Introduction to intake packet 10-20-19 (revision date)

Hello prospective new client,

Attached is the intake packet. Please print it out single-sided and fill it out. Bring it to your first appointment rather than emailing it back to me, as it will have confidential information on it at that point. The last five pages are your HIPAA (privacy act) packet. There is nothing to fill out there. Please read it and ask me any questions you may have about HIPAA.

The intake packet is lengthy because, to the best of my knowledge, it contains every question the different insurance companies want answered at a first appointment. However, ***if you find some of the questions too sensitive to answer before meeting me, leave them blank and we can discuss them when we meet.***

And some of the questions may sound unusual, such as "Do you have pets?" However, there are insurance companies which include that question in their assessment requirements.

Most insurance companies are managed care companies and requesting that you fill out an intake form is one way they manage the care. Also, the more complete information you share with me, the better you and I can work together to help you reach your goals.

If there isn't sufficient room on the form to answer a particular question, print out a blank page and add the information there.

If you don't wish to fill out this emailed or downloaded intake packet, one will be provided for you half an hour before your first appointment. It will be on a clipboard in the waiting room (there is no receptionist). Just let us know the day before your appointment that you'll be coming in to fill out the intake packet.

Whether emailed, downloaded, or filled-out in person, each intake packet contains the following:

- *This introductory letter (1 page)*
- *Intake packet counseling guidelines 2010 (4 pages)*
- *Intake_form_June_09 (4 pages)*
- *Medication_ form_ june_ 09 (2 pages)*
- *Release form 09-26-2010 to insurance company (1 page)*
- *HICFA billing form to insurance companies (1 page with a 2nd. page explaining the form)*
- *HIPAA (2 pages to fill out; 5 page HIPAA packet to read)*

Thank You,
Mike Fatula MS, LMFT

Welcome to counseling... Mike Fatula, MS, MFT (Licensed Marriage & Family Therapist M15257), is **a sole proprietor in private practice** and is **not** associated with any other therapists in this suite of offices or in his other suite of offices. **He has a post-master's degree license in Marriage & Family Therapy**. While this license includes providing counseling to individuals, couples, families and groups, he currently limits his practice to adults: individuals and couples.

This intake packet, counseling, and records associated with counseling are **generally confidential; however**, **there are exceptions to confidentiality**, including, but not limited to, the following (while the following reads "abuse,", it may also include neglect and endangerment): child abuse; elder abuse; dependent adult abuse; if you seriously threaten to harm yourself, others, or property; or when your mental state is at issue in a legal proceeding (e.g., trial). If you apply for some types of insurance, including but not limited to life insurance, disability insurance, or worker's compensation benefits, a copy of your records could be requested with your signed consent. A more detailed description of exceptions to confidentiality appears in the **HIPAA packet** (the "privacy act" regarding confidentiality & exceptions to confidentiality of your Protected Health Information), which I will give you today. Records are maintained for a period of seven to ten years. After that time, records are destroyed in a confidential manner. Also, there are particular guidelines for confidentiality which are followed when a patient dies.

If your counseling is funded in part or entirely by an insurance/managed care company (including Employee Assistance Programs), some or all of the intake, chart, and progress **notes may be shared** with them at the time of diagnosis & assessment, billing, renewal requests (requests for additional sessions), and chart audits. **If you have been mandated to attend counseling by your employer or the courts, I no longer see clients who are mandated referrals.**

The length of a session is 50 minutes and the frequency is usually once a week. More often than weekly sessions usually requires permission from the insurance company. Generally, it is better not to leave an unsupervised child, dependent adult, (or pet) in **the waiting room** to wait for you, or bring them into your counseling session, unless there is a therapeutic reason to bring them in. Please discuss the reason with me before bringing someone into the session, as we will need to determine together, before the session, whether or not the purpose for them coming is a therapeutic purpose.

Should you need to cancel an appointment, please give 24-hour notice (e.g., if your appointment is for 2pm Wednesday, call by 2pm Tuesday, not Tuesday night). Please let me know of cancellations 24 hours in advance at the latest. That is, call me anytime to cancel, as soon as you know, at 323-422-9433.
I need to know about Monday cancellations by the previous Friday. If you cancel late or fail to keep an appointment without notice, you will be charged the full contract rate or the "late cancel/no show rate" designated by your insurance company, (e.g., if your copay is $20 and the full contract rate is $90, you will probably be charged $90 not $20 for a late cancel or no show, unless your insurance company specifies otherwise)...

