Orange County Health Psychologists, Inc.

Intake Information

Name: _____ Date of Birth: _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Best phone number to reach you: _____ Alternate Phone: _____

E-mail: _____

Phone calls, mail and email will be discreet, but are there any restrictions for contacting you?

❑ None ❑ Yes, please describe: _____

Driver's License Number: _____ Social Security Number: _____

Who Referred You to Us _____

Emergency Information

In an emergency, if we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Primary Concern

Please describe the main difficulty that has brought you in today: _____

_____

_____

When did this start? _____

What current stressors are you experiencing in your life today that may affect your sense of happiness and well-being?

❑ Relationships ❑ Family ❑ Health ❑ Work or Career ❑ Educational ❑ Financial ❑ Legal ❑ Age Related Transitions

❑ Traumatic Events ❑ Identity ❑ Other _____

HEALTH & SOCIAL HISTORY

Sex Assigned at Birth: ❑ Female ❑ Male ❑ Intersex ❑ Decline to Answer

Gender: ❑ Female ❑ Male ❑ Transgender Female ❑ Transgender Male ❑ Genderqueer ❑ Nonbinary ❑ Other

With what race and ethnicity do you identify? Race: _____Ethnicity: _____

Sexual Orientation: ❑ Heterosexual ❑ Gay/Lesbian ❑ Bisexual❑ Asexual ❑ Pansexual ❑ Questioning ❑ Other

Which Best Describes You: ❑ Single ❑ Married ❑ Divorced ❑ Separated❑ Widowed ❑ Living with Partner ❑ Other

Do you have children: If so, how many/ages? _____ Do they live with you? ❑ Yes ❑ No

Religious or Spiritual Affiliation (if any): _____

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Education: What level of education did you complete? _____

Do you have any area of specialization? _____

Work History: Are you currently working? ❑ Yes ❑ No

If yes, Employer: _____ Job Title _____

If not currently working, do you have any prior work history? ❑ Yes ❑ No Type: _____

Health History

Primary Physician/Clinic Name: _____ Phone: _____

Address: _____

Consent to Collaborate on Care? ❑ Yes ❑ No ❑ Prefer to discuss first

Are you being treated for any chronic health problems? (Explain)

_____

Have you had any major surgeries and, if so, please describe: ❑ Yes ❑ No

_____

Have you had any head trauma and, if so, please describe? ❑ Yes ❑ No _____

Do you smoke tobacco products and, if so, please describe type and frequency: _____

How many caffeinated beverages do you drink a day? ❑ Coffee _____ ❑ Tea _____ ❑ Soda _____

How often do you have a drink containing alcohol? ❑ Never ❑ Monthly or less ❑ 2-4 times a month ❑ 2-3 times a week ❑ 4-5 times a week

How many standard drinks containing alcohol do you have on a typical day? ❑ None, I do not drink ❑ 1 or 2 ❑ 3 or 4 ❑ 5 or 6 ❑ 7 to 9 ❑ 10 or more

How often do you have six or more drinks on one occasion? ❑ Never ❑ Less than monthly ❑ Monthly ❑ Weekly ❑ Daily

Do you use cannabis products and, if so, please describe: ❑ Yes ❑ No _____

Prior Behavioral Health Treatment

1. Have you received psychological, psychiatric, drug / alcohol treatment or counseling services before? ❑ No ❑ Yes

If yes, when? _____ From whom? _____ For what? _____

With what results? _____

Orange County Health Psychologists, Inc.

2. Have you ever taken medications for psychiatric or emotional reasons? ❑ No ❑ Yes

If yes, when? _____ From whom? _____ Which medications? _____

With what results? _____

Medication List
Please list current medications, dose, and purpose. Include all prescribed and over the counter vitamins and supplements. If you have a list with you, we would be happy to make a copy.

Name	Dosage	Reason for Taking?	Effective?

FINANCIAL INFORMATION

We request credit card information to cover the cost of services including any insurance co-pays, deductibles, or late cancellation fees. If you prefer not to leave a credit card on file, please call the office to make other arrangements.
Credit Card Information:

Account Number: _____ Name on Card: _____

Expiration Date: _____CVS Code: _____ Billing Zip Code:_____

I authorize my OCHP provider to charge my credit card for the agreed-on amounts as services are rendered.

