

+ Michael Beavers, MS LMFT

Lake Arrowhead:

28200 Highway 189, Suite 240
Lake Arrowhead, CA 92352-2367
Phone: 909.336.3330

Crestline:

340 Highway 138
Crestline, CA 92325-6300
Phone: 909.338.5807

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E-Mail: Mike@MikeBeaversLMFT.com

Web: MikeBeaversLMFT.com



Welcome!

Attached are a few documents it would be helpful to complete before our appointment. You can use the checklist below as a guide to make this a quick process.

In addition, I'd like to see anything else (material you've written about goals, frustrations, etc.) that helps me get a better picture of who you are and what you want to achieve in counseling.

Forms to Complete before Our Session:

- Client Welcome
- Informed Consent
- Receipt (for Notice of Privacy Practices)
- Anything you'd like me to know (goals, treatment goals, frustrations, etc.)

The "Notice of Privacy Practices" is only for your reference.

Let me know if any part of the pre-session process is unclear or if I can answer any questions to get the best possible start to your counseling experience.

Sincerely,

MICHAEL BEAVERS, MS LMFT
Licensed Marriage and Family Therapist
Leadership/Life Coach

Patient Instruction:

Please complete this form as completely as possible. Feel free to ask your therapist if there are any questions. All information becomes a part of the client chart and is confidential, as described in the Informed Consent document. Feel free to use the reverse side if you need more space for explanation.

Identification:

Name _____ Date _____
Address _____ P.O. Box _____ City _____ Zip _____
Home phone _____ Work phone _____
Cell _____ E-mail _____ Referred by _____
Age _____ Date of birth _____
Marital status _____ Social Security # _____ Educational level _____
Occupation _____ Names and ages of children _____

Emergency contact information _____
What is the best way for me to contact you? __Email __Phone/home __Phone/work

Financial Information:

How do you intend to pay for treatment? (cash, check, insurance) _____
If planning to use health insurance:
Name of insurance company _____
Policy number _____ Group number _____
Telephone number _____

Areas of Concern

What issues/concerns causes you to seek treatment? Please describe. _____

Do you have any specific goals with regard to your treatment? _____

Do you have any particular concerns/fears with regard to treatment? _____

Psychological History

Have you ever received mental health treatment before? _____
When and for how long? _____
What was the focus of treatment? _____
Name of treating therapist(s), address(es), telephone number(s) _____

Note: A separate authorization for release of confidential information will be needed so that any former therapist may be contacted.
Have you ever been subjected to one or more psychological tests? _____
If so, by whom? _____
Name of person(s) administered psychological tests, address(es), telephone number(s) _____

Note: A separate authorization for release of confidential information will be needed so that any test administrator may be contacted.

Have you ever been hospitalized for mental or emotional problems? _____

When and for how long? _____

Why were you hospitalized? _____

Name of treating therapist, address, telephone number _____

Note: A separate authorization for release of confidential information will be needed so that any former therapist may be contacted.

Are you currently taking any prescription medications? _____

Prescribed by whom? _____

How long have you been on the medications? _____

Have you ever taken any medications for a mental or emotional condition? _____

When and for how long? _____

Note: A separate authorization for release of confidential information will be needed so that any former healthcare provider may be contacted.

Have you ever attempted suicide? _____

When? _____

Describe the circumstances that led to that attempt. _____

Are you currently having any suicidal thoughts? Please describe _____

Please describe your childhood. _____

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.

Have you ever been a victim of a violent crime? Please describe _____

Medical History

Have you ever been diagnosed with a serious illness? Please describe _____

Do you have any medical conditions that may affect your mental health treatment? _____

Please describe your overall health today. _____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. _____

Have you ever been in a 12-step program? __yes __no If yes, please describe:

Do you smoke? _____ How much? _____ For how long? _____

Do you drink alcohol? __yes __no If yes, please describe: _____

On average, how much alcohol do you consume in a week? _____

Do you currently use illegal drugs? __yes __no If yes, please describe:

Have you ever used illegal drugs? __yes __no If yes, please describe:

Family of Origin History

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother. _____

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father. _____

Names and ages of siblings. _____

Other Information

Please describe your spiritual identity/orientation. _____

Please describe your interests/hobbies _____

Are you now or have you ever been involved in a lawsuit? __yes __no If yes, please describe (use reverse if necessary): _____

How do you learn best? __reading __listening to lectures (like in school or college) __other

What are three of your strengths?

