Registration Form

Rosemarie Calleros, Ph.D., LMFT
Tel. 949-916-8271 CA Lic. PSY12881 LMFT18234

PATIENT INFORMATION-Please complete one registration form for each patient

Last Name	First		Middle Initial
Street Address			
City	State		Zip
Date of Birth	Sex M F	Social Security #	
Marital Status		Occupation	Work Phone
Home Phone	Cell Phone		Email
If Minor, Legal Guardian:			Phone
Emergency Contact		Relationship	Phone

INSURANCE INFORMATION-Please include a photocopy of front and back of your insurance card with this registration form

Primary Insurance Co		Ins Co Phone	
Policy/ID Number		Subscriber Name	
Subscriber Date of Birth		Deductible Amount Met? Yes No	Co Pay Amount $
Relationship to Patient		Subscriber Social Security	
Is patient covered by this policy?		Effective Date of Policy	
Is authorization required?		Authorization Number(s) (include all authorization letters)	
Secondary Insurance Co		Co-pay Amount	
Policy/ID Number		Relationship to Patient	
Subscriber Employer		Employer Phone	
Employer Address			

AUTHORIZATION AND ACKNOWLEDGEMENT

AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

I hereby authorize Rosemarie Calleros, PhD, LMFT to release any medical or other information needed for claims reimbursement. I hereby assign, transfer, and set over to Rosemarie Calleros, PhD, LMFT all my rights, title, and interest to medical reimbursement benefits under my insurance policy. I acknowledge and agree it is my responsibility to know my eligibility and benefits, including co-pay & deductible amounts, covered benefits, and obtaining authorization prior to treatment. I acknowledge and agree I am financially responsible for payment in full to Rosemarie Calleros, PhD, LMFT for any services not covered by my health insurance for any reason. I acknowledge and agree I am financially responsible for any balance attributed to "patient responsibility" including, but not limited to co-pay, deductible and/or co-insurance. I acknowledge and agree that by signing this form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Patient/Legal Guardian Signature _____ **Date** _____

Email: rmcallerosphd@cox.net

Rosemarie Calleros PhD, MFCT
Clinical Psychologist, #Psy 12881
Marriage, Family and Child Therapist, #Mv 18234
4 Montpellier, Laguna Niguel, CA, 92677
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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 than24 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) Your 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_____

Top half of the page only

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

12. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED X _____ DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED X

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN: 33-010-5564 ✓

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Rosemarie Calleros, PhD
~~26461 Crown Valley Pkwy #100~~
~~Mission Viejo, CA 92691~~

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Rosemarie Calleros Ph.D
Lic Psychologist # Psy 12881
4 Montpellier
Laguna Niguel, CA. 92677
(949)916-8271

PLEASE PRINT OR TYPE

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
HCFA-1500-CS-N00

FORM OWCP-1500 (1240)

FORM RRB-1500

SECOND FOLD

FIRST FOLD

HCFA-1500/EIN / NHCF-1500/EIN

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 of 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 you 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 treamtne, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members of 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 of 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 you 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 of 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 form 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 of disclose your protected health information to notify, or assist in notifying, a family member, personal representation, or other person responsible for you care, about you location, and about you 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 hat 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.

Aw 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.

Rosemarie Calleros PhD, MFCT
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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:_____

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Client Information **Today's Date:**____/____/____

Client Name:_____/_____
First Last Name you like to be called

Client Address:_____
Street/PO Box City State Zip

Phone: Home:(__)_____ **Cell:**(__)_____ **Work:**(__)_____

E-Mail:_____@_____ **Best way to leave message:** ☐ Home ☐ Cell ☐ Work ☐E-mail
Birthdate____/____/____ **Age:**_____ **SS#**_____ **Gender:** ☐ Male ☐ Female

Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Oriental ☐Asian ☐ Other:_____
Marital Status: ☐ Married____yrs. ☐ Divorced____yrs. ☐ Single ☐ Separated ☐ Widowed