Signature: _____

_____ **I will not be using insurance and agree to pay my provider's stated rate by credit card, check, or cash at the time of service.**

INSURANCE INFORMATION:

_____ **I have the following insurance policy(s) in effect and understand I am responsible for any copays, deductibles, and uncovered portion(s) of the services rendered:**

(If using insurance, please be prepared to provide our staff with your insurance identification card(s)).

Orange County Health Psychologists, Inc.

Name of Primary Insurance Company: _____

Insurance Co Phone Number (For Behavioral Health): _____

Insurance ID#:_____ Group ID#: _____

Is your policy in your name? ❑ Yes ❑ No If no, is the policy in the name of your ❑ Spouse ❑ Parent?

Name on Policy (if different than yours): _____Date of Birth of Policy Owner: _____

Name of Secondary Insurance Company: _____

Insurance Company Phone Number (Behavioral Health): _____

Insurance ID#: _____ Group ID#: _____

Is your policy in your name? ❑ Yes ❑ No If no, is the policy in the name of your ❑ Spouse ❑ Parent?

Name on Policy (if different than yours): _____Date of Birth of Policy Owner: _____

The above information is true to the best of my knowledge.

Patient Signature:	**Date:**

IF APPLICABLE: For additional signature, identify whether you are:
☐Parent/Legal Guardian ☐Legal Representative ☐Power of Attorney ☐Other:
_____

Signature:	**Date:**

Orange County Health Psychologists, Inc.

CONSENT TO TREATMENT

Name:	Date of Birth:

Welcome to Orange County Health Psychologists. During our initial session, we will explore the reasons that you are seeking our services and your goals for treatment. We will then provide you with a recommended treatment plan including a description of the type of services and the number of sessions recommended. We will periodically review your progress and update the treatment plan as needed. Our hope is that you will play a very active role in this process and together we can create meaningful change in your life. This agreement serves as your consent to treatment and outlines some of your rights and obligations.

Initial	
	Cancellations and Missed Appointments: I understand that sessions should occur on a timely and regular basis to be effective. I agree to give at least 24 hrs. notice when cancelling or rescheduling an appointment. If I do not provide at least 24 hrs. notice, I agree to pay a cancellation fee of $75 and I understand that insurance cannot be billed for this fee. As a courtesy, the late cancellation fee may be waived one time.
	Consent to Use and Disclose Your Health Information: Treatment includes collecting and maintaining information that the law calls "protected health information" (PHI). I understand that my provider needs to use this information to provide treatment to me, and that this information may be shared with others to arrange payment for my treatment, to help carry out certain business or government functions, or to help provide other treatment to me. By signing this form, I agree to let OCHP use or share my PHI for the purposes described above. My signature below acknowledges that I have received the *Notice of Privacy Practices*, which explains in more detail how my PHI can be used and shared, and what my rights are with respect to my PHI.
	Agreement to Pay for Professional Services: I agree to pay my provider's per session fee. I accept responsibility for payment although other persons or insurance companies may make payments on my account. If my insurance company pays my provider directly, I assign payment or benefits to my provider. If my treatment is not covered by my insurance plan or if my provider is not in network with my plan, I agree to pay my provider's per session fee and receive reimbursement, if any, from my insurance company. I understand that if payment is not made, my treatment may be terminated.
	Telehealth Services: I understand that an option for therapy, assessment, or other services may include telehealth and that there are potential risks and benefits to telehealth that differ from in-patient sessions.