1. _____
2. _____
3. _____

What are three of your weaknesses?

1. _____
2. _____
3. _____

BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEMS

Current problems/Goals

Duration (months)

Additional information:

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning

Moderate = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

| | None | Mild | Moderate | Severe | | None | Mild | Moderate | Severe | | None | Mild | Moderate | Severe |
|----------------------|------|------|----------|--------|-------------------------|------|------|----------|--------|---------------|------|------|----------|--------|
| depressed mood | [] | [] | [] | [] | bingeing/purging | [] | [] | [] | [] | guilt | [] | [] | [] | [] |
| appetite disturbance | [] | [] | [] | [] | laxative/diuretic abuse | [] | [] | [] | [] | elevated mood | [] | [] | [] | [] |
| sleep disturbance | [] | [] | [] | [] | anorexia | [] | [] | [] | [] | hyperactivity | [] | [] | [] | [] |

Patient Intake Form

| | | | | | | | | | | | | | | |
|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| elimination disturbance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | paranoid ideation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | dissociative states | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| fatigue/low energy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | circumstantial symptoms | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | somatic complaints | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| psychomotor retardation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | loose associations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | self-mutilation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| poor concentration | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | delusions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | significant weight gain/loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| poor grooming | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | hallucinations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | concomitant medical condition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| mood swings | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | aggressive behaviors | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | emotional trauma victim | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| agitation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | conduct problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | physical trauma victim | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| emotionality | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | oppositional behavior | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | sexual trauma victim | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| irritability | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | sexual dysfunction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | emotional trauma perpetrator | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| generalized anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | grief | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | physical trauma perpetrator | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| panic attacks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | hopelessness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | sexual trauma perpetrator | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| phobias | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | social isolation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | substance abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| obsessions/compulsions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | worthlessness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | other (specify) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

EMOTIONAL/PSYCHIATRIC HISTORY

Prior outpatient psychotherapy?

No Yes If yes, on _____ occasions. Longest treatment by _____ for _____ sessions from ____/____/____ to ____/____/____
 Provider Name Month/Year Month/Year

| Prior provider name | City | State | Phone | Diagnosis | Intervention/Modality | Beneficial? |
|---------------------|-------|-------|-------|-----------|-----------------------|-------------|
| _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ |

Has any family member had outpatient psychotherapy? If yes, who/why (list all): _____

No Yes

Prior inpatient treatment for a psychiatric, emotional, or substance use disorder?

No Yes If yes, on _____ occasions. Longest treatment at _____ from ____/____/____ to ____/____/____
 Name of facility Month/Year Month/Year

| Inpatient facility name | City | State | Phone | Diagnosis | Intervention/Modality | Beneficial? |
|-------------------------|-------|-------|-------|-----------|-----------------------|-------------|
| _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ |

Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder? If yes, who/why (list all): _____

No Yes

Prior or current psychotropic medication usage? If yes:

| No | Yes | Medication | Dosage | Frequency | Start date | End date | Physician | Side effects | Beneficial? |
|----|-----|------------|--------|-----------|------------|----------|-----------|--------------|-------------|
| | | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| | | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

Has any family member used psychotropic medications? If yes, who/what/why (list all): _____

No Yes

FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

| | Present entire childhood | Present part of childhood | Not present at all |
|-----------------|--------------------------|---------------------------|--------------------------|
| mother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| father | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| stepmother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| stepfather | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| brother(s) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| sister(s) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| other (specify) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | |
| toward others | | | |

Parents' current marital status:

married to each other
 separated for ____ years
 divorced for ____ years
 mother remarried ____ times
 father remarried ____ times
 mother involved with someone
 father involved with someone
 mother deceased for ____ years
 age of patient at mother's death ____
 father deceased for ____ years
 age of patient at father's death ____