Rarely, insurance companies pay for late cancel/no shows. Late cancels/no shows are usually the patient's responsibility. I can never bill your insurance company as if you attended an appointment. Also, insurance companies usually do not pay for telephone sessions. They usually only pay for one face-to-face session/ day (not for double sessions or two sessions in the same day).

If you need a letter or telephone call (e.g., to the court/employers/schools/licensing boards, "leave of absence," "return to work," etc.) **documenting that you are attending counseling, please mention this before the first session, as we need to discuss the appropriate source of the letter or telephone call. If I am the appropriate source**, I may need time to provide the letter or call. (In some cases, depending on the time required for the letter, etc., there might be a charge.) Also, **if you are now on worker's compensation or disability or planning to file**, please inform me before the first session. And **if you are attending counseling as part of a legal case** you are preparing, or a case that is currently in process, please inform me of this before the first session.

Once individual counseling has begun please do not bring a family member (spouse or child) or another person into counseling without discussing it with me in your individual session first.
Once conjoint counseling (couples counseling) has begun, please do not come individually without discussing with me first. In couples counseling, if a spouse is late (or cannot attend), I do not generally meet with one spouse until the other spouse arrives, as this may change the context of couples counseling to individual counseling.

If counseling begins as individual counseling, I usually continue seeing only the individual. And ***if counseling begins as couple counseling***, I usually continue seeing only the couple as a couple. I do not switch from individual to couples counseling, or vice versa, unless I see it as therapeutically necessary. However, this is not the policy or perspective of all therapists.

Sometimes, especially at the start of counseling, problems can seem to worsen before they get better. While problems usually improve over time, counseling is not a guarantee of improvement or resolution of problems. **Let me know if you're feeling worse or if you feel you are not making progress toward your goals.**
In couples counseling, one spouse sometimes **initiates** counseling to get help with the other spouse's problems. However, both spouses share most relationship problems and the spouse who initiated counseling may learn, after starting counseling, that s/he is contributing to the difficulties as well as the good in the relationship. Also, sometimes one spouse **has more history** of counseling than the other but the spouse with more of a history of counseling, personal growth workshops, etc., can still also be contributing to the couple's current difficulties. Therapeutic modalities I employ include (but are not limited to) behavioral, supportive, and ISTDP (intensive, short-term, dynamic psychotherapy… see DAVIDWOLFFMD.COM website for further information). These approaches hopefully provide support and challenge to help you achieve your goals.

I do not do psychological testing or "neuropsychological evaluations."(cognitive, dementia, ADD, or personality assessments). And I usually don't do "emotional security animal assessments."

Except for mandated referrals, you are not required to attend counseling and you may terminate at any time. If you have any complaints or concerns during the course of counseling, regarding services through this office or through your insurance company, please bring them up to me first. If I cannot resolve them, I will inform you of the process for you to resolve them through your insurance company (appeals, etc). Also, if you wish to change therapists during the course of treatment, you have a right to do so. Simply inform me and then inform your insurance company.

Please do not call in between sessions to discuss your spouse's issues/information or your issues/information, **unless there is a true psychological emergency.** Counseling should occur in the context of the session. I support a "no secrets" policy in couples counseling, i.e., if you call and discuss information about yourself or anyone involved in counseling with you (or communicate information in other ways such as voicemail/email/letter), I may ask you to acknowledge the communication at the next couples counseling session. **I am on-call for psychological emergencies**, including nighttime and weekends. Call 323-422-9433 or 323-876-8861. **However, if you're experiencing a life-threatening psychological emergency, that cannot wait for a response from me in the time needed (particularly over night or on weekends), go to your nearest emergency room, call 911, or call LA Crisis Line at 877-727-4747**

While I'm on vacation, there is a backup licensed therapist covering for me. You can call the main number/s and leave the information on my machine and then ***call the backup therapist*** (their tel# will be on my outgoing message). If you can't wait for a return call from them, go to the nearest emergency room, call 911, or call LA Crisis Line at 877-727-4747.

