

MEME RHEE, MFT MFC#45434
9713 SANTA MONICA BLVD SUITE 207
BEVERLY HILLS, CA 90210
(310) 430 3990 m@memerhee.com

Patient: _____ Age: _____ Sex: M F

Address: _____

e-mail: _____

Phone: (_____) _____ Cell: (_____) _____ Date of Birth: ____/____/____

SS#: _____-____-_____ Emergency Contact & #: _____

Responsible Person: (Note: If this information is same as patient, write “same as above”)

Name: _____ Relationship: _____

Address: _____

Phone: (_____) _____

Consent for Treatment:

I consent to assessment, treatment, and/or diagnostic procedures for myself or for my family member. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I authorize the release and exchange of information between my therapist and the referral source and other co-treating providers for the purpose of treatment, payment, and Health Care Operations. I also authorize the release of information to my health plan for claims or other health plan purposes.

Patient/Legal Representative Signature

Date

PATIENT NOTICE OF PRIVACY PRACTICES

Confidentiality

All information disclosed within sessions or consultations is held strictly confidential and may not be revealed to anyone without a written release of information, except where disclosure is permitted or required by law. Disclosure is required in the following circumstances:

1. When there is a reasonable suspicion of child abuse or neglect, or abuse to a dependent or elder adult,
2. When the patient presents an imminent danger to self,
3. When the patient presents an imminent danger to others,
4. If a judge determines that our discussions are not confidential, a judge may request specific information.

If the patient is a minor, you acknowledge that your child's records are confidential except in the above stated exceptions. Please be aware that submitting mental health claims to your insurance company carries a certain amount of risk to confidentiality, privacy, and to future capacity to obtain health or life insurance, or even a job. I receive regular professional consultation. In such cases, neither your name, nor any identifying information about you is revealed.

Phone & Emergency Contact

If you need to contact me by phone, do not hesitate to call my office number. If I am not available, you can leave a message on my voicemail and I will usually return the call that day. In the event of an emergency, you may be able to reach me on my personal cell phone at (310) 430-3990. You will be charged for phone calls if we have a conversation of an information-exchanging or problem-solving nature that lasts more than 10 minutes. If you cannot reach me in an emergency, you can find help at the following suicide prevention/crisis numbers: (800) 784 – 2433. 1 800 SUICIDE.

Therapy Process & Termination

Psychotherapy can result in a number of benefits to you, including improved relationships and a reduction in psychological symptoms. The process of talking about painful memories, thoughts, and feelings, however, can be difficult and can make patients feel worse for a time. Please discuss this with me if you are feeling worse. There is no guarantee that therapy will yield positive or intended results. Most problems require at least 8-12 sessions. Many times it takes much longer than this, up to a few years. You are free to terminate therapy at any time. I can provide you with referrals to other therapists at your request. **I do not perform custody evaluations and do not make recommendations regarding custody.** I also do not prescribe medication or make recommendations about medication, but will refer you to your physician or to a psychiatrist if I believe you are in need of a medication evaluation.

Cancellation of Appointment

The scheduling of an appointment involves the reservation of time specifically for you. In the event of a “No Show” or failure to give a **full 24-hour notice** of a cancellation, **you will be charged the full session fee for all late cancellations and missed appointments.** Please be aware that insurance companies will not cover cancellation charges.

By initialing here, you acknowledge that you have received a copy of the “Notice of Privacy Practices” and the “Patients’ Rights and Responsibilities.”

Patient/Legal Representative Signature

Date

Fee Agreement

Fees & Insurance: Fees are \$175 for the initial assessment, \$200 for couple/family therapy, and \$175 for individual therapy. Sliding Scale is dependent on financial need and availability. Sessions are 50 minutes in length. Letter writing, consultations with other professionals, telephone conversations, reading records or reports, travel time, longer sessions, etc. will be billed at the same rate as your therapy sessions. Returned checks are subject to a \$25 fee. This agreement supersedes all previously agreed to financial agreements and is effective as of the date signed.

Patients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. Please be aware that not all issues/problems/conditions dealt with in therapy are covered by insurance. It is your responsibility to verify the specifics of your coverage. If you are using insurance, I will submit claims for you. You understand that insurance is billed as a courtesy to you and that **you are responsible for full payment if the insurance company denies the claim.**

If your account is overdue (unpaid) and there is no written agreement on a payment plan, I can use legal or other means (court, collection agencies, etc.) to obtain payment.

Cancellation policy: The scheduling of an appointment involves the reservation of time specifically for you. In the event of a “No Show” or failure to give a **full 24-hour notice** of a cancellation, **you will be charged the full session fee for all late cancellations and missed appointments.** Please be aware that insurance companies will not cover cancellation charges. Patients are required to provide a credit card number which will be charged the full session fee in the event of a “no show” or failure to give a full 24-hour notice of cancellation.

PHONE SESSIONS NEED TO BE SCHEDULED 24 HOURS IN ADVANCE. PLEASE DO NOT CALL AT YOUR SCHEDULED APPOINTMENT HOUR IF YOU HAVE NOT SET THIS UP IN ADVANCE.

