Debra Sloss, M.A.
Licensed Marriage & Family Therapist

725 Front St., Suite 200, Santa Cruz, CA 95060
Phone: 831/ 426-4800 Fax: (831) 515-3645
www. debrasloss.com

New Client Information Form (For Minors)

Client's Last Name (Minor):_____ First:_____ Middle:_____

Age:_____ Date of Birth:_____

Primary Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

May I send mail to your home address? Yes ( ) No ( ) May I phone and/or leave a message at Hm ( ) Cell ( )

Email: _____ May I contact you via email? Yes ( ) No ( )

School/Work:_____ School/Work Phone:_____

Medications & Dosage/s:_____

Prescribing Doctor: ( ) Physician ( ) Psychiatrist Dr. Name:_____

Dr. Phone:_____

Parent #1 Last Name:_____ **Parent #2** Last Name:_____

First:_____ Middle:_____ First:_____ Middle:_____

Age:_____Date of Birth:_____ Age:_____Date of Birth:_____

Address:_____ Address:_____

City:_____ State:_____ Zip:_____ City:_____ State:_____ Zip:_____

May I send mail to your home address? Yes ( ) No ( ) May I send mail to your home address? Yes ( ) No ( )

Home Phone:_____ Home Phone:_____

Cell Phone:_____ Cell Phone:_____

May I phone and/or leave a message at Hm ( ) Cell ( ) May I phone and/or leave a message at Hm ( ) Cell ( )

Email: _____ Email: _____

May I contact you via email? Yes ( ) No ( ) May I contact you via email? Yes ( ) No ( )

Occupation:_____ Occupation:_____

Employer:_____ Employer:_____

Wk. Address:_____ Wk. Address:_____

City:_____ State:_____ Zip:_____ City:_____ State:_____ Zip:_____

Wk. Phone:_____ Wk. Phone:_____

Please complete both sides of this form

Person/s to be contacted in case of emergency:

Full Name: _____Relationship:_____Phone:_____

Full Name: _____Relationship:_____Phone:_____

Additional Family Members Living in Home	**Relationship:**	**Age:**	**Date of Birth:**

Method of Payment: Self: ( ) Insurance: ( ) Insurance Company:_____

Previous Therapy (Dates): _____ Previous Therapist/s: _____

Would it be helpful to contact your previous therapist/s about your current concerns?

Yes ( ) No ( ) Not Sure ( ) Previous Therapist Phone #/s: _____

How did you learn about my practice?_____

Specific Referring Person/s:_____

May I acknowledge the person/s who referred you? Yes ( ) No ( ) Their Phone: _____

Their Address:_____City:_____State:_____ Zip:_____

Parent/Guardian Signature:_____ Date:_____

Minor's Signature:_____ Date:_____

HEALTH & DEVELOPEMENTAL HISTORY (rev 1/13)

Child's Name _____ (Last) _____ (First, Middle Intial) Date _____

Birthdate _____ School _____ Grade _____

Number of Children In Family _____ Child's Birth Order (1st, 2nd, 3rd, etc) _____

PRESENT MEDICAL CARE AND HEALTH

CHILD'S LOCAL PHYSICIAN_____ PHONE NO_____ MEDI-CAL YES ____ NO ____

DATE OF LAST HEALTH CHECK_____ IF TAKING MEDICATION REGULARLY, PLEASE GIVE NAME OF MEDICATION AND PURPOSE _____

HOW MANY DAYS A YEAR DOES YOUR CHILD USUALLY MISS SCHOOL_____ USUAL REASON _____

ANY PHYSICAL LIMITATIONS?_____ DESCRIBE_____

PAST MEDICAL HISTORY & ILLNESES (Mark with X)

	Age		Age		Age		Age
☐ Concussion	____	☐ Drug Allergy	____	☐ Bone & joint problems	____	☐ Whooping Cough	____
☐ Headaches	____	☐ Asthma	____	☐ Skin problems	____	☐ Polio	____
☐ Eye Problems	____	☐ Pneumonia	____	☐ Stomach aches	____	☐ Tuberculosis	____
☐ Wear glasses	____	☐ Anemia	____	☐ Heart murmur	____	☐ Diptheria	____
☐ Hearing loss	____	☐ Sickle cell_	____	☐ Diabetes	____	☐ Scarlet fever	____
☐ Ear infections	____	☐ Bedwetting	____	☐ Convulsions	____	☐ Rheumatic fever	____
☐ Nose bleeds	____	☐ Hernia	____	☐ Red Measles (10 days)	____	☐ Meningitis	____
☐ Frequent colds	____	☐ Undescended testicle	____	☐ Chickenpox	____	☐ Other illnesses	____
☐ Sore throats	____	☐ Bladder infection	____	☐ Mumps	____	☐ Broken bones	____
☐ Allergy	____	☐ Kidney disease	____	☐ Rubella (3 day)	____	☐ Date of Dental Work	____

Further Information

BEHAVIORAL OBSERVATIONS - Please check if applies to your child.

