Martin J. Eaton, PhD
Licensed Psychologist, PSY 15533
Well Street Psychological Group Inc. • 626 E. Chapman Avenue • Orange, Ca 92866 • (714) 730-9355

Client Registration

Date: ______________

Name: ______________ Date of Birth:______________ Age: ______________

Address:______________ City:______________, CA Zip: ______________

SS#: ______________ DL#: ______________ Sex: M F Marital Status: ______________

Home Phone: (___) _____-______ Message OK? ❑ Yes ❑ No ______________ Occupation: ______________

Work Phone: (___) _____-______ Message OK? ❑ Yes ❑ No ______________ Employer: ______________

Other Phone: (___) _____-______ Message OK? ❑ Yes ❑ No ______________ E-mail: ______________

Emergency Contact: ______________ Relationship to Client: ______________

Emergency Contact Home Phone: (___) _____-______ Emergency Contact Work Phone: (___) _____- ______________

Billing Information (if different from above or Client is a minor)

Name: ______________ Date of Birth:______________ Age: ______________

Address:______________ City:______________, CA Zip: ______________

SS#: ______________ DL#: ______________ Sex: M F ______________ Relationship to Client: ______________

Home Phone: (___) _____-______ Work Phone (___) _____-______ Other Phone: (___) _____-______________

Occupation: ______________ Employer: ______________ E-mail:

Insurance Information ❑ Not applicable, will be cash Client

Primary Carrier: ______________ Effective Date: ______________

Phone Number: (___) _____-______ Policy Number: ______________ Group Number: ______________

Policy Holder: ______________ SS#: ______________ Relationship to Client: ______________

Complete if different from Client registration:

Sex: ❑ M ❑ F Age: ______Language spoken at home: ❑ English ❑ Other: ______________

Present Address: ______________

City: ______________ State: ______________ Zip: ______________

Home Phone: (___) _____-______ Work Phone: (___) _____-______ E-mail:______________

Cell Phone: (___) _____-______ Fax Phone: (___) _____-______ Other: ______________

CONFIDENTIAL HISTORY:

Educational Level:______________ Current Occupation:______________ Satisfied with Job? ❑ Yes ❑ No

Marital Status: (Check all that apply.) Years Married: ______________

❑ Married ❑ Living Together ❑ Never Married ❑ Divorced ❑ Separated ❑ Custodial Parent Remarried ❑ Non-custodial Parent Remarried

Are there current marital problems? ❑ Yes ❑ No Comments:______________ ______________

____

Spouse's Name *(If Applicable)*: ______________ Highest Level of Education: ______________

Occupation: ______________ Spouse Satisfied with Job? ❑ Yes ❑ No

Mother's Name: ______________ Stepmother? ❑ Yes ❑ No

Occupation: ______________ Highest Level of Education: ______________

Father's Name:______________ Stepfather? ❑ Yes ❑ No

Occupation: ______________ Highest Level of Education: ______________

Children or Siblings (Circle One) :

Name: ______________ Sex: ❑ M ❑ F Age: ______________

Name: ______________ Sex: ❑ M ❑ F Age: ______________

Name: ______________ Sex: ❑ M ❑ F Age: ______________

With whom were you raised? (Check all that apply.)

❑ Biological Parents ❑ Parents and Step Parent ❑ Foster Parents ❑ Single Parent ❑ Adoptive Parents

❑Relatives ❑ Institution ❑ Legal Guardian ❑ Other: ______________

Marital Status of Parents: (Check all that apply.) Years Married: ______________

❑ Married ❑ Living Together ❑ Never Married ❑ Divorced ❑ Separated ❑ Custodial Parent Remarried ❑ Non-custodial Parent Remarried Comments: ___

Your Medical Conditions or Health Issues: ____

____

Current Physician: ______________________________ Phone #: (___) ______- ______________

Date and Reason of your last visit:______________________________ When was your last physical?______________

Medications You Take: ______________________________ ❑ I do not take prescription medication at this time.

Medication: ______________________________ For What Condition: ______________________

Medication: ______________________________ For What Condition: ______________________

Please describe other serious illnesses or injuries:____

____

Is there a family history of treatment for psychological/psychiatric conditions? ❑ Yes ❑ No Comments:______________________

Have you had previous counseling or psychotherapy? ❑ Yes ❑ No With whom and when:______________________

Have you ever felt suicidal? ❑ Yes ❑NoDo you feel this way now? ❑ Yes ❑ No Comments:______________________

Are you involved in any legal proceedings? ❑ Yes ❑ No Comments: ______________________

Do you exercise? ❑ Yes ❑ No What type: ______________ Frequency: ______________

Do you take sleeping pills? ❑ Yes ❑ No What type: ______________ Frequency: ______________

