Jeffrey Chernin, Ph.D., MFT
6310 San Vicente Blvd. Suite 410
Los Angeles, CA 90048
(323) 692-7781

Confidential Intake form

Name _____

Address _____

City _____ State/Zip _____

Birth date _____

Home phone _____ Cell phone _____

Email address _____

Place of employment and position _____

Work phone _____

Spouse/partner's name _____

In case of emergency, contact:

Name:_____ Phone _____

Please note that if you would like to be reimbursed by your insurance company, I will give you a form to send to your insurance company. In order to complete the form, please fill out the following information.

Insurance Company_____ Phone #_____

Subscriber ID#_____ Group #_____

Do you have additional insurance (yes/no)? _____

Why are you seeking counseling at this time? Please include current sources of stress:

_____
_____
_____
_____
_____

MARK THE BOX TO THE LEFT FOR ITEMS THAT ARE TROUBLING YOU

☐ Relationship	☐ Co-workers	☐ Family members	☐ Alcohol/drugs
☐ Eating/food	☐ Panic Attacks	☐ Depression	☐ Suicidal thoughts
☐ Anger outbursts	☐ Racing thoughts	☐ Self-harm	☐ Mood swings
☐ Shopping	☐ Gambling	☐ Internet use	☐ Sexual activities
☐ Legal matters	☐ Debt/spending	☐ Career/work	☐ Isolation
☐ Friendships	☐ Anxiety		

Are you taking any medications (yes/no)?___

If yes, please list:

Medication Dosage Reason for taking

_____
_____
_____
_____
_____
_____

Do you have a Primary Care Physician (PCP)? (yes/no) _____

If yes, PCP Name:_____ Phone number:_____

Have you had any previous psychotherapy, psychiatric care, or hospitalization for a mental disorder, or drug/alcohol problem? (yes/no) _____

Please provide the approximate dates and reasons you sought assistance:

_____
_____
_____
_____

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Information and Office Policies

Qualifications

I am a Marriage and Family Therapist (Lic. #37670), Nationally Certified Counselor (#28399), Master Addictions Counselor, and have a Ph.D. in Counseling. My education, training, and experience include providing psychotherapy to individuals, couples, and families since 1992.

Nature of Psychotherapy

Psychotherapy presents an opportunity to work on your personal issues, to learn, and to grow. You are responsible for your counseling experience, and we will explore ways in which you may possibly have greater fulfillment and understanding. You will also be encouraged to seek out alternatives to current actions and to explore new directions.

Our counseling relationship is based on equality, cooperation, and trust. Goal-setting will be discussed and mutually decided. Please note that while it is impossible to guarantee specific results, progress can be made with the required amount of effort on your part.

Counseling has many potential benefits, but there may be times you feel uncomfortable as you explore new ways of thinking and acting. There may be unexpected life changes, and possible negative consequences may occur, which may be discussed at any time.

Some clients need just a few sessions to achieve their goals; others require longer. As a client, you are in complete control – including refusing or modifying any technique. You may terminate at any time. When you leave, please consider a "closure" session to discuss progress, areas which may require further attention, and referrals.

Although our sessions may be very intimate psychologically, ours is a professional relationship that will be rendered in accordance with acceptable ethical standards. Our contact will therefore be limited to counseling sessions.

Referrals

Should you or I feel it is appropriate, we will identify and make referrals, including for severe emotional distress or medical attention. If at any time you're dissatisfied with this service, please let me know. If you have a complaint that cannot be resolved by discussion or referral, you may contact the Board of Behavioral Sciences, 400 R St. 3150, Sacramento, CA 95814.

Appointments

Your therapy time is reserved for you. Please give me 48 hours notice for a missed session. If you're unable to notify me the day before your appointment, you will be charged for the session.

Telephone Contact

Although our contact will be limited to sessions, there may be reasons for you to contact me. Generally, I do not charge for short phone conversations. If you cannot reach me, and if your safety is involved, please call 911 and leave a message on my voicemail.

Payment of Fees

All fees are payable in full at the time of each therapy session. I accept checks, credit cards, or cash for payment. An insurance receipt will be provided for you so that you may file your own insurance at your convenience. I will be happy to complete any additional forms related to that process which your insurance company may require. The only time I file insurance for you is if it is required by your insurance company.

