M. Therese Mascardo, Psy. D.
Licensed Clinical Psychologist, PSY 25022
Phone: 949-682-9474
Fax: 714-992-5259
therese@drtherese.com

CLIENT INFORMATION FORM

☐ 1619 E. Chapman Avenue
Fullerton, CA 92831

☐ 329 N. Wetherly Drive, Suite 206
Beverly Hills, CA 90211

Client Information

FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____

HOME ADDRESS (including apartment number) _____ CITY _____ STATE _____ ZIP _____

CELL PHONE _____ Is it okay to leave a message? Y N

HOME PHONE _____ Is it okay to leave a message? Y N

_____ AGE _____/_____/_____ DATE OF BIRTH Gender: M or F

_____ E-MAIL

Financial Information

Person who is financially responsible: Self or _____
NAME OF RESPONSIBLE PARTY RELATIONSHIP

BILLING ADDRESS (if different than above) _____

PHONE (if different than above) _____

How do you want to be billed? Snail-Mail or E-Mail?

How often do you . . .

	Never	1x/month	1x/week	2x/wk	Everyday
Smoke					
Drink					
Recreational Drugs					

Current Medications

Medications	Dosage	Frequency
Ex: Lexapro	100 mg	2x a day

Do you currently have thoughts of wanting to hurt or harm yourself or another person? Yes or No

What are the main concerns you would like to address in counseling?:

_____

_____

What is your faith/religious background? _____ Are you actively practicing/engaged in your faith? Yes or No

What is your cultural/ethnic background? _____

How did you hear about Dr. Mascardo? _____

Insurance Information (only complete if you would like us to bill your insurance)

Insurance Co.: _____ Insurance Co. Phone#: _____

Insured's ID#: _____

Who is the insured? Self Spouse Child Other

Insured's Date of Birth: _____/_____/_____

Patient's ID#: _____

Insured's Gender: M or F

*****Please attach a scanned copy of your insurance card, front and back.*****

_____ _____
Signature of Client or Guardian (if client is under 18) Date

_____ _____
Signature of Financially Responsible Party Date

For Office Use Only

Call Date: _____/_____/_____	Spoke with: _____

Request "outpatient mental health benefits".

	Non-Parity Diagnosis	**Parity Diagnosis**
Co-payment (flat fee) or Co-insurance (percent)		
Deductible	Ind.: Family:	Ind.: Family:
Out-of-Pocket Max.	Ind.: Family:	Ind.: Family:
Sessions Allowed per year		
Effective Date of Coverage	_____/_____/_____	
When do benefits renew?	_____/_____/_____ Calendar Year _____	
Deductible met this year	$ _____._____	
Is Pre-authorization needed?	Yes _____ No _____	

Diagnosis: Axis 1: _____ Axis 2: _____ Axis 3: _____ Axis 4: _____ Axis 5: _____

Description: _____

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INFORMED CONSENT FOR TREATMENT

As a patient, you are the holder of the privilege of confidentiality. This means that what you discuss in psychotherapy must be held in confidence. I am not permitted to discuss your case with anyone, or even the fact that you are my client, without your expressed written consent. There are, however, exceptions to this privilege that are specific in nature and required by law and ethical standards. Be informed that:

1) Your right to confidentiality is forfeited if you become a danger to yourself or others.

This means that should you report being suicidal and/or in my professional judgment present a high suicide risk, I must act to protect you by involving necessary personnel to keep you safe. This might include family members or close friends if necessary. It may also include hospitalization.

b. If, by your own admission, you report a serious intent and/or plan to harm a named individual, I am mandated to report that to the police and the intended victim.

2) If, in the course of your treatment, you report sexual or physical abuse or neglect of a child, I must report that to the Department of Children & Family Services who then acts to protect the child.

3) If you report your own sexual abuse as a child, and the perpetrator still has access to children via family or profession, I am mandated to report the name and address of that person to the Department of Children & Family Services in California or its equivalent agency if outside the state.

4) If, in the course of your treatment, you report physical abuse or neglect of an elder or incapacitated adult, I must report that to the Department of Family Services who then acts to protect the adult.

5) If you place your mental status at issue in a court of law, your records can be disclosed.

6) If my records are subpoenaed by a court order from a judge, your records can be disclosed. Such subpoenas are usually the result of a lawsuit in which your mental health records are considered pertinent.

Medical bills and insurance claims are generated by a third party who must have access to your name and contact information in order to do so. No other information, including personal information, is shared beyond what is necessary for billing. You have the right to a full and complete explanation of my credentials, training, areas of expertise, and treatment philosophies and strategies both in general and related to your specific issues or concerns. If you are unclear about these, at any time, or have concerns about your treatment or progress, please raise your questions with me immediately and directly.

Orange County Location: I rent office space from a group of independent mental health professionals, under the name Pacific Coast Psychological Associates. This group is an association of independently practicing professional which shares certain expenses and administrative functions. While the members share a name and office space, I am completely independent in providing you with clinical services and am fully and independently responsible for those services. Professional records are separately maintained and no member of the group can have access to them without your specific, written permission.

Los Angeles Location: I rent office space from independent mental health professional, Timothy Long, LMFT. I am completely independent in providing you with clinical services and am fully and independently responsible for those services. Professional records are separately maintained and no other practitioners at the office can have access to them without your specific, written permission.

I HEREBY CONSENT TO TREATMENT:

_____ _____

Client Signature Date

_____ _____

Client Signature (or Parent Signature if client is under 18) Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Our Duty to Safeguard Your Protected Health Information.

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" (PHI). As part of our normal business operations, we encounter your PHI as a result of your treatment, our payment and other related health care operations. We also receive your PHI via the application and enrollment process, from healthcare providers and health plans, and by a variety of other activities. Accordingly, we are required to extend certain protections to you and your PHI, and to give you this Notice about our privacy practices that explains how, when and why we may use and/or disclose your PHI. Except in specified circumstances, we are required to use and/or disclose only the minimum amount of your PHI necessary to accomplish the purpose of our use and/or disclosure.

We are required to follow the privacy practices described in this Notice, although we reserve the right to change our privacy practices and the terms of this Notice at any time. In the event that we change our privacy practices, we will post our updated Notice in the office.

How We May Use and Disclose Your Protected Health Information.

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its Privacy Rule (Rule), we may use and/or disclose your PHI for a variety of reasons. Generally, we are permitted to use and/or disclose your PHI for the purposes of treatment, the payment for services you receive, and for our normal health care operations. For most other uses and/or disclosures of your PHI, you will be asked to grant your permission via a signed Authorization. However, the Rule provides that we are permitted to make certain other specified uses and/or disclosures of your PHI without your Authorization. The following information offers descriptive examples of our potential use and/or disclosure of your PHI:

A. Uses and/or disclosures related to your treatment, the payment for services you receive, or our health care operations (TPO):
    1. For treatment (T): We may use and/or disclose your PHI with psychologists, psychiatrists, physicians, nurses, and other health care personnel involved in providing health care services to you. For example, your PHI may be shared with your primary care physician, medical specialists, members of your treatment team, mental health service providers to whom your are referred, and other similarly situated health care personnel involved in your treatment.
    2. For payment (P): We may use and/or disclose your PHI for billing and collection activities and related data processing; for actions by a health plan or an insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and the provision of benefits under its health plan insurance agreement; to make determinations of eligibility or coverage, adjudication or the subrogation of health benefit claims; for medical necessity and appropriateness of care reviews, utilization review activities; and related payment activities so that individuals involved in delivering health services to you may be properly compensated for the services they have provided.

    3. For health care operations (O): We may use and/or disclose your PHI in the course of operating the various business functions of our office. For example, we may use and/or disclose your PHI to evaluate the quality of mental health services provided to you; develop clinical guidelines; contact you with information about treatment alternatives or communications in connection with your case management or

care coordination; to review the qualifications and training of health care professionals; for medical review, legal services, and auditing functions; and for general administrative activities such as customer service and data analysis.

4. Appointment reminders: Unless you request that we contact you by other means, the Rule permits us to contact you regarding appointment reminders.

B. Uses and/or disclosures requiring your Authorization: Generally, our use and/or disclosure of your PHI for any purpose that falls outside of the definitions of treatment, payment and health care operations identified above will require your signed Authorization. The Rule does not grant us permission for certain specified uses and/or disclosures of your PHI that fall outside of the treatment, payment and health care operations definitions as itemized below. However, for all other uses and/or disclosures of your PHI by any other person or entity, you retain the power to grant your permission via your signed Authorization. Additionally, if you grant your permission for such use and/or disclosure of your PHI, you retain the right to revoke your Authorization at any time except to the extent that we have already undertaken an action in reliance upon your Authorization.

C. Use and/or disclosures <u>not</u> requiring your Authorization: The Rule provides that we may use and/or disclose your PHI without your Authorization in the following circumstances:

1. When required by law: We may use and/or disclose your PHI when existing law requires that we report information including each of the following areas:
2. Reporting abuse, neglect or domestic violence: We may use and/or disclose PHI of suspected victims of abuse, neglect, or domestic violence including reporting the information to social service or protective service agencies.
3. Public health activities: We may use and/or disclose your PHI to prevent or control the spread of disease or other injury, in the case of public health surveillance or investigations, when reporting adverse events with respect to food, dietary supplements, product defects and other related problems to the Food and Drug Administration, for medical surveillance of your workplace or to evaluate whether or not you have a work-related illness or injury, in order to comply with Federal or state law.
4. Health oversight activities: We may use and/or disclose your PHI to accomplish designated activities and functions including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs.
5. Judicial and administrative proceedings: We may use and/or disclose your PHI in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process.
6. Law enforcement activities: We may use and/or disclose your PHI for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, reporting crimes in emergencies, or reporting a death.
7. Relating to decedents: We may use and/or disclose the PHI of an individual's death to coroners, medical examiners and funeral directors.
8. For research purposes: In certain circumstances, and under the supervision of an Internal Review Board, we may disclose your PHI to assist in medical/psychiatric research.
9. To avert a serious threat to health or safety: We may use and/or disclose your PHI in order to avert a serious threat to health or safety.
10. For specific government functions: We may use and/or disclose the PHI of military personnel and veterans in certain situations. Similarly, we may disclose the PHI of inmates to correctional facilities in certain situations. We may also disclose your PHI to governmental programs responsible for providing public health benefits, and for workers' compensation. Additionally, we may disclose your PHI, if required, for national security reasons.

D. Uses and/or disclosures requiring you to have an opportunity to object: We may disclose your PHI in the following circumstances if we inform you about the disclosure in advance and you do not object. However, if there is an emergency situation and you cannot be given an opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and is determined to be in your best interests. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

1. To families, friends or others involved in your care: We may share your PHI with those people directly involved in your care, or payment for your care. We may also share your PHI with these people to notify them about your location, general condition, or death.

Your Rights Regarding Your Protected Health Information (PHI).

The HIPAA Privacy Rule grants you each of the following individual rights:

A. The right to view and obtain copies of Your PHI. In general, you have the right to view your PHI that is in my possession or to obtain copies of it.
B. The right to request limits on uses and disclosures of your PHI. You have the right to ask that I limit how I use and disclose you PHI. I will abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.
C. The right to choose how I send your PHI to you. It is your right to ask that your PHI be sent to you at an alternate address or by an alternate method, e.g., email.
D. The right to get a list of the disclosures I have made. You are entitled to a list of disclosures of your PHI that I have made.
E. The right to amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. I will advise all others who need to know about the change(s) to your PHI.
F. The right to get this notice by email. You have the right to get this notice by email. You have the right to request a paper copy of it as well.

How To Complain about our Privacy Practices.

If you believe that we may have violated your individual privacy rights, or if you object to a decision we made about access to your PHI, you are entitled to file a complaint by submitting it in writing to M. Therese Mascardo, Psy.D at 329 N. Wetherly Drive, Suite 206, Beverly Hills, 90211. Your written complaint must name the person or entity that is the subject of your complaint and describe the acts and/or omissions you believe to be in violation of the Rule or the provisions outlined in our Notice of Privacy Practices. If you prefer, you may file your written complaint with the Secretary of the U.S. Department of Health and Human Services (Secretary) at 200 Independence Avenue S.W., Washington, D.C., 20201. However, any complaint you file must be received by us, or filed with the Secretary, within 180 days of when you knew, or should have known, the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

Effective Date: This Notice is effective February 1, 2008.

I acknowledge receipt of this Notice.

_____ _____

Client Signature (or Parent Signature if client is under 18) Date

_____ _____

Client Signature (or Parent Signature if client is under 18) Date

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FINANCIAL & CANCELLATION POLICY

Charges for psychological services are due and payable at the time services are rendered. Payment can be made in the form of cash or personal check. A fee of $20 will be charged for each personal check returned by your bank for any reason. Please make checks payable to: **Dr. Therese Mascardo, Psy.D.**

A monthly statement will be issued to you noting charges incurred, payments made, and balance due, if any. This statement is sufficient for submitting to insurance companies for reimbursement of costs.

As a courtesy, we offer the option of billing your insurance. You may choose to submit receipts to your insurance for services rendered out of network. In that case, I will do my best to provide information that may help you get reimbursed. It should be understood that your health insurance policy is a contract between you and your insurance company. It is important for you to understand its provisions, and that payment of your claim(s) is not guaranteed. **You are responsible for payment of your bill regardless of the status of your insurance reimbursement. If your insurance company reimburses only a portion of the bill or rejects your claim(s) entirely, an explanation should be made to you as the insured.** Reduction or rejection of your claim(s) by your insurance company does not relieve you of your financial obligation to Dr. Therese Mascardo, Psy.D.

If you must cancel an appointment, a 24 hour advance notice (by phone call) is required to avoid being charged for that appointment.

These policies are a necessary part of maintaining reasonable fees for professional services.

Your cooperation is appreciated.

Regular Fee (50-minute session):$_____

Fee Agreement: $_____

I HAVE READ AND AGREE TO THE ABOVE TERMS:

_____ _____

Client Name (PRINT) Date

_____ _____

Client Signature (or Parent Signature if client is under 18) Date