Describe parents:

| Father | Mother |
|----------------------|--------|
| full name _____ | _____ |
| occupation _____ | _____ |
| education _____ | _____ |
| general health _____ | _____ |

Describe childhood family experience:

outstanding home environment
 normal home environment
 chaotic home environment
 witnessed physical/verbal/sexual abuse

experienced physical/verbal/sexual abuse

from others

Age of emancipation from home: _____ Circumstances: _____

Special circumstances in childhood: _____

IMMEDIATE FAMILY

Marital status:

- single, never married
- engaged ___ months
- married for ___ years
- divorced for ___ years
- separated for ___ years
- divorce in process ___ months
- live-in for ___ years
- ___ prior marriages (self)
- ___ prior marriages (partner)

Intimate relationship:

- never been in a serious relationship
- not currently in relationship
- currently in a serious relationship

Relationship satisfaction:

- very satisfied with relationship
- satisfied with relationship
- somewhat satisfied with relationship
- dissatisfied with relationship
- very dissatisfied with relationship

List all persons currently living in patient's household:

| Name | Age | Sex | Relationship to patient |
|-------|-------|-------|-------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

List children not living in same household as patient:

| | | | |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Frequency of visitation of above: _____

Describe any past or current significant issues in intimate relationships: _____

Describe any past or current significant issues in other immediate family relationships: _____

MEDICAL HISTORY (check all that apply for patient)

Describe current physical health: Good Fair Poor

List name of primary care physician:

Name _____ Phone _____

List name of psychiatrist: (if any):

Name _____ Phone _____

List any medications currently being taken (give dosage & reason):

List any known allergies: _____

List any abnormal lab test results:

Date _____ Result _____
Date _____ Result _____

Is there a history of any of the following in the family:

- tuberculosis
- heart disease
- birth defects
- high blood pressure
- emotional problems
- alcoholism
- behavior problems
- drug abuse
- thyroid problems
- diabetes
- cancer
- Alzheimer's disease/dementia
- mental retardation
- stroke
- other chronic or serious health problems _____

Describe any serious hospitalization or accidents:

Date _____ Age _____ Reason _____
Date _____ Age _____ Reason _____
Date: _____ Age _____ Reason _____

SUBSTANCE USE HISTORY (check all that apply for patient)

Family alcohol/drug abuse history:

- father
- stepparent/live-in
- mother
- uncle(s)/aunt(s)
- grandparent(s)
- spouse/significant other

Substances used:

(complete all that apply)

- alcohol
- amphetamines/speed
- barbiturates/owners

Current Use

| First use age | Last use age | (Yes/No) | Frequency | Amount |
|---------------|--------------|----------|-----------|--------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Patient Intake Form

[] sibling(s) [] children
[] other _____

[] caffeine
[] cocaine
[] crack cocaine
[] hallucinogens (e.g., LSD)
[] inhalants (e.g., glue, gas)
[] marijuana or hashish
[] nicotine/cigarettes
[] PCP
[] prescription _____
[] other _____

Substance use status:

[] no history of abuse
[] active abuse
[] early full remission
[] early partial remission
[] sustained full remission
[] sustained partial remission

Treatment history:

Consequences of substance abuse (check all that apply):

[] outpatient (age[s] _____)
[] inpatient (age[s] _____)
[] 12-step program (age[s] _____)
[] stopped on own (age[s] _____)
[] other (age[s] _____)
describe: _____
[] hangovers [] withdrawal symptoms [] sleep disturbance [] binges
[] seizures [] medical conditions [] assaults [] job loss
[] blackouts [] tolerance changes [] suicidal impulse [] arrests
[] overdose [] loss of control amount used [] relationship conflicts
[] other _____

DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent patient)

Problems during

Birth:

Childhood health:

mother's pregnancy: [] normal delivery [] difficult delivery [] cesarean delivery [] complications
[] none [] high blood pressure [] kidney infection [] German measles [] emotional stress [] bleeding [] alcohol use [] drug use [] cigarette use [] other
[] chickenpox (age _____) [] German measles (age _____) [] red measles (age _____) [] rheumatic fever (age _____) [] whooping cough (age _____) [] scarlet fever (age _____) [] autism [] ear infections [] allergies to _____ [] significant injuries _____ [] chronic, serious health problems _____
[] lead poisoning (age _____) [] mumps (age _____) [] diphtheria (age _____) [] poliomyelitis (age _____) [] pneumonia (age _____) [] tuberculosis (age _____) [] mental retardation [] asthma