Most health insurance companies require that I diagnose your mental health condition and indicate you have an illness before they will agree to reimburse you. I will inform you of the diagnosis before I place it on the receipt for you to submit to your insurance company. Any diagnosis made will become a part of your permanent insurance records.

Confidentiality

The law gives you, the client, a right to confidentiality. This means that anything you say to me will be held in strictest confidence. However, all MFT's are governed by various laws and regulations, including the obligation to break confidentiality in certain situations, which are:

1) If a determination is made that you are in imminent danger to harming yourself, I must do what I can to ensure your safety. The same is true if you are about to harm someone else or their property. (Please note: Imminent danger does not mean thinking about or considering it. It's imminent if you have the means to carry it out and are determined to do it soon).
2) If I suspect or learn about actual child abuse, adult dependent abuse, and elderly abuse. As a mandated reporter, I must report this.
3) If a court of law (a judge) requires disclosure, I have no option but to comply.
4) If you're filing insurance and your insurance company requires information for filing insurance claims, it becomes part of your insurance records.
5) In the event that I become ill, disabled, or unavailable for any reason, Dr. Faith Szalay (or another trusted, licensed therapist) will be responsible for my practice and administering practice materials. Dr. Szalay can be contacted at (323) 878-2263.

PLEASE NOTE: Sessions are 50 Minutes in Length

Jeffrey Chernin, Ph.D., MFT
Los Angeles, California

Notice of Privacy Practices

Federal privacy regulations known as the Health Insurance Portability and Accountability Act (HIPAA, eff. date April 14, 2003) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as "health care operations"), including how to access your health information. Nevertheless, I ask for you consent in order t make this permission explicit.

My commitment to your privacy

I am dedicated to maintaining the privacy of your health information. Being required by law to maintain the confidentiality of your health information, I am also required to provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require me to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official, for example by subpoena.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. I will only make disclosures to another person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by appropriate authorities for national security.
6. To federal officials for intelligence or national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For lawsuits or claims for Workers Compensation and similar programs.

Please note: Your health information does not include progress notes and are therefore <u>not</u> subject to disclosure to an outside party.

Additional disclosures:

1. To obtain payment for treatment from your insurance company or health plan.
2. To disclose health information to others without your consent if you are incapacitated or if an emergency exists.
3. To remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that may be of interest to you.

Your rights regarding your health information

1. Communications: You can request that I communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may ask that I contact you at home rather than at work. I will accommodate all reasonable requests.
2. Restrictions: You can request a restriction in the use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that I restrict disclosure of your health information to only certain individuals involved in your care or payment for your care, such as family members and friends. If you are referred to a physician or if I refer you to a physician for additional care, disclosure of your health information will most likely be made to that physician. I am not required to agree to a request not to do so; however, if I do agree, I am bound by this agreement except when required by law, in emergencies, or when the information is necessary to treat you.
3. An accounting of disclosures: You can request to receive an accounting of certain disclosures of your health information I have made, if any.
4. Receiving a copy of your health records: You can inspect and receive a copy of your health information that may be used to make decisions about your care, including medical records and billing records, but not including psychotherapy notes. You must submit your request in writing. I will respond to your request within 30 days. In certain situations, I may deny your request, and if I do, I will explain the reasons for the denial and explain your right to have the denial reviewed. Also, instead of providing the health information you request, you may be provided with a summary or explanation as long as you agree to receive one. I hold records for seven (7) years after termination except in the case of minors, which is seven (7) years or until age 19, whichever is later.
5. Amending your health information: You may ask me to amend your health information if you believe it is incorrect or incomplete. To request an amendment, you must provide the request and your reason for the request in writing. I will respond within 60 days. I may deny the request in writing if I feel your health information is correct and complete, are not part of my records, or may cause you harm. I will state the reasons for a denial and explain that your request and denial be attached to all future disclosures. If I approve your request, I will make the change and inform you that it has been done.
6. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask me to give you a copy at any time.
7. If you believe that your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.
8. I will obtain your written authorization for uses and disclosures that are not identified in this notice or permitted by applicable law.
9. I reserve the right to change this Notice in the future, and before any important changes to my policies are made, I will promptly change this Notice and offer you a new copy of the policy.

SIGNATURE PAGE

I acknowledge that I have been presented with a copy of the *Notice of Privacy Practices* and *Information and Office Policies Forms* and have read them, with any relevant questions answered:

_____

Client signature

Date _____

_____

Jeffrey Chernin, Ph.D., MFT

Date _____