

Patient Information

NAME (OR PARENT OF MINOR) _____ DATE _____
ADDRESS _____ ZIP _____
HOME PHONE _____ WORK PHONE _____
MOBILE PHONE _____ PAGER _____ EMAIL _____
DOB _____ PLACE OF BIRTH _____ ETHNICITY _____
MARITAL STATUS: Single Married Separated Divorced Widowed Domestic Partnership
EDUCATION (YEARS) _____ DEGREE _____ AREA _____
OCCUPATION _____ EMPLOYER _____
SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____

NAME OF SPOUSE/PARTNER _____
ADDRESS _____ ZIP _____
HOME PHONE _____ WORK PHONE _____
MOBILE PHONE _____ PAGER _____ EMAIL _____
DOB _____ PLACE OF BIRTH _____ ETHNICITY _____
EDUCATION (YEARS) _____ DEGREE _____ AREA _____
OCCUPATION _____ EMPLOYER _____
SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____

| NAMES OF CHILDREN: | DOB: | AGE: | NAMES OF CHILDREN: | DOB: | AGE: |
|--------------------|-------|-------|--------------------|-------|-------|
| 1 _____ | _____ | _____ | 4 _____ | _____ | _____ |
| 2 _____ | _____ | _____ | 5 _____ | _____ | _____ |
| 3 _____ | _____ | _____ | 6 _____ | _____ | _____ |

FAMILY PHYSICIAN _____ PHONE _____
ADDRESS _____ ZIP _____
PERSON TO CONTACT IN CASE OF EMERGENCY _____
RELATION _____ PHONE 1 _____ PHONE 2 _____
ADDRESS _____ ZIP _____

WHO REFERRED YOU TO THIS OFFICE? _____
MAY WE CONTACT THIS PERSON TO THANK HIM/HER FOR THE REFERRAL? _____ (INITIAL): _____

2. Informed Consent

The following information is intended to answer some of the questions you may have about my practice, services, fees, and office policies. Please carefully read this document and sign, indicating that you understand and accept these conditions. If you have any questions, please contact me to discuss any issue that may be of concern to you. My independent practice is specialized in the areas of clinical and educational psychology. Specific services include psychological and educational testing, individual, couples, group and family psychotherapy, and consultation/liason services. If I determine that your needs are not within my area of specialty, I will assist you in finding an appropriate referral.

I will keep a clinical record that will contain information about your condition and treatment. Specifically, that record will contain dates of contact, a psychological history, a diagnosis, a treatment plan, notes about your progress, and other documents relevant to your treatment. This record is confidential and may be released only with your written consent. (Please refer to exceptions to confidentiality in the section below).

Dr. Kathline Colvin provides psychological services as a licensed psychologist in the state of California.

ABOUT PSYCHOTHERAPY. Psychotherapy is usually helpful to people who wish to improve their lives. People may enter therapy to increase self-awareness, gain a better understanding of personal goals and values, improve relationships, resolve many kinds of personal traumas or dilemmas, and develop skills in areas of assertion, boundaries, communication, problem solving, and emotional management. Research shows that many people who enter therapy find that it helps them in some way. A person's outcome from therapy is improved by putting forth a sincere effort, being honest with oneself and with his/her therapist, being open to feedback, and being willing to follow through with recommendations offered by the therapist.

POTENTIAL RISKS & BENEFITS. Although psychological services are helpful to most patients, there are no guarantees of success. Furthermore, there are some risks in psychotherapy. People who receive psychological testing may have difficulty learning that they have a particular psychiatric diagnosis that they find unexpected or distressing. Persons participating in therapy may experience strong emotions such as anxiety, frustration, sadness, and anger when dealing with troubling situations or unpleasant past events. Therapy can bring up memories or realizations that may be distressing, and some people may experience unanticipated personal dilemmas, worries, or nightmares. Also, trying to resolve issues with other important people in your life, such as a spouse/partner, child, or other family member, can lead to discomfort and may result in changes that were not originally intended. Similarly, patients who request evaluations for court purposes may discover that our clinical impressions and opinions differ from what they expected. Like any professional or medical service, psychotherapy may not work, and for some people, symptoms or problems may get worse. In general, however, the discomfort experienced in psychotherapy is part of the process of delving into uncomfortable feelings or problems so that you might emerge at a more satisfying and rewarding place in your life and relationships.