Activity Level: Is always moving	☐	Prefers quiet activities	☐	Acts impulsively	☐
Attention: Trouble completing tasks	☐	Can't follow directions	☐	Daydreams or "tunes out"	☐
Emotional Development: Acts without thinking	☐	Quick to Anger	☐	Fearful and shy	☐
Social Development: Gets along well	☐	Frequent fighting	☐	Gets pushed around	☐

Problems in school? Describe

PRENATAL AND BIRTH HISTORY

Number of pregnancies _____ Number of live Births _____

Mother's age at delivery _____

Illness during pregnancy: ☐ Yes ☐ No

Specify _____

Any medication taken

Length of Pregnancy:_____ mos. Labor _____ hrs.

Delivery: Vaginal ___ Breech_____ Lamaze _____

Natural ___ Cesarean Section_____

Anesthesia _____

INFANT HISTORY:

Condition of newborn _____

Birth Weight lbs. oz.

1st month complications: ☐ Yes ☐ No

Specify _____

Home from hospital with mother: ☐ Yes ☐ No

Breast fed how long? _____

Bottle fed how long? _____

Type of formula _____

DEVELOPMENTAL OR EARLY HISTORY

At what age did your child:

Crawl _____ Ride tricycle _____ Say three words _____

Walk _____ Skip _____ Use short sentences _____

Develop hand preference_____ Toilet trained _____ Speak clearly _____

Development compared to brothers and sisters _____

FAMILY HISTORY (Mark with X the diseases any family members have had)

Rheumatic fever	Cancer	Kidney problems	Mental retardation
Tuberculosis	Syphills	Heart problems	Emotional illness
Diabetes	Bleeding disorder	High blood pressure	Allergies
Epilepsy	Jaundice	Anemia	Other _____

Specify family member and condition on items marked _____

What are you concerns about your child (if any)? _____

_____

Does your child have any special problems? _____

What are your goals for this child? _____

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Agreement For Service / Informed Consent

Welcome to my practice. This agreement is intended to provide you with important information about my professional services and business policies. Debra Sloss. LMFT will herein be referred to as "Therapist" and you will be referred to as "Client." Please read this document carefully and bring any questions or concerns you have so that we can discuss those at our first meeting.

When you sign this document, it will represent an agreement between Debra Sloss, LMFT and Client(s):

_____, _____,

Print Client #1 or Minor's Name

Print Client #2, or 1st Parent Name(s)

_____,

Print Client #3, or 2nd Parent Name(s)

Consent: It is assumed that in signing this form, you are freely requesting my counseling and psychotherapy services, that you are freely participating in these services and that you are consenting to these services without undue influence or duress. If this is not the case, please clarify your needs for my services prior to signing this.

Appointments: Appointments are 50 minutes in length (the additional 10 minutes are used for record-keeping and treatment planning). Longer appointments are available as needed or requested. My preference is to meet with couples for 75 minutes. If you are accessing your insurance coverage, these longer appointments are often not permitted. Your appointment time is set aside specifically for your use. Because of this, it is necessary for you to make any cancellations 24 working/weekday hours in advance of your scheduled time. Missed or late-cancelled appointments without this advance notice will be billed to you in full. Please be aware that insurance companies typically do not pay for missed appointments. **Cancellation notice, or appointment change requests should be left on my voicemail at (831) 426-4800.**

Fees: The usual and customary fee for service is a sliding scale hourly rate for a 50 minute session or a 75 minute session. The current sliding scale hourly rates can be found on my website on the Hours/Fees/Payments page (www.debrasloss.com). Clients are asked to place themselves wherever they think they fit on this sliding scale. I reserve the right to periodically adjust this fee and Clients will be notified of any fee adjustment in advance. This fee may be adjusted by contract with third-party payors, or by agreement with this therapist. The agreed upon usual & customary hourly fee between Therapist and Client is $ _____

Choose fee from the sliding scale

If you plan to use your insurance coverage, you will be asked to pay the co-pay amount designated in your plan. However, if your insurance plan declines coverage of your mental health benefits you will be asked to pay for sessions at the above designated fee.