Infancy:

Delayed developmental milestones (check only those milestones that did not occur at expected age):

Emotional / behavior problems (check all that apply):

[] sitting [] rolling over [] standing [] walking [] feeding self [] speaking words [] speaking sentences [] controlling bladder [] other
[] controlling bowels [] sleeping alone [] dressing self [] engaging peers [] tolerating separation [] playing cooperatively [] riding tricycle [] riding bicycle [] other
[] drug use [] alcohol abuse [] chronic lying [] stealing [] violent temper [] fire-setting [] hyperactive [] animal cruelty [] assaults others [] disobedient
[] repeats words of others [] not trustworthy [] hostile/angry mood [] indecisive [] immature [] bizarre behavior [] self-injurious threats [] frequently tearful [] frequently daydreams [] lack of attachment
[] distrustful [] extreme worrier [] self-injurious acts [] impulsive [] easily distracted [] poor concentration [] often sad [] breaks things [] other _____

Social interaction (check all that apply):

Intellectual / academic functioning (check all that apply):

[] normal social interaction [] isolates self [] very shy [] alienates self [] inappropriate sex play [] dominates others [] associates with acting-out peers [] other
[] normal intelligence [] high intelligence [] learning problems [] authority conflicts [] attention problems [] underachieving [] mild retardation [] moderate retardation [] severe retardation
Current or highest education level _____

Describe any other developmental problems or issues: _____

Informed Consent

The following are some important issues in beginning a therapeutic relationship and concerning what you can expect in therapy. Please discuss with Michael Beavers, MS LMFT any items that are unclear to you. Please initial each section, as indicated.

Patient Consent to Therapy

I hereby voluntarily request and consent to counseling services provided by Michael Beavers, MS LMFT. This consent applies to myself, child, ward and/or client signing on the signature page. I understand that my continued participation implies voluntary informed consent and I have the right to refuse services at any time. I understand that the services are limited to assessment, consultation and intervention that may include counseling and brief psychotherapy. I understand that my counselor is not warranting a cure or offering any guarantee of results or improvement of any condition. If you have been referred for brief psychotherapy, this means you and your counselor will focus on your goals and treatment plan within a brief time frame. If you were referred by an EAP (Employee Assistance Program) the counseling may be limited to assessment and referral to another therapist or community resource.

Client(s) initial(s) of agreement and understanding: _____

Treatment Philosophy-Explanation of Brief Therapy

Brief therapy is goal-directed problem focused treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal(s) in mind and progress is made toward accomplishment of that goal in a time efficient manner. You will take an active role in setting and achieving your treatment goals. Your commitment to this treatment approach is necessary for you to experience a successful outcome. Your initials below indicate that you understand that there is a risk of feeling uncomfortable as a result of psychotherapy. If you ever have any questions about the nature of the treatment or your care, please do not hesitate to ask.

Client(s) initial(s) of agreement and understanding: _____

Fees and Cancellations

The usual and customary fee for individual and marital/family treatment is

\$110/hour¹. Any increase in fees will be communicated to patients at least two weeks prior to the new fee becoming effective. Appointments may be cancelled with 24 hours notice by leaving a voice mail at 909-338-5807. Missed appointments not cancelled with such notice will be billed at the regular rate. Though insurance will typically not be billed for missed appointments, patient may become responsible for full billed rate in the case of missed appointments.

Patients are expected to pay the standard fee of per 50-minute session at the start of each session unless other arrangements have been made. Patients who carry insurance are advised that professional services are rendered and charged to the patients and not to the insurance company, although as a service to you the insurance company may be sent a billing.

I understand and agree that I am responsible for payment of all clinical services at the time they are rendered. I understand that I am responsible for all deductibles, copayments or other services not covered by my insurance company, or any other entity. I hereby assign payable benefits to my counselor.

