A Balanced Communication

LMFT# 91316
731 Hwy 101, Suite # 1E
Solana Beach, CA 92075
(858) 342-5514

PATIENT

Name:_____ Referred by: _____

Home Address:_____ City:_____ I _____ Zip: _____

Telephone Numbers: home #: ( )_____ work # ( )_____ CELL #: ( ) _____

Employer's name & address: _____

Social Security #:_____ Date of Birth:_____ Single / Married / Divorced

Driver's License #:_____ Email Address: _____

Emergency contact: Name:_____ Phone #: _____

INSURANCE

Name of Insured: _____ Relationship to Patient: _____

Insured's Soc. Sec. #:_____ Insured's Date of Birth: _____

Insured's Address:_____ City:_____ Zip:___ Insured's

Employer:_____

Employer's Address:_____ City:_____ Zip: Insurance

Company:_____ Phone #: (_____) _____

Insurance Company's Address for Claims:_____ City:_____ State:____ Zip:_____

Policy #:_____ Group #: _____

Is there secondary insurance?_____ If so, please request a separate form for Secondary Insurance.

AUTHORIZATION (Signature on File)

Patient hereby agrees to a No Show or Late Cancelation fee of $ 75.00 _____ (patient's initials)

I authorize use of this form on all my insurance claim submissions. I authorize the release of any medical or other information necessary to process my insurance claims. I understand that **I am responsible** for my bill.

I authorize **Zohreh N. Sadatrafiei, PsyD, LMFT (aka "Dr. Nikoo")** to act as **my** agent in helping to obtain payment from my insurance carrier(s). I irrevocably authorize payment of medical benefits directly to **Zohreh N. Sadatrafiei, PsyD, LMFT** for services rendered to me.

I request payment of government benefits be made directly to **Zohreh N. Sadatrafiei, PsyD, LMFT**, who hereby accepts such assignment. I permit a copy of this authorization to be used in place of the original.

Dated: _____ Signature: _____

Print Name: _____

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DIAGNOSIS / COMMENTS

Diagnosis: _____ ICD-10 code: _____

COMMENTS:

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P A T I E N T: _____

SECONDARY I N S U R A N C E

Name of Insured: _____ Relationship to Patient: _____

Insured's Soc. Sec. #: _____ Insured's Date of Birth: _____

Insured's Address: _____ City: _____ Zip: ___ Insured's

Employer: _____

Employer's Address: _____ City: _____ Zip: Insurance

Company: _____ Phone #: (_____) _____

Insurance Company's Address for Claims: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group #: _____

AUTHORIZATION (Signature on File)

I authorize use of this form on all my insurance claim submissions. I authorize the release of any medical or other information necessary to process my insurance claims. I understand that **I am responsible** for my bill.

I authorize **Zohreh N. Sadatrafiei, PsyD, LMFT (aka "Dr. Nikoo")** to act as **my** agent in helping to obtain payment from my insurance carrier(s). I irrevocably authorize payment of medical benefits directly to **Zohreh N. Sadatrafiei, PsyD, LMFT** for services rendered to me.

I request payment of government benefits be made directly to **Zohreh N. Sadatrafiei, PsyD, LMFT**, who hereby accepts such assignment. I permit a copy of this authorization to be used in place of the original.

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Print Name: _____

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CLIENT REGISTRATION FORM

1. **Personal Information** Today's Date: _____

Full Name:_____Date of Birth:_____Age: _____

Address:_____City: _____

State:_____Zip:_____Marital Status:_____Children: _____

Home: (____)_____Work: (_____)_____Cell: (_____)_____

e-mail:_____

2. Emergency Contact Information

Name:_____Relationship: _____

Address:_____City:_____State:_____Zip:_____

Home Phone:(____)_____Work: (_____)_____Cell: (____)_____

3. Responsible Party Information

Name of Responsible Party: _____

Address: (if it's different than client's) _____

Relationship:_____Date of Birth: _____

Level of Education:_____Occupation: _____

Home: (____)_____Work: (_____)_____Cell: (_____)_____

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4. Health History:

Please list any serious illness that you *currently* have (i.e.: diabetes, hypertension, …) :

Please list any prescription medication/s *currently* you are taking:

Please list any allergies/adverse reactions to treatment:

Primary Care Physician:_____Phone: _____

Address: _____

City_____State_____Zip _____

5. Psychological situation

- Are you currently seeing a counselor/therapist? YES NO If so, name of therapist_____

- Have you ever been in therapy before? YES NO If so, was it helpful? YES NO

- Briefly describe the issues of your previous counseling:

- Please briefly describe the reasons for seeking help at this time:

- When did these issues arise? _____

- Please describe some goals you hope to achieve in coming here:

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6. **Contact and communication method**:

A. Call cell phone ___ B. Email ____ C. Texting ____ D. All ____

7. PAYMENT AUTHORIZATION

I understand that it is my responsibility to pay for the fee established for professional services rendered to the above client. I hereby authorize payment directly to Nikoo Sadatrafiei, PsyD LMFT. In addition, **24 hours** notice is required to cancel and appointment in order to avoid late charges. Please provide a valid credit card information

Signature of Responsibly Party_____Date _____

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CONSENT FOR TREATMENT

The Process of Therapy

Welcome. Please read this document that contains important information about my professional services and business policies. After you sign this document, it will represent an agreement between us.

Before you begin treatment, it is important that you be informed of the process and potential benefits and costs of psychotherapy. Therapy is joined effort, the results of which cannot be guaranteed. Progress depends upon multiple factors including motivation and effort devoted as well as other life circumstances. Talking about unpleasant topics may initially result in experiencing strong feelings of anger, sadness, stress or worry. However, successful therapy can result in mood and life improvements that include better coping skills, more effective problem-solving abilities and an increase in self-awareness about your behaviors, motivations and needs.

I will start therapy with evaluation of your current problems, concerns, and needs as well as the history and context of those problems and your hopes for therapy by the end of the evaluation period, I will offer you my clinical impressions and a recommended approach to treatment during this time, it is important that we both consider if I am the best person to provide the services you need to meet your specific treatment goals. If indicated (e.g., your presenting problem is outside the scope of my clinical expertise), a referral to a more appropriate therapist will be provided. As therapy involves a commitment of time, energy, and money, it is important that you feel comfortable working with me. The goals of therapy are arrived at by mutual collaboration between us the goals we establish will be reviewed during the course of our work in order to assess and /or modify the focus of therapy according to your needs.

Contacting Me
As your therapist, I agree to be reasonably available to you during regular business hours via phone. You may contact me at (858) 342-5514. I will make every effort to return your call on the same day you make it, or by the next business day at the very latest. However, if you should require emergency attention and I cannot be reached, **please contact County Crisis Access Team 24-hours a day at (800) 479-3339 or call 911.** It is preferable to use E-mail for scheduling purposes or for exchanging information on resources. However, I do not recommend using e-mail as a means to convey personal information or thoughts related to therapy sessions as e-mail is not a confidential means of communication. **Please do not email me if you are in crisis.**

Payment
My hourly fee is $90.00-$130.00. If you have a health insurance policy, it may provide some coverage for mental health treatment I will provide whatever assistance I can in helping you receive the benefits to which you are entitled; however, because you (not your insurance company) are responsible for full payment of my fees, you should find out exactly what mental health services your policy covers and required that you pay the co-pay and/or the deductible fee at the time of each session. If there is a need for me to write a court or other report and/or letter on your behalf, you will be charged at a prorated rate of $150.00 per hour.

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If any legal action is necessary to enforce or interpret the terms of this agreement, the prevailing party shall be entitled to reasonable attorney's fee, costs, and necessary disbursement in addition to any other relief to which that party may be entitled.

It is important to know that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands.

Cancellations and Missed Appointments
Your appointment begins at a precise time. Each session will last approximately 50 minutes. Once our appointment time is set, there is a 24-hour cancellation requirement to avoid full session charge. Sessions are 50-minutes in duration and payment is expected according to the payment agreements set forth at the beginning of treatment. Exceptions to this are physical illness or any unanticipated circumstance that could reasonably be called and "emergency". Excessive no shows will result in your case being closed.

