



(PLEASE READ AND RETAIN THIS COPY FOR YOUR RECORDS)

Please read these guidelines carefully to help make our work together more effective.

1. **Therapy sessions are 45 minutes long.** In order to make the most of our time together, please arrive a few minutes early for your session. All sessions will begin and end on time unless I have a treatment issue that requires immediate attention.
2. **Note-Taking:** To increase the effectiveness of our sessions, I will be taking notes during them. These notes document the issues we are addressing which meet the “medical criteria” as required by your insurance company in order to ensure their ongoing support of your treatment.
3. **To schedule, change or cancel an appointment:** Whenever possible, please use the **24-hour, secure online scheduler** at www.eastlakecounseling.com. This service is available to view, schedule, change or cancel appointments up until 48 hours prior to the scheduled appointment time. If there are fewer than 48 hours prior to your appointment, you must contact me to change or cancel.
4. **Consistency of treatment:** When scheduling an appointment, you will have the option of scheduling up to eight (8) appointments in advance. If you have any specific scheduling needs, it is **strongly** recommended that you do this in order to avoid lapses in treatment and to ensure convenient appointment times. Appointments after 2 p.m. tend to fill up several weeks in advance.
5. **Appointment Reminders:** If you have provided a valid email address, you will receive email reminders to help you remember to keep your scheduled appointments. If you entered a valid cell phone number, you will also receive a text message reminder. If you do not wish to receive these reminders, you must log in to your account and turn off this feature. If you have not provided a valid email address or cell phone **you will not receive an appointment reminder**. Reminder messages are a courtesy only – ultimately it is your responsibility to keep track of all appointments. **Even if you do not receive a reminder you are still responsible for all late cancellation/no show fees.**
6. **Late-cancellations and missed appointments (no shows):** If you cancel your appointment less than **24 hours** prior to your appointment time, you will be assessed a **\$50 fee for which you are solely responsible**. If you arrive to your appointment **more than 15 minutes late**, your appointment will be considered missed (insurances cannot be billed for partial appointments). You will be assessed a **\$50 fee for all missed appointments as well**. **Appointments can be cancelled by leaving a voicemail at 619-271-8886 24 hours a day, 7 days a week.** All messages will be time and date-stamped.
7. **Co-pays and deductibles:** All co-pays and deductibles must be paid before your session begins. If you do not pay at the time of your session, Jeff Palitz, MFT may, at his discretion, temporarily suspend your treatment until a financial agreement is reached.
8. **If you have an emergency: Call 9-1-1 or go to your nearest emergency room.** If you have a crisis and you need to speak with someone immediately, call 1-800-479-3339 and someone will assist you. If you absolutely must speak with Jeff, please leave a message at 619-271-8886 and your call will be returned as quickly as possible.
9. **No Secrets Policy:** When working with **couples** it is essential for the effectiveness of treatment that you know **I do not keep secrets between couples**. Should I happen to speak with either party individually (on the phone, by email or in person) the content of those conversations **will not be kept secret from the partner/spouse**. *The only exception is if there is an immediate or ongoing safety issue.*
10. **If you have questions:** If you ever have any questions of any kind regarding your treatment or any issues related to your treatment please feel free to ask me at any time. You may also contact me via telephone or email at your convenience. All messages will be returned as soon as possible. Always remember that I am here to support you in every way I can.



Welcome to Eastlake Community Counseling and thank you for entrusting me with your treatment. **Please take some time to carefully review this paperwork packet.** The following paperwork serves several purposes. First, it provides me with valuable information that I will need in order to provide the best possible services to you. Second, if it is completed prior to your first session, it will allow us to focus on matters relevant to your life during that session rather than collecting information. Finally, it provides you with the information you will need to understand the therapeutic process, set your treatment goals and begin working on achieving these goals. Your participation in and understanding of the treatment goals is essential in order to achieve the best possible outcome from your therapy. *If you ever have any questions about the nature of your treatment or anything else about your care, please do not hesitate to ask.*

CONFIDENTIALITY AND MANDATED REPORTING

All information exchanged between patient and therapist is considered strictly confidential. I will not release any information about your therapy unless permitted by law or:

1. It is agreed upon **in writing** and complies with State Laws
2. The patient presents an imminent danger to himself or herself or to others
3. There is any reason to suspect the abuse or neglect of a child or elderly person
4. As necessary for continuity of care
5. If a judge determines that our discussions are not confidential, the judge may order that specific information be released
6. As requested by a court appointed attorney for a child involved in court proceedings.
7. If you are bringing in your child for treatment, it is up to the therapist to determine the level of confidentiality he or she will require. As a general rule, children ages 12 and up will retain confidentiality from their parents, prohibiting me from discussing the content of our sessions with parents. (Except in the cases of numbers 2 and 3).

