RAVONKAVI

Homayoun Shahri, Ph.D., M.A., MFT86676
4199 Campus Drive, Suite 550, Irvine, CA 92612-4694

PLEASE COMPLETE THE FOLLOWING INFORMATION CLEARLY AND THOROUGHLY:

Date: _____

Name of Client: _____
First Middle Last

Address: _____
Number Street Apt. City Zip Code

Home Telephone: ( ) _____ *Cell Telephone:* ( ) _____

Date of Birth ____/____/____ *Marital Status*: _____ *DL#*_____

*Employe*r: _____ *Occupation:*_____

Email: _____

IF CLIENT IS A MINOR COMPLETE THE FOLLOWING INFORMATION:

Name of Parent/Guardian: _____
First Middle Last

Address: _____
Number Street Apt. City Zip Code

Home Telephone: ( ) _____ *Cell Telephone:* ( ) _____

Date of Birth ____/____/____ *Marital Status*: _____ *DL#*_____

*Employe*r _____ *Occupation*_____

Spouse's Name: _____
First Middle Last

Address: _____
Number Street Apt. City Zip Code

Email: _____

REFERRAL INFORMATION:

Who referred you to us? _____

Describe the concerns that have brought you here_____

_____

_____

_____

_____

_____

_____

_____

How long ago did they start? _____

What have you done about this problem? _____

_____

_____

_____

_____

_____

_____

Primary Care Physician: _____ Date of Last Exam: _____

Current Medical Condition(s): _____

_____

Are you currently taking any prescription or "over the counter" medication(s)? No___ Yes___

If Yes, please identify the name, current dosage, and date began for each: _____

_____

Please answer whether or not you are experiencing any of the following symptoms:

Suicidal Thoughts/Impulses	N____ Y____
Homicidal Thoughts/Impulses	N____ Y____
Appetite Problems	N____ Y____
Sleep Problems	N____ Y____
Physical Complaints	N____ Y____
Anger/Irritability	N____ Y____
Isolation/Social Withdrawal	N____ Y____
Anxiety/Panic	N____ Y____
Phobia	N____ Y____
Bingeing/Purging	N____ Y____
Poor Impulse Control	N____ Y____
Violence Toward Others	N____ Y____
Destruction of Property	N____ Y____
Strange or Unusual Behavior	N____ Y____
Confused or Irrational Thinking	N____ Y____
Bothersome Repetitive Thoughts or Behaviors	N____ Y____
Self-mutilation	N____ Y____

THERAPEUTIC CONSENT AND THE THERAPEUTIC CONTRACT

Part I: The Therapy Process

Participating in the therapy can result in a number of benefits to you, including the better understanding of your personal goals and values, improved interpersonal relationship, and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part and may result in your experiencing considerable discomfort. Change will sometimes be easy and swift, and more often it will be slow and frustrating. Remembering unpleasant events and resolving them through therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also led to discomfort and may result in changes that were not originally intended.

Part II: Client's Rights

You have the right to confidential relationship with me. Within certain legal limits (see #3 below), information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any person without your written permission.

1. You have the right to know the content of your records at any time, and I have the right to provide you with either the complete records or a summary of their content.

2. If you ask me, I can release any part of your records on file with me to any person you specify. I will tell you when you make your request whether or not I think releasing that information to that agency or person might be harmful to you at any time.

3. Under certain legally defined situation, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situation include:

    a. If you reveal information to me about active child abuse or neglect, elder abuse, or dependent adult abuse, I must make a report to protective services. When a perpetrator of child abuse is in contact with minors and there is a <u>reasonable suspicion</u> that he/she may still be abusing minors, I must also report that information.
    b. If you seriously threaten to harm another person, I am required to warn the intended victim and notify the appropriate law enforcement agencies.
    c. If you are in therapy or being tested due to an order of a court or lawyer, the results of the treatment or tests ordered must be revealed to that court or lawyer.
    d. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena.
    e. If you are in a lawsuit where emotional harm is being claimed, the opposing side may subpoena your therapy records.

4. You have the right to ask questions about any of the procedures used in the course of your therapy. If you ask, I will explain my customary approach and methods to you.