CHOOSING THE RIGHT THERAPIST FOR YOU. It is very important that you feel comfortable with your therapist and confident in his/her approach. Please feel free to ask pertinent questions about our backgrounds, training, and experience, our impressions about your situation, and what treatments may be used inside or outside of this office (including alternative treatments and how to access them). If you feel that another therapist might be better able to help you, please discuss this with Dr. Colvin and you will be helped with recommendations and/or reputable referrals in your area.

I understand that I have the right to end therapy at any time with no obligation except to pay for completed services.

3. Confidentiality Policies

Confidentiality is the legal right to privacy for all patients who receive psychological services, and is protected by both ethical practice and by California law. That is, all personal information presented in this office will not be discussed with persons or agents outside of this office except as authorized by a written release or as required by law. However, there are exceptions to confidentiality. I understand that all information discussed in this office will remain confidential *except* under the following circumstances:

- ◆ I consent in writing for Dr. Colvin to release information.
- ◆ A breach of confidentiality is required or permitted by law. Examples include instances in which Dr. Colvin has a reasonable suspicion of child abuse, elder/dependent adult abuse, dangerousness toward self or others.
- ◆ Dr. Colvin at her discretion may decide to obtain consultation on my case with a colleague or legal counsel, in which case no identifying information will be revealed.
- ◆ I fail to make regular payments on my outstanding bill, which can result in my bill being turned over to a collection agency.
- ◆ If this is a Social Service Agency case, wherein all information shared with Dr. Colvin will be conveyed to the assigned Social Worker and/or other SSA representatives and agents.
- ◆ If you are a party in litigation, including divorce litigation, and you tender your mental condition as an issue, your privilege may be waived. In custody cases, you may be required to waive your privilege to facilitate an evaluation by a court ordered evaluator. We may be required to produce your records and/or testify at deposition or trial if we are served with subpoenas or court orders. We cannot give you legal advice as to what actions may or may not waive your privilege.
- ◆ Please be aware that under California's Family Code, a parent without custody may still be entitled to information about his or her child's treatment.
- ◆ **Note:** This office frequently contacts clients by Cellular Phone and Email. These technologies are **not** guaranteed of privacy. *Please circle whether you authorize contact by Mobile Phone & Email.*
YES / NO Initial: _____.

NOTE TO PARENTS ABOUT CHILDREN'S CONFIDENTIALITY: If my child/adolescent participates in treatment, I understand the importance of allowing him/her to develop a semi-confidential relationship with his/her therapist. As such, I understand that most personal information that my child/adolescent discusses with his/her therapist will not ordinarily be shared with me. Rather, my child's therapist will provide me with *general summaries* of my child's progress without private details. However, I understand that this office is committed to informing me about unusual or dangerous symptoms or behaviors (including violence, criminal activities, child abuse, self-abuse, suicidality, or intentions to harm others, harm oneself, alcohol and substance use).

4. Financial Policies

PROFESSIONAL SERVICES AND RATES. Our professional services and rates are as follows:

| PROFESSIONAL SERVICES: | TIME: | RATES: | |
|---|--|--|-------------|
| ◆ Initial Evaluation (first appointment): | 60 minutes | \$195.00 | |
| | 90 minutes | \$285.00 | Or Prorated |
| Review of Records | 60 minutes | \$150.00 | Or Prorated |
| <hr/> | | | |
| ◆ Psychotherapy: | 45-50 minutes | \$150.00 | |
| | 90 minutes | \$250.00 | |
| Late Cancellation/No Show | Billed at Full Fee | | |
| <hr/> | | | |
| ◆ Psychological and Educational Testing | 60 minute session | \$150.00 | |
| | 90 minute session | \$250.00 | |
| <hr/> | | | |
| ◆ Consultation (Face to Face) | 60 minutes | \$195.00 | Or Prorated |
| Phone Consultation and E-mail | 10 minutes | \$ 30.00 | Or Prorated |
| <hr/> | | | |
| ◆ Report Writing: (Treatment summaries, letters, etc.) | Prorated. | \$150.00 per hour | |
| <hr/> | | | |
| ◆ Court-Related Services: (Any court-related services, including evaluations, depositions, conferencing, testimony, preparation, standby and travel time, reports to be used for legal purposes, etc.) | Prorated. Half-Day minimum for court attendance or standby status. Retainer required in advance. | \$200 per hour | |
| <hr/> | | | |
| ◆ Workshops: (One-Day, 8-Week & 16-Weeks) | Please call for workshop dates. | \$200.00 per hour (includes all materials). | Or Prorated |