In the cases of numbers 2 and 3, I am **mandated by law** to inform potential victims and legal authorities so that protective measures can be taken. If you participate in couples counseling as part of your treatment, please be advised that no information will be released without the written consent of **both parties**. As a standard, I will follow the “minimum necessary” rule for information being released.

GENERAL CONSENT TO TREATMENT

By signing below, I authorize and request that Jeff Palitz, MFT carry out psychological examinations, treatment and/or diagnostic procedures that now or during the course of my care as patient are advisable. I also understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable and that the therapist can make no guarantees regarding treatment progress or outcomes.

Further, **if I am consenting on behalf of a minor child, dependent or beneficiary**, I hereby authorize Jeff Palitz, MFT to deliver mental health services to the patient. I understand that all policies stated in this packet apply to the patient. **I further accept that although my participation may be required as part of the patient’s treatment, the patient’s records are confidential, and by law I cannot access these records if Jeff Palitz, MFT believes such access would be detrimental to the patient.**

INITIALS: _____

FINANCIAL TERMS

Upon verification of health plan/insurance coverage and policy limits, my insurance carrier will be billed for me and my provider will be paid directly by the carrier. I will be responsible for any applicable deductibles and co-payments at the time of service, prior to the session beginning. I agree to make payments at the beginning of each appointment. I understand that if I am not eligible at the time that services are rendered, I am solely responsible for payment, even if this determination is made after services are rendered.

APPEALS AND GRIEVANCES

I acknowledge my right to request reconsideration in the case that outpatient care (number of visits) is denied certification. I understand that I would request an appeal through Jeff Palitz, MFT and that I risk nothing in exercising this right. I also acknowledge that I may submit a grievance to Jeff Palitz, MFT at any time to register a complaint about any aspect of my care. If I am not satisfied with the response I receive, I may submit grievance to my insurance directly.

EMERGENCY PROCEDURES

If you need to contact me at any time, please leave a detailed message according to the instructions given on my voicemail and your call will be returned. *If a medical emergency/immediate safety concern arises, call 9-1-1 or go immediately to the nearest emergency room.* In the case of a crisis, leave a detailed message, and Jeff Palitz, MFT will return your call as soon as possible or call 1-800-479-3339 for immediate help. Please do this only for true crises, as there may be a charge for telephone consultations that require more than 10 minutes.

\$50 CHARGE FOR LATE CANCELLED/MISSED APPOINTMENTS

BY INITIALING AT THE END OF THIS LINE, I ACKNOWLEDGE THAT IN THE EVENT OF A “NO SHOW” OR FAILURE TO GIVE 24-HOUR NOTICE PRIOR TO A CANCELLATION, A \$50 CHARGE WILL ASSESSED TO MY ACCOUNT. THIS CHARGE IS SOLELY MY RESPONSIBILITY AND WILL NOT BE PAID BY MY INSURANCE.

PATIENT’S INITIALS

HEALTH INSURANCE BILLING/PAYMENT AUTHORIZATION

I authorize Jeff Palitz, MFT to release any medical or other information necessary to process insurance claims for services rendered as part of my treatment. I also request payment of government benefits either to myself or to the party who accepts assignment of these benefits. I authorize payment of medical benefits to the undersigned physician or supplier for services rendered as part of my treatment with Jeff Palitz, MFT.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that Eastlake Community Counseling (ECC) and Jeff Palitz, MFT have either provided me with a copy of the ECC Notice of Privacy Practices or that I will obtain my own copy at www.eastlakecounseling.com as required by the Health Insurance Portability and Accountability Act (HIPAA).

BY SIGNING BELOW, I UNDERSTAND, ACKNOWLEDGE AND AGREE TO ALL OF THE ABOVE TREATMENT GUIDELINES, POLICIES AND PROCEDURES. I AM ALSO AWARE THAT EASTLAKE COMMUNITY COUNSELING IS A PROFESSIONAL CORPORATION OWNED AND OPERATED BY JEFF PALITZ, MFT, INC.

Patient/Legal Representative Signature

Date

Provider Signature

Please Print Name

Relationship to Client

A Message to My Clients About Arbitration

Please Read Before Continuing to the Next Page And Retain For Your Records

The attached contract is an arbitration agreement. By signing this agreement, we are both agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. I believe that the method of resolving disputes by arbitration is one of the fairest systems for both clients and providers. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement, you are changing the place where your claim will be presented. **You are not forfeiting your right to file a claim should you feel the need arises.** You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators) who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and providers. Further, both parties are spared some of the rigors of a trial and the publicity that may accompany judicial proceedings.

My goal is always to provide mental health services in such a way as to avoid any such disputes. Still, I know that most problems begin with miscommunication. If you have any questions at any time about your care, please ask me immediately.

Please sign/initial the highlighted areas on the next page. A copy of this agreement will be provided to you upon your request.

THERAPIST-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical/mental health services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the therapist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the therapist, and the therapist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the therapist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the therapist within 30 days, or signature. It is the intent of this agreement to apply to all medical/mental health services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical/mental health services.