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There may be a **need for me to contact other providers** (physician, psychiatrist, hospital, past therapists etc.) who are providing care to you now or have provided care for you in the past. I will ask you to sign a release form prior to contacting these professionals. (However, please note that a signed release may not be necessary to share information and coordinate care between the professionals providing care to you, particularly in emergencies.) Also, your insurance/managed care company may request that I coordinate care with other professionals, particularly when you're taking psychotropic medications or if you have a physical illness that could impact emotional/cognitive functioning.

Please note that I may seek **consultation/supervision** from other therapists, from time to time, in which case, I may not need your written consent.

Your EAP (employee assistance company) or your insurance/managed care company may require a **pre-authorization** before your first visit with me. In this case, **you need to**

initiate the authorization by calling the tel# for mental health on the back of your insurance card. (Some companies require that you meet with your physician first and that s/he initiate the referral to me for counseling.)

While my billing company will verify your insurance benefit before your first appointment, it is your responsibility to also verify your benefits and *notify me of changes* which may include but not be limited to the following: 1) pre-authorization; 2) eligibility; 3) deductible (often it is a combined mental and physical health deductible)**; 4) copays** (constant or tiered)**; and 5) max# of sessions per benefit/calendar year** (sometimes the max is shared with your psychiatrist).
I can accept Medi-Cal; however, I cannot accept Medi-Care. If an insurance company denies payment for services provided by me, then you, the patient, may be responsible to pay, depending on the guidelines of the particular insurance company. Also, **let me know if your insurance company** (or type of plan) **changes** during the course of treatment. Let me know, also, if your medications (for physical and mental health) change during the course of treatment with me or if your address and/or contact information changes.

Your full session fee or contracted **copay is payable at the end of each session**. Please pay by check (only if necessary on occasion, cash). I cannot accept credit or debit cards. If requested, a monthly statement of payments can be provided to you for tax purposes or if you have a "health services account," or "health savings account."
Should you terminate counseling without paying a balance within a reasonable time, and I have notified you about the balance, a collections process could be initiated. In that event, confidentiality will be maintained in accordance with provisions for psychotherapists to collect unpaid balances.

There is a **client parking** space marked "FATULA" in the gated lot **behind the West Hollywood office building**. The car of the person before you may still be there when you arrive. If you don't wish to wait, there is free parking on residential streets east and west of LaCienega during most days (read parking hour restriction signs) and metered parking on LaCienega. **Please don't park in the parking lot spot past your session time**, as the next person/s will need to park there.
There is **no parking for clients in the lot behind the Ventura Blvd. office**. There should be **ample metered parking on Ventura Blvd. or on the residential streets** one block south of the office (try Rhodes first and read parking hour restriction signs).
If you understand and agree to these counseling practice guidelines, **please sign your name**, print your name with date of birth, below.

I authorize and request Mike Fatula MS, MFT, to perform psychological treatment as mutually deemed advisable and necessary by me, Mike Fatula, and my insurance company (if I am using my insurance to cover this service).
If you have any questions, please ask me before signing. Signature indicates understanding and agreement to these four pages:
print name and DOB: **sign name:**
today's date

INTAKE FORM
Mike Fatula, MS, MFT

About You ... (rev 04-27-14) please do not leave any question blank: write yes, no, or N/A (not applicable)

Your full name_____Social Sec#_____

Today's date _____ Date of birth_____Age _____Insurance member ID# _____

Reason seeking counseling today, symptoms_____severity: MILD MODERATE SEVERE
Length of time you've experienced symptoms _____
Goals & timelines to achieve goals to reduce symptoms _____
Any concerns or fears regarding counseling?_____

Your home address (apt #) and zip _____ email_____
Your Phone #1 _____ Your Phone #2. _____
Is this ... Cell Home Work (circle one) Is this ... Cell Home Work (circle one)

Emergency Contact Name & relation to you_____ Ph# _____
Other professionals treating you, to contact in emergency_____ Ph#_____

Insurance Coverage ... Are you the insured? Yes No If no, what is insured's name? _____

How is the insured related to you? (Circle one) Spouse/Partner/Parent/Child/Other _____

INSURED's member id# _____ group #_____ date of birth _____ employer of insured_____
Is there more than one insurance policy for you (ex: EAP)? Provide the same data for that policy as above:

Your Background ... Current Employer & length of employment_____ If unemployed, please describe period of unemployment _____ Your current occupation _____