Other services are often provided to Clients and in doing so, I will prorate my hourly rate (in 15-minute increments) if I work for periods of less than one hour. Other services include telephone conversations with Client lasting longer than 5 minutes, report writing, reading emails, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, or performance of any other service you have requested and I have agreed to perform. In addition, Therapist may engage in telephone contact with third parties at Client's request and with Client's advance authorization.

Payment: Clients are expected to pay for services at the time services are rendered. For those using insurance benefit coverage, I accept cash and checks. Private-pay clients may also pay with a credit card in advance through Paypay or my website, or pay with a credit card while in the office. A $15 invoicing fee will be added when clients do not pre-pay, or pay at the time of service and invoices must be issued for services already rendered. All invoices must be paid within 3 business days.

Insurance: I am a contracted provider with Anthem Blue Cross of California and will make efforts to verify Client's eligibility prior to the first session. However, this does not guarantee your insurance company and plan will cover your services. You may want to contact your provider directly to inquire about your benefits and covered services. Client understands that he/she/they are responsible for the deductible and non-covered services. Client also understands that her/his/their insurance policy may have certain limitations on mental health benefits and Client agrees to accept full responsibility for charges once these limits have been reached. Client, or Client's representative further agrees to accept full financial responsibility for payment of charges rendered to the Client. I can also accept Victim Witness coverage.

I am not a contracted provider for any other insurance companies or managed care organizations. Should a Client choose to use his/her/their insurance for which I am not a contracted provider, I will provide Client with a statement which the Client can submit to the third-party of her/his/their choice to seek reimbursement of fees already paid. If you would like me to communicate with your insurance company, I will do so with your written consent and will need to bill you for the time it takes to negotiate with them on your behalf. Please keep in mind any insurance information shared with insurance companies by you or me will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their system.

Therapist Availability: I will make efforts to return calls within 48 hours on weekdays, usually between 9-5. I generally do not return calls evenings, weekends and holidays. I cannot guarantee that calls will be returned immediately and am unable to provide 24-hour crisis service. While Therapist provides an email on her business cards and website, it is understood that it is to be used for scheduling requests and non-urgent information that may be discussed at your next session. All cancellations and all requests for clinical therapeutic communication should be made via voicemail at (831) 426-4800. In the event that you are feeling unsafe or require immediate medical or psychiatric assistance, please call 911, or the Santa Cruz County Behavioral Health Center at (831) 600-2800, or go to the nearest emergency room.

Electronic Communications: While electronic modes of communication have become the norm in our society, many of these methods of communication are not secure enough to adequately protect your confidentiality. I use email communication only with your permission and solely for administrative purposes unless we have made another agreement. I will only text you if I am unable to leave a voicemail message and at that time I will request you make your voicemail box accessible rather than continuing the communication with you through texting. Email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. I prefer to use the phone and voicemail for clinical content whenever possible. **So please make sure your voicemail box is set up and able to receive messages while you are in therapy with me.** I do not intentionally communicate with, or contact any of my clients through social media platforms like Twitter or Facebook.

Sickness Policy: Please do not attend your scheduled appointment if you may have a contagious illness more serious than a mild cold. Instead, call my office to reschedule. The well members of the family or couple may attend. If you notify your therapist, provisions to the cancelation policy can be made to allow for unexpected illness on a case-by-case bases. If you have a recurring condition, please discuss this with me in advance. If you are obviously sick upon arrival, I may decline or end the session and will charge the fee. Please contact me as soon as you realize you may be too sick to attend.

> **What is too sick to attend?** Please do not attend your appointment if you have been running a fever within the last 48 hours, if you have chills and/or body aches, if you have a serious cough, sore throat, or any symptoms that are lasting longer than a week, or are more significant than a mild cold.

Diagnosis: If a third party such as an insurance company is covering or reimbursing you for all or part of your treatment cost, I will be required to provide a diagnosis on your receipt. Coverage is often based on the insurance company's evaluation of "medical necessity." Diagnoses are technical terms that describe the nature of your problems as well as whether they are short-term or long-term concerns. All diagnoses come from a book titled the **DSM-V.** Not all diagnoses meet "medical necessity" as defined by your insurance company and may not be a covered service under your insurance plan.

The Therapy Process: Psychotherapy is a joint collaborative effort between Client and Therapist. Progress and success may vary depending upon the particular problems or issue being addressed, as well as many other factors. I am committed to supporting the development of inner and outer resources to meet your therapeutic goals. I will ask you to identify specific therapy goals, and I will monitor progress on those and talk with you periodically about your progress in therapy. Psychotherapy is not like a medical doctor visit. Instead, it calls for very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and in the time between them. Please discuss with me any concerns you have regarding your (or your child's) progress in therapy.