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT. IF YOU WISH TO HAVE A COPY OF THIS CONTRACT, YOU MUST REQUEST ONE. PLEASE NOTIFY YOUR PROVIDER AND A SIGNED COPY WILL BE PROVIDED.

By: _____
Therapist's Signature (Date)

By: _____
Patient's or Patient Representative's Signature (Date)

By: Jeff Palitz, MFT, President, JEFF PALITZ, MFT, Inc.
Printed Name of Provider

By: _____
Print Patient's Name

If Representative, Print Name and Relationship to Patient

Eastlake Community Counseling
Client Information/Initial Evaluation

Substance Use/Abuse

To Be Completed By Client: Please provide a complete history of substance use/abuse

Coffee(__# of cups/day)||Cigarettes(__# per day)||Alcohol(__# per day/week) Date Last Drank: _____

Street Drugs (please list type, amount and frequency): _____

Prescription Drugs (list all you are currently taking, dosage and frequency): _____

Please Rate the Impact of Substance Abuse on Your Life (on a scale of 1 to 10): _____

Past Treatment for Substance Abuse: _____

Family History of Substance Abuse: _____

Family History of Mental Illness: _____

This Section To Be Completed By Provider. Please do not write in this space

Counseling/Psychiatric/Medical Treatment History

To Be Completed By Client: Please provide a complete treatment history

Have you ever seen a psychiatrist/psychologist/therapist? Yes___ No___

If yes, when? (mo/yr) _____ Inpatient___ Outpatient ___ Both ___

Where was the treatment? _____ How long/how many sessions? _____

Names(s) of therapist/doctor: _____ Previous Medications: _____

Was treatment for same/similar issue(s)? Yes___ No ___ Was treatment helpful? Yes ___ No ___

Any medical/physical issues (past or present)? If so, please list: _____

Date of last physical: _____ Pregnant? _____ Recent child birth (last 12 months)? _____

Please use this area to include any other relevant medical/psychological information: _____

Eastlake Community Counseling
Client Information/Initial Evaluation

Additional Information

To be completed by client:

What do you see as your/client's strengths? _____

What do you see as your/client's weaknesses? _____

Goals for treatment: _____

Any specific cultural/religious issues? _____

Impairment in: Marriage/Relationship Work/School Family Finances Social

Legal Housing Hygiene/Daily Living Physical Health

Please use this area to add any additional information about anything you feel is relevant: _____

This Area For Provider Use Only

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current GAF _____ Highest in last 12 months: _____

Tx Objectives: Rapid Stabilization Symptom Reduction Education Abstinence

Develop/Improve Coping Skills Medication Compliance Absence of SI/HI/Self Harm

Other: _____

Type of Tx: Inpatient (Specify: _____) CD-IOP Individual Psychotherapy

Conjoint Therapy Family Therapy Group Therapy Cog/Bx Therapy Play Tx

Psych Testing M.D. Eval. Self-help: Addiction Reading/Homework

Estimated Length of Tx: 0-3 mos. 3-6 mos. 6-12 mos. 12+ mos.

Discharge Plan: Med Compliance Use of Coping Skills Self-help/Self-eval. Referral

Transfer Care to M.D. Evidence of Support Structure

Recommended Return: _____

Provider Signature

Eastlake Community Counseling

Coordination of care with Primary Care Physician (PCP) and other Healthcare Providers

Please sign either Option #1 OR Option #2. **PLEASE DO NOT SIGN BOTH.**

Option #1: I AUTHORIZE the disclosure of confidential mental health information between Jeff Palitz, MFT and my Primary Care Physician/Healthcare Provider. I give permission to disclose the diagnosis and treatment information about my child or myself for the purpose of Continuity of Care. I understand and expressly authorize the release of information related to substance abuse and HIV status. This authorization is valid for one year and may be revoked by me in writing at any time.

Client/Legal Guardian Signature: _____ Date: _____

Patient Name: _____ Birth Date: _____

Patient's Complete Address: _____

PCP Name: _____ PCP Phone#: _____ PCP Fax#: _____

PCP's Complete Address: _____

Option #2: I REFUSE to authorize the disclosure of confidential mental health information between Jeff Palitz, MFT and my Primary Care Physician/Healthcare Provider for the purpose of promoting continuity of care.

Client/Legal Guardian Signature: _____ Date: _____

THIS AREA FOR OFFICE USE ONLY

Dear: _____,

I met with the above-named patient for an initial evaluation on _____.

Current diagnoses are _____

Outpatient care is appropriate at this time and the initial treatment will consist of the following:
 Individual Psychotherapy Family Psychotherapy CD-IOP Referral For Medication Mgmt.

Inpatient care/partial hospitalization is necessary and patient has been referred to: _____

Other Clinical Information: _____

If you need additional information, please contact me at 619-271-8886 or at jeff@eastlakecounseling.com.

Jeff Palitz, MFT Lic. No. MFC41250

Date