Client Information

Name (s)_____

_____

Address_____

City_____State____Zip_____

Cell Ph. ( ) _____ - _____

Home Ph. ( ) _____ - _____

Work Ph. ( ) _____ - _____

Email:_____

D.O.B. _____ / _____ / _____

Employer_____

Address_____

City_____State____Zip_____

Primary Care Physician

Name_____

Address_____

City_____State_____Zip_____

Date of most recent physical exam_____

Closest relative not living with you

Name_____

Address_____

City_____State____Zip_____

Ph. ( ) _____ - _____

Billing **(if other than patient)**

Name_____

Address _____

City_____State____Zip_____

_____

Referred by (circle): Friend Online search Physician Coach Other_____

Preferred Method of Payment

Check_____Cash_____CC____

Please Read & Sign on the Last Page

INFORMED CONSENT AND CONDITION OF TREATMENT

Benjamin W. Strack, Ph.D.
Licensed Psychologist, PSY24425

Preamble

The psychotherapeutic relationship is a collaborative relationship where you and your personal consultant seek to maximize your full potential. I understand the importance of the issues you bring to this process and endeavor to provide the highest quality consultation possible. I am privileged to participate in this venture and trust that you will reflect upon various aspects of our meetings for years to come. The following document should be read, fully completed and signed by the patient or responsible party. If you have any questions, please feel free to ask them at any time.

Confidentiality

Professional ethics and state law mandate that all communications and discussions be held in strict confidence. If your consultation format is marital therapy or family therapy, both husband and wife must sign this document. By signing this document, it is understood that any future requests for release of records concerning marital or family therapy must be authorized by the written consent of both husband and wife. The purpose of this explicit stipulation concerning confidentiality is to create a basis of trust necessary for successful therapy. In the rare event that this stipulation of confidentiality is challenged, for example, in the form of a subpoena in a divorce proceeding, child custody hearings, or other legal proceedings, ***it is understood that the undersigned parties will incur any and all additional expenses associated with our duty to assert the other parties privilege of confidential communication including minimal fees stipulated in Litigation Limitation.***

Notice of Privacy Statement

There are limits to confidentiality also required by state law. Confidentiality cannot be maintained when a patient is in (1) imminent danger of hurting himself/herself or another party (2) there is a suspicion of child or elderly abuse, neglect or sexual molestation (3) if you raise the question of your/patient's mental competence in a legal proceeding (4) utilizing the doctor/patient privilege to shield the planning of a crime or tort.

When Disclosure May Be Required

Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapeutic records and/or testimony of your therapist. In couples and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. The therapist will use his clinical judgment when revealing such information. ***Limited information will be released to further your treatment with other health care professionals and school personnel when treatment involves, for example, a minor child.***

Emergencies

If there is an emergency during our work together, or in the future after termination where your therapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, he will do whatever he can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, he may also contact the person whose name you have provided on the biographical information sheet.

Health Insurance

Disclosure of confidential information may be required by your health insurance carrier or HMH/PPO/MCO/EAP in order to process the claims. Only the minimum necessary information will be communicated to the carrier but enough to satisfy reimbursement for

services. Your therapist has no control or knowledge over what insurance companies do with the information he submits or who has access to this information.

Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc) neither you (the client) nor your attorneys, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. **If this litigation limitation agreement is violated, fees to assert privileged communication, preparation/review/stand-by status, and/or to testify in court or for a deposition are $450.00 per hour with a minimal charge of a half day when compliance entails travel.**

Treatment Authorization

Minors in treatment, whose family has been issued a custody agreement, must provide a copy of the custody decree to your therapist. It is this therapist's policy, when feasible and possible, to obtain the written or verbal consent to treatment of both parents. Refusal to allow this contact with the other parent will likely terminate treatment.

Professional Fess/Cancellations/Availability

The fee for the initial consultation (60 minute Evaluation) is $300. Subsequent sessions or the regular rate for therapy is $225 (45 minutes). This will be discussed during your first visit. Full payment for services is due when services are rendered. Cancellations less than 24 hours in advance of your scheduled appointment or missed appointments will be charged the regular fee. Office hours are by appointment. A 24 hour voicemail is always in operation to avoid interruptions while in session. All communications, both emergency and routine, should be initiated by calling (949) 629-2560.