Last year of schooling completed _____ Who referred you to Mike Fatula? _____

Have you ever struggled with emotional/psychological issues before? Yes No (circle one)

If yes, what was the concern? _____
(example: anxiety, depression, mood swings, manic episodes, manic-depressive or bipolar, obsessive-compulsive, attention deficit, learning disabilities, panic attacks, suicidal thoughts or attempts, cutting or self-mutilation, eating issues such as anorexia, bulimia, over-eating)

Have you been to counseling for these issues *in the past*? Yes No (circle one)

If yes, how long did you attend counseling, with whom (license, address, tel#); & what year/s? What type of therapy/ how helpful/ any particularly positive or negative experiences? What was the reason for seeking counseling? May I contact the therapist/s? Yes No _____

Are you in counseling with any other therapist *currently* (marital/ /individual/ hypnotherapy/biofeedback)
_____

Have you ever been hospitalized for these issues? Yes No (circle one)/ If yes, primary treating Dr. _____

If yes, how long, when, and where were you hospitalized? _____

Has anyone in your family (at least 2 generations back) ever struggled with emotional/psychological issues? Yes No (circle one)

How are they related to you (parents, maternal or paternal grandparents, children), and what were they struggling with? (example: mother-depression) _____

Double-sided: Turn Over
→ → → → →

_____
Full Name (printed)

Date of Birth _____

Background cont'd, pg 2----------

Do you currently experience any of the following? Circle relevant description items below:

Trouble *sleeping*? Yes No ***Eating*** **problems? Yes No**

Circle (falling/staying asleep/early awakenings) **Circle (low appetite, anorexia, bulimia, over-eat?)**

Length of time you've had sleeping difficulty _____ **Length of time you've had eating difficulty**_____

Do you have any history or current alcohol or drug abuse? Yes No (circle one)

Which substance(s)? _____1

Did you receive treatment? Yes No (circle one)

If yes, what kind of treatment? _____

(12-step, therapy, outpatient treatment, detox, residential rehabilitation/hospitalization, medication)

Does anyone in your family (at least 2 generations back) have a history or current alcohol or drug abuse?

Yes No (circle one)

How are they related, and what drugs were/are they struggling with? _____

_____

Do you currently (or have you in the past)... Smoke cigarettes? Yes No

Drink caffeinated beverages? Yes No (#/ size of cups of coffee, tea, soft drinks with caffeine daily)_____

Drink alcoholic beverages? Yes No (#/ size & type of glasses/bottles of alcohol daily)_____

Frequency of alcoholic intake (is your alcohol intake a problem for you? for anyone else?)_____

_____

Use "recreational drugs?" Yes No Which drugs, frequency, (indicate now or in the past)? Is this use a problem for you or anyone else? _____

Do you have any physical illnesses that interfere with your life, (now or in the past)? Yes No (circle one)

(ex: thyroid, diabetes I or II?; blood pressure, heart, liver, headaches, migraines, menstrual, gastro-intestinal, IBS, chronic pain, etc.) if yes, describe:

_____

Have you ever been hospitalized for physical illness or had any surgeries? Yes No If yes, describe:

_____

Any ALLERGIES to medication/ to foods/ respiratory or skin allergies? _____

Date of last physical exam _____**relevant findings** _____

Name (& telephone #) of primary care physician _____

Name (& telephone #) of specialist physicians/providers _____

Do you consent or refuse consent for the release of information with your doctor/s & other providers?
circle one: consent refuse ...(please specify with whom you consent or refuse release of information)

_____

Are there any legal incidents or law suits that have affected or will affect your life, including childhood? (e.g., juvenile detention; divorce/custody proceedings; DUI; restraining order; charges filed against you; charges filed by you against someone else; arrests? Yes No (circle one) If Yes, please describe:_____

Full Name (printed)

Relationships (pg 3)… **Date of Birth _____**

Are you (circle one) Single/Married/Partnered/Registered Domestic Partners/Divorced/Separated/Widowed? (first marriage for you or spouse?_____how long have you been separated, divorced or widowed?_____

If married or partnered, for how long? _____ Spouse's occupation _____

If you have children, what are their names (genders) and ages (indicate if blended family i.e., step-parent, half-sibs or step-sibs).):