Employed?: ☐ No ☐ Yes **Company:**_____ **Position:**_____
Student?: ☐ No ☐ Yes ☐ Fulltime ☐ Part time **School you attend:**_____
Highest Level of Education Completed: ☐ Grade School ☐ Middle School ☐ High School
☐ Vocational School ☐ Some College ☐ AA Degree ☐ College Graduate ☐ Master's Degree
☐ Ph.D. ☐ M.D. ☐ Other

Responsible Party Name/Phone:_____ (__)_____
(If different from Client) First Last Phone
Responsible Party Address:_____
Street/PO Box City State Zip

Please share with me how you first found out about my services: ☐Insurance ☐Friend (Name_____)
☐ Yellow Pages (☐ Under "Psychology" ☐Under "Marriage") ☐ Internet (☐Search engine ☐Yahoo ☐AOL
☐ Other_____) ☐ Doctor:_____ ☐ Other:_____

Other Household Members:

Name_____ **Relationship**_____ **Age**_____

Name_____ **Relationship**_____ **Age**_____

Name_____ **Relationship**_____ **Age**_____

Name_____ **Relationship**_____ **Age**_____

Name_____ **Relationship**_____ **Age**_____

Name_____ **Relationship**_____ **Age**_____

Rosemarie Calleros Ph.D
Lic Psychologist # Psy 12881
4 Montpellier
Laguna Niguel, CA. 92677
(949)916-8271

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____/____/____ **Todays 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)

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

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: _____
_____
_____

Rosemarie Calleros, Ph.D., MFT
Licensed Clinical Psychologist #PSY12881
Licensed Marriage, Family and Child Psychologist #MV18234
Phone: 949-916-8271

Tele-mental Health Informed Consent

I _____ (name of client)("**Client**", "**You**") hereby consent to participate in tele-mental health with **Dr. Rosemarie Calleros** ("**Practitioner**") as part of psychotherapy.

I understand that tele-mental health is the practice of delivering clinical health services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. Client and Practitioner may also be referred to individually as a "**Party**" and collectively as the "**Parties**".

I understand the following with respect to tele-mental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2. I understand there are several benefits to tele-mental health, including convenience for scheduling, location and potentially increased access to my Practitioner. I understand that I may benefit from tele-mental health services, but that results cannot be guaranteed or assured.

3. I understand that there are risks and consequences associated with tele-mental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentially by unauthorized persons, and/or limited to respond to emergencies.

4. I understand that there will be no recording of any of the online session by either Party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without Client's written authorization, except where the disclosure is permitted and/or required by law.

5. I understand that the privacy laws that protect the confidentially of my protected health information ("**PHI**") also apply to tele-mental health unless an exception to confidentially applies. Exceptions include, but are not limited to, mandatory reporting of child, elder or vulnerable adult abuse, danger to self or others, and practitioner's raising mental/emotional health as an issue in a legal processing.

6. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined by Practitioner that tele-mental health services are not appropriate, and a higher level of care is required.

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7. I understand that I am responsible for: (a) providing the necessary computer, telecommunications equipment and internet access for my tele-mental health sessions, (b) ensuring security on my computer, and (c) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my tele-mental health session.

8. I understand that during a tele-mental health session, we could encounter technical difficulties resulting in services interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at **949-916-8271** to discuss since we may have to re-schedule.

9. I understand that my Practitioner may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

10. I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

Emergency Protocols

Your Practitioner needs to know your location in case of an emergency. You agree to inform your Practitioner of the address were you are at the beginning of each session. Your Practitioner also needs information of a contact person whom your Practitioner may contact on your behalf in case of a life-threatening emergency only. This emergency contact person will only be contacted to go to your location or take You to the hospital in the event of an emergency.

In case of an emergency, my location is:_____

My emergency contact person's name:_____

My emergency contract person's information is:_____

Phone:_____

Email:_____

Address:_____

[Signature Page to Follow]

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I have read the information provided above and discussed it with my Practitioner. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____

Signature of Client/Parent/Legal Guardian Date

_____

Signature of Practitioner Date