Welcome!

I want to thank you for scheduling an initial appointment to meet with me.

I look forward to learning about you, your current concerns and your goals for therapy. After listening and asking a variety of questions, I will share my impressions of how I may be able to assist you in achieving your goals or I will give you the names of other providers or resources in the area that may better serve you.

Please find enclosed my Office Policies and Forms for you to fill in before you come to your first session. Please feel free to either mail, email, or fax these to me at jesse_engdahl@yahoo.com before our initial session or bring them with you.

- ➢ Intake form(1,2) – please fill in the best you can.
- ➢ Informed consent (3) – this is a description of your rights to confidentiality along with my office policies. If you have any questions, please feel free to ask me during our sessions.
- ➢ Release forms for other doctors, therapists (4) (optional)
- ➢ HIPPA form (5) – rights to confidentiality explained in the Notice of Privacy Practices. By signing this form (top portion) it is acknowledging that I have given you a copy of the Notice of Privacy Practices.
- ➢ (6) Payment information form
- ➢ (7) Credit card authorization form
- ➢ If you have any further questions please do not hesitate to call me at 310.266.8269 I look forward to meeting with you.

Sincerely,

JESSE ENGDAHL, M.A., MFTI

1. Primary Client

Name________________________________ Date__________

Mailing Address

____

City ____ Zip___________

Home Phone _______________________Work Phone_____________

Mobile Phone_____________________

Email____

DOB ________________Age _______Place of Birth_______________

Ethnicity_____________________

Can we leave a message for you: Y N

Marital Status (circle)

Married Separated Divorced Widowed Domestic Partnership

Education (years)__________Degree Area ______________________

Occupation ____

Employer ____

Spiritual/Religious Orientation ____________________

I Attend Religious Services (circle)
Never Weekly Monthly Rarely/Special Occasions

Spouse/Partner/Parent

Name of Spouse/Partner (Parent of Minor) _______________

Mailing Address_______________________________________
City ____ Zip___________

Home Phone __________________Mobile Phone_________________
Email____

DOB ________________Age _______Place of Birth_______________

Ethnicity_____________________

Children

Names of Children (if minor - name siblings)	Age

Living Arrangements

Whom do you presently live with?________________________________

____

Is this working for you? ____________________________________

____

Physician

Family Physician____________________________Phone_______________

Address ____

City____ Zip_____________

Person to contact in case of emergency__________________________

Relationship___________________Phone________________ Phone________

______

Address ____

City ____ Zip_____________

Reference

Who referred you to this office?_____________________________

May we contact this person to thank him/her for the referral?
Yes / No

2. BACKGROUND INFORMATION

WHAT BROUGHT YOU HERE TODAY?____

____

____

____

WHAT ARE YOUR GOALS FOR COUNSELING? ______________________________

____

____

____

WHAT ARE YOUR FEARS AND CONCERNS ABOUT BEING IN COUNSELING?

____

____

____

ARE YOU EXPERIENCING ANY STRESS IN ANY OF THESE AREAS? (DESCRIBE)

GRIEF:_______________________________________FINANCIAL:______________

WORK:_______________________________________SCHOOL:_______________________

RELATIONSHIPS:______________________________FAMILY:__________________

LEGAL:_______________________________________OTHER:________________________

WHO ARE THE PEOPLE YOU FEEL EMOTIONALLY SUPPORTED BY? (DESCRIBE)

FAMILY:_______________________________________FRIENDS:________________

SPIRITUALLY:_________________________SCHOOL:________________________

WORK:__________________________________PROFESSIONALS:______________

WHAT IS YOUR USE OF SUBSTANCE USE (CURRENT & HISTORY) CONFIDENTIAL

SUBSTANCE	AMOUNT	FREQUENCY	LAST USE
ALCOHOL			
PRESCRIPTION			
RECREATIONAL DRUGS:			
OTHER :			

HAVE YOU TAKEN ANY PSYCHOTROPIC MEDICATIONS IN THE PAST AT ANY TIME?

ANTIPSYCHOTICS ____

____

ANTIDEPRESSANTS ANTI-ANXIETY____

____

ARE YOU TAKING ANY MEDICATIONS CURRENTLY?

MEDICATION	AMOUNT	FREQUENCY	PURPOSE

Are you or have you been involved in AA/NA/SA/CODA/SLAA?

