Tessa Magill M.S., L.M.F.T. #98868 (805) 633-0848

INTAKE PACKET

Today's Date: _____

Clients name:_____Referred by:_____

Age:_____Date of birth:_____Marital status:_____

Spouse/partners name:_____Date of birth:_____

Address:_____

City: _____State: _____Zip: _____

Main phone:_____E-mail:_____

Primary M.D.:_____Phone:_____

Emergency Contact: _____ Emergency Phone: _____

Health Insurance Company: _____Member ID #: _____

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OFFICE POLICIES

Payment: Full payment for service is due at the end of each session unless other prior arrangements have been made. Please notify us if any problem arises during therapy regarding your ability to pay for services and/or co-payments.

Cancellation: Please inform me at least ***48 hours in advance*** of any appointment you must miss. Failure to abide to this policy more than once may result in a late fee or all future appointments being canceled. Late cancelations (under a 48 hrs.) or no shows are subject to a **Fee of half your session fee,** to be paid before rescheduling. We are not allowed to bill your insurance company for missed appointments.

Confidentiality: All information disclosed within sessions, including that of a minor, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law.
Disclosure may be required in the following circumstances:
1. When there is reasonable suspicion of abuse of a child or a dependent or elder adult.
2. When the client communicates a threat of bodily injury to others.
3. When the client is suicidal.
4. When disclosure is required pursuant to a legal proceeding (e.g., court subpoena). The Notice of Privacy Practices (attached) provides specifics on safeguarding your information.

Emergency Procedures: If you need to contact me between sessions, please call my phone number provided. If you cannot reach me, please leave a message. Reasonable effort will be exerted to return your call as quickly as possible.
If you cannot reach me and/or it is a true emergency, please call 911.

I acknowledge that I have carefully read and understand the above policies and procedures and agree to comply with them.

PRINT NAME: _____ DATE: _____SIGNATURE: _____
Client or Parent/Guardian

PRINT NAME: _____ DATE: _____SIGNATURE: _____
Client or Parent/Guardian

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CONSENT FOR TREATMENT

I, _____

(PLEASE PRINT NAME: CLIENT **OR** PARENT/GUARDIAN) authorize and request **Tessa Magill,** a Licensed California Marriage & Family Therapist, to provide psychological examinations, treatment and/or diagnostic procedures, which, now or during the course of my/my child's care as a client, are deemed advisable. The frequency and type of treatment will be decided between the therapist and me.

Please initial that you understand each of the statements below:

_____ I understand that the purpose of such procedures will be explained to me and be subject to my verbal agreement.

_____ I understand that, while there is an expectation that I/my child will benefit from psychotherapy, there is no guarantee that this will occur.

_____ I understand that maximum benefit will occur with consistent attendance and that I may feel conflicted about my/my child's therapy as the process, at times, can be uncomfortable.

I have read and fully understand this Consent for Treatment form

PRINT NAME: _____ DATE: _____SIGNATURE: _____
Client or Parent/Guardian

PRINT NAME: _____ DATE: _____SIGNATURE: _____
Client or Parent/Guardian

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, CONSENT FOR TREATMENT AND OFFICE POLICIES

By signing this form, you acknowledge receipt of my Notice of Privacy Practices, and executed copies of the Consent for Treatment and Office Policies forms that I have given to you.

We have reviewed the Consent for Treatment and Office Policies forms.
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 as listed above.

If you have any questions about my Notice of Privacy Practices, please contact me.

I acknowledge receipt of the Notice of Privacy Practices and executed copies of the Consent for Treatment and Office Policies.

PRINT NAME: _____ DATE: _____SIGNATURE: _____
Client or Parent/Guardian

For Clinician Only _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, CONSENT FOR TREATMENT AND OFFICE POLICIES FORMS

I made good faith attempts to obtain my client's acknowledgement of receipt of my Notice of Privacy Practices, Consent for Treatment and Office Policies forms.
However, because of _____,
I was unable to obtain my client's acknowledgement.

Clinician Signature : _____ Date: _____

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INFORMED CONSENT & AGREEMENT FOR PSYCHOTHERAPY SERVICES

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. The therapy varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address such as by exploring and evaluating the various facets of your life, which include your thoughts, beliefs, behaviors, lifestyle and goals. Psychotherapy is not like a medical doctor visit; instead it requires a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Together, we will identify and agree upon goals for therapy.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

RELATIONSHIPS WITH THE THERAPIST

The therapeutic relationship is a unique relationship and is different than most relationships. It is different in how long it last, the topics we discuss, the goals we set and how we interact both inside and outside the therapy office. In order to maintain professional boundaries, I will not be your supervisor, teacher or evaluator. I will not give legal, medical or financial advice and I will not have any other business relationship with you. Therapists are required to keep the identity of our clients confidential. If we see each other in public, we may decline to acknowledge each other. You may chose to greet me, and I will respond, but you do not need to introduce me to anyone present. Due to the nature of living in a small town, there may be individuals we may mutually know. Even if you have

shared with them that I am your therapist, I will not divulge our relationship. Lastly, when therapy is complete, I will not be able to socialize with you.

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. If you need to cancel or reschedule a session, I ask that you provide me with 48 hours notice. If you miss a session without canceling, or cancel with less than 48 hours notice, my policy is to charge a fine per office policy (unless we both agree that you were unable to attend due to circumstances beyond your control). In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

In addition to weekly appointments, it is my practice to charge on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

CONTACTING ME

I am often not immediately available by telephone. I do not answer my phone when I am with clients or between the hours of 9PM and 9AM. If you experience a crisis or an emergency call 911 or the Ventura County Crisis Line 1-866-998-2243. You may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) Call 911, or 2) go to your Local Hospital Emergency Room, and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences and make appropriate arrangements.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision

reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY
My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. I will discuss with you the limits to confidentiality and will provide you with a copy of the document entitled Notice of Privacy Practices for you to keep for your review at any time. Please remember that you may reopen the conversation at any time during our work together.

OTHER RIGHTS
If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

TERMINATION OF THERAPY
The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. It is best to discuss this in a planned termination session if at all possible.

CONSENT TO PSYCHOTHERAPY
Your signature below indicates that you have read and fully understand this Agreement and agree to their terms.

PRINT NAME: _____ DATE: _____SIGNATURE: _____
Client or Parent/Guardian

Tessa Magill M.S., L.M.F.T. #98868 (805) 633-0848

Tessa Magill, LMFT
GOOD FAITH ESTIMATE

As of January 2022, I am required by law to provide an estimate of costs to any client who is uninsured or not billing insurance for my services. I need nothing back from you; this is only for your records. This estimate in no way obligates you to obtain services, but is required so there are "no surprises" from me as a licensed healthcare provider.

Primary Service: Psychotherapy
Service Code: 90837/ 90837.95 (Individual visit/Telehealth visit)
Diagnostic Code: F43.20
Tessa Magill, CA LMFT 98868
NPI: 1568856540

The fee for a 45-50 minute psychotherapy visit is $140. Depending on your changing and evolving needs, the following are estimates of charges:
• If we have 12 sessions this year, approximately once a month at $140 per session, your estimated total cost will be $1,680.
• If we have 24 sessions this year, approximately twice a month at $100 per session, your estimated total costs will be $3,360.
• If we have 48 sessions this year, approximately four sessions per month at $100 per session, your estimated total costs will be $6,720.

You have the right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges). If you have any questions about this, please let me know.

For more information about your right to a Good Faith Estimate or the dispute process, visit https://www.cms.gov/nosurprises/consumers or call 1- 800-985-3059. The initiation of the patient-provider dispute resolution process will not adversely affect the quality of the services furnished to you.