center, Inc may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

4. Patient Incapacitation or Emergency. Sync Counseling Center, Inc 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 Sync Counseling Center, Inc tries to get your consent after treatment is rendered, or tries to get your consent but you are unable to communicate with Sync Counseling Center, Inc or your therapist (for example, if you are unconscious or in severe pain) and Sync Counseling Center, Inc or your therapist 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. Sync Counseling Center, Inc 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, Sync Counseling Center, Inc 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, Sync Counseling Center, Inc may have to use or disclose your PHI in response to a court or administrative order. Sync Counseling Center, Inc may also have to use or disclose your PHI in response to a subpoena.
3. When law enforcement requires disclosure. For example, Sync Counseling Center, Inc may have to use or disclose your PHI in response to a search warrant.
4. When public health activities require disclosure. For example, Sync Counseling Center, Inc 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, Sync Counseling Center, Inc 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, Sync Counseling Center, Inc 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, Sync Counseling Center, Inc 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, Sync Counseling Center, Inc 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 Sync Counseling Center, Inc offers 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. Sync Counseling Center, Inc 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, Sync Counseling Center, Inc will need 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 writing to stop any future uses and disclosures (to the extent that Sync Counseling Center, Inc hasn't taken any action in reliance on such authorization) of your PHI by Sync Counseling Center, Inc.

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 Sync Counseling Center, Inc restrict or limit disclosures of your PHI to 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. Sync Counseling Center, Inc will consider your requests, but is not legally required to accept them. If Sync Counseling Center, Inc does accept your requests, Sync Counseling Center, Inc will put them in writing and will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that Sync Counseling Center, Inc is legally required to make.

B. The Right to Choose How I Send PHI to You. You have the right to request that Sync Counseling Center, Inc send confidential 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). Sync Counseling Center, Inc 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 Sync Counseling Center, Inc with information as to how payment for such alternate communications will be handled. Sync Counseling Center, Inc 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 Sync Counseling Center, Inc doesn't have your PHI but knows who does, they will tell you how to get it. Sync Counseling Center, Inc will respond to your request within 30 days of receiving your written request. In certain situations, Sync Counseling Center, Inc may deny your request. If they do, Sync Counseling Center, Inc will tell you, in writing, their reasons for the denial and explain your right to have their denial reviewed.

If you request copies of your PHI, Sync Counseling Center, Inc 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.

Sync Counseling Center, Inc will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list Sync Counseling Center, Inc 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. Sync Counseling Center, Inc will provide the list to you at no charge, but if you make more than one request in the same year, they 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 Sync Counseling Center, Inc correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. Sync Counseling Center, Inc will respond within 60 days of receiving your request to correct or update your PHI. Sync Counseling Center, Inc may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by Sync Counseling Center, Inc, (iii) not allowed to be disclosed, or (iv) not part of Sync Counseling Center, Inc records. Sync Counseling Center, Inc 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 Sync Counseling Center, Inc denial be attached to all future disclosures of your PHI. If Sync Counseling Center, Inc approves your request, they will make the change to your PHI, tell you they 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.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that Sync Counseling Center, Inc may have violated your privacy rights, or you disagree with a decision Sync Counseling Center, Inc 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 Dr. Curtis Miller, Sync Counseling Center, Inc. 482 N Rosemead Blvd #207 Pasadena CA, 91107, (626) 802-5490

VII. EFFECTIVE DATE OF THIS NOTICE: July 24, 2010

Counseling Center, Inc

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of Sync Counseling Center, Inc.'s Notice of Privacy Practices.

_____ _____

Signature of Patient Date

Counseling Center, Inc

Authorization to Bill Insurance

Section 1: Patient Information

Last Name_____ First Name:_____

DOB:_____ SS#: _____ Preferred Phone#:_____

Section 2: Insurance & Billing Information

I. Primary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of Policy Holder:_____ Policy Holder DOB:_____

Patient Relationship to Policy Holder: _____

Policy Holder's Gender (circle): Male Female Insurance Phone#:_____

Is your Primary Insurance Policy a (circle): POS PPO EPO HMO Other (specify):_____

II. Secondary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of Policy Holder:_____ Policy Holder DOB:_____

Patient Relationship to Policy Holder: _____

Policy Holder's Gender (circle): Male Female

Is your Primary Insurance Policy a (circle): POS PPO EPO HMO Other (specify):_____

Section 3: Guarantor Information

Last Name:_____ First Name:_____

Address: _____ City:_____ State: _____ Zip:_____

Phone: (___)-_____ - _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above -named patient.

X _____ _____

Guarantor's Signature Date

I understand that all out of pocket payment per session agreed upon by therapist and patient are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Sync Counseling Center, Inc. to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

Patient Signature: _____ **Date**: _____