Symptom Inventory & Treatment History

Person completing form (if different from patient) _____

Patient's Occupation _____ Education Level _____

Ethnicity _____ Religion _____ Practicing? Yes No

Reason for seeking therapy: _____

Please rate the severity of the following symptoms over the last month according to the following rating scale: **0-No difficulty** **1-Mild** **2-Moderate** **3-Severe**

- | | |
|--|---------------------------------------|
| _____ Decreased appetite | _____ Nightmares |
| _____ Increased appetite/eating more | _____ Hypervigilance |
| _____ Bingeing and/or purging | _____ Obsessive thoughts |
| _____ Weight change? +/- _____ lbs. | _____ Compulsions |
| _____ Depressed mood | _____ Spending sprees |
| _____ Decreased energy/fatigue | _____ Racing thoughts |
| _____ Sleep changes: trouble falling asleep;
trouble staying asleep; trouble
waking up | _____ Rapid heart beat |
| Avg. # hours sleep _____ | _____ Trouble breathing |
| _____ Decreased sexual desire | _____ Sweating |
| _____ Difficulty with sexual functioning | _____ Phobia |
| _____ Loss of interest in activities | _____ Police/Probation involvement |
| _____ Crying | _____ Stealing |
| _____ Feelings of hopelessness | _____ Lying |
| _____ Feelings of helplessness | _____ Truancy |
| _____ Decreased attention span | _____ Violent behavior towards others |
| _____ Inattentive/Distractible | _____ Destruction of property |
| _____ Memory problems: Long-term;
short-term | _____ Harming animals |
| _____ Self-injurious behavior | _____ Fire setting |
| _____ Thoughts of suicide | _____ Opposition |
| _____ Thoughts of harming others | _____ Anger outbursts |
| _____ Impulsivity | _____ Irritability |
| _____ Hyperactivity | |
| _____ Anxiety/Nervousness | |
| _____ Worry/Fear | |
| _____ Flashbacks of traumatic event | |

How many alcoholic beverages do you consume per week? _____

List street drugs used in last 2 months (type/frequency/amount): _____

Family history of substance abuse problems? _____

Previous psychological or psychiatric treatment? (List dates & provider names): _____

Any psychiatric hospitalizations? _____

Medical history: _____

Current medications & dosages: _____

Name of prescribing physician: _____

Current stressors: _____

Goals for treatment: _____

Any other information you would like your therapist to know? _____

PATIENT NOTICE OF PRIVACY PRACTICES

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health information is protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

I want you to know that I respect the privacy of your personal medical records and will do all I can to secure and protect that privacy. I strive to always take reasonable precautions to protect your privacy. When appropriate, I provide the minimum necessary information to only those I feel are in need of your health care information. This includes information about treatment, payment, and/or health care operations in order to provide health care that is in your best interest.

I also want you to know that I support appropriate access to medical records. With your consent, I may disclose personal health information for purposes of treatment, payment, or health care operations such as communication with hospitals, co-treaters, and health plans.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, if you refuse to disclose your personal health information, I have the right to refuse to treat you. If you choose to give consent in this document, at some future time you may request to refuse to disclose all or part of you personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You may request a restriction on any authorization to disclose personal health information. I am not required to agree with this restriction request. You have the right to have your clinician amend your protected health information. If the request is denied, you may file a disagreement with me and prepare a rebuttal, which will be added to your personal health information. You have the right to receive accounting of any disclosures I have made.

I want you to know that I continually undergo training to understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the “Privacy Rule.” I strive to achieve the very highest standards of ethics and integrity in providing services to my patients.

If you have any questions or problems, please speak with me directly, as I welcome your feedback. You may also file a complaint with the Secretary of Health and Human Services if you believe that I have violated your privacy rights.

Meme Rhee, M.F.T.

CONSUMER NOTICE OF RIGHTS AND RESPONSIBILITIES

Dignity and Respect

You have the right to be treated with consideration, dignity, and respect, and the responsibility to respect the rights, property, and environment of all health care providers, employees, and other patients. You have the right to have the privacy and confidentiality of your health records maintained. You are also entitled to these rights regardless of gender, age, sexual orientation, marital status, or culture, or economic, education, or religious background.

Knowledge and Information

You have the right to receive information about your practitioner's services and any treatment recommendations. You have the right—and the responsibility—to know about and understand your health care and your coverage, including the following: participating with your practitioner in decision-making regarding your treatment planning; your clinical condition; any services and procedures involved in your recommended course of treatment; and how your health plan operates as stated in your policy.

Eligible Employee Accountability/Autonomy

As a partner in your own health care, you have the right to refuse treatment, providing you accept responsibility for the consequences of such a decision. You have a responsibility to participate, to the degree possible, in understanding your behavioral health problems and in developing mutually agreed upon treatment goals. You also have the responsibility to identify yourself and insurance coverage or changes in coverage when receiving behavioral health services. You have the responsibility to provide your current provider with previous treatment records, if requested, as well as to provide accurate and complete medical information to any other health care professionals involved in the course of your treatment. You have the responsibility to be on time for your appointments and to notify your provider as far in advance as possible if you need to cancel or reschedule an appointment. You have the responsibility to notify your behavioral health plan within 48 hours—or as soon as possible—if you are hospitalized or receive emergency care. And, you have the responsibility to pay all required co-payments and deductibles as the time you receive behavioral health care services.

Filing a Complaint

I welcome direct feedback if you have a grievance. You also have the right to file a complaint with the state Department of Health Services at 1-(800)-824-0613. If you have a grievance against your health insurance plan, you should contact the plan and use the plan's grievance process. If you are not satisfied with the plan's resolution, you may appeal the decision by contacting the California Department of Corporations at 1-(800)-400-0815 (they are responsible for regulating health care service plans).

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