Ending Therapy

Your participation in therapy is voluntary and you have the right to terminate therapy at any time. If you choose to do so, your provider will offer to provide you with names of other qualified professionals. However, I encourage you to make this decision in collaboration with me. There are two situations in which I may decide the therapy will end:

- If I assess in my clinical judgment that I am not able to help you, I will inform you of this fact and refer you to another therapist who may meet your needs. Some reasons I may reach such a decision include, but not limited to:

- If you are coping with a problem that is outside my scope of competence or expertise.
-If the existing relationship with you, your family, a client, or a shared mutual friend that may interfere with my objectivity or role as your therapist
-Any indirect and direct behavior (verbally, physically or electronically) that may threaten my safety, my office, my clients, or family.

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 written permission except where disclosure is required by law.
When Disclosure is Required by Law: Reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to the therapist that the client presents a danger to others.

My signature below indicates that I have read and understand these policies and stipulations. I authorize and agree to evaluation, treatment, and abide by its terms.

Client Name	Client Signature	Date

Clinician Name	Clinician Signature	Date

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NOTICE OF PRIVACY PRACTICES

(Health Insurance Portability and Accountability Act Provisions)

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

I. Disclosure of Payment, Health Care Operations, & Treatment

I may use or disclose your *protected health information* (PHI) without your authorization in situations related to payments, health care operations, and/or treatment. In certain circumstances, I can only do so when the person or business requesting your PHI provides me with written requests that contain promises to protect the confidentiality of your PHI. Below are some definitions to assist in your understand of this process.

"PHI" means information in your health record that could identify you

- ***Payment***: when I contact your insurance provider to clarify coverage and obtain reimbursement for services.
- ***Health Care Operations:*** when I disclose your PHI to your health Care service plan or to other health care providers contracting with your plan when administering, modifying or consulting abut your treatment plan.
- ***Treatment***: anytime I consult with another healthcare provider, such as your family physician or another therapist regarding your treatment.

II. Uses and Disclosures Requiring Authorization

- I may use (*within* my office/practice) or disclose (*outside* of my office) PHI with your authorization, for purposes outside the above described treatment, payment, and health care operations. I will ask for your written authorization prior to releasing any of this information.

- I will also request your written authorization if another party requests your psychotherapy notes, which are notes made regarding our private conversations during counseling. These notes are keep separate from any medical record information and are given a greater degree of protections than PHI.

- You have the right to revoke or modify all signed authorizations at any time; however the revocation/modification is not effective until I receive it.

III. Uses and Disclosures with Neither Consent nor Authorization

There are some general circumstances in which I may use or disclose PHI <u>without</u> your consent.

1. <u>Child Abuse:</u> In my professional capacities, whenever I observe or have reasonable suspicion that a child has been the victim of abuse or neglect, I legally MUST make an anonymous report to the appropriate local authorities/agencies.

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2. Adult or Domestic Abuse: if in my professional capacities, I observe or have knowledge of an incident in which a dependent or elder adult has suffered physical abuse, abandonment, abduction, isolation, neglect or financial abuse, I legally MUST report the known or suspected abuse immediately to the appropriate local authorities/agencies.
3. Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made about your therapy, there are several circumstances in which I may be required to break our confidentiality. These situations are described below:
a. If you, your lawyer or personal representative providers
b. If I am presented with a court order
c. If there is a subpoena to produce therapy records and the party making the request provides me with evidence that you and your attorney have been served with a copy of the subpoena, and you have not told me that you are bringing a motion to block or modify the subpoena.
d. If you are in a legal proceeding and are being psychologically evaluated by a third party or an evaluation is court ordered
e. If you initiate a worker's compensation suit claiming emotional damage, and I am requested to make a report, your PHI will not remain confidential.

4. Serious Threat to Health or Safety: if you communicate to me a serious threat of physical violence against and identifiable victim, I MUST make reasonable efforts to contact the intended victim and the police. If I suspect that you are in such a condition as to be dangerous to yourself or others, I may release relevant information to prevent any danger.

IV. Patient's Rights

The following is a list of some of your client/patient rights regarding your PHI:

- Right to Receive Confidential Communications by Alterative Means and Locations: You have the right to request and receive confidential communications of PHI by alternative means and locations. (For example, if you do not want family members to know that you are seeing me, I can arrange to have bills sent to a different address.)

- Right to Inspect and Copy: You have the right to inspect or copy PHI in our counseling and billing records. If this request is made, I will charge you no more than $.25 per page copied. In some cases, I may deny this access but may opt to provide you with a summary instead. You also have the right to have this denial reviewed. Upon your request, we can discuss this process.

