



Desert Marriage and Family Counseling Inc.

Personal Information

Client Name: _____

Date of Birth: _____ Social Security No. _____ Gender: _____

Marital status: Single / Married / Divorced / Widowed / Separated / Domestic Partner

Address: _____ City: _____ Zip: _____

Home phone: _____ Cell phone: _____

Email: _____

Emergency Contact -Relationship to client: _____

Name: _____ Phone: _____

Do you have a DNR Order? Yes / No. If so, who is your Power of Attorney?

Name: _____ Phone: _____

Primary Care Doctor -If any

Name: _____ Phone: _____

Client Signature: _____ Date: _____



Desert Marriage and Family Counseling Inc.

Patient Medical History

Current Medications

Medication

Prescribed Dosages

Substance Use/Abuse History

Substances	Amount	Duration	First Use	Last Use
Alcohol				
Cannabis				
Other				



Desert Marriage and Family Counseling Inc.

Consent for Treatment

I hereby authorize and request **Desert Marriage and Family Counseling** and/or its Designate to carry out psychiatric and psychological examination, evaluation, treatment and/or diagnostic procedures which now, or during my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that these are subject to my agreement. I fully understand that while the course of my treatment is designed to be helpful, **The Clinician** can make no guarantees whatsoever about the outcome of my treatment. I also understand that the psych pharmacotherapeutic process can initiate and bring up uncomfortable feelings and reactions including anxiety, sadness, anger and physical side effects. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be jointly worked on between my therapist and me.

Client Signature: _____ Date _____

GENERAL CONSENT TO TREATMENT IN CASE OF DEPENDENT/CHILD/MINOR

I am the legal guardian and/or representative of the client and on the client's behalf I legally authorize **Desert Marriage and Family Counseling** and /or its Designate to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

Signature of Guardian/Legal Representative: _____ Date: _____

Relationship to Client: _____

"This information has been disclosed to you from records protected by the federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains to or as otherwise permitted by 42 CFR part 2."



Desert Marriage and Family Counseling Inc.

Office Policies

1. Confidentiality:

Confidentiality is essential for effective psychiatric treatment. No information will be released without your consent, except for the following reasons: By law, I am required to report suspected child or elder abuse, domestic violence, and take action when a patient is considered to be a danger to themselves or others.

2. Payment Policy:

Scheduled appointment times are reserved specifically for you. **Failure to provide 24-hour cancellation notice or missed appointments will be billed and your credit card will automatically be charged a fee of \$75.00**

All Returned checks will be charged a fee of \$25.00

Additional fees not covered by your insurance policy can be charged. Some of these fees are not known until notification is sent to Desert Marriage and Family Counseling Inc, and/or you from the insurance company.

A credit card will be held on file to guarantee payment but will not be charged without notification.

3. Additional Services:

Services required outside of treatment session will be charged a fee. These could include consultations with other professionals, court appearances, and document preparation such as completing legal forms, conservatorship petitions, letters, etc.

4. Copy of Records:

Patients have the right to access their records. Written consent is not required. Children under the age of 18 hold the privilege of their records, and those records can only be released with the agreement of the young client.

The policy for releasing records to patients is detailed below:

- Records are released to client in summary form
- Records for minors are only released with the minor's consent
- The clinical director approves the release of all records from DMFC
- DMFC requests two full business days for release of summary records

"I have read, understand, and agree to the above policies."

Client Name: _____ Signature of Client: _____ Date: _____

(If the client is a minor or services are being paid for by other party, please sign below.)

Responsible Party Print Name: _____

Signature Of Responsible Party: _____ Date: _____



Desert Marriage and Family Counseling Inc.

Credit Card Information

I, _____ authorize Desert Marriage and Family Counseling Inc. to charge my credit card for outstanding balances on my account due to late cancellations, no show appointments, returned checks, credit cards charge backs and fees not collected from original time of service.

Name on Card: _____

Card #:

Grid for card number: 16 empty boxes

Visa | MasterCard | Discover | Amex | FSA/HSA

Exp Date: _____ Security Code: _____ Billing Address: _____

City: _____ State: _____ Zip: _____

Would you like a receipt emailed to you? Yes | No

Email address: _____

PLEASE PRINT CLEARLY

Signature of Card Holder: _____ Date: _____

(* To help offset processing fees, a 3% service charge will be added to all payments made by credit card. This charge does not apply to payments made via cash, check, or non-credit card methods. *)

Insurance Information

Date: _____ Client Name: _____ DOB: _____ SSN: _____

Name of Insured: _____ DOB: _____ SSN of Insured: _____

Insured Co Name: _____ TELE: _____ Policy #: _____

Mental Health Insurance Carrier: _____

EAP Auth: _____ How many sessions: _____

Do you have a deductible? Yes, _____ No _____ Amount \$ _____

Do you have a co-payment? Yes, _____ No _____ Amount \$ _____

Does your insurance plan require pre-authorization? Yes, _____ No _____ Unknown _____ Auth #: _____

PLEASE HAVE YOUR INSURANCE CARD AVAILABLE FOR PHOTOCOPYING

Sign below to authorize billing of insurance carrier

Client Signature: _____ Date: _____

I hereby give consent for release of clinical/psychological information as needed to be given to my insurance carrier upon their request of payment on my account. I realize that I am responsible for obtaining any pre-authorizations. I also understand that I am financially responsible for any balance due if my insurance denies payment for any reason.