5. You have the right to choose NOT to receive therapy from me. If you choose this, I will provide you with names of other qualified professionals whose services you might prefer.

6. You have the right to terminate therapy with me at any time without financial, legal, or moral obligations other than those you've already incurred. I have the right to terminate therapy with you under the following conditions:

    a. When I believe that therapy is no longer beneficial to you.
    b. When I believe that you will be better served by another professional, whom I will recommend. If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If you have written consent from you, I will provide that professional with the essential information she or he requires.
    c. When you have not paid for the last two sessions, unless special arrangements have been made with me.
    d. When you have failed to show up for your last two therapy sessions without a 24-hour notice of cancellations.

If any of these situations apply, I will send you a certified letter to your address of record to inform you of my decision, and I will give you the names of several therapists for your future counseling needs.

As life can bring unexpected circumstances, should I be unable to continue your therapy, my trusted colleague, _____, will contact you to discuss what would be best for you at that time.

I, _____, read and understood my rights and the limits of confidentiality.

Signature _____ Date _____

Grievances and complaints: should you have concerns regarding the misconducts of the therapist, and believe that your rights, as described above, have been **intentionally** compromised, you may make a formal complaint to the Board of Behavioral Sciences (BBS). See the links below for more information and access to the appropriate sites.

BBS: Home Page for Board of Behavioral Science: http://www.bbs.ca.gov/;
For Complaints: http://www.dca.ca.gov/

PART III: FEES & FINANCIAL RESPONSIBILITIES

- I agree to enter therapy with Dr. Homayoun Shahri. I also agree that, I am responsible for paying my bill in full. I also agree that I will pay the agreed upon fee of _____ per session. **Initial**_____

- Any other agreements:

  _____

- I will make payment by cash or check **at the starting time** of the therapy appointment. I am contracting only to pay for completed therapy sessions. I will pay a fee of $50 for sessions I miss without providing 24-hour notice and the telephone time as outlined in the Part V of this contract. **Initial_____**

I understand that there is a $15.00 charge for bounced checks. I also understand that delinquent bills will be sent to a collections agency, which may then compromise the confidential nature of the services I am obtaining. Initial _____

Date _____ Client's Signature _____

PART IV: CONSENT FOR TREATMENT

I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read and fully understand this Consent for Evaluation & Treatment form.

Date _____ Client's Signature _____

Therapist's Signature_____

PART V: OFFICE POLICIES *(PLEASE READ AND INITIALIZE).*

Cancellation: A minimum of 24-hour notice is required for rescheduling or cancellation of an appointment. A fee of $50 will be charged for sessions missed without such notification. Insurance companies do not reimburse for missed sessions. **Initial**_____

Office Hours: My office hours are from 9:00 a.m. to 6:00 p.m., Monday thru Friday. If you need to contact me between sessions, please leave a message at (949) 391-7790 and I will return your call. **Initial**_____

***Telephone Time**: After **10 minutes** of telephone time, you will be charged at your regular prorated fee for the total time of the phone contact. **Initial_____**

***Sessions Greater Than 50 Minutes:** Sessions that go beyond **50 minutes** will be prorated to the nearest quarter hour. **Initial**_____

Copy of Records: If you need a copy of your records you must give us 10 working days advanced notice to copy the material for you. There is a $0.20 per page cost for copies. **Initial** _____

Court Appearance: If you need a testimonial or any court appearance or depositions of the therapist on your behalf, you need to pay a fee for service, and including the driving time, and waiting time. **Initial _____**

Emergency Procedure: A clinical emergency is an unexpected not life threatening event that requires immediate attention and can be a threat to your psychological health. If a clinical emergency situation arises, please call my cell and follow the instructions on the voice message system. **In case of medical or life-threatening emergencies, please call 911 and do not leave a message for the office. Initial**_____

Letters or summary of contact: For any letters written to verify diagnosis or provide a summary of contact there is a fee of $50.00 per hour, which will be collected at the time you pick up the letter. Initial _____

I have understood the above policies and procedures and accept these policies.

Client or (Parent/Guardian)_____ Date: _____