Attendance:________________________________ Other:________________________

Previous Counseling Experience – Outpatient/Inpatient:

With Whom	Where	Diagnosis (known)	Frequency

Are you currently working with any other therapist, psychologist, group, etc.?

If yes, explain____

____

____

May we contact them? Y / N

Name________________________________Phone____________________

MEDICAL HISTORY

Current medical problems:

____

____

Name of Physician:______________________________________ Phone:__________

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING IN THE PAST YEAR?
(IF YES, EXPLAIN)

FATIGUE/SLEEP DISTURBANCE: ____
____

DEPRESSION/EXTREME SADNESS: ____
____

LOSS OF INTEREST IN DAILY ACTIVITIES:____
____

PANIC/ANXIETY: ____
____

DECREASED CONCENTRATION/MEMORY LOSS: ____
____

MOOD SWINGS: ____
____

WEIGHT GAIN/LOSS:____
____

EXCESSIVE WORTHLESSNESS/GUILT:____
____

PARANOIA/OBSESSIVE BEHAVIOR: ____
____

ISOLATION/LONELINESS: ____
____

HAVE YOU EVER ATTEMPTED OR SERIOUSLY CONSIDERED SUICIDE? Y N

WHEN?____

HAVE YOU EVER SELF-MUTILATED/CUTTING/BURNING? Y N
HOW? ____

HAVE YOU ANY CONCERNS ABOUT YOUR SEXUALITY WITH YOUR PARTNER OR FOR YOURSELF? Y N

HOW? ____
____

HAVE YOU EVER HAD:

SEIZURES____________HALLUCINATIONS_________BLACKOUTS_______________

SCARY THOUGHTS__________CONFUSION______________TREMORS __________

OTHER____

Have You Ever Had:

Heart Palpitations____________Difficulty__________ Breathing_____

Stomach Problems_________________________Diabetes_____________________

Other____

Any Other Comments/Concerns:

Please check any past or impending issues that apply to you, your parents and/or siblings?

	Self	mother	father	sibling(s)
alcohol abuse				
Drug abuse				
Emotional problems				
Psychiatric				
Anxiety				
Depression				
Other mental				
Ulcers/colitis				
Asthma				
Anorexia				
Bulimia				
Insomnia				
Attempted/				
Serious physical				
Epilepsy				
Physical abuse				
Sexual abuse				
Numerous				
Frequent				
Learning problems				
Deaths				
Divorce				
Financial crisis/				
Legal problems				

3. INFORMED CONSENT

CLIENT:_________________________________ DATE:______________

3.1 CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY

Confidentiality is the legal right to privacy for all clients who receive psychological services. That is, all personal information presented in this office will not be discussed with persons or agents outside of this office except as authorized by a written release or as required by law. However, there are exceptions to confidentiality. Understand that all information discussed in this office will remain confidential except under the following circumstances:

- You consent in writing for Jesse Engdahl. M.A., MFTI to release and disclose information.
- A breach of confidentiality is required or permitted by law. The State of California requires that if there is a reasonable possibility of child abuse or elder abuse, this must be reported to the proper protective service immediately. There is no statute of limitations according to California law, so conceivably a report might be required for instances of abuse that occurred many years ago even if they are no longer occurring. Depending on the exact circumstances, this could result in an investigation of that possibility. Any investigation would determine if the law has been broken and if legal action is warranted.
- Ethically and legally, if there is a reasonable possibility of harming others or yourself, then as a Marriage Family Therapist Intern, Jesse Engdahl. M.A., MFTI is responsible to inform others, in order to protect them or yourself. For this reason or if there is an emergency during our work together, who would you like me to contact:

Name: _________________________________ Phone:_____________________

Address: ____

- Jesse Engdahl. M.A., MFTI in her discretion decides to obtain consultation on your case with a supervisor, colleague or legal counsel, in which case no identifying information will be revealed.
- You fail to make regular payments on your outstanding bill, which can result in your bill being turned over to a Collection Agency or submitted to Small Claims Court.
- This is a Social Service Agency case, wherein all information shared with Jesse Engdahl. M.A., MFTI will be conveyed to the

assigned Social Worker and/or other SSA representatives and agents.

- IF you are a party in litigation, including divorce litigation, and you tender your mental condition as an issue, your privilege may be waived. In custody cases, you may be required to waive your privilege to facilitate an evaluation by a court ordered evaluator. Jesse Engdahl. M.A., MFTI may be required to produce your records and/or testify at deposition or trial if she is served with subpoenas or court orders. Jesse Engdahl. M.A., MFTI cannot give you legal advice as to what actions may or may not waive your privilege.