	If my provider and I decide to use telehealth, I understand and agree to the following: 1) Telehealth sessions require that I use a smartphone, WiFi-enabled tablet, or a laptop or PC with microphone and webcam. 2) Telehealth is conducted through Zoom HealthCare which is HIPAA-compliant platform that provides video conferencing in real time. 3) I should use a secure internet connection and not a public or unsecured WiFi connection. 4) Confidentiality still applies, and the session will not be recorded without the consent of both myself and my provider. 5) I should be in a private, comfortable location, free from distractions during the session. 6) At the beginning of the session, I will be asked to provide my location and a contact phone number for my provider to reach me in case of emergency or technical problems. 7) Due to licensing restrictions, it is important that I am in California at the time of the session, or in a state with reciprocal permissions with the state of California. 8) Many insurance companies will now pay for telehealth sessions, but I understand that it is my responsibility to verify coverage and pay for uncovered services.
	Email, Cell Phones, Computer and Fax Communication: I received a *Notice of Privacy Practices* containing detailed information about protecting my PHI. I understand that computers and unencrypted email, texts, and e-fax communication can be accessed by unauthorized people and can compromise my privacy and confidentiality. While stored data on OCHP computers may be encrypted; email, texts and e-faxes are not. If I choose to use unsecured text or email messages, I understand and accept the inherent risks.
	Legal or Forensic Services: I understand that my provider does not offer legal or forensic services such as claims for Worker's Compensation or lawsuits for child custody, disability, or employment disputes in the regular scope of practice. If any exceptions arise, I understand that fee schedules for forensic services are substantially higher and my provider will give me a written disclosure of those fees.
	Consent for Minors: I am either over the age of 18 or the parent or legal guardian of the minor named above. If giving consent for a minor, I give my permission for this minor to receive psychotherapy and/or assessment services. I affirm that there are no court orders in effect that would prohibit treatment of this minor child and I understand that it is my responsibility to provide OCHP with the name and contact information of the other party if any such a court order is in effect.
	Complaints: I understand that Orange County Health Psychologist providers are committed to providing optimal patient care and services using evidence-based therapies. However, if I am unhappy in any way, I agree to contact OCHP's founder, Dr. Kristin Kleppe, or the Practice Manager, Jennifer Koran by calling the main office number or emailing to Kleppe@ochealthpsych.com or Jennifer@ochealthpsych.com.

	If my complaint is not resolved, I understand a formal complaint can be filed with the following state agencies: **For Licensed Marriage Family Therapists (LMFT's), Licensed Professional Clinical Counselors (LPCC's), and Licensed Clinical Social Workers (LCSW's):** Notice to Clients: *The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of Marriage and Family Therapists, Licensed Educational Psychologists, Clinical Social Workers, or Professional Clinical Counselors. You make contact the board online at www.bbs.ca.gov or by calling (916) 574-7830.* **For Licensed Psychologists (PsyD's or PhD's):** Notice to Consumers: *The Department of Consumer Affairs' Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. If you have questions or complaints, you may contact the Board at www.psychology.ca.gov, by e-mailing bopmail@dca.ca.gov, or calling 1-866-503-3221 or writing to the following address: California Board of Psychology, 1625 North Market Blvd., Suite N-215, Sacramento, CA 95834.*

I have read and understand all the terms and conditions stated above regarding therapy, assessment, or other services. All my questions have been answered. My signature below shows that I understand and agree with all these statements.

Patient Signature:	**Date:**

I have discussed the terms of therapy or testing and assessment services with the patient and/or representative. My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent. A copy of the *Notice of Privacy Practices* has been given to the patient.

Provider Signature:	**Date:**

IF APPLICABLE: For additional signature, identify whether you are:
☐Parent/Legal Guardian ☐Legal Representative ☐Power of Attorney ☐Other:

Signature:	**Date:**

Orange County Health Psychologists, Inc.

Office: 949.528.6300 • Fax 855.PSY.DOCS • www.OCHealthPsych.com
15635 Alton Parkway, Suite 350, Irvine, CA 92618-7333

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

Orange County Health Psychologists, Inc.

NOTICE OF PRIVACY PRACTICES

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.

Privacy is an important concern for all those who come to this office. It is also complicated because of the many federal and state laws and the professional code of ethics that we follow. Because the rules are so complicated, some parts of this notice are very detailed. If you have any questions, we will be happy to help you understand our procedures and your rights.

I. Introduction

This notice will tell you how we handle your health information. It details how information is used in this office, how it is shared with other professionals and organizations, and how you can see it. We want you to know all of this so that you can make the best decisions for yourself and your family regarding privacy and confidentiality. If you have any questions or concerns about this information, please ask your provider.