Patient(s) initial(s) of agreement and understanding: _____

Additional Payment Arrangements

Upon agreement between Michael Beavers, MS LMFT and myself, it is understood that the arranged fee for each 50 minutes sessions is \$ _____. This agreement supercedes the standard rate of reimbursement stated in the previous section for clinical services. All other aspects of the previous section remain unchanged.

Patient(s) initial(s) indicating agreement and understanding: _____

Payment

Payment must be made via check or cash at the time of treatment unless otherwise agreed. Unless Michael Beavers, MS LMFT has a prior arrangement with a particular insurer and the authorization is already secured, reimbursement from any insurer is the responsibility of the patient. Michael Beavers, MS LMFT may provide assistance in completing forms and/or appealing denials.

Patient(s) initial(s) indicating agreement and understanding: _____

¹Therapy typically occurs during a 50 minute period, leaving 10 minutes for documentation.

Therapist Legal Entity

Michael Beavers, MS LMFT is practicing as an independent private provider, with no legal or other connection with any other practicing professionals or professional group.

Patient(s) initial(s) indicating agreement and understanding: _____

Description of the Therapeutic Process

It may be helpful to know some specifics about what is likely to happen during therapy. Here are some common strategies and other realities of therapy:

1. Homework. Rarely does a session end without my prescribing something to do before the next session. This may take the form of trying out new behaviors, journaling, reflecting on a particular principle, or having a particular conversation with a significant person.
2. Reading. I will often recommend reading a book or article that may be helpful to the work you're doing. I only recommend reading for those patients who are comfortable with this change method. Though it is powerful, it is certainly not the only way of changing.
3. Strong feelings. In most authentic therapy experiences, strong feelings arise which will be addressed honestly and supportively.
4. Assessments. A variety of written or other assessment tools (for example, the Myers-Briggs Type Indicator) may be used to help generate insight and/or life change.
5. Progress of Therapy. It is important to understand that progress in treating relationships and emotions is seldom without negative feelings; in fact patients often will feel worse for a period of time before they feel better. Therapy is not always successful. Treatment planning will be revisited occasionally to ensure progress is being made toward patient goals.
6. Termination. Both patient and therapist are free to terminate therapy at any time. The patient is encouraged to allow at least one session for termination issues (closure, solidifying gains, planning, etc.).
7. Ethical Standards. Michael Beavers, MS LMFT has agreed to be bound by the California Association of Marriage and Family Therapists (CAMFT) ethical guidelines which are available online at www.CAMFT.org or may be requested from Michael Beavers.

Patient(s) initial(s) indicating agreement and understanding: _____

Confidentiality

Information disclosed by you during the course of your therapy is generally confidential. However, there are exceptions to confidentiality including, but not limited to: reporting child, elder and dependent adult abuse, expressed threats of violence towards an ascertainable victim, and where you offer your mental or emotional state in a legal proceeding

Patient(s) initial(s) indicating agreement and understanding: _____

Use of Email

If email is used for communication of routine matters (e.g. scheduling) I acknowledge and accept the risk inherent in this communication medium. If email communication includes more sensitive information, it is agreed that an MS Word attachment will be encrypted with a mutually agreed password.

Patient(s) initial(s) indicating agreement and understanding: _____

Availability and After-hours Contact Information

Except under special conditions mutually agreed, this therapist is generally not available after hours or “on call”. If an emergency arises, patients are instructed to call “911” and seek appropriate emergency services. If a patient desires to schedule a session between normally scheduled sessions patient can call (909) 336-3330 and schedule an appointment or use the online scheduler at MikeBeaversLMFT.com.

Patient(s) initial(s) indicating agreement and understanding: _____

FOR FAMILY/MARITAL THERAPY

This therapist has a “no secrets” policy which means in cases where information is shared with the therapist full freedom is granted to the therapist to use the information in therapy with this couple according to his clinical judgment.

Patient(s) initial(s) indicating agreement and understanding: _____

FOR GROUP THERAPY

It is agreed that any information shared by other group members will be held in the strictest confidence.