- Right to a Paper Copy: You have the right to a paper copy of all signed forms.

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of PHI, although I am not required to agree with or abide by these restrictions.

- Right to know: You have a right to know if any PHI has been shared as described in sections II and III. These circumstances will be discussed with you and should not be of surprise.

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V. Psychologist's Duties

The following are some of my professional duties regarding your PHI:

- I am required to maintain the privacy of your PHI, to provide you with a legal notice (this form) of this duty and the privacy practices related to your PHI.
- I reserve the right to change these policies, however, I must abide by them unless I have notified you of any changes.
- I must provide you with written information about any changes these privacy practices.

VI. The Right to File a Complaint

You have the right to file a complaint if you believe your privacy rights have been violated. You must do so in writing, and may address it directly to Dr. Sadatrafiei or to the Secretary of the Department of Health and Human Services (address: Office for Civil Rights, 200 Independence Ave., S.W., Washington, D.C. 20201). Filling a complaint will not change the health care provide by this office in any way. If you have questions or concerns about this notice or your health information privacy, please do not hesitate to contact Dr. Sadatrafiei at (858) 34205514.

VII. Internet and Mobile Phone Use

In the event that you and I correspond via the Internet or mobile phones, it is important that you are aware of the limits of confidentiality related to these devices. Although all possible efforts will be made to ensure you PHI is maintained, they are not 100% protected from outside interference. You have the right to request that information not be shared in this way.

Your signature indicates that you have read and understand the above information. Please feel comfortable to discuss any and al issues that may not yet be clear prior to signing

_____ _____

Client Signature Date

My signature indicates that we have discussed this information and related questions regarding the use and disclosure of your PHI.

_____ _____

Therapist Signature Date

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COUNSELING CONTRACT

PATIENT AGREEMENT: I agree to attend the scheduled appointments with all designated family members. Regular sessions are 45 minutes in length. We, the undersigned parent(s) or legal guardian(s)_____a minor, do hereby consent to counseling services by the above-named counselor. This authorization shall remain in effect until revoked in writing by the undersigned.

APPOINTMENTS: Time is reserved for your therapy session by agreement with you. If you need to cancel or change an appointment time, please give 24 hours advance notice. **Cancellation without 24 hours advance notice will result in you being charged for the session.** Three (3) or more late cancellations or "no shows" may result in termination of treatment. Please help us to serve you better by keeping scheduled appointments. This fee is NOT covered by insurance, so it will be your personal responsibility.

Patient hereby agrees to a No Show or Late Cancellation fees of: $ 75.00_____(patient initials)

CONFIDENTIALITY: My legal and ethical responsibilities require that our sessions remain confidential. As a result, I will only release clinical information to another professional or agency with your written consent. Only necessary or pertinent information will be shared with written authorization. There are some exceptions under which I am required by law to share information with specific
outside parties. These situations would include actual or potentially dangerous behavior towards yourself, towards others or in the case of child abuse.

PATIENT AUTHORIZATION: It is with my full understanding and consent that information about my case may be exchanged with Zohreh N. Sadatrafiei, PsyD, MFT (aka "Dr Nikoo") and her staff in the capacity of providing assessment and referral, billing and collecting fees and offering ancillary recovery services.

STATEMENT OF FINANCIAL ARRANGEMENTS FOR PROFESSIONAL SERVICES RENDERED: Please read this document carefully, for it describes the financial policy of this office. Any exceptions to this policy must be in writing and signed by all parties involved. It is expected that full payment will be made at the time services are rendered, in the form of cash, check or money order. If special arrangements are necessary, these need to be discussed with Zohreh N. Sadatrafiei, PsyD, MFT (aka "Dr Nikoo") in advance. It is understood that you are responsible for any charges made. Payment for all co-payments, co-insurance or deductible is expected at time of service. It is also understood that, if for any reason, the insurance company does not pay the full amount verified, denies any charges for services that are rendered or if the yearly or lifetime maximum amount is exceeded, that any remaining balance will be the full responsibility of the patient. Any services not covered by insurance or done outside of session time, such as, but not limited to, reviews with managed care, consultations, report writing, etc., will be at my regular fee rate. My regular fees are $125 per therapy session (regular sessions are 45 minutes in length).