II. What We Mean by Your Medical Information

Each time you visit us or any doctor's office, hospital, clinic, or other health care provider, information is collected about you and your physical and mental health. The information we collect from you is called "PHI," which stands for "protected health information." This information goes into your medical or health care records in our office.

In this office, your PHI is likely to include the following information:

- Personal history, including family, educational, occupational, relational, and medical status and history, including medications;
- Reasons you sought treatment including issues, symptoms, and/or treatment goals;
- Treatment plan;
- Progress notes that document your progress in treatment;
- Records we get from others who treated or evaluated you;
- Psychological test scores, school records, and other reports;
- Information about medications you took or are taking;
- Legal matters; and
- Billing, credit card and insurance information.

Although your health care records in our office are our physical property, the information belongs to you. You can read your records and can request a copy (although we may charge for the costs of copying and mailing). In some rare situations, you cannot see all of what is in your records.

If you find anything in your records that you think is incorrect or believe that something important is missing, you can ask us to correct or amend your records. In certain rare situations, we would have to agree to the requested correction or amendment. Ask your provider if you would like more information on the circumstances when we would not amend your records.

III. Privacy and the Laws on Privacy

We are required to tell you about privacy because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires us to keep your PHI private and to give you this notice about our legal duties and our privacy practices. We will obey the rules described in this notice. If we change our privacy practices, they will apply to all the PHI we keep. You may request a printed copy of this notice at any time.

IV. How Your Protected Health Information Can Be Used and Shared

Except in some special circumstances, when we use your PHI in this office or disclose it to others, we share only the minimum PHI needed for those other people to do their jobs. The law gives you rights to know about your PHI, to know how it is used, and to have a say in how it is shared.

Mainly, we use and disclose your PHI for routine purposes related to your care. For most other uses, we must inform you and ask you to sign a written authorization. However, the law sets forth certain other uses and disclosures that do not require your consent or authorization.

A. Uses and disclosures with your consent

After you have read this notice, you will be asked to sign a separate consent form to allow us to use and share your PHI. In almost all cases we intend to use your PHI here or share it with other people or organizations to provide treatment to you, arrange for payment for our services, or some other business functions called “health care operations.” In other words, we need information about you and your condition to provide care to you.

1. The basic uses and disclosure

a. For treatment. We use your medical information to provide you with psychological treatment or services. These might include individual, couples, family, or group therapy; psychological, educational, or vocational testing; treatment planning; or measuring the benefits of our services. We may share your PHI with others who provide treatment to you. If you are being treated by a team, we can share some of your PHI with the team members, so that the services you receive will work best together.

The other professionals treating you will also enter their findings, the actions they took, and their plans into your medical record, so we all can decide what treatments work best for you and make up a treatment plan. We are likely to share your information with your personal physician. If you receive treatment in the future from other professionals, we can also share your PHI with them. We may refer you to other professionals or consultants for services we cannot provide. When we do this, we need to tell them things about you and your conditions. In any of these examples, we would request your written permission prior to releasing any information. When we receive any reports from other providers, their report will go into your records here.

b. For payment. We may use your information to bill you, your insurance, or others, so we can be paid for the treatment we provide to you. We may contact your insurance company to find out exactly what your insurance covers. We may have to tell them about your diagnoses, what treatments you have received,

and the changes we expect in your conditions. We will need to tell them about when we met, your progress, and other similar things.

c. For health care operations. Using or disclosing your PHI for health care operations goes beyond our care and your payment. For example, we may use your PHI to see where we can make improvements in the care and services we provide.

2. Other uses and disclosures in health care

a. Appointment reminders. We may use and disclose your PHI to reschedule or remind you of appointments for treatment or other care. If you want us to contact you only at your home or your work, or if have a preferred means to reach you, we usually can accommodate that upon request.

b. Treatment alternatives. We may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of help to you.

c. Other benefits and services. We may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

d. Business associates. We hire other businesses to do some jobs for us. In the law, they are called our "business associates." Examples include a billing service that bills your insurance company for services or an accountant who manages our financial data. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy, they have agreed in their contract with us to safeguard your information.

