CLIENT REGISTRATION
Susan Pazak, PhD (PSY17583)
30131 Town Center Drive, #280, Laguna Niguel, CA 92677

NAME/CLIENT ______________________________

AGE __________ DOB _____________ GENDER M / F MARITAL STATUS __________

ADDRESS ____

CITY ______________________________ STATE ________ ZIP CODE _____________

Phone Contact# _______________________

E-mail address _________________________
[ ]I give permission to leave message or text message at this number, check box if okay.

NAME/SPOUSE ________________________________

AGE _____________ DOB __________________ GENDER M / F

ADDRESS ____

CITY ______________________________ STATE ________ ZIP CODE _____________

Phone Contact # _______________________
[ ]I give permission to leave message or text message at this number, check box if okay.

PARENT/GUARDIAN or Financially Responsible Party (for children 18 years and under)

NAME ____
Address ____
City ____ State ________ Zip Code __________

Phone # ____________________________________

FEES/PAYMENT:
I agree that I am responsible for payment of all scheduled services. Payment for services rendered to a minor is considered responsibility of the parent(s) that has requested treatment.

Insurance Procedure Codes

90791	250.00 Initial Assessment 45 to 50 minutes
96101	400.00 Psychological Evaluation with report
90837	250.00 Individual Adult/Child, Couple or Family 45 to 50 minutes

Rates vary for each insurance company depending on coverage; we will adjust or discount the fee, as per our agreement with your insurance plan. You are responsible for your initial deductibles and any services rendered that are not covered by your insurance plan. Please be aware of your insurance policy benefits and limitations.

My signature represents my informed consent for treatment and acknowledges my responsibility for payment of services. I hereby assign my insurance/health plan benefits to Susan Pazak, PhD. I further agree to the release of my records to necessary third party payors and agree to release my prior health records as necessary and mutually agreed upon. The agreement for the release of your records may be withdrawn at any time.

Signed/Client: ____ **Date:** ____________________

CLIENT AGREEMENT / INFORMED CONSENT
Susan Pazak, PhD (PSY17583)

<u>Please read the following carefully.</u> If you have any questions please do not hesitate to discuss.

CONFIDENTIALITY

I understand that my appointment, and the contents shared during that time are held in confidence. This includes all file notes, personal information provided, and data collected. **NO** disclosures will be made without my permission. Using insurance to pay for services limits confidentiality.

I acknowledge that California state laws limits confidentiality and mandates reporting to authorities in the following circumstances:

1) Incidence that involve child or elder abuse. Including neglect, sexual abuse, emotional abuse and/or psychological abuse.

2) Disclosures of intent to take harmful, dangerous, or criminal action against another person or against myself.

APPOINTMENTS/SESSIONS

The client/therapist relationship is established and maintained by mutual TRUST and RESPECT.

The majority of individuals who obtain therapy benefit from the process. Success may vary depending on the particular problems being addressed. Therapy requires a very active effort on your part. Self-exploration, gaining understanding, finding ways for dealing with problems and learning new skills are generally quite useful. Some risks do exist, however.

While the benefits of therapy are well known, you may experience unwanted feelings such as unhappiness, anger, guilt or frustration. These are a natural part of the therapy process and often provide the basis for change. Important personal decisions are often a result of therapy. These decisions, including changing behavior, exploring employment options, substance abuse patterns, schooling or relationships, are likely to produce new opportunities as well as unique challenges. Sometimes a decision that is positive for one family member will be viewed quite negatively by another family member. There are no guarantees although commitment to the therapy process should assist in a helpful, desired outcome.

As your therapist I commit to provide you professional services within my scope of practice. If at any time I determine that another professional might better serve you, I commit to make the necessary referrals and /or resources available to you.

As the client, I understand that Dr. Pazak does not participate in clients' legal actions such as custody suits, divorce proceedings, personal injury suites, etc. If you are considering or are involved in such actions, Dr. Pazak can refer you to a mental health professional that is experienced in legal matters.

As the client, I understand that the length of the session is limited to 45 minutes. I understand that arrangements can be made for longer sessions for family or conjoint appointments. Fees and the length of these sessions will be discussed prior to scheduling any special appointments. A telephone answering system is available 24 hours for messages or rescheduling appointments. This service is also available if a crisis should arise.

CANCELLATIONS / RESCHEDULING

I understand all appointments <u>must be cancelled 24 hours in advance</u> in order to <u>avoid charges</u>.
I am aware of my responsibility for payment in full for missed appointments or late cancellations.

Signed/Client ____ **Date** ________________

Confidentiality of Personal and Health Information (PHI)
Susan Pazak, PhD (PSY17583)

This notice describes how medical about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Dr. Susan Pazak is committed to protecting the personal and health information (PHI) of her patients in the setting in which such information is received or disclosed.

When you complete an application for health coverage, your signature authorizes your health plan to collect personal information that includes both your medical information and individually identifiable information about you such as you social security number, date of birth, address, telephone number, etc. As a patient of Dr. Susan Pazak this general consent allows Dr. Pazak to communicate with your authorized providers and health plan about treatment and payment decisions.

Dr. Pazak will not disclose, sell or otherwise use your PHI unless permitted by law for protection of personal safety and to the extent necessary to administer your benefit.

Dr. Pazak will obtain written authorization from you to use your PHI for any other purpose than indicated above.

For any patients unable to give consent, we have a policy in place to protect your rights and which permits your legally authorized representative to give consent on your behalf.

Dr. Pazak will also not release your PHI to your employer without your specific authorization, unless law permits such release.

Dr. Pazak has policies in place to allow you to inspect your medical records maintained after April 4, 2003 and when needed, to include a written statement from you. You also have the right to request an accounting of disclosures of PHI made for purposes other than those stated above. To exercise any of these rights, you may speak with Dr. Pazak.

If at any time you have a complaint regarding how your PHI was used and/or disclosed, you may contact Dr. Pazak and file a grievance, which will be investigated and outcome reported in writing to the client and health plan, if applicable.

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Signature

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Date