Termination of Therapy: Clients have the right to terminate therapy at their discretion. Whenever possible, I ask that you plan for at least one, or possibly more termination sessions to give us an opportunity to reflect on the work that has been done, to plan for supports and next steps. I also ask that you give me advanced notice (1 week is best) if you are planning to terminate therapy. If you do this, I work to insure that I am prepared to support and anchor your progress in therapy thus far and consider resources for you going forward. My Clients continually tell me that when these closure meetings are planned, they are very helpful and worthwhile.

Therapist Background and Qualifications: I hold a License as a Marriage & Family Therapist (LMFT 38982) and have more than 20 years of combined experience in the counseling and education fields. As an LMFT, I am trained to work with a wide variety of issues that affect individual lives and relationships.

Confidentiality: The information disclosed by you is generally confidential and will not be released to any third party without your written authorization, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependant adult abuse, when a Client makes a serious threat of violence towards a reasonably identifiable victim, or when a Client is dangerous to him/herself, or the person or property of another. When you are seeing me as a couple or as a family, the contacts and communications of the family members involved are assumed to be open among family members only and are otherwise confidential.

No Secrets Policy: In couples therapy, if you or your partner or the Therapist decides to have individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be part of the couples therapy, and can be discussed in our joint sessions. *Do not tell me anything you wish to keep secret from your partner.*

When I see Clients around town outside of the therapy office I make it a practice to simply nod with a slight smile in order to subtlety acknowledge you while still protecting your privacy. I will not initiate conversation with you in public places.

Records and Record Keeping: I may take notes during sessions and will also produce other notes and records tracking the course of therapy. These notes constitute the clinical and business records, which by law, I am required to maintain. Should you wish a copy of these records, such a request must be made in writing. I reserve the right, under California law, to provide you with a treatment summary in lieu of actual records and also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy for the record to another treating health care provider. I will maintain your records for ten years following termination of therapy. However, after ten years, your records will be destroyed in a manner that preserves your confidentiality.

Professional Consultation: Consultation is an important component of a healthy psychotherapy practice. I regularly participate in clinical, ethical and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding Clients unless I have specific written release to do so. Under extenuating circumstances I may consult another medical professional with identifying information without consent if the safety and welfare of my Client or someone else is at stake.

Client Litigation: This Therapist will not voluntarily participate in any litigation or custody dispute in which Clients and another individual, or entity, are involved. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving a Client, Client will reimburse me for any time spent for preparation, travel, or other time in which I make myself available for such an appearance at an hourly rate of $250 per hour, with a 4-hour/day minimum.

Psychotherapist-Client Privilege: The information disclosed by you, as well as any records created, is subject to the psychotherapist-client privilege. If this Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-client privilege on the Client's behalf until instructed, in writing, to do otherwise by the Client or the Client's representative. Clients should be aware that s/he/they might be waiving the psychotherapist privilege if s/he/they make her/his/their mental or emotional state an issue in a legal proceeding. Clients should address any concerns s/he/they might have regarding the psychotherapist-client privilege with her/his/their attorney.

Snacks: I provide healthy snacks (e.g. water, tea, granola & nut bars, crackers) should your child or teen requests them. Please initial your permission for me to provide these snacks to your child and indicate any food allergies s/he/they may have: _____
If you do not want to give permission, please cross out this section and initial.

NOTICE TO CLIENTS: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of professional clinical counselors. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Acknowledgment

By signing below, I acknowledge that I have reviewed and fully understand and will abide by the full content of this agreement and consent to participate in psychotherapy with Debra Sloss. I agree to hold Debra Sloss free and harmless from any claims, demands, or suits from damages from any injury or complications whatsoever, save negligence, that may result from psychotherapy treatment. I understand that I am financially responsible to Debra Sloss for all charges, including unpaid charges by any third-party payer. I understand that Debra Sloss is the sole proprietor of this psychotherapy practice and maintains no business affiliation with other practitioners in this suite of offices beyond shared office space.

Print Client #1 Name	**Signature of Client #1** (or authorized representative)	**Date**
Print Client #2 Name	**Signature of Client #2** (or authorized representative)	**Date**

CONSENT FOR TREATMENT OF A MINOR #1

(for Clients under 18 years of age)

As the legal guardian of : _____, I agree, consent that my child (named above) may participate in counseling/psychotherapy with Debra Sloss, LMFT.