Patient(s) initial(s) indicating agreement and understanding: _____

HIPAA RECEIPT

Initial here to indicate having received “Notice of Privacy Practices”

My signature indicates I have read, understand, and agreed to these items as stated herein.

Patient Name (printed)

Spouse (if applicable)

Other

Patient Signature

Signature

Signature

Date

Date

Date

Name (printed)

Spouse (if applicable)

Parent (if applicable)

Patient Signature

Signature

Signature

Date

Date

Date

Relation to Family

Relation to Family

Relation to Family

Notice of Privacy Practices

I. 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.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will “use” and “disclose” your PHI. A “use” of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is “disclosed” when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (*if applicable*). You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at (*insert website address, if applicable*).

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care

Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

2. To Obtain Payment for Treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. For Health Care Operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you

received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

4. Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.
2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.
3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.
4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.
5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to Family, Friends, or Others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Restrictions on My Uses and Disclosures. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. The Right to Choose How I Send PHI to You. You have the right to request that I send confidential information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is

reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Copy of Your PHI. In most cases, you have the right to inspect and copy the PHI that I that I have on you, but you must make the request to inspect and copy such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, I will charge you not more than \$.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Receive a List of the Disclosures I Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003.

I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure

was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Michael Beavers, MS LMFT, 580 Forest Shade Drive, #10; Crestline, CA 92325, (909) 317-6579, MikeBeaversLMFT@earthlink.net.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

Receipt Acknowledgement

I acknowledge having received (not necessarily read) a copy of the HIPAA Notice of Privacy Practices.