FINANCIAL RESPONSIBILITY. Please use the following table to specify who will be financially responsible for services. Adults seeking and paying for their own individual therapy will typically designate themselves as solely (100%) responsible. However, couples and families may divide financial responsibility. Specifying in advance exactly who will be financially responsible will help us bill the appropriate parties.

| RESPONSIBLE PARTIES (PRINT NAME): | Percentage of Services responsible for: | Do you wish to receive a monthly statement? | Do you need extra invoices to attach to insurance claims? | SIGNATURE: |
|--------------------------------------|---|---|---|------------|
| | % | Yes No | Yes No | |
| | % | Yes No | Yes No | |
| | % | Yes No | Yes No | |
| Comments: | | | | Date: |
| | | | | |

PAYMENTS: Please make checks payable to “Dr. Kathline Colvin.” The policy of this office is to collect payment at the time of service. You will receive a monthly statement that will show all payments made. Balances not paid within 30 days are PAST DUE. There is a one and one half percent monthly service charge added to all amounts after 30 days. This is an annual rate of eighteen percent. Balances not paid within 90 days may be sent to our collection agency. If I am not able to make a full payment, I agree to make regular monthly payments (minimum or \$100.00) until all fees are paid. A returned check fee is \$25.00.

INSURANCE CLAIMS. If you have private insurance you will be responsible for full payment to me, and you can then submit the charges to your insurance carrier for possible reimbursement. This office makes no guarantees that fees paid will be reimbursed by insurance companies. I understand that I am obligated to pay for services regardless of which charges my insurance company may or may not cover. I know that I have the right to verify coverage with my insurance company prior to beginning services. Unless other arrangements are made, the filing of insurance claims is my responsibility, except where information must be furnished by the provider, in which case Dr. Colvin will gladly provide the necessary information.

MISSED APPOINTMENT OR LATE CANCELLATION CHARGE. Services are provided by appointment only. *Your scheduled appointment time is reserved for you alone.* While one hour is typically scheduled for an appointment, you will be seen for 45-50 minutes. The remainder of the time is used to maintain a clinical record. I agree to pay a Late Cancellation Fee (See table above) for any missed appointment that I do not call to cancel at least 48 hours in advance and by Friday 5:00 PM for Monday appointments, except in the case of verifiable emergencies. I understand that I will be billed at full fee for late cancellations and no shows, and will be asked to pay for the missed appointment in full at the next visit. Cancellation Fees are generally *not* covered by insurance.

TELEPHONE CALLS, E-MAILS, & CRISIS COUNSELING. Dr. Colvin does not charge for routine telephone calls to schedule or change appointments. However, if I ever need to contact Dr. Colvin by phone or by email to discuss clinical issues or concerns, to get advice, to obtain resources, or to receive crisis counseling, I understand that I will be charged according to the financial policy outlined above (\$30.00/10 minutes, and per minute after the first 10 minutes). Telephone & Email charges will show on my monthly statement, and I understand that insurance may not cover these charges.

I maintain a *Confidential* Voice-Mail service to take messages when I am not available to speak with you in person. When you call please leave suggested times and phone numbers where you can be reached, preferably during business hours. If your call is an EMERGENCY please page me at (714) 321-8056. If I am not available to promptly return your call and you require Emergency Services call 911, or go to your nearest Emergency Room. Please be aware that there may be times that other Doctors are covering my practice for me, and you may speak with them instead.

I understand that I have the right to end therapy at any time with no obligation except to pay for completed services.

5. Arbitration Agreement

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

6. Notice of Privacy Practices

Please refer to our Notice of Privacy Practices for additional important information.

7. Contact Us

- ♦ Mailing Address: 3419 Via Lido, Suite 173 • Newport Beach, CA 92663
- ♦ Office Phones: (714) 593-6900 EMERGENCY: (714) 321-8056
- ♦ Fax (714) 593-6955
- ♦ Online: www.KathlineColvin.com - kcolvin@KathlineColvin.com

8. Special Circumstances

Any special circumstances should be outlined below:

9. Signatures

It is important that you review this service agreement carefully and have a clear understanding of the policies and procedures of this office. Please ask any questions you have and discuss them with Dr. Colvin prior to beginning services.

By signing below, I indicate that I understand and agree to comply with the policies and agreements of this office as outlined in this service agreement.

| Names of all persons participating in services (Please print): | SIGNATURES: | DATE: |
|--|-------------|-------|
| | | |
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| | | |
| | | |

Thank you for seeking services from this office. We look forward to serving you!