FINANCE CHARGES: If patient balances are not paid on date of service, finance charges will be applied. Finance charges are not covered by insurance, so it will be your personal responsibility.

RETURNED CHECKS or PAST DUE ACCOUNTS: For checks returned as unpaid by your bank, a $25.00 service fee will be applied. Overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account. I am generally available via telephone in case of an urgent or emergency situation which cannot wait until our regular scheduled session. Please remember, I may not be able to return your call immediately. When I am out of town, I will generally have another therapist answering calls for me.

I have completely read, fully understand and agree to the above terms and information. I understand and agree to the Financial Policy.

Signature of Patient_____Date: _____

Signature of Parent / Legal Guardian_____Date ----------

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Page 1 of 2)

1. **Client's name**: _____
2. **Date of Birth**: ____/____/____
3. **Date authorization initiated:** ____/____/____
4. **Authorization initiated by**: _____
   Name (client, provider or other)
5. **Information to be released**:

   ____ Authorization for Psychotherapy Notes ONLY (**Important**: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

   ____ Other (describe information in detail): _____

6. **Purpose of Disclosure** The reason I am authorizing release is:

   ____ My request

7. **Person(s) Authorized to Make the Disclosure**: _____
8. **Person(s) Authorized to Receive the Disclosure**: _____
9. **This Authorization will expire on____/___/___or upon the happening of the following event**:

   _____

10. **Authorization and Signature**: I authorize the release of my confidential protected health information, as described in my above directions. I understand that this authorization is voluntary, that the information to be disclosed is protected by law and the use/disclosure is to be made to conform to my directions. The recipient may re-disclose the information that is used and/or disclosed pursuant to this authorization, unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Date:_____ Signature of Patient: _____

Name & Signature of Personal Representative:_____Relationship: _____

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PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("***HIPAA***").

1. Tell your counselor if you don't understand this authorization, and the counselor will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address: **Dr. Nikoo (Zohreh N. Sadatrafiei, PsyD, MFT) at 731 S. Hwy 101, Ste 1-E, Room 9, Solana Beach, CA 92075**.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, then you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following:
(a) medication prescription and monitoring, (b) counseling session start and stop times,
(c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and
(e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

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TREATMENT PLAN

Client Name:_____ Client #: _____

Session Date:_____ Attendees: _____

Target Problem(s): _____

Specific Counseling Goal(s): _____

_____

_____

Specific Strategies and Interventions: *(Define in specific terms and time frames include homework assignments and treatment coordination)*

_____

_____

Treatment Coordination: (*Check all appropriate boxes when coordination is needed to meet goals, then note when the meeting occurred and what transpired. * Use additional blank pages is more notes are needed)*

1. ☐ Communicate with Primary Care Physician? _____
2. ☐ Communicate with other treatment providers? _____
3. ☐ Request records from previous counseling? _____
4. ☐ Communicate with client's school or other agencies? _____
5. ☐ Involve family members in treatment?

My signature indicates I have participated in the development of this counseling plan and agree with the recommended goals and interventions.

I would like a copy of my treatment plan: ☐ YES ☐ NO

_____ _____ _____

Client/Parent/Guardian Printed Name Client/Parent/Guardian Signature Date

_____ _____ _____

Clinician Printed Name/Credentials Clinician Signature Date

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RELEASE OF INFORMATION

Your signature given permission allows me to communicate with the following individuals, agencies, or insurance companies on your behalf.

Individual/s or group to be contacted

Located at _____

Phone_____Fax _____

I_____, born on _____
(Print your full name)

Hereby authorize Dr. Nikoo Z. Sadatrafiei to disclose/obtain (circle one or both) the following information from clinical records:

_____ Entire Record _____Diagnosis & dates of treatment

_____ Summary of treatment _____Psychological Evaluation

_____ History & background _____HIV status, if relevant

_____ Complete treatment records _____Substance abuse history

_____ Other _____

about me/my child _____
(Child's full name)

for the following purposes: _____

This authorization and request to disclose or obtain information from records will expire **one (1) year** from the date on which it was signed. I agree that a photocopy of this release form is acceptable. I understand that I have the right to receive a copy of this authorization upon my request.