Do you drink alcohol? ❑ Yes ❑ No What type:______________ Frequency: ______________

Do you use tobacco? ❑ Yes ❑ No What type:______________ Frequency: ______________

Do you use other drugs? ❑ Yes ❑ No What type:______________ Frequency: ______________

What are your main concerns/reasons for seeking treatment?______________________________

____

Did a specific event lead to this session? ❑ Yes ❑ No Comments:______________________________

____

Have you been a victim of physical or sexual abuse/assault? ❑ Yes ❑ No Comments:______________________

____

Describe your relationship with God.______________________________________

____

Please circle the items that cause you the most trouble in you life:

Abuse	Disrespect	Health	Insignificance	Pride	Thought Process
Addictions	Dominance	Hypocrisy	Irresponsible	Rebellion	Unapproachable
Anger	Doubts	Immorality	Lack of wisdom	Rejection	Unawareness
Anxiety	Extravagance	Worry	Laziness	Resistance	Underachievement
Apathy	Fantasizing	Impulsive	Loneliness	Restlessness	Unfairness
Callousness	Fear	Impulsiveness	Lustful thoughts	Rudeness	Unfaithful
Carelessness	Feeling	Inadequacy	Memory	Sadness	Ungratefulness
Children	Friends	Incompleteness	Mood swings	Self-gratification	Unorganized
Compulsive Thoughts	Giving up	Inconsistency	Obsessive Thoughts	Sex	Unreasonable
Covetousness	Goalessness	Indecisive	Panic	Spouse	Unresponsiveness
Cowardice	Guilt	Indifference	Poor concentration	Stinginess	Wasteful
Daydreaming	Harshness	Inferiority	Poor decisions	Stress	Withdraw
Deception	Headaches	Insecurity	Prejudice	Tardiness	

Please list all family members, **including yourself** and aunts, uncles, brothers, sister, parents, grandparents and cousins which suffer from the following problems

Depression______________	Loss f Consciousness ______________	Child Abuse ______________
Alcoholism ______________	Seizures ______________	Incest ______________
Drug Abuse ______________	Sleep Disturbance ______________	Grief Issues ______________
Addictions ______________	Eating Problems ______________	Cancer or Other Health Issues ______________
Suicide Attempt/Completion ______________	Coordination Problems ______________	Abortion ______________
Suicidal thoughts ______________	Hearing Problems ______________	Homosexuality ______________
Suicidal Behavior______________	Sight Problems ______________	Physically Harmful Activities ______________
Psychiatric Hospitalization______________	Sense of Smell Problems ______________	Mentally Harmful Activities ______________
Psychiatric Medications______________	Head Injury ______________	ADD or ADHD ______________
Manic/Depression ______________	Speech Problems ______________	Dyslexia ______________
Mood Swings______________	Hypoglycemia ______________	Processing Information Problems ______________
Schizophrenia ______________	Heart Trouble ______________	Memory Problems ______________
Thought Disorder______________	Anxiety ______________	Reading Difficulties ______________
Developmental Delays______________	Unexplained Lapse in Time______________	

Well Street Psychological Group Inc.
HEALTH INFORMATION PORTABILITY & ACCOUNTABILITY ACT
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 It Carefully.

It Is Your Therapist's Legal Duty To Safeguard Your Protected Health Information (PHI). By law your therapist is required to insure that your PHI is kept private. The PHI constitutes information about your past, present, or future health or condition or the payment for such health care. Use of PHI means when your therapist shares, applies, utilizes, or analyzes information within the practice; PHI is disclosed when your therapist releases, transfers, gives, or otherwise reveals it to a third party outside the practice. With some exceptions, your therapist may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, your therapist is always legally required to follow California law described in this Notice.

Most disclosures will require your prior written authorization; others, will not. Below you will find categories of your therapist's uses and disclosures.

Disclosures Related to Treatment, Payment, or Health Care Operations That Do Not Require Prior Written Consent:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement,** your therapist may make a disclosure to the appropriate officials when the law requires them to report information government or, law enforcement agencies, or if any one places your mental condition as part of any litigation (such as divorce, custody, or personal injury)

2. **Disclosure is compelled or permitted when you are in such mental or emotional condition as to be dangerous to yourself or when you tell your therapist of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.** For example, suicidal or serious self-destructive behavior.

3. **Confidentiality does not apply to disclosure of crimes planned for the future. This applies to interests of national security.**

4. **Disclosure is mandated by the California Child Abuse/Elder/Dependent Adult Abuse and Neglect Reporting law.** For example, if your therapist has a reasonable suspicion of child abuse/ elder abuse or neglect or dependent adult abuse, your therapist is legally obligated to report it.

5. **When disclosure is required to obtain payment for treatment.** Your therapist might send your PHI to your insurance company, health plan, or other third party payer in order to receive payment for services your therapist provided to you.

