

Rosemarie Calleros PhD, MFCT
Clinical Psychologist, #Psy 12881
Marriage, Family and Child Therapist, #Mv 18234
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(P) 949-916-8271 (F) 949-499-2397 Email: rmcalledrosphd@cox.net

OFFICE POLICY

FEE SCHEDULE: \$150 per 45 minute sessions for Individual, Couple, or Family Sessions;
\$175 for 60 minute sessions.
\$200 for Initial Sessions.
\$225 per hour for Psychological Testing (includes- testing time, scoring interpretation and report writing.)
\$4 per minute for URGENT calls.

PAYMENT FOR SERVICES: Payment is due at the time services are rendered and must be paid by cash or check. Kindly have your check written prior to the session.

I understand that I am financially responsible to pay all fees denied by my insurance.

Patient Initials _____

KEEPING APPOINTMENTS: Therapy sessions are 45 or 60 minutes. The last few minutes are generally reserved to review the session and schedule any further appointments. Time is reserved only for you. A missed appointment or sessions cancelled less than 24 hours are charged \$75 and cannot be billed to the insurance. After two "NO-SHOWS" our doctor-patient relationship will formally be terminated.

Patient Initials _____

EMERGENCIES: If you are in imminent danger call 911, your nearest police station, or emergency room. Otherwise leave a message on my voice mail. Also, my voice mail will have an alternate number where I can be reached in an emergency.

CONFIDENTIALITY: All information between therapist/doctor and patient is held strictly confidential unless;

- 1) You authorize release of information with your signature.
- 2) You present a physical danger to self or others;
- or 3) child or elder abuse is suspected.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

CONSENT FOR TREATMENT: I further authorize and request that my Psychologist carry out psychological examinations, treatment, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, it at times may be difficult and uncomfortable.

Patient Initials _____

Release of Information to Health Plan: I authorize the release of information for the benefit of my Health Plan.

Patient Initials _____

Release of Information to Primary Care Physician and/or Psychiatrist:

I authorize the release of information to my primary care physician.

Primary Care Physician (name) _____

Psychiatrist (name) _____ for purposes related to my health.

Patient Initials _____

I Provide Therapy: I do not get involved in work grievances, lawsuits, custody disputes, disability determinations, work excuses and requests for change in job conditions or other legal or administrative proceedings.

I have read the attached Health Insurance Portability and Accountability (HIPAA) form.

I understand and agree to all the above information.

Patient name _____ Signature _____ Date _____

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!

With your consent, my practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of use of your health information for treatment purposes:

I obtain treatment information about you and record it in your case record. During the course of your treatment, I determine a need to consult with another specialist in the area. I will share the information with such specialist for input.

Example of use of your health information for payment purposes:

I submit a request for payment to your health insurance company. The insurance company requests information from me regarding psychological care given. I will provide information to them about you and the care given.

Example of use of your information for health care operations:

I obtain services from my insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credential, medical review, legal services, and insurance. I will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record I maintain and billing records are the physical property of my practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information as required to be maintained by law by delivering a written request to my office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to my office.

If you want to exercise any of the above rights, please contact my office, in person or in writing, during normal hours. I will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

My practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of my duties and privacy practices as to the information I collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if I cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

I reserve the right to amend, change, or eliminate provisions in my privacy practices and access practices and to enact new provision regarding the protected health information I maintain. If my information practices change, I will amend my Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of my "Notice" or by visiting my office and picking up a copy.

To Request Information or File a Complaint

If you have question, would like addition information, or want to report a problem regarding the handling of your information, you may contact my office.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at my office. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address is: Federal Office Building, 50 United Nations Plaza- Room 322, San Francisco, CA 94102.

- I cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- I cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.

Other Disclosures and Uses

Notification

Unless you object, I may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using my best judgment, I may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

I may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation

If you are seeking compensation through Workers Compensation, I may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, I may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse and Neglect

I may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, I may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

I may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or the extent an individual is in the custody of law enforcement.

Research

I may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

I may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations

Consistent with applicable law, I may disclose your protected health information to organ procurement organization or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

For Specialized Government Function

I may disclose your protected health information for specialized government functions as authorized by law, such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

I may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website

If I maintain a website that provides information about my entity, this Notice will be on the website.

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Acknowledgement of Receipt of "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information"

The federal government mandated that as of April 14, 2003 all health care patients are to receive from their clinicians a notice (hereafter referred to as "Notice") regarding the protection of their private health care information in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule (45 C.F.R. parts 160 and 164).

This acknowledgement documents that your mental health care provider has given you the "Notice" that is required. HIPAA covers what is called "protected health information" (PHI) that is used for treatment, payment, and health care operations. PHI is information in your health record that could identify you.