- Please be aware that under California's Family Code, a parent without custody may still be entitled to information about his or her child's treatment.

- We frequently contact clients by Cellular Phone and Email. These technologies are not guaranteed of privacy. Please circle whether you authorize contact by Cell Phone and Email.

YES / NO Initial: ______

- NOTE TO PARENTS ABOUT CHILDREN'S CONFIDENTIALITY: If your child participates in treatment, please understand the importance of allowing him/her to develop a confidential relationship with Jesse Engdahl. M.A., MFTI As such, you understand that most personal information that your child discusses with his/her therapist will not ordinarily by shared with you. Rather, your child's therapist will provide you with general summaries of your child's progress without private details. However, understand that this office is committed to informing you about unusual or dangerous symptoms or behaviors. ____________ (Initial)

3.2 GENERAL OFFICE POLICIES

Appointments

Services are provided by appointment only. Your scheduled appointment time is reserved specifically for you. While one hour is typically scheduled for an appointment, you will only be seen for 50 minutes. The remainder of the time is used to maintain a clinical record. _______ (Initial)

Phone Calls

I am available to return calls Monday through Friday between the hours of 9am and 8pm. If you leave a message for me and I do not respond within twenty-four hours, please call again to ensure that my phone system worked properly. . _______(Initial)

If you need to make more than occasional calls that are other than scheduling related, I may encourage you to increase the amount of time we have together in the office. I have found this to be the best way to

address your needs. Where phone consultations are necessary, and it lasts more than ten minutes, you will
be billed for the time which will appear on your next statement. I will inform you at the time if you will be billed for the time. You will not be billed for routine scheduling or information calls. In case of an emergency, please call your own medical doctor or go to your local emergency room. __(Initial)

Cancellations

Normally, APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS NOTICE WILL BE CHARGED AT THE REGULAR FEE _____(Initial) If an emergency arises and you cannot keep your appointment, please call so that we can discuss the possibility of rescheduling. Also, MONDAY APPOINTMENTS MUST BE CANCELLED BY FRIDAY 8PM. ___________ (Initial)

Termination

When it is time for therapy to end, it is important to complete the last sessions. These are an important part of the therapeutic process. If you decide at any time that you want to terminate, please inform me so we can discuss this process._____(Initial)

Fees

Initial fee for first session is $150.00. Thereafter, our agreed upon fee is $150.00 for a 50 minute psychotherapy session. Please present payment at the beginning of each session, unless wanting monthly billing which is to be discussed prior. Fees are due when services are rendered. My office provides monthly statements which clients may submit to their insurance companies for reimbursement. Balances not paid within 30 days are 'PAST DUE'. Balances not paid within 60 days may be sent to our collection agency or pursued through Small Claims Court. If you are not able to make a full payment, please discuss this issue with Jesse Engdahl, M.A., MFTI so we may look at other possible options.

When planning a fee increase, I will give you at least four weeks notice. Returned check fee is $25.00.____(Initial)

Insurance Claims

You are obligated to pay for services regardless of which charges your insurance company covers. You have the right to verify coverage with your insurance company prior to beginning services. The filing of insurance claims is your responsibility. A super bill will be Emailed monthly to you for you to file your claim with your insurance company. ______(Initial)

Other Services

Charges for other services, such as hospital visits, consultations with other therapists, home visits, or any court-related services will be based on the time involved in providing the service at my regular fee schedule._________(Initial)

Arbitration Agreement

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

______________(Initial)____________(Initial) (Each adult client)

Commitment

I realize that my services involve a substantial amount of money and time, although they are well in line with similar professionals' charges, I encourage you to make a commitment to yourself that you are willing to work hard and honestly with yourself and me to make the most of your sessions. Please do not hesitate to ask any questions about therapy, the process, my experience and qualifications, risks and benefits of therapy or any concerns you may have. I look forward to working with you.

My signature below shows that I understand and agree with the confidentiality and limits to confidentiality as well as the general office policies.