Signature

Date

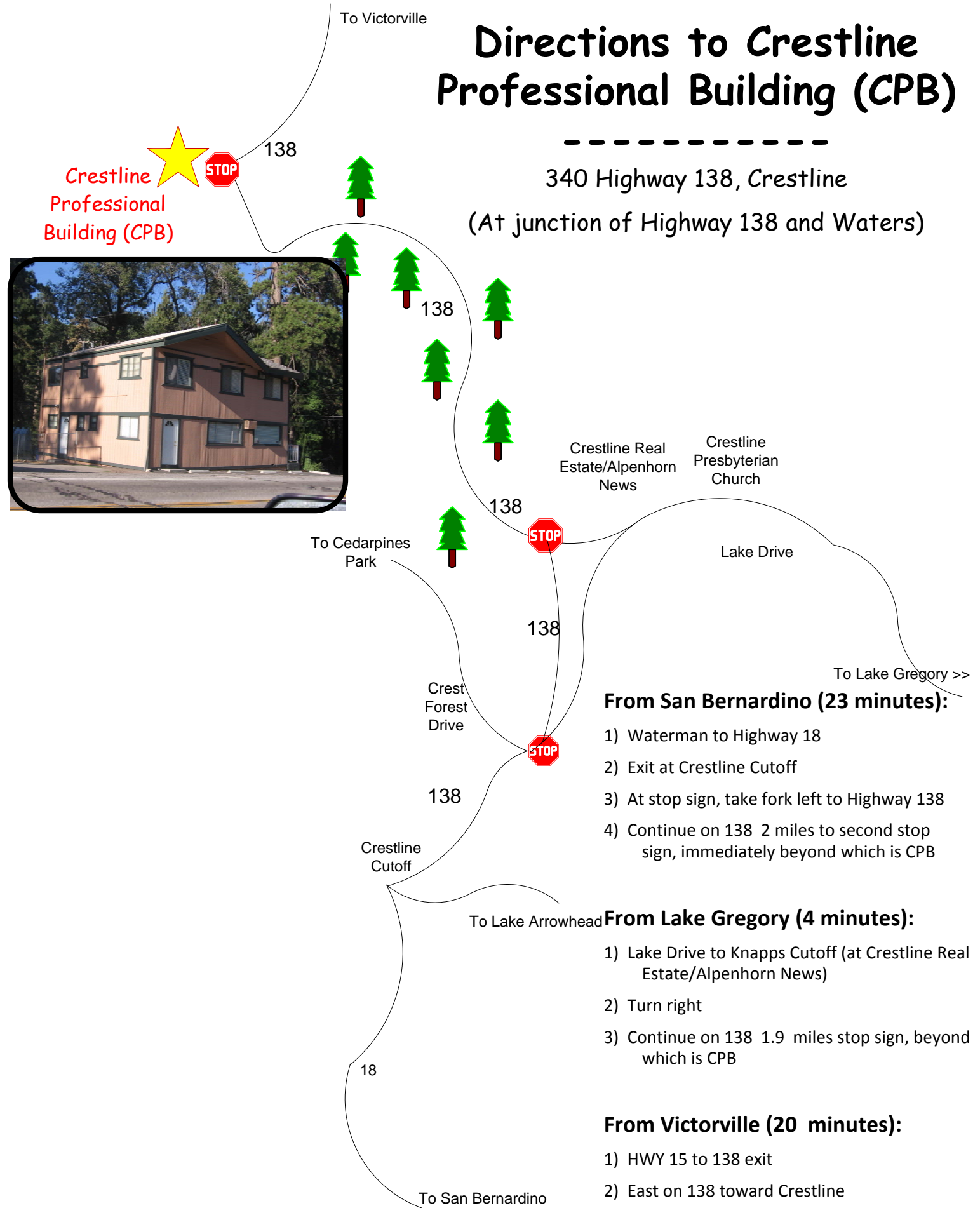
Name Printed

Directions to Crestline Professional Building (CPB)

340 Highway 138, Crestline

(At junction of Highway 138 and Waters)

Crestline Professional Building (CPB)



From San Bernardino (23 minutes):

- 1) Waterman to Highway 18
- 2) Exit at Crestline Cutoff
- 3) At stop sign, take fork left to Highway 138
- 4) Continue on 138 2 miles to second stop sign, immediately beyond which is CPB

From Lake Gregory (4 minutes):

- 1) Lake Drive to Knapps Cutoff (at Crestline Real Estate/Alpenhorn News)
- 2) Turn right
- 3) Continue on 138 1.9 miles stop sign, beyond which is CPB

From Victorville (20 minutes):

- 1) HWY 15 to 138 exit
- 2) East on 138 toward Crestline
- 3) Pass Lake Silverwood
- 4) Continue about 5 miles to CPB, at stop sign, on right.

Directions to Lake Arrowhead Village Office

From Crestline:

1. Crest Forest Drive to 18
2. Left on Hwy 18 (6.9 miles)
3. Left on Hwy 173 (1.6 miles)
4. At Lake Arrowhead Village, look for Subway restaurant
5. Office is in Suite F-240 (#20), Arrowhead Executive Suites, directly above Pendletons.

From San Bernardino:

1. Waterman to Hwy 18
2. Hwy 18 up mountain to Highway 173 (16 miles)
3. Left on Hwy 173 (1.6 miles)
4. At Lake Arrowhead Village, look for Subway restaurant
5. Office is in Suite F-240 (#20), Arrowhead Executive Suites, directly above Pendletons.

From Victorville:

1. Hwy 15 to 138 (21.2 miles)
2. Left on 18 (approximately 7 miles)
3. Left on Hwy 173 (1.6 miles)
4. At Lake Arrowhead Village, look for Subway restaurant
5. Office is in Suite F-240 (#20), Arrowhead Executive Suites, directly above Pendletons.