6. **Appointment reminders and health related benefits or services.** Your therapist may use PHI to provide appointment reminders.

7. **When disclosure is otherwise specifically required by law. Other Uses and Disclosures Require Your Prior Written Authorization.** For situations not described above, your therapist will require written authorization before disclosing any of your PHI. This includes communication with family members or other health care providers. Even if you signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future disclosures.

The Right to See and Get Copies of Your PHI. In general, you have the right to see or get copies of your PHI from your therapist. You must request it in writing, and your therapist will respond within 5 days of receiving your written request. Under certain circumstances, your therapist may deny your request and will give you, in writing, the reasons for the denial. You have the right to have the denial reviewed. If you ask for copies of your PHI, you will not be charged more than $.25 per page. Your therapist may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

The Right to Choose How Your PHI is Sent to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail).

The Right to a List of the Disclosures Your Therapist Has Made. You are entitled to a list of disclosures of your PHI that your therapist has made after April 15, 2003. The list will not include uses or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

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 your therapist correct the existing information or add the missing information. Your request must be made in writing. Your therapist may deny your request, in writing, if your therapist finds that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of their records, or (d) written by someone other than your therapist. Your therapist's denial must be in writing and must state the reasons for the denial. You have a right to file a written statement objecting to the denial. You have the right to ask that your request and the denial be attached to any future disclosures of your PHI. When approved, your therapist will advise others who need to know about the change to your PHI.

The Right to Get a Copy of This Notice. You have the right to get this notice by email or paper hard copy.

How To Complain About Your Therapist's Privacy Practices

If, in your opinion, your therapist may have violated your privacy rights, or if you object to a decision your therapist made about access to your PHI, you are entitled to file a complaint with your therapist or if applicable, their clinical supervisor. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about privacy practices, your therapist will take no retaliatory action against you.

I acknowledge the terms of this notice and the privacy practices of this office.

Print Name
______________________________ Date: ______________________________

Signature
______________________________ Relationship to Client: ____________________

Print Name
______________________________ Date: ______________________________

Signature
______________________________ Relationship to Client: ____________________

Well Street Psychological Group Inc.

INFORMED CONSENT FOR PSYCHOTHERAPY SERVICES & OFFICE POLICIES

This form provides you (Client) with information that is additional to that detailed in the Notice of Privacy Practices. Please initial each paragraph in the space provided, indicating that you have read and understand the content of that paragraph.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (Client's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were descried to you in the Notice of Privacy Practices that you received with this form. Initial ____________

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect and where a Client presents a danger to self, others or is gravely disabled.Initial __________

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your therapist. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Your therapist will not release records to any outside party unless they are authorized to do so by all adult family members who were part of the treatment. Initial ____________

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be highly sensitive and of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you, nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify at any proceeding, nor will a disclosure of the psychotherapy records be requested Initial ____________

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier, HMO/PPO/MCO/EAP, or other third party payer in order to process the claims. Only the minimum necessary information will be communicated to the carrier. Unless authorize by you explicitly the Psychotherapy Notes will not be disclosed to your insurance carrier. Your therapist has no control or knowledge over what insurance companies do with the information they submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information, including diagnosis, is entered into insurance companies' computers and will also be reported to the Congress-approved National Medical Data Bank. Initial ____________

Confidentiality of E-mail, Cell Phone and Faxes Communication: It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify your therapist at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail or faxes for emergencies. Initial ____________

Consultation: Your therapist may consult with other professionals regarding their Clients; however, the Client's name or other identifying information is never mentioned. The Client's identity remains completely anonymous, and confidentiality is fully maintained. This is done to provide you with the best care possible. Initial ____________

THE PROCESS OF THERAPY: Psychotherapy is most effective when there is a collaborative relationship between client and therapist with mutual understanding and agreement about goals and treatment methods. Your therapist normally evaluates your needs within the first 2 to 4 sessions so that I will be able to offer you some initial impressions of what our work and whether I am the best person to provide the services you need to meet your objectives. If therapy is initiated, I will usually schedule one 45 minute or 60 minute therapy session once per week at a mutually agreed upon time. Sometimes sessions will be scheduled more or less frequently depending on the need. We will decide together what would be best for you.

Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Psychotherapy requires your very active involvement, honesty, and openness in order to change. Your therapist will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. During therapy, remembering or talking about painful memories, unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings. Attempting to resolve issues that brought you to therapy, may result in changes that were not originally intended. Sometimes, a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results **Well Street Psychological Group Inc does not directly or indirectly practice medicine or provide medical advice. There is no intention in the explanation of wellness concepts as a substitution for medical advice, diagnosis or treatment. The client agrees to contact their doctor if they need medical advice or treatment or have any questions regarding their medical condition**. Initial____________

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, your therapist will discuss with you their working understanding of the problem, treatment plan, therapeutic objectives, and view of the possible outcomes of treatment. If you have any unanswered questions about the course of your therapy, the possible risks, your therapist's ability, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that your therapist does not provide, they have an ethical obligation to assist you in obtaining those treatments. Initial ____________

Termination: You have the right to terminate therapy at any time. Ideally, this happens when the goals of therapy have been met. If at any point during psychotherapy, your therapist believes they are not effective in helping you reach the therapeutic goals, they are obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, they would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, your therapist will talk to the new psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, your therapist will assist you in finding someone qualified, and with your written consent will provide her or him with the essential information needed. Initial ____________

Dual Relationships: A dual relationship exists when you have some type of relationship with your therapist outside the clinical setting. This may include civic and philanthropic groups, religious communities, sports leagues, etc. Appropriate dual relationships are not unethical. Therapy never involves sexual or any other dual relationship that can be exploitative in nature, or impairs your therapist's objectivity, clinical judgment and/or therapeutic effectiveness. Appropriate non-sexual dual relationships can be clinically beneficial, and may, in fact, be the reason you chose your therapist. Your therapist will discuss with you the potential benefits and difficulties that may be involved in dual relationships and will discontinue the dual relationship if it interferes with the effectiveness of the therapeutic process. Initial ____________

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact your therapist between sessions, please leave a message with the office secretary, your therapist's voice mail, or our answering service and your call will be returned as soon as possible. Your therapist checks messages a few times a day, unless they are out of town. Understand that your therapist may charge you for services rendered over the phone. If an emergency situation arises, please indicate it clearly in your message. Each therapist covers emergencies for their own Clients unless they are out of town, in which case whom-ever your therapist has made on-call arrangements with will respond to you as soon as possible. Initial_____________

I am often not immediately available by telephone. While I am in my office Monday through Friday until 5 p.m., I usually will not answer the phone when I am with a client. Please call my voice mail number (714) 730-9355. Leave a message, and I will make every attempt to return your call within 24 hours. Weekends and holidays are an exception. If you call on the weekends or holidays, I will get back to you the following business day; usually on the following Monday. If you can't reach me, and you feel you can't wait for me to return your call, you should call your family physician, emergency room or 911. In case of medical emergency, or when there is immediate danger or potential harm, call 911. Initial ____________

PAYMENTS & INSURANCE REIMBURSEMENT: My fees for out-Patient services at my office are $145 per 30 minute session, $176 per 45-minute session and $235 an hour. If I need to provide in-patient services my fees are $275.00 per hour plus a prorated travel time of $275 an hour. It is my practice to charge on a prorated basis for other professional services that you may require such as telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records,-longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed otherwise (other than scheduling an appointment). If you become involved in litigation which requires my participation, you will be expected to pay for my participation. Because of the complexity and difficulty of legal involvement, I charge $475 per hour for preparation and attendance of any legal proceedings.

You will be expected to pay for each session at the time it is held, unless we agree otherwise. I accept personal checks, cash and MasterCard or Visa. Please make checks payable to "**Well Street**." I request you have your payment ready before you begin your session. **You will be charged for cancellations or missed appointments made with less than a 48 hour notice.** If you are eligible for insurance coverage, use the receipts you receive to bill your insurance directly. It is important to note that you are responsible for your treatment. Your insurance company is responsible to you, not to me. Be sure of what they will pay for in the area of mental health coverage and ask about pre authorization.

Please notify your therapist if any problem arises during the course of therapy regarding your ability to make timely payments. Health insurance is a contract between you and your insurance company. Clients who carry insurance should remember that professional services are rendered and charged to the Client and not to the insurance company. As was indicated in the section Health Insurance & Confidentiality of Records, be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. Initial ____________

Alternative Fee Agreement: I agree to pay $____ per session, to be paid: ❑ at time of service ❑ when billed.

Therapist's Approval of Alternative Fee Agreement:_____ Duration of this Alternative Fee Agreement: ______________________

CANCELLATION: Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hours (2 days) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions. Initial ____________

I've read the above Informed Consent For Psychotherapy Services & Policies carefully; I understand and agree to comply with them:

______________________________ Relationship to Client:______________________

Print Name

______________________________ Date: ______________________

Signature

______________________________ Date: ______________________

Therapist Signature

Request Copy of :HEALTH INFORMATION PORTABILITY & ACCOUNTABILITY ACT NOTICE OF PRIVACY PRACTICES ❑ Yes ❑ No

INFORMED CONSENT FOR PSYCHOTHERAPY SERVICES & OFFICE POLICIES ❑ Yes ❑ No Initial______________