The Notice contains basic information about:

1. how your PHI may be used and disclosed for treatment, payment and health care operations (these terms are defined in the Notice)
2. which uses and disclosures require authorization from you and which don't
3. how you may revoke an authorization you have made
4. certain rights you have to restrict use and disclosure of PHI, to receive confidential communications by alternative means and at alternative locations, to inspect and copy your records, to amend your records, to have an accounting of disclosures
5. a list of my duties to protect the privacy of your PHI, my right to change the privacy policies and practices described in the Notice, and how I will inform you of changes
6. what you can do if you have any complaints about violations of your privacy rights, about decisions about access to your records I may make
7. any restrictions and limitations you or I wish to put on the use and disclosure of your PHI.

The Privacy Notice is a few pages in length. Generally, this Notice is given on a patient's first visit unless there is good reason to delay. A copy of the Notice is available in my waiting room and will be on my website if I create one. I will also give you a copy of this notice. This page documents that I have given you a copy of the Notice.

I acknowledge that Dr. Calleros has given me a copy of the Privacy Notice (version dated 8/24/03) as required by the federal government's HIPAA legislation. I have been given the opportunity to ask any questions I may have regarding this Notice.

Date _____

Print Patient's Name

Signature

Print name of Parent or Legal Guardian

Signature

if patient is a minor, Personal Representative

Describe your role in regard to the patient and/or the authority by which the person is signing for the patient: _____

Rosemarie Calleros Ph.D
 Lic Psychologist # Psy 12881
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Medication Record

Date	Current Medication	Dose	Date Started	Date Ended	Indication (for what problem?)	Name of Prescribing Doctor
						__MD __PCP __ Psychiatrist
						__MD __PCP __ Psychiatrist
						__MD __PCP __ Psychiatrist
						__MD __PCP __ Psychiatrist
						__MD __PCP __ Psychiatrist
						__MD __PCP __ Psychiatrist
						__MD __PCP __ Psychiatrist
						__MD __PCP __ Psychiatrist
						__MD __PCP __ Psychiatrist
						__MD __PCP __ Psychiatrist

Medications you have you taken in the past:

CONFIDENTIAL INFORMATION (Please check the answers that best fit for you and fill in the appropriate blanks)

Name: _____ DOB _____ / _____ / _____ Today's Date: _____ / _____ / _____

1. PRESENTING PROBLEM

a. The main problem I am seeking help for is _____

- b. I would rate the severity of this problem as Mild (7) Moderate (6) Severe (5) Disabling (4)
- c. I have had this problem for Several days Several wks Several mos Past year Past 2 yrs Over 2 yrs
- d. During the past year, the best this problem has been was: Not a problem Mild Moderate Severe Disabling
- e. This problem effects my Work Personal relationships Marriage Health School work Family relationships
- f. Symptoms I've been experiencing are (please fill in the bubble ③=Severe ②=Moderate ①=Mild (if not an issue, leave blank))

③②① Feeling depressed	③②① Crying	③②① Avoiding situations	③②① Feeling over-responsible
③②① Feeling inadequate	③②① Feeling worthless	③②① Afraid of people	③②① Distressing memories
③②① Disinterested	③②① Feel like want to die	③②① Panicky	③②① Nightmares
③②① Withdrawing	③②① Losing weight	③②① Obsessed with body	③②① Constantly on edge
③②① Feeling guilty	③②① Gaining weight	③②① Discouraged	③②① Flashbacks
③②① Angry and irritable	③②① Afraid of the future	③②① Losing control	③②① Feelings of unreality
③②① Not eating well	③②① Worrying a lot	③②① Afraid of dying	③②① Highs and lows
③②① Eating too much	③②① Feeling anxious	③②① Feeling faint	③②① Binge eating
③②① Not concentrating	③②① Not focusing	③②① Abdominal distress	③②① Afraid of situations Describe: _____
③②① Feeling hopeless	③②① Tired	③②① Pounding heart	③②① Afraid of objects Describe: _____
③②① Feeling lethargic	③②① Trembling inside	③②① Pain in my chest	③②① Other _____
③②① Not sleeping well	③②① Tense	③②① Obsessing over things	
③②① Indecisive	③②① Jittery	③②① Compulsive actions	

2. SUBSTANCE USE

- a. In regard to using alcohol I drink occasionally I drink regularly I drink daily I do not drink at all
- b. When I drink, the number of drinks I usually have is _____
- c. What I like about drinking is _____
- d. I consider my drinking to be A definite problem A growing problem A potential problem Not a problem
- e. In regard to illegal drug use I do not use any illegal drugs I have experimented on an occasional basis in the past
 I used for a short period of time but no longer use I used for a long period of time but no longer use
 I have used drugs in the past and continue to use
- f. The drugs I currently use are Speed Pot Cocaine LSD Heroin PCP Sedatives Inhalants Other
- g. I use drugs Daily 3 to 6 times a week 1 to 2 times a week 1 to 3 times a month
- h. What I like about using drugs is _____
- i. I consider my drug use to be A definite problem A growing problem A potential problem Not a problem