Client Signature: ____

(or clients' parent or guardian)________________________________

Jesse Engdahl, M.A. MFTI ______________________________________

4. CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Client's Name: ________________________________ DOB:_______________

and/or (Printed name of parent/conservator)

____

I Hereby authorize: Jesse Engdahl, M.A., MFTI to exchange information about my treatment with: (name professional/person whom Jesse Engdahl, M.A., MFTI may contact)

Name: _____________________________Title: _______________

Phone: ________________ Fax: _____________________

Address: ____

I acknowledge that such discloses the fact that the named person has received mental health treatment services. This disclosure of records is required for evaluation, treatment planning, and coordination of services or for the following purposes and shall be limited to the following purposes and shall be limited to the following specific information either orally, in writing or by photocopy or fax.

Educational__________ Social__________________

Medical______________ Psychometric (testing)___________

Psychological____

Any and all information____________________________________

Psychiatric____________ Other:________________________

I understand that I may revoke this consent at any time. If not previously revoked, this consent terminates at the completion of termination of treatment by: Jesse Engdahl, M.A., MFTI I understand I entitled to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. A fax photocopy of this consent is to be considered as valid as the original. Reference California Civil Code Section 56.11

Client's Signature _______________________________Date ____________

Printed NAME____

Signature of Parent/Conservator_________________________________

Printed Name____

5. 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 from me by contacting me at 310.266.8269.

If you have any questions about my Notice of Privacy Practices, please contact me at 45 Breeze Ave, Venice Beach, ca, 90291. 310.266.8269

I acknowledge receipt of the Notice of Privacy Practices of Jesse Engdahl, M.A., MFTI.

Signature:________________________________ Date:______________
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Do not sign this portion of the form)

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including____
____ However, because OF _____________________________________I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____________________________ Date:_____________

6. PAYMENT INFORMATION FORM

JESSE ENGDAHL, MA, MFTI
45 BREEZE AVE, VENICE BEACH, CA, 90291
P: 310.266.8269
JESSE_ENGDAHL@YAHOO.COM

PAYMENT INFORMATION FORM

(PLEASE PRINT)

FINANCIALLY RESPONSIBLE PARTY:

NAME:____

FIRST MIDDLE LAST

DOB: ________________________ PHONE:________________________________

RELATIONSHIP TO THE PATIENT:____

MONTLY INVOICE/SUPERBILL:

_____I WOULD LIKE TO RECEIVE A GENERAL INVOICE.

_____I WILL BE SUBMITTING MY MONTHLY BILLS TO INSURANCE COMPANY (I UNDERSTAND I MUST PAY MR. ENGDAHL'S INVOICE IN FULL BEFORE SUBMITTING TO INSURANCE).

_____I WOULD LIKE MY INVOICE TO BE EMAILED TO ME**:

**EMAIL:____

_____NO, THANK YOU. I DON'T NEED A MONTHLY INVOICE.

PAYMENT METHODS (PLEASE CHECK ONE):

_____I AUTHORIZE MR. ENGDAHL TO CHARGE MY CREDIT CARD MONTHLY UPON RECEIPT OF AN INVOICE FOR ANY SERVICES PROVIDED.

_____I WILL BE PAYING BY CASH AT THE END OF EACH SESSION.

_____I WILL BE PAYING BY CHECK AT THE END OF EACH SESSION.

_____I WILL BE PAYING BY CREDIT CARD AT THE END OF EACH SESSION.

_____I WILL BE PAYING BY CHECK UPON RECEIPT OF AN INVOICE EACH MONTH FOR ANY SERVICES PROVIDED.

(PLEASE MAKE ALL PAYMENTS TO JESSE ENGDAHL, MA, MFTI)

I_________________________________AGREE TO THE TERMS OF PAYMENT AS INDICATED ABOVE.

____

NAME (PLEASE PRINT)

____

SIGNATURE DATE

7. CREDIT CARD AUTHORIZATION FORM

Jesse Engdahl, MA, MFTI

45 Breeze Ave, Venice Beach, CA, 90291
P: 310.266.8269
Jesse_Engdahl@yahoo.com

CREDIT CARD AUTHORIZATION FORM
(Please print)

Name (as it appears on card):

____
First, Last

Billing Address:
____
Street Apt. City State, Zip

E-Mail:____

Credit Card Type:
____

Credit Card Number:__________- __________- __________- __________
Expiration Date: _______/________/________
3 Digit CVN#:___________________

ALL INFORMATION PROVIDED WILL BE KEPT CONFIDENTIAL

I____________________________________authorize Jesse Engdahl to charge my credit card for any missed appointments on the day of the missed appointment for breach of the cancellation policy, which is 24 hours notice.

__________________________________ ________________
Signature Date