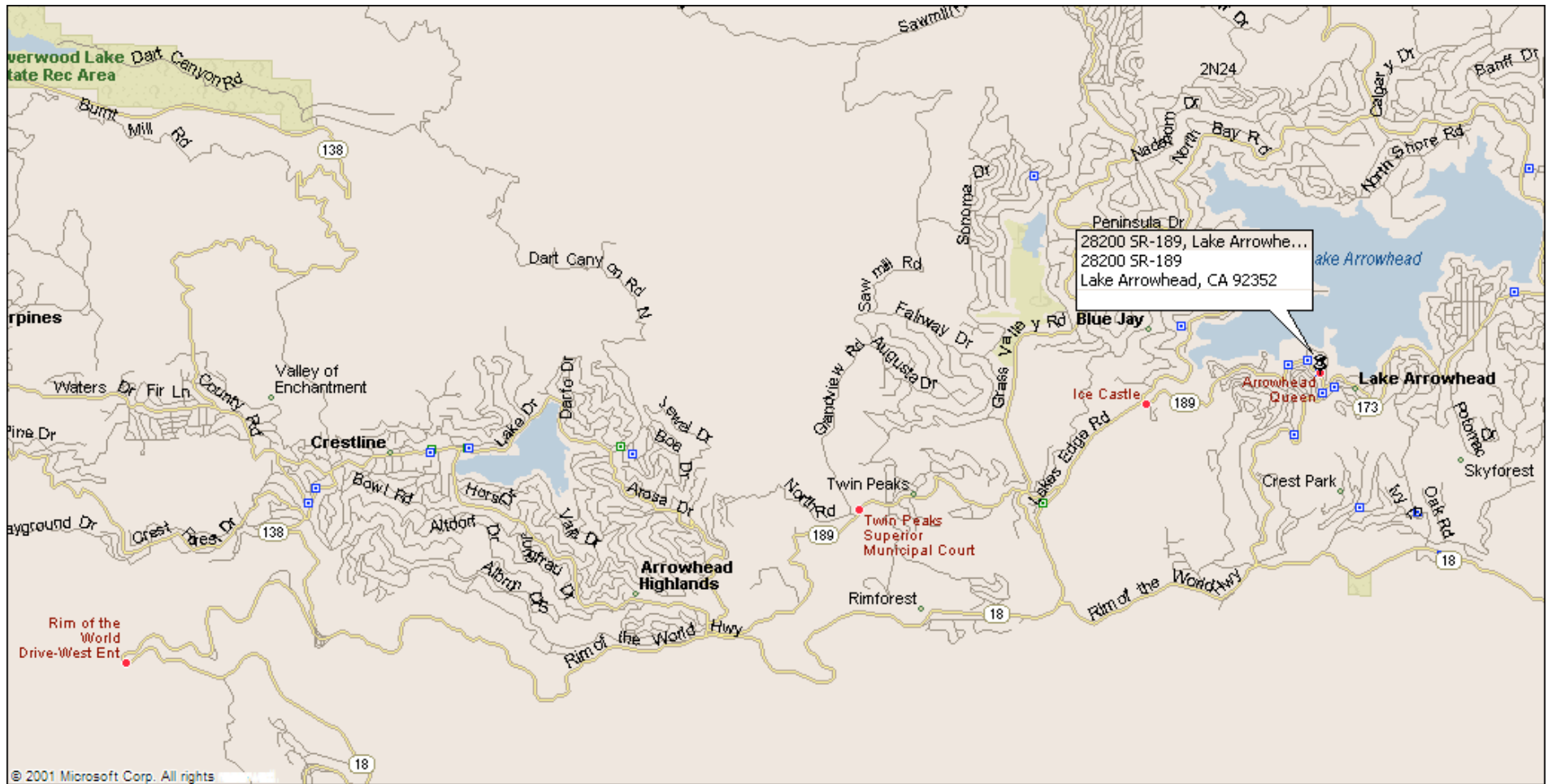
Address:

28200 Highway 189, Suite F-240 (#20)
Lake Arrowhead, CA 92352-2367

Mailing Address:

P.O. Box 2367
Lake Arrowhead, CA 92352-2367

Phone: 909.336.3330



Arrowhead Lake State Rec Area

Maple

Pine Dr

Playground Dr

Rim of the World Drive-West End

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Valley of Enchantment

Crestline

Arrowhead Highlands

Twin Peaks Superior Municipal Court

Blue Jay

Ice Castle

Lake Arrowhead

Crest Park

North Rd

Oak Rd

Peninsula Dr
28200 SR-189, Lake Arrowhead...
28200 SR-189
Lake Arrowhead, CA 92352

Arrowhead Queen

Skyforest

Palomares

North Rd

Oak Rd

Waters Dr

Fir Ln

County Rd

Crest Area Dr

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Bowl Rd

Herschel

Alford Dr

Alford Dr

Rim of the World Hwy

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Darfo Dr

Seval Dr

Arosa Dr

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Fairway Dr

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