Are your parents … Single Married/Partnered Divorced Separated Widowed Deceased

Duration of your parents' marriage/partnership? _____ if parents divorced/separated, how old were you then_____; if parents are deceased, how old were you when they passed away _____

Who raised you primarily _____

List your siblings and their ages (indicate if blended family, i.e. step-parent, half-sibs or step-sibs).
***WHERE DO YOU FALL IN THE ORDER OF BIRTH* of your siblings (eldest, youngest, middle)?**

_____

_____

_____

Are your maternal grandparents… Single Married/Partnered Divorced Separated Widowed Deceased

Are your paternal grandparents… Single Married/Partnered Divorced Separated Widowed Deceased

Describe your social support system of friends & family. Do you think it is adequate to meet your needs now?

_____

Any other important things about *you*, your current family, or your extended *family*? (examples: ADOPTION; PRIOR PSYCHOLOGICALTESTINGAND/OR DIAGNOSES, problem pregnancies; incidence of post-partum depression; chronic or serious physical illness of a family member; problems at work; are you/were you in the military; are you from a military family? did your family move a lot and why: have you ever been a victim of a violent crime; have you ever been a caretaker for someone who was ill; describe your childhood and relationships with family then and now)… _____

Describe your strengths and weaknesses as they relate to you addressing your issues in therapy: _____

_____

how motivated you are to be in therapy: mild/moderate/strong; anyone pressure you to come?NO/YES, who?

What is your ethnic background? _____ Is there anything you would like me to understand regarding ethnicity, nationality, race, culture, sexuality, gender identity, sexual functioning issues, religion, or spirituality _____

_____

Are you currently on worker's compensation or any type of disability benefit (physical or mental health)? Are there claims pending or are you planning to file? Yes No (please describe)

_____

HOW TO CONTACT OUR OFFICES… At this time, ***please DO NOT contact the office by EMAIL OR TEXT, especially not for an emergency. Only contact us by phone and leave your telephone number every time you call,*** even if we already have it. This policy is requested due to concerns about confidentiality. In the future, we may add email communication for scheduling appointments—not for communicating with you about clinical information.

Initial understanding of how to contact us: ____ **Double-Side Page: please turn page over**

Full Name (printed)

Date of Birth _____

RISK ISSUES, PG. 4----------

Are there any current risk issues or history of risk issues (such as suicide or homicide) you want me to be aware of today? Please circle YES or NO.
If there are no risk issues and the examples below do not apply to you, please state here that they are not applicable. If there are risk issues (such as suicide or homicide), please describe them here_____

_____

Has anyone in your family (or have any friends) ever attempted or committed suicide? If yes, who?

Do you have any current or recent *thoughts* about harming or killing yourself (suicidal ideation) or anyone else (homicidal ideation)? If so, please describe these thoughts here (are they mild, moderate, or severe?) (are they occasional or frequent?) (do you think about them for a moment or for a long time?) And please talk to me about the thoughts in the first session after you describe them here: _____

_____

If you have thoughts, do you have a *plan*? _____ If yes, what is the plan?_____

_____

Do you *intend* to implement this plan?_____**If so, when?** _____

Do you have the *means* to implement this plan? _____

Do you have any prior suicide attempts or history of harming yourself or anyone else, including in adolescence or childhood? If yes, please describe the history here, including what circumstances led to the event: _____

Were you hospitalized during these attempts? ___ If so where, date, how long, primary dr's name _____

_____

****

Do you have any current or recent incidence of cutting behavior (cutting your skin) or pulling out your hair anywhere on your head or body or picking at your skin, particularly on your face?

_____

Or do you have persistent thoughts about these behaviors? _____

Do you have any history of these behaviors, including childhood or adolescence? _____

_____

****

Do you have any current or recent active eating disorder such as anorexia or bulimia? If so, p|lease describe here _____

_____

Or do you have persistent thoughts about these behaviors? _____

Do you have any history of eating disorders, including childhood or adolescence? _____

If you have no current/historic risk issues but this changes during treatment with me, please let me know.
Also, if you have current risk issues which worsen during treatment with me, let me know.
Please also mention, in session, any history of abuse (physical, sexual, incestuous, emotional/verbal).