Consultation

In an effort to provide the best care possible, your therapist consults regularly with other professionals regarding his clients. When possible, as much personal health information will be omitted according to the clinician's privacy policy and Protected Health Information stipulated by HIPAA. The full text of this policy is posted in the waiting room and available upon request. This consent contains the details of this policy and constitutes notice of policy. ***Limited information will be released to further your treatment with other health care professionals and school personnel when treatment involves for example a minor child.***

Your Right to Review Records

As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when your therapist assesses that releasing such information might be harmful in any way. In such a case your therapist will provide the records to an appropriate and legitimate mental health professional of your choice. There is a standard charge for copy and release of all records.

The Process of Therapy/Evaluation

Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty and openness in order to change your thoughts, feelings, and/or behavior. Your therapist will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. During evaluation or therapy, remembering or talking about unpleasant events, feelings or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc… or experiencing anxiety, depression, insomnia, etc… Your therapist may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about or handling situations which can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you into therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, your therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his/her assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, biofeedback, existential, system/family, developmental (adult, child, family), or psycho-educational.

Discussion of Treatment Plan

Within a reasonable period of time after the initiation of treatment, your therapist will discuss with you (the client) his working understanding of the problem, treatment plan, therapeutic objectives and his view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in this course of our therapy, their possible risks, your therapist's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that your therapist does not provide, he has an ethical obligation to assist you in obtaining those treatments.

Termination

As set forth above, after the first couple of meetings, your therapist will assess if he can be of benefit to you. Your therapist does not accept clients who, in his opinion, he cannot help. In such a case, he will give you a number of referrals whom you can contact. If at any point during psychotherapy, your therapist assessed that he is not effective in helping you reach the therapeutic goals, he is obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, he would give you a number of referrals with may be of help to you. If you request it and authorize it in writing, your therapist will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, your therapist will assist you in finding someone qualified, and if he has your written consent, he will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, your therapist will offer to provide you with the names of other qualified professionals whose services you might prefer.

Dual relationships

Therapy never involves sexual or business relationships or any other dual relationship that impairs your therapist's objectivity, clinical judgment, therapeutic effectiveness or relationships that can be exploitative in nature. Sexual relations with a psychotherapist are against the law and are against the policy of this therapist.

Financial Conditions

The undersigned agrees, whether he/she signs as agent or as patient, to pay the account of Benjamin W. Strack, Ph.D. in accordance with the regular rates and terms. Should the account be referred to an attorney or collections agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. *It is understood and authorized that after 90 days of delinquency, your account may be assigned to a collection agency.* All delinquent accounts shall bear interest at the legal rate. The current finance charge, including interest, is 1.5% per month on all unpaid balances over 60 days (18% per annum). By signing this form you are also authorizing the use of your credit card to pay for professional services if this is the chosen method of payment or under any of the following conditions:*(a) no-show for a scheduled appointment, (b) cancellation less than 24 business hours in advance, or (c) participation in treatment (e.g., appointment or a phone/Skype session) without payment rendered.*. The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____Date ____/____/____ _____

Patient/Parent Signature **Spouses Signature (required for marital therapy)**

_____ _____Date____/ ____/ ____

If other than patient please indicate relationship **Psychologist's Signature**

Benjamin W. Strack, Ph.D.
23 Corporate Plaza, Suite 150
Newport Beach, CA 92660

Credit Card Authorization

I, the undersigned, authorize Benjamin W. Strack, Ph.D. to charge my credit card in the event that I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify me at least 24 business hours in advance for a cancelled appointment, as agreed to in the Treatment Consent. Furthermore, for outstanding payments of services rendered, I authorize charges to my credit card for the full amount due. I agree to not dispute charges for any of these reasons and understand that clinical information will need to be released if a dispute is initiated. I further authorize Benjamin W. Strack, Ph.D. to disclose information about my attendance and/or cancellation to my credit card company if I dispute a charge. This form will be securely stored in a clinical file and may be updated upon request at any time.

Card Type: · Visa · MasterCard · Discover · AMEX

Card #: _____

Expiration Date: _____ Verification/Security Code: _____

Name (as printed on card):_____

Billing Address:_____
(Street; City, State & Zip)

Signature: _____ Date:_____
(Patient or financially responsible party)

**Please note, your credit card will not be charged unless one of the following conditions apply:(a) no-show for a scheduled appointment, (b) cancellation less than 24 business hours in advance, or (c) participation in treatment (e.g., appointment or a phone/Skype session) without payment rendered.*

PLEASE SIGN BELOW IF YOU PREFER YOUR CREDIT CARD TO BE CHARGED FOR REGULARLY SCHEDULED APPOINTMENTS:

Signature:_____ Date: _____
(Patient or financially responsible party)