



**Who lives in your household?**

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How were you referred to our office? \_\_\_\_\_

Who may we thank for referring you? Name \_\_\_\_\_ Address \_\_\_\_\_

Spiritual/Religious Beliefs \_\_\_\_\_ Organization/Church \_\_\_\_\_

Military Service? \_\_\_\_ Yes \_\_\_\_ No if Yes, when and what branch? \_\_\_\_\_

***Reason(s) for Coming***

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Health Insurance***

**Primary Insurance:**

Insurance Name: \_\_\_\_\_ Policy Number \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Whose Policy \_\_\_\_ Self \_\_\_\_ Partner \_\_\_\_ Other \_\_\_\_\_

**Secondary Insurance:**

Insurance Name: \_\_\_\_\_ Policy Number \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Whose Policy \_\_\_ Self \_\_\_ Partner \_\_\_ Other \_\_\_\_\_

### **Physicians Information**

Name of Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone Number: \_\_\_\_\_

### **Emergency Contact**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone Numbers: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### **Education**

What is the highest grade level you have completed? \_\_\_\_\_

Are you currently attending school? \_\_\_ Yes \_\_\_ No if Yes, which one \_\_\_\_\_

### **Medical History**

Present physical health: \_\_\_ excellent \_\_\_ good \_\_\_ poor

Date of last medical check-up: \_\_\_\_\_ Reason: \_\_\_\_\_

#### **List all medication currently being taken:**

Medication	Dosage	When started	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had psychotherapy before? \_\_\_\_ Yes \_\_\_\_ No If Yes, please answer the following questions:

Name of Therapist \_\_\_\_\_ Phone \_\_\_\_\_

Dates of Treatment \_\_\_\_\_ Reason(s) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Where you satisfied with the outcome? \_\_\_\_ Yes \_\_\_\_ No Why? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Therapist \_\_\_\_\_ Phone \_\_\_\_\_

Dates of Treatment \_\_\_\_\_ Reason(s) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Where you satisfied with the outcome? \_\_\_\_ Yes \_\_\_\_ No Why? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever been hospitalized? \_\_\_\_\_ Yes \_\_\_\_\_ No if Yes, please answer the following questions:

When: \_\_\_\_\_ Where: \_\_\_\_\_ How long: \_\_\_\_\_

Reason: \_\_\_\_\_

When: \_\_\_\_\_ Where: \_\_\_\_\_ How long: \_\_\_\_\_

Reason: \_\_\_\_\_

***Thank you***



# Valley Center Counseling, Inc.

## POLICIES AND PAYMENT INFORMATION

This statement contains information regarding my office policies. Please read them and if you have any questions, feel free to contact me. Your signature at the bottom of this sheet signifies that you have read, understood and agree to abide by these policies and that you have received a copy of the policies for yourself.

### **Appointments**

Your appointment time is held exclusively for you – please arrive on time as you use your own time when you are late. If you are going to be unable to keep an appointment, you are asked to provide at least 24 hours notice or you will be charged for the time as though you attended. Please note that insurance companies will not cover this charge and you will have to pay the entire amount out of pocket.

### **Fees**

The fee for my professional services is: \$125.00 for a 50-minute individual session; \$140.00 for a 50 minute couple or family session; \$190.00 for a 90 minutes individual session; \$210.00 for a 90 minute couple or family session or \$45.00 for a 90 minutes group session. You will also be charged this same rate for additional services provided at your request or for your benefit (at the request of an insurance company, attorney, etc.) such as report writing, consultation with other professionals, hospital visits and phone calls over ten minutes with you or others. **Payment in full is expected at the time of the visit** unless other arrangements are made in advance of the appointment. **Fees are subject to change every six months.** Speak to me about signing up an optional automatic payment program. I accept MasterCard, Vista, Discovery and American Express credit cards. Per your request you will receive an insurance ready monthly invoice. There will be a \$25.00 charge for returned checks.

**Medicare Clients Only:** If you are a Medicare client then you pay only your co-pay at each session. I will bill Medicare directly. You are responsible for the entire fee whether your insurance pays or not. You are responsible for any charges applied to your deductible and for whatever co-pays your insurance stipulates. You can pay by cash, check or credit card.

