Keira Merkovsky, LCSW

License: 26330

Welcome to my practice. I look forward to helping you reach your goals. Please take a few moments to complete this form and review my policies.

Name:_____ Date:_____ DOB:_____

Street Address:_____

City, State, Zip:_____

Home/Cell Phone:_____ *Okay to contact you there?* *Yes* *No*

Employer:_____ Occupation:_____

Length of time at current employment (if applicable):_____

Email Address:_____ *May I email you?* *Yes* *No*
(Please be aware that email might not be confidential)

Do you plan to use your insurance? *Yes* *No* If yes, complete the following:

Company:_____ Policy ID:_____

Policy holder name and DOB (if not you):_____

Relationship Status (indicate the length of time):

- ☐ SINGLE _____
- ☐ SEPARATED _____
- ☐ DIVORCED _____
- ☐ WIDOWED _____
- ☐ IN A RELATIONSHIP _____
- ☐ MARRIED _____

If in a relationship or married, indicate your overall level of satisfaction with the relationship:

DISSATISFIED CONTENT VERY SATISFIED UNSURE

Have you had a physical exam within the last year?: ***Y*** ***N***

Do you currently have any health concerns?_____

Medications/Drugs currently prescribed/used:_____

Please list any traumas, or very difficult situations, that you have experienced in your life._____

_____

Check all that apply to your childhood:

__ Nightmares	__ Abuse	__ Bed wetting
__ Thumb sucking	__ Fears	__ Stammering/stuttering
__ Happy childhood	__ Rebellion	__ Sexual molestation
__ Unhappy childhood	__ Academic problems	__ Being bullied
__ Extreme sibling conflict	__ Sleep-walking	__ Sleep terrors

How were emotions dealt with in your family of origin?_____

_____

Who do you currently use for emotional support?_____

Do you have a spiritual or religious affiliation? ***Y*** ***N***

*How would you describe your spirituality/spiritual life?_____

_____

Have you received counseling in the past? When?_____

Have you ever been hospitalized for psychiatric reasons? When?_____

Do you have thoughts of hurting yourself or others?_____

What are the goals you would like to achieve through counseling?_____

_____

Current Physician:_____ Physician's Phone:_____

Current Psychiatrist:_____ Psychiatrist's Phone:_____

Who referred you to my practice?_____

Please provide the name and phone number(s) of whom I may contact in case of emergency:

Name:_____ Phone Number(s):_____

Name:_____ Phone Number(s):_____

OFFICE POLICIES

TREATMENT PHILOSOPHY

I believe in providing goal-directed treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal in mind and progress is made toward accomplishing that goal in a time-efficient manner. If you ever have any questions about the nature of the treatment or anything else about your care, please don't hesitate to ask.

CONFIDENTIALITY

All information between provider and patient is held strictly confidential unless:

1. The client authorizes release of information with his or her signature.
2. The client presents a physical danger to self.
3. The client presents a danger to others.
4. Child/elder abuse or neglect is suspected.

In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken.

FINANCIAL TERMS

All fees are to be paid at the time of service unless other arrangements have been made in advance. Sessions are typically 45-50 minutes in length. For clients with insurance coverage, you are responsible for any applicable co-pays or deductibles at the time of your appointment. If your insurance provides out-of-network coverage, you are responsible to pay at the time of service and you will be issued a Superbill which you can submit to your insurance for reimbursement.

CANCELLED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. ***If an appointment is missed or cancelled with less than twenty-four-hours notice, for any reason, you will be billed directly for the cost of the session.*** If the client is a child and they are sick, a parent can attend the session in their place.

Please initial here to indicate that you have read the above statement:_____

EMERGENCY PROCEDURES

If you have an emergency situation and need to contact me, please leave me a message at 949-293-9643 and your call will be returned. Please state that your call is an emergency. Please do this for true emergencies only. There will be a charge for telephone consultations lasting longer than 10 minutes.

CLIENT CONSENT

AGREEMENT OF OFFICE POLICIES

I have received a copy of Keira Merkovsky's office policies. I understand and agree to all policies and procedures.

RELEASE OF INFORMATION

I authorize the release of information regarding my care to my health plan for the payment of claims, certifications/case management decisions, and other purposes related to the administration of benefits for my health plan.

CONSENT FOR TREATMENT

I further authorize and request that my treating provider carry out mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I 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. I understand that I have the right to terminate treatment at any time for any reason.

I understand and agree to all of the above information.

_____

Name – Printed

_____ _____

Signature Date

P: 949.293.9643 F: 855.301.9805 keiramerk@yahoo.com 23591 El Toro Rd, Suite 201 Lake Forest, CA 92630

HIPAA Privacy Authorization Form

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Legal Duties

State and Federal laws require that therapists keep your medical records private. Such laws require that I provide you with this notice informing you of my privacy of information policies, your rights, and my duties. I am required to abide by these policies until replaced or revised. I have the right to revise my privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed in an evaluation, intake, or counseling session are covered by the law as private information. I respect the privacy of the information you provide to me and abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information

Information about you (the client) may be used for diagnosis, treatment planning, treatment, and continuity of care. It may be disclosed to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health professionals affiliated with this therapist, such as billing and quality enhancement.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is my policy not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the emergency contact the client has provided in the intake paperwork.

Public Safety

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being help regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns. Health care professional are required to release records of clients when a court order has been placed.

Other Provisions

When payment for services is the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of **this therapist** or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries. Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. In the event in which this mental health professional must telephone the client for purposes such as appointment, cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when this therapist calls you at home or work, the therapist not say her full name and title or the nature of the call, but rather the mental health professional's first name only. If this information is not provided (below), I will adhere to the following procedure when making phone calls:

First, this therapist will ask to speak to the client (or guardian) without identifying the name of therapist. If the person answering the phone asks for more identifying information, this therapist will say that it is a personal call. This therapist will not identify her full name (to protect confidentiality). If the therapist reaches an answering machine or voicemail the same guidelines will be followed.

Your Rights

You have the right to request to review or receive your medical files. The procedure for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $1.00 per page, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than the address on file, you must provide this information in writing. You have the right to restrict which information might be disclosed to others. However, if this therapist does not agree with these restrictions, we are not bound to abide by them. You have the right to request that information about you be communicated by other means or to another location. This request must be made to the therapist in writing.

You have the right to disagree with the medical records. You may request that this information be changed. Although this therapist might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing. If you desire a written copy of this notice, you may obtain it by requesting it from your therapist.

Complaints

If you have any complaints or questions regarding these procedures, please contact me at (949)293-9643. This therapist will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services.

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name (please print)_____ Date:_____/_____/_____

Signature:_____ Signed by: _____ client _____ guardian