_____ _____ _____
Printed Name Date Signature of client/guardian

Relationship to client: Self____Guardian_____Parent of Minor___Other _____

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MINOR CONFIDENTIALITY

Confidentiality means privacy. You are assured of privacy in my office. This means that I cannot repeat anything **YOU** say to anyone else **UNLESS** you tell me I can and /or your parent signs a form called Release of Information telling me I can do so.

There are some RULES to Confidentiality. Here they are:

1. Your mom or dad can tell me whatever they want to. I listen but cannot tell them things you have said to me (unless you say I can).

2. You can tell your mom or dad anything we say or do in my office OR tell them nothing at all. That is up to you.

3. If we are working on something together, like a goal, I may tell them about the goal (with your permission) so that can know what you are working on.

4. If you tell your dad or mom something I have said and they are confused about it, they can call me and ask me to CLARIFY what I have said.

Lastly, there are some important exceptions that I HAVE to report to authorities. The law requires that I notify others if I have reasonable cause to believe…

1. You plan to hurt yourself
2. You plan to hurt someone else
3. Some other adult is hurting you or your body
4. If a court or judge asks me to share my notes about our work

Your signature means that you understand and agree with these rules.

Client/Minor Full Name	Signature	Date
Therapist Name	Signature	Date

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ADULT CONFIDENTIALITY

You are assured of confidentiality. Only a Release of Information form signed by you my authorize me to discuss information with other individuals. You can revoke this authorization anytime. Also, that I know you or how I know you is confidential. If I see you out on the world, I will not acknowledge you unless you initiate contact. Below are important exceptions to confidentiality that re legally mandated:

1. The law requires that I notify others if I have reasonable cause to believe that a client is a danger to others and disclosure is necessary to prevent the threatened danger.

2. I am also obligated by law to report any suspected child or elder abuse, neglect or molestation, or any other crime against a minor under the age of 18, to protect the children or elders involved. This includes reasonable suspicion that a child has witnessed domestic violence.

3. If I assess a client to be a danger to self, or unable to take care of him or herself.

4. Some legal actions initiated by the patient or the patient's estate may result in the court ordering the release of records.

IF THE CLIENT IS A MINOR, THEIR CONSENT IS REQUIRED BEFORE I CONVERSE WITH A PARENT ABOUT ALL TOPICS INCLUDING DRUGS AND ALCOHOL UNLESS ANY OF THE ABOUVE 4 POINS APPLY.

Lastly, as parent of a minor client, **YOU** can tell **ME** whatever information you deem pertinent to treatment. You can also ask me to clarify something I may have said to your child during a session. If I am working on goals with your minor, I will keep you informed (with their consent) of the work we are doing in session and may invite you into sessions as needed.

My signature indicates that I have received a copy of the above material, have read it and agree to abide by its terms. I understand that I may question this or any other therapeutic procedure at any time

_____ _____ _____
Client Full Name Signature Date

_____ _____
Therapist Signature Date

A Balanced Communication

LMFT# 91316
731 Hwy 101, Suite # 1E
Solana Beach, CA 92075
(858) 342-5514

Legal Case Agreement

I understand that I am receiving individual therapy from Zohreh Nikoo Sadatrafiei, Psy.D. My therapist is providing treatment with goals that will facilitate me to learn new coping skills to develop better mental health stability and move positively towards my goals. I fully and completely understand that my therapist is providing treatment and is not acting as an evaluator for any legal cases.

I further understand that my therapist is not conducting a legal mediation or evaluation for me. I agree not to involve my therapist in any legal cases that I am involved outside my therapy treatment, as I understand that this would not be in the best interest of my treatment with my therapist and that this would be counterproductive to the therapeutic process.

I agree not to involve my therapist in court proceedings regarding any legal procedures or therapy treatment of me now or in the future. I understand that if my therapist is subpoenaed to court that my therapist will be considered an unfriendly witness and that my therapist will charge a full 8 hour session rate at $200.00 per hour, or $1000.00 per day payable in advance.

I understand that my therapist has more clients than just me, and that their well being is equally important.

I agree not to ask my therapist to share any of my confidential records regarding such proceedings. This is for the wellbeing of me and for their own emotional security.

Client's Name _____ Client's Signature _____ _____ Date

_____ _____
Zohreh Sadatrafiei, Psy.D LMFT Date