Lisa Montalvo, MFT, CEAP, SAP
1395 San Carlos Avenue, Suite C#4
San Carlos, California 94070
(650) 631-0909
www.BayAreaCounselingService.com

Date _____/_____/_____

Patient Information:

Name_____

Address_____

City_____State_____Zip_____

Home Phone____/_____ Work Phone____/_____ext_____

Cell Phone ____/_____ Email Address_____

*Please indicate your preferred telephone contact number.

Birth Date ____/_____/_____ Age_____

Last 4 Numbers of Social Security: __XXX_/_XX_/_____ Marital Status _____

Employer_____Occupation_____

Spouse's Employer_____Occupation_____

Name of those living in household	Relation to you	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Insurance Information:

Company_____Plan Name_____

Group or Policy Number _____

Address_____City_____State_____Zip_____

Phone_____/_____/_____

Name of Insured_____

Last 4 Numbers of Social Security of Insured___XXX / XX /_____

How were you referred? _____

Have you had previous counseling?____ With Whom?_____When_____

Briefly describe the difficulties for which you are seeking help:

Medical History Questionnaire

Current Health- On a scale of 1 (very poor) to 10 (excellent) how would you rate your present health?

(Circle one) 1 2 3 4 5 6 7 8 9 10

Who is your Primary Care Physician:

_____

What prescription medications are you currently taking and why?

_____ _____ _____

What non-prescription medications are you currently taking and why?

_____ _____ _____

Describe your alcohol consumption: What kind_____

How frequently_____

How much_____

Has it changed recently? _____

Mental Health Questionnaire

Please answer each of the questions below by circling the appropriate number or response appearing at the right side of the page. Each of the items should be answered according to how you currently feel.

	Poor(ly)			Good	Very well
How well are you sleeping	1	2	3	4	5

Has your sleep pattern changed recently? Yes No

How would you describe your energy level 1 2 3 4 5

How high is your current level of stress 1 2 3 4 5

	Hopeless				Very bright
How does your future look to you?	1	2	3	4	5

	Sad				Happy
How would you describe your recent mood?	1	2	3	4	5

	Disappointed				Satisfied
How do you generally feel about yourself?	1	2	3	4	5

Do you worry a great deal? Yes No

Have you been very nervous or anxious recently? Yes No

How would you describe your relationship with:	Poor				Excellent
Your spouse (or significant other)	1	2	3	4	5
Your family	1	2	3	4	5
Your friends	1	2	3	4	5

Do you have any trouble concentrating? Yes No

Do you have any trouble making decisions? Yes No

Do you have any trouble remembering things? Yes No

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Client Agreement Form

Fee Payment My fee is $180.00 per session, per agreement, and appointments are 50 minutes in length. Payment is requested at the beginning or end of each session.

Cancellations I will make every effort to accommodate your scheduling needs. In return I ask that you help out by keeping your scheduled appointment, and by notifying me in advance if you are unable to do so. With advance notice, I am often able to accommodate other clients that are waiting to get an appointment.

ALL APPOINTMENTS THAT ARE CANCELLED WITH LESS THAN 48 HOURS ADVANCE NOTICE ARE SUBJECT TO A MISSED APPOINTMENT FEE. 48 hour cancellation policy is Monday – Friday during business hours. Please note that this is NOT covered by insurance/ EAP companies. It is the client's responsibility.

If you fail to arrive for your appointment without 48 hour advance notification, you will be charged the full hourly rate which is $180.00. This fee is due and payable at your next appointment.

Insurance For clients who participate in a qualified insurance or EAP plan, applicable co-payments and deductibles will be collected during the scheduled appointment. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event my insurance plan fails to reimburse, I agree to pay all costs accrued.

Therapy involving Legal issues If you are seeking a therapist to support you with legal issues involved in therapy, e.g. divorce, child custody issues, disability claims, harassment claims, etc. Please note I do not have the training, education or experience to represent you. I will be glad to give you a referral to a competent therapist.

Assignment of benefits I hereby authorize Lisa Montalvo, MFT, CEAP, SAP to release any information required to process my mental health claims, and I also give authorization for direct payment of mental health claims reimbursement to Lisa Montalvo, MFT, CEAP, SAP.

Acknowledgement of receipt of Notice of Privacy Practices I hereby acknowledge that I have received a copy Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available upon request, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Confidentiality All communications between the therapist and client in the therapeutic sessions are privileged and confidential with the following exceptions mandated by law:

- If there is reasonable cause to believe there is a clear and imminent danger to another person or persons.
- If there is a reasonable cause to believe that the client is in danger to himself/herself.
- If there is reasonable cause to believe there is child, elder or dependent adult abuse.

Consent to Treatment Most people who participate in behavioral or mental health treatment benefit from it. Like most kinds of healthcare, this kind of treatment requires a very active effort on the individual's part. In addition, there may be certain kinds of risks involved. For example, the counseling process can be challenging and sometimes may involve experiencing some uncomfortable feelings, or engaging in difficult interactions, or facing difficult aspects of your life. Nevertheless, most people find the benefits outweigh any such risks.
It is important that the individual participates in this treatment willingly. If you have any questions or concerns about this document, about the services being provided, or about the treatment options, please feel free to ask questions.

Termination of Therapy
Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside the Therapist's scope of practice or competence, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals when appropriate.

By signing this agreement, I acknowledge that I have read this agreement, understood its terms, agree to be subject to its provisions, and voluntarily agree to the participation in the treatment.

Signature **Date**

_____ _____

Telehealth Consent Form

I, _____ hereby consent to engage in Telehealth with Lisa Montalvo, MFT.

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in–person psychotherapy. The same mandatory and permissive expectations to confidentiality outlined in the informed consent form I received from my therapist also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
6. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above and had discussed it with my therapist, and I understand that I have the right to have all my questions regarding this information answer to my satisfaction.

_____ _____

Patient Signature Date

_____

Patients Printed Name

Verbal Consent Obtained

Therapist reviewed Telehealth consent form with patient, patient understands and agrees to the above advisement, and patient has verbally consented to receiving psychotherapy services from therapist via Telehealth.

_____ _____

Therapist Signature Date