3. PERSONAL SAFETY

- a. As far as any suicidal thoughts are concerned
 I have no thoughts of suicide The thought has crossed my mind but I would never do it.
 The thought has crossed my mind, and I have thought of ways of doing it but I would not do it.
 I have had some serious thoughts of suicide and I am afraid I could follow through with them.
- b. As far as any thoughts of harming anyone
 I have not had any recent thoughts of harming anyone
 I have had recent thoughts of harming someone but I would not act on them
 I have had some recent thoughts of harming someone and I am afraid I could carry them out

4. MY MARRIAGE/PRIMARY RELATIONSHIP

- a. I have been married/in this relationship for _____ years
- b. I have known my partner for _____ years
- c. My commitment to this marriage/relationship is 100% Questionable I am having serious thoughts about leaving
- d. My major dissatisfactions in my marriage/relationship are: Our sexual relationship Our communication
 Our finances Our parenting My in-laws Our mutual interests Our mutual goals Other _____
- e. Major feelings I have with my partner are: Anger Resentment Regret Sadness Fear Betrayal
 Abandonment Guilt Rejection Unimportance Hurt Jealousy Disappointment Abuse
 Distance Warm Loving Respect Other _____

MY WORK

- a. My current work is _____, I have been at my present job for _____ years
- b. In regard to my work I am Pleased Mostly satisfied Mixed Mostly Dissatisfied Unhappy
- c. My major dissatisfactions with my work are: The job itself My career My coworkers My boss My income
 Other _____

5. MY FAMILY OF ORIGIN

- a. My father is Alive; I live with him Alive; lives nearby Alive; lives far away Died when I was _____ years old
- b. In general, I would describe my father as Argumentative Physically abusive Sexually abusive Critical
 Absent Emotionally distant Supportive and nurturing Caring Other _____
- c. Major feelings I have with my father are Anger Resentment Regret Sadness Fear Betrayal
 Abandonment Guilt Rejection Unimportance Hurt Jealousy Disappointment Abuse
 Distance Warm Loving Respect Other _____
- d. My mother is Alive; I live with her Alive; lives nearby Alive; lives far away Died when I was _____ years old
- e. In general, I would describe my mother as Argumentative Physically abusive Sexually abusive Critical
 Absent Emotionally distant Supportive and nurturing Caring Other _____
- f. Major feelings I have with my mother are Anger Resentment Regret Sadness Fear Betrayal
 Abandonment Guilt Rejection Unimportance Hurt Jealousy Disappointment Abuse
 Distance Warm Loving Respect Other _____

6. PREVIOUS THERAPY

- a. I have Never seen a therapist before Been in therapy with (#) _____ different counselors, the last time was _____
- b. The last time I saw a therapist my experience was Positive Neutral, received limited benefit Negative
- c. I was in therapy for A problem similar to the one I have now A different problem _____
- d. I have been hospitalized for psychiatric or substance abuse problems Never Yes, (#) _____ times Year(s) _____
- e. Medications I am now taking are _____ by Dr. _____ Not taking any

7. HEALTH

- a. In the past I have received major medical treatment for _____ Have not had major medical problems
- b. Currently I am being treated for _____ Nothing in particular
- c. Physical symptoms I am having but not being treated for are _____ Do not have any physical symptoms
- d. The number of cigarettes I smoke per day are _____ Do not smoke
- e. In the past year I have exercised Regularly Occasionally Rarely Never
- f. I consider myself to be In excellent health In good health In fair health In poor health
- g. I consider my diet to be Very healthy Questionably healthy Not very healthy Often changing

8. SOCIAL

- a. In regard to my social network I have Virtually no close friends One close friend A few friends Many friends
- b. I mostly make contact with my friends Rarely Spontaneously On special occasion At parties
 At organized activities To discuss personal problems To make small talk Other: _____
- c. In general, my friends Influence me positively Influence me negatively Don't have a big influence on me
- d. What I most like to do for fun or recreation is _____

9. FOR PARENTS

- a. The number of children I have is _____. Their ages and gender are _____
- b. In regard to parenting, my partner and I Are pretty agreeable Seem to disagree I am a single parent
- c. My general approach to parenting is to Punish misbehavior Reward good behavior Teach good behavior
 Try to listen Give responsibility Be a model Involve myself Other _____
- d. Major feelings I have with my children are Anger Guilt Regret Disappointment Distance Warm Loving

10. SELF ASSESSMENT

- a. My problems would seem to clear up If others would change If I would change If I understood myself better
 If I could express myself better If I could let go of the past If I could get rid of certain emotions
 If I could make a decision If I could change my thinking If I had some direct answers

12. GOALS FOR THERAPY

- a. Three results I am looking for in therapy are: _____