Signature of Parent/Legal Guardian #1	**Relationship** (parent/conservator/guardian)	**Date**
Signature of Parent/Legal Guardian #2	**Relationship** (parent/conservator/guardian)	**Date**

CONSENT FOR TREATMENT OF A MINOR #2

(for Clients under 18 years of age)

As the legal guardian of : _____, I agree, consent that my child (named above) may participate in counseling/psychotherapy with Debra Sloss, LMFT.

Signature of Parent/Legal Guardian #1	**Relationship** (parent/conservator/guardian)	**Date**
Signature of Parent/Legal Guardian #2	**Relationship** (parent/conservator/guardian)	**Date**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have given to you. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full. My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice by contacting me. If you have any questions about my *Notice of Privacy Practices,* please contact me at: 725 Front St., Ste 200, Santa Cruz, CA 95060, 831/426-4800.

I acknowledge receipt of the *Notice of Privacy Practices* of Debra Sloss, MA, LMFT,

Signature of Client #1 (or Legal Representative #1)	**Relationship to Client #1** (parent/conservator/guardian)	**Date**
Signature of Client #2 (or Legal Representative #2)	**Relationship to Client #2** (parent/conservator/guardian)	**Date**
Signature of Client #3 (or Legal Representative #3)	**Relationship to Client #3** (parent/conservator/guardian)	**Date**

FOR OFFICE USE ONLY: Inability to Obtain Acknowledgement of Receipt of Notice of Privacy Practices: I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices,

including _____.
[describe good faith attempts]

However, because of _____,
[reasons why acknowledgement was not obtained]

I was unable to obtain my patient's acknowledgement.

Signature of Provider	**Date**

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You will need to fill out *either Pg. 10 or Pg. 11*
Only complete this form if Debra Sloss, LMFT is a "Contracted Provider" for your insurance plan.

FOR USE OF INSURANCE BENEFITS

Patient Information (please print) **Date:** _____

Client's Name: _____ Date of Birth: _____ Age:_____ Gender: _____

Address:_____ City:_____ Zip:_____

Telephone: H: _____ W/Office: _____ Cell: _____

Email: _____ Emergency Contact/Telephone: _____

Primary Insurance

Insurance Company: _____ Subscriber ID#: _____

Group Number: _____ Subscriber Name (if different): _____

Subscriber Address (if different): _____ Insurance Company Phone: _____

City: _____ State: _____ Zip: _____

Subscriber Date of Birth: _____ Subscriber relationship to patient: _____

Secondary Insurance

Insurance Company: _____ Subscriber ID#: _____

Group Number: _____ Subscriber Name (if different): _____

Subscriber Address (if different): _____ Insurance Company Phone: _____

City: _____ State: _____ Zip: _____

Subscriber Date of Birth: _____ Subscriber relationship to patient: _____

CONSENT FOR TREATMENT

With my signature, I provide my consent to receive treatment from Debra Sloss, LMFT.

Client's Signature: _____ Date: _____

SIGNATURE FOR THE RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

Insurance: *Your signature is required if you wish our office to be of service to you in billing your insurance company. Should we not receive this signed authorization, we cannot bill your insurance company for you and you will have to bill your insurance directly*.

I understand that I am responsible for the deductible and non-covered services. I understand that my insurance policy may have certain limitations on mental health benefits. I agree to accept full responsibility for charges once these limitations have been reached. I further agree to accept full financial responsibility for payment of charges rendered to the above-named patient. I authorize the release of any medical or other information necessary to process this claim.

Assignment of Benefits: I authorize payment of medical benefits from my insurance company for health services provided. I permit a copy of this authorization to be used in place of the original.

Client's Signature: _____ Date: _____

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You will need to fill out *either Pg. 10 or Pg. 11*
Complete this form if you will be Self-Paying and/or Debra Sloss is not a contracted provider for your insurance plan.

SELF –PAY AGREEMENT

I ATTEST THAT I …

(check one)

a. ___ do not have insurance coverage

b. ___ have insurance coverage but choose not to use it, and understand that in doing so I am waiving my right to reimbursement

c. ___ have insurance coverage but understand that these services are not covered by the plan.

Agreed upon hourly fee between Therapist and Client is $ _____
Choose fee from the sliding scale

Print Client #1 Name	**Signature of Client #1** (or authorized representative)	**Date**
Print Client #2 Name	**Signature of Client #2** (or authorized representative)	**Date**
Debra Sloss, LMFT		
Provider	**Signature of Provider**	**Date**