Client Signature: _____ Date: _____

Note on Insurance: DMFC bills for most "In network" insurances on behalf of client. We also courtesy bill for "out of network" insurance companies, therefore your out of network benefits may apply depending on your insurance. We bill for many insurances but do not contract for fees at network rates. You might be billed for the difference in rates between the two. Generally, we collect the fee at time of service, before insurance is billed. Our goal is to be helpful and assist you in accessing your insurance benefits no matter which company you are insured with. There are "NO CHARGES" with this service, but it is a courtesy provided that we are not required to perform.

Phone: 760-777-7720

www.desertmarriagefamily.com
43585 Monterey Ave STE 1
Palm Desert, CA 92260

Fax: 760-452-8532



Desert Marriage and Family Counseling Inc.

HIPPA Notice of Privacy Practices

A federal law, known as the "HIPAA Privacy Rule" requires that we tell you how we may use and give out personal health information about you to others. This summary will tell you what our Privacy Notice contains.

HOW WE MAY USE AND SHARE YOUR PROTECTED HEALTH INFORMATION

We may use and share personal health information that is protected (PHI) to you or your personal representative.

We may use and share this information:

- For healthcare treatment that doctors, nurses and other clinicians give you
- For certain business activities called "health care operations" and
- For payment.

Some examples of how we may use and share PHI about you without your written permission including sharing information:

- To report abuse, neglect, or domestic violence
- To prevent a serious threat to your other's health or safety
- To prevent public health problems
- To agencies that audit, investigate and inspect health programs for the public's health
- For lawsuits and other legal proceedings
- For research
- To the Government for specialized purposes, such as military or national security; and
- For worker's compensation.

YOUR RIGHTS You have the following rights as described in our Notice:

- The right to ask us if we will put more limits on the way we use and share PHI about you
- The right to share confidential communications from us
- The right to see and get a copy of PHI about you
- The right to ask us for a report that describes how and with whom we share PHI about you.

If you have any questions regarding your rights or privacy, please inquire with our office or reference <http://www.hhs.gov/ocr/privacy>.

HIPAA NOTICE OF PRIVACY PRACTICES I hereby acknowledge that I have read a copy of this HIPAA Notice of Privacy Practices. I further acknowledge that I may obtain a copy if requested.

Client Name (Print): _____ Client Signature: _____ Date: _____

For Patients Under The Age OF 18

Responsible Party (Print): _____ Relationship to client: _____

Signature: _____ Date: _____



Desert Marriage and Family Counseling Inc.

Disclosure Statement & Agreement for Psychotherapy Services

Desert Marriage and Family Counseling Inc., provides psychotherapy services to you as a client in addition to other services you might be receiving as part of your treatment.

This document provides important information to you regarding your treatment and other services. Please read the entire document carefully and be sure to ask your therapist or therapist supervisor any questions you may have regarding its contents.

Information about your Clinician:

Name: _____ License Type: _____ License #: _____

Your therapist will discuss his/her professional background with you and provide you with information regarding his/her experience, education, special interests, and professional orientation.

Supervision

Your therapist is supervised by: _____

Details of your counseling will be discussed in weekly supervision meetings with the Intern and the Supervisor to ensure that the quality of your continued progress at **Desert Marriage and Family Counseling Inc.**

Confidentiality: All communication between you and your therapist will be held confidential unless you provide written permission to release information about your treatment, other than disclosures to Supervisors, as listed above. If you are participating in conjoined or group sessions, the therapist will not disclose information about your counseling unless all persons including you that participate in the sessions provide their written authorization.

Notice to Clients: **Desert Marriage and Family Counseling Inc.** and responds to complaints regarding a practice of psychotherapy by any unlicensed or unregistered counselor providing services at DMFC. To file a complaint, contact (760) 777-7720, Monterey Ave STE 1, Palm Desert, CA 92260, desertmarriagefamily.com, or kellyvl@dmfcinc.com.

Notice to Clients: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov or by calling (916) 574-7830.

Client Name: _____ Date: _____

Client Signature: _____

GENERAL CONSENT TO TREATMENT IN CASE OF DEPENDENT/CHILD/MINOR

Responsible Party (Print): _____ Date: _____

Relationship to client: _____ Signature: _____



Desert Marriage and Family Counseling Inc.

Acknowledgment of Content in the Intake Packet

Instructions: This form is to be completed during the intake process for any person receiving therapy sessions at **Desert Marriage and Family Counseling, Inc. (DMFC)**.

I acknowledge that I have read or have had explained to me the following information concerning my intake packet and Patient Rights with **Desert Marriage and Family Counseling, Inc. (DMFC)**.

(Please check all boxes below and initials fields)

- Patient Rights and Responsibilities (08/08/24) Client Initials: _____
- DMFC Services Provided (03/06/25) Client Initials: _____
- Consent for Treatment
- Office Policies
- Credit Card Information
- Insurance Information
- HIPPA Notice of Privacy Practices- copy will be given when requested
- Disclosure Statement & Agreement for Psychotherapy Services

I further acknowledge that if I need additional information I may contact:

- Management at (760) 563-6623
- Billing at (760) 563-6623
- Receptionist at (760) 777-7720
- Insurance Department at (760) 563-6623

I have filled out to the best of my knowledge all the information needed in the Intake Packet for **Desert Marriage and Family Counseling, Inc. (DMFC)**. I hereby authorize **Desert Marriage and Family Counseling, Inc. (DMFC)** to bill my insurance and give consent for release of clinical/psychological information as needed to be given to my insurance carrier upon their request of payment on my account. I realize that I am responsible for obtaining any reauthorizations. I also understand that I am financially responsible for any balance due if any insurance denies payment for any reason. I authorize **Desert Marriage and Family Counseling, Inc. (