3. Uses and disclosures that require your authorization

If we want to use your information for any purpose besides those described above, we need your permission on an authorization form. We do not expect to need this very often. If you do allow us to use or disclose your PHI, you can cancel that permission in writing at any time. We would then stop using or disclosing your information for that purpose. Of course, we cannot take back any information we have already disclosed or used with your permission.

B. Uses and disclosures that do not require your consent or authorization

In some cases, the law requires that we use and disclose some of your PHI without your consent or authorization. Although we make every effort to protect your privacy, here are some examples of when federal, state, or local laws or regulations would require disclosure.

1. When federal, state, or local laws or regulations require us to disclose PHI:

a. We are required to report suspected child, dependent adult and elder abuse, neglect, or exploitation.

b. If we come to believe that there is a serious threat to your health or safety, we can disclose some of your PHI to prevent or reduce the threat to your health or safety. We will only do this to persons who can prevent the danger.

c. In the event of a serious threat of physical violence made to a reasonably identifiable person(s), we have a duty to warn and protect by making reasonable efforts to communicate the threat to the person(s) and to a law enforcement agency.

d. We may have to release some of your PHI if you are involved in a lawsuit or legal proceeding and we receive a subpoena, discovery request, court order, or related legal request. We will only do so after attempting to tell you about the request, consulting your lawyer, or taking steps to protect the information they requested.

e. We must disclose some information to the government agencies that check on us to see that we are obeying privacy laws.

2. For law enforcement purposes

We *may* release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

3. For public health activities

a. We *may* disclose your PHI to agencies that investigate diseases or injuries relating to decedents.

b. We *may* disclose PHI to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.

4. For specific government functions

a. We *may* disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment.

b. We *may* disclose your PHI to workers' compensation and disability programs, to correctional facilities if you are an inmate, or to other government agencies for national security reasons.

C. Uses and disclosures where you have an opportunity to object

We can share some information about you with your family or close others. We will only share information with those involved in your care and anyone else you choose, such as close friends or clergy. We will ask you which persons you want us to tell, and what information you want us to tell them, about your condition or treatment. You can tell us what you want, and we will honor your wishes if it is not against the law.

If it is an emergency, and we cannot ask if you disagree, we can share information if we believe that it is what you would have wanted and if we believe it will help you if we do share it. If we do share information, in an emergency, we will tell you as soon as we can. If you do not approve, we will stop, as long as it is not against the law.

When we disclose your PHI, we may keep some records of whom we sent it to, when we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures.

V. Your rights concerning your health information

You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.

You have the right to ask us to limit what we tell people involved in your care or with payment for your care, such as family members and friends. We do not have to agree to your request, but if we do agree, we will honor it except when it is against the law, or in an emergency, or when the information is necessary to treat you.

You have the right to look at the health information we have about you, such as your medical and billing records. You may request a copy of these records but may be charged a copying or processing fee.

If you believe the information in your records is incorrect or incomplete, you may request additions or corrections to your records. The request must be made in writing and state the reasons for the addition or correction.

You have the right to a copy of this notice. If we change this notice, we will provide you with a revised copy.

You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with your provider and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. You may have other rights that are granted to you by the laws of our state, which may be the same as or different from the rights described above.

VI. If you have questions or problems

If you need more information or have questions about the privacy practices described above, please contact your provider at the address listed below. If you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, please let us know. Your concerns should be addressed to Dr. Kristin Kleppe at the address listed below. You also have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services. We will not limit your care or take any actions against you if you file a complaint. The effective date of this notice is July 1, 2012.

For concerns or questions regarding your privacy rights, contact your provider at:

Orange County Health Psychologists, Inc.
Attn: Kristin Kleppe, Psy.D.
15615 Alton Parkway, Suite 230 Irvine, CA 92618
Tel: 949.528.6300; Fax: 855.PSY.DOCS
Kleppe@OCHealthPsych.com

Orange County Health Psychologists, Inc.

To file a complaint with the Federal Government, contact:

Region IX, Office for Civil Rights
U.S. Department of Health and Human Services
50 United Nations Plaza, Room 322
San Francisco, CA 94102
Tel: 415.437.8310; Fax: 415.437.8329