MEDICATION
Mike Fatula, MS, MFT

Your full name & DOB _____ Today's date _____ (rev 04-27-14)

Mental Health Medications********

Do you *CURRENTLY* take medication(s) for emotional or psychological concerns? Yes No

What medication(s), dose/frequency; length of time taken/when started; how effective/ side effects; purpose for which meds were prescribed:

_____

_____

Which kind of MD or provider prescribed it? (circle one) MD Psychiatrist/ MD General Practitioner or Internist/ Physician Assistant/ Nurse Practitioner Other _____

Name, tel#, fax# of prescribing MD or provider _____

_____

Have you ever taken medication(s) for emotional or psychological concerns *IN THE PAST*? Yes No

What medication(s), dose/frequency; length of time taken/when started and stopped; how effective/ side effects; purpose for which meds were prescribed:) _____

_____

What MD or psychiatrist prescribed these past meds? _____

Physical Health Medications********

Do you *CURRENTLY* take medication(s) for physical concerns (such as sleep/diet/migraine, etc.)

Yes No (circle one)

What medication(s), dose/frequency; length of time taken/when started; how effective/ side effects; purpose for which meds were prescribed: _____

_____

Name and phone # of prescribing MD or provider _____

Did you take any important meds for physical concerns *IN THE PAST*? Yes No (circle one)
What medication(s), dose/frequency; length of time taken/when started and stopped; how effective/ side effects; purpose for which meds were prescribed and who prescribed the meds _____

_____

Double-sided: Turn Over
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Full Name (printed)

Date

Are you taking any hormones, such as estrogen, testosterone, steroids, etc.

Do you have moods/ mood swings related to menstrual cycle, hormone therapy, steroid use, drug/alcohol use; caffeine, etc.

Yes No (if yes, describe) _____

Are you on any diets or do you take any natural supplements (vitamins & minerals, fish oil, St John's Wort, SAM-e, melatonin, etc.) _____

Do you do any healthy sorts of activities/exercise such as cardiovascular, yoga, meditation

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Have you had any injuries to the head or brain in childhood or adulthood (concussions; "being knocked out"; accidents even if they didn't involve loss of consciousness such as falling from a tree or fence or bike; a sports injury; car or motorcycle accidents)

Have you or anyone in your family (at least 2 generations back) ever been formally diagnosed with a mental health diagnosis that you are aware of? If so, what was the diagnosis or diagnoses? Are there any past mental health diagnoses you disagree with? Have you or anyone in your family had any psychological testing in the past? If so, please describe, including the type of testing & reason for testing:

Have you or anyone in your family ever been diagnosed with a learning disability (such as dyslexia), or ADD, in childhood or adulthood?

Do you have any difficulty with attention, concentration, or memory (short/long-term)?

Is there any history in your family for a diagnosis of mental retardation?

Is there any family history for Alzheimer's or dementia? _____

Any other important things about your mental/physical health and your medication history?... _____

Release of Information Form (release form rev. 09-22-2013) This release form is confidential information intended for _____ and their colleagues only. ***If you are not one of these persons do not read further than the next two lines of instruction:*** please fax the release back to 323-876-8941 & shred it. Then please call 323-876-8861 to inform us of the error.

Doctor, insurance company, or other provider, please *respond in the way checked below:*
_____ **call Mike Fatula MFT at 323-422-9433 at ten minutes before any hour *OR***
_____ send records ***OR***
_____ call & send records.

X _____

PRINTED PATIENT NAME AND DATE OF BIRTH

1. I initial here ___ to affirm that I GIVE MY PERMISSION TO MIKE FATULA, MFT, TO RELEASE AND EXCHANGE ALL INFORMATION DESCRIBED IN THIS PARAGRAPH OR THE FOLLOWING INFORMATION AS SPECIFIED: diagnosis, symptoms and assessment___; treatment plan, goals, interventions, & timelines___; dates of service, fees, type of service___; client & family physical/mental health background and current status___; medications___; test results___; progress & prognosis___; summary of treatment___; termination of treatment___; WITH:

X _____ ***who is*** _____.
(print **name** of professional/agency/insurance company) (print **title** of professional/ agency/ or insurance company)

The professional's tel# _____ fax# _____.
The professional's address _____.

2. I initial here _____ to affirm that I ***also*** give my permission to the aforementioned professional (name) _____, to release and exchange information with Mike Fatula, MS, MFT. The exchange includes all the topics mentioned above OR only the following topics as specified here:

_____

I specifically ***do not give my permission*** to either party to discuss these topics:_____
_____.

THE PURPOSE OF SHARING INFORMATION BETWEEN MIKE FATULA MFT AND THE ABOVE PROFESSIONAL IS COORDINATION/CONTINUITY OF COUNSELING CARE AND _____

THE SPECIFIC LIMITATIONS ON USE OF THE INFORMATION BY MIKE FATULA MFT AND THE ABOVE PROFESSIONAL ARE COORDINATION/CONTINUITY OF COUNSELING CARE AND _____.

I understand I have a right to receive a copy of this authorization and that any modification or revocation of this authorization must be in writing. If I cannot read any of the print on this page, I will let Mike Fatula know before signing (patient) or before sharing information (provider).

X _____

PATIENT SIGNATURE (or signature of patient representative)/today's date/release valid 2 yrs.

signature of witness (Mike Fatula, MFT)

MIKE FATULA, MS, MFT Tel 323-422-9433; Fax 323-876-8941
Offices: 519 N LaCienega Blvd #16 LA CA 90048/ 12402 Ventura Blvd 2nd Fl. Studio City CA 91604

STAPLE IN THIS AREA

[redacted]

Name of Ins. Co.:
Authorization #:

PICA HIPAA restrictions:

HEALTH INSURANCE CLAIM FORM

PICA

Top of Form Fill-out Only

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)		a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITE
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) (1)	3. PATIENT'S BIRTH DATE MM DD YY SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) (2)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single Married Other	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? PLACE (State) YES NO	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. (3)

SIGNED

DATE (4)

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. (5)

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ / 29. AMOUNT PAID $ / 30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) rewrite left here you wish us to call:		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP# double-sided

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1218-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHA

00031750

rev. 11-27-2001

(fill-out #s 1-5 above only)

(HICFA)

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 [*insert telephone number*]. 323-876-8861 or 323-422-9433

If you have any questions about my *Notice of Privacy Practices,* please contact me at:

[*insert address and telephone number*].

* tel # above or addresses below

I acknowledge receipt ~~of the~~ *Notice of Privacy Practices* of *[name of covered entity]*.

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including [describe good faith attempts]. However, because of [*insert reasons why acknowledgement was not obtained*] I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____ Date: _____

* 519 N. La Cienega #16, LA 90048

or

12402 Ventura Blvd. 2nd Floor, STUDIO CITY 91604

REQUEST FOR RESTRICTION ON THE MANNER/METHOD OF CONFIDENTIAL COMMUNICATIONS

Date: _____

Name of Patient: _____

Date of Birth: _____

You may request to receive confidential communications of your protected health information ("PHI") from me by alternative means or at alternative addresses. For example, you may not want your appointment notices or your bill to go to your home where a family member might see it.

I cannot ask you the reason for your request, and I will accommodate all reasonable requests that you make.

If you make a special request, you must give me an alternative address or other method of contacting you (phone number, email address, etc.). Please specify how and where you wish to be contacted: if no restrictions, check box ☐

1. ____ By Mail at (*) _____
2. ____ By Telephone at _____
3. ____ By E-mail at _____
4. ____ Other: _____

Signature of patient or representative: _____

If representative, give relationship: _____

For more information about your privacy rights, see the "Notice of Privacy Practices" that was given to you by me.

For Provider Use Only

Request(s)Accepted: _____

Request(s) Denied: _____

Provider's Signature: _____

(*) if you leave a copay balance at the time of termination, the therapist will follow established procedure to collect the balance for 90 days/3 months. which may include a statement sent to your home

Notice of Privacy Practices

I. 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.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (*if applicable*). You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at (*insert website address, if applicable*).

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

2. To Obtain Payment for Treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. For Health Care Operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

4. Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.

3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.

4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to Family, Friends, or Others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Restrictions on My Uses and Disclosures. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. The Right to Choose How I Send PHI to You. You have the right to request that I send confidential information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is

reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Copy of Your PHI. In most cases, you have the right to inspect and copy the PHI that I that I have on you, but you must make the request to inspect and copy such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Receive a List of the Disclosures I Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003.

I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section Vl below. You also may 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. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: _____.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.