### **Termination of Services**

Services will be terminated for the following reasons: failure to pay for services (including bounced checks); excessive cancellations (more than one per month unless discussed prior); failure to follow treatment plan including homework assignments; any display of physical violence; any threats toward provider or staff; stocking of provider and/or staff and inappropriately over stepping personal boundaries (example, coming to provider home, calling after 10:00 PM or before 9:00 AM unless emergency). No notice is needed to terminate service you will be provided with a written explanation.

### **Confidentiality and the Release of Information**

Your participation in treatment and all information about you is confidential and will not be disclosed to anyone without written consent. Please review our PRIVACY POLICY statement for a complete description of our practices.

**Please sign below to indicate that you understand and agree to these policies.**

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Name

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Date



# Valley Center Counseling, Inc.

## PRIVACY POLICY

### ***Policies and Procedures for Maintaining the Confidentiality & Privacy of Medical Information***

Maintaining Patient's trust and confidence is my top priority. The information that follows is intended to help Patients to understand my policies for collections, use and disclosure of their medical information.

### ***Information Security and Collected***

All Patient information is kept in a locked filing cabinet. The only person who has access to that cabinet is me. In addition to the Patient's personal folder, I do maintain electronic chart notes. Every security measure to safeguard Patient medical information is maintained, including a security password system to access electronic files. By law, all medical files will be maintained for seven years.

With Patient's written permission, I may request medical information from other health care providers. This information will be kept in the Patient's confidential folder and not distributed without their permission. .

### ***Sharing Information***

I will not release Patient health information without the Patient's prior written authorization, except as permitted or required by law. There are situations in which I may release Patient medical information without the Patients written authorizations, including:

- ◆ Pursuant to a court order or subpoena
- ◆ To providers of the Patients health care for purposes of treatment
- ◆ To insurers or other entities responsible for paying for health care services rendered to patients
- ◆ To business associates of mine for the purpose of providing services such as processing claims or other administrative services.

I am a mandated reported which means in the below cases that I break confidentiality and make appropriate reports to authorities:

- ◆ If Patient is suicidal, by law I must contact the listed emergency person and the Patient's physician.
- ◆ If Patient is homicidal, by law I must contact the person the Patient is homicidal towards and police.
- ◆ If Patient is abusive (physically, mentally, emotionally or financially) toward a child or elderly person, I must contact the Department of Children Services or Department of Elderly Abuse and make a verbal as well as a written report.

### ***Patient's Rights to Review Own Health Information Record***

Patients have the right to review their own health information records maintained by me by requesting such information in writing to the address below.



# Valley Center Counseling, Inc.

Dear New Client,

Welcome to the practice of Penny Blazej, LCSW. This letter is intended to inform you of current billing procedures. Please feel free to discuss the information in this letter with your provider.

***Forms of Payment:***

This provider accepts the following forms of payment: Visa, MasterCard, Discover, and American Express. Please indicate your preferred form of payment on the *Electronic Payment Authorization* form. The Electronic Payment Form will be securely stored in your clinical file and may be updated upon request at any time. Your provider will deduct your session fees from the account designated on this form.

***Monthly Statements:***

Per requests, clients will receive monthly statements for all sessions attended within a calendar month. If you need insurance ready invoices, please inform me and I would be happy to provide them to you.

If you have any questions, please call me at 760-685-3403.

Sincerely yours,



Penny Blazej, LCSW, BCD  
Licensed Clinical Social Worker



# Valley Center Counseling, Inc.

## ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information. Session fees for all clinical treatment will be deducted from the account designated on this form. Forms of payment accepted: Visa, MasterCard, Discover, and American Express. This form will be securely stored in your clinical file and may be updated upon request at any time.

### CLIENT INFORMATION:

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Social Security Number (Responsible Party): \_\_\_\_\_

Responsible Billing Party Name (as shown on Credit Card/Account): \_\_\_\_\_

Billing Address (as registered with Credit Card Company/Bank):  
\_\_\_\_\_  
\_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Office/Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

FORM OF PAYMENT: Check One: Credit Card \_\_\_\_\_ Debit Card \_\_\_\_\_

### ACCOUNT INFORMATION:

Card Type (Visa, MasterCard, American Express, Discover): \_\_\_\_\_

Card#: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Three/Four Digit Card Code (Located on Back/Front of Card): \_\_\_\_\_

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
**Date**

**Please return this form to your provider**