Audra Potz, LMFT
4419 Van Nuys Boulevard
Suite #406
Sherman Oaks, CA 91403
(323) 539-3552

AUDRA POTZ, LMFT

CLIENT INFORMATION

Today's Date

First name

Last name

Middle name/initial

Preferred Name

EMAIL

***Email address (will be used for forms, communications, billing and invoicing)**

PHONE

***Primary Phone number**

Phone type

- ❒ Mobile
- ❒ Home
- ❒ Work
- ❒ OK to leave voice message
- ❒ OK to send text message
- ❒ Send me Text Message reminders for Appointment

Secondary Phone number

Phone type

- ❒ Mobile
- ❒ Home
- ❒ Work
- ❒ OK to leave voice message
- ❒ OK to send text message
- ❒ Send me Text Message reminders for Appointment

ADDRESS

AUDRA POTZ, LMFT

Full Address (street, unit number), City, State, Zip

DEMOGRAPHICS

Birth date (MM/DD/YYYY) and age

Gender

Born in what country, state, city?

Grew up where?

Parents and Siblings: Relationship to client, age, if deceased at what age, now resides where

❒ Client is a minor

EMERGENCY CONTACT

First Name

Last Name

Relationship

Phone Number

INSURANCE

Add insurance information, if applicable.

AUDRA POTZ, LMFT

Insurance Company	
Group ID	
Plan ID	
Member ID	

Client's relationship to insured:

- ❍ Self
- ❍ Client's spouse
- ❍ Client's parent
- ❍ Other

INTAKE QUESTIONNAIRE

AUDRA POTZ, LMFT

What brings you to counseling at this time? Is there something specific, a particular event? Be as detailed as you can. Describe length of time experienced (weeks, months, years).

What are your goals for counseling?

Have you seen a mental health professional before?

- ❍ Yes
- ❍ No

Are you court-mandated to seek therapy?

- ❍ Yes
- ❍ No

Have you been arrested before?

- ❍ Yes
- ❍ No

Specify all medications and supplements you have taken in the past and/or are presently taking and for what reason.

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

Who is your primary care physician? Please include type of MD, name and phone number.

Do you drink alcohol?

- ❍ Yes
- ❍ No

How often (days per week, drinks per sitting)?

Do you use marijuana?

- ❍ Yes
- ❍ No

How often?

Do you use recreational drugs?

- ❍ Yes
- ❍ No

How often?

Do you have suicidal thoughts?

- ❍ Yes
- ❍ No

Have you ever attempted suicide?

- ❍ Yes
- ❍ No

Do you have thoughts or urges to harm others?

- ❍ Yes
- ❍ No

Have you ever been hospitalized for a psychiatric issue?

- ❍ Yes
- ❍ No

Is there a history of mental illness in your family?

- ❍ Yes
- ❍ No

If yes, please describe

Relationship status:

- ❍ Married
- ❍ Single
- ❍ Divorced
- ❍ Separated
- ❍ Widowed
- ❍ Living together
- ❍ Dating
- ❍ Other

If you are in a relationship, please describe the nature of the relationship and months or years together.

Any history of physical arguments? Please describe.

Living Arrangement:

- ❍ Alone
- ❍ With Partner
- ❍ With Roomate(s)
- ❍ With Parents
- ❍ With Children
- ❍ Other

Describe your current living situation.

Children? Names and ages

AUDRA POTZ, LMFT

What is your level of education? Highest grade/degree and type of degree.

What is your current occupation? What do you do? How long have you been doing it?

Please check any of the following you have experienced in the past six months

- ❑ Increased appetite
- ❑ Decreased appetite
- ❑ Trouble concentrating
- ❑ Difficulty sleeping
- ❑ Excessive sleep
- ❑ Low motivation
- ❑ Isolation from others
- ❑ Fatigue/low energy
- ❑ Low self-esteem
- ❑ Depressed mood
- ❑ Tearful or crying spells
- ❑ Anxiety
- ❑ Fear
- ❑ Hopelessness
- ❑ Panic
- ❑ Hallucinations
- ❑ Auditory/Hearing voices
- ❑ Changes in eating patterns
- ❑ Rapid thoughts
- ❑ Increased energy
- ❑ Other

Please check any of the following that apply

- ❑ Headache
- ❑ High blood pressure
- ❑ Gastritis or esophagitis
- ❑ Hormone-related problems
- ❑ Head injury
- ❑ Angina or chest pain
- ❑ Irritable bowel
- ❑ Chronic pain
- ❑ Loss of consciousness
- ❑ Heart attack
- ❑ Bone or joint problems
- ❑ Seizures
- ❑ Kidney-related issues
- ❑ Chronic fatigue
- ❑ Dizziness
- ❑ Faintness
- ❑ Heart valve problems
- ❑ Urinary tract problems
- ❑ Fibromyalgia
- ❑ Numbness & tingling
- ❑ Shortness of breath
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Asthma
- ❑ Arthritis
- ❑ Thyroid issues
- ❑ HIV/AIDS
- ❑ Cancer
- ❑ Other

What else would you like me to know?

Who referred you to this office? Relationship?

CREDIT CARD AUTHORIZATION FORM

AUDRA POTZ, LMFT

Please complete all fields below. You may cancel this authorization at any time by contacting us.This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ❒ MasterCard ❒ VISA ❒ Discover ❒ AMEX ❒ Other
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
Cardholder ZIP Code (from credit card billing address):

I,_____, authorize _____to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____

Client Signature Date

PRACTICE POLICIES

AUDRA POTZ, LMFT

APPOINTMENTS AND CANCELLATIONS

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours.

You also agree to a 75% participation contract, in which you are allowed no more than 25% excused absences per year for illness, vacation, holidays, work-related and pre-planned absences (unless otherwise agreed upon). This is necessary and important because a) a time commitment is made to you and is held exclusively for you and b) it ensures you are best benefiting from therapy by meeting on a regular basis. I will make every effort to reschedule your appointment in times of excused absence, to remain within the contracted 75% time. Any cancellations beyond the 25% rate will be charged the scheduled fee. We will also evaluate your availability for therapy and make changes, if need be.

The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist in order for time to be scheduled in advance. If you are late for a session, you may lose some of that session time.

A $12.00 service charge will be charged for any checks returned for any reason for special handling.

TELEPHONE ACCESSIBILITY

If you need to contact me between sessions, please leave a message on my voicemail, text or email me. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that Face- to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail, is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

1. You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
2. All existing confidentiality protections are equally applicable.
3. Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.
4. Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.

5. There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs.

Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), gender, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally to the therapist.

MINORS

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____

Client Signature Date

_____

Audra Potz, LMFT Date

NOTICE OF PRIVACY PRACTICES

AUDRA POTZ, LMFT

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. **Psychotherapy Notes.** I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
    a. For my use in treating you.

   b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
   c. For my use in defending myself in legal proceedings instituted by you.
   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
   e. Required by law and the use or disclosure is limited to the requirements of such law.
   f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
   g. Required by a coroner who is performing duties authorized by law.
   h. Required to help avert a serious threat to the health and safety of others.
2. **Marketing Purposes.** As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. **Sale of PHI.** As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made.You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on September 1, 2018.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Signature Date

INFORMED CONSENT FOR PSYCHOTHERAPY

AUDRA POTZ, LMFT

GENERAL INFORMATION

The therapeutic relationship is unique in that it is highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

THE THERAPEUTIC PROCESS

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

THE THERAPEUTIC AGREEMENT

I, **Audra Potz, LMFT**, as the therapist agree to see you, _____, as the client on a weekly basis (unless otherwise agreed upon) at the rate of **$**_____ per session. Payment may be made by cash, check made out to Audra Potz, LMFT, or by credit card through your client portal. If payment through your client portal is not made on or before your session date, I will process payment through your credit card on file. You will receive an invoice and/or statement in your portal.

Any temporary change in fee must be discussed in advance and agreed upon. A temporary reduction may last no more than two months, at which time the fee will revert, an extension may be considered or an alternative referral may be offered. Please note, there will be a reasonable fee increase on a yearly basis, discussed together before established. Sliding scale clients' rates will be increased $5 per quarter until the full fee is met or a reasonable rate agreed upon by both parties is reached, to be reviewed annually.

CONFIDENTIALITY

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Signature	Date
Audra Potz, LMFT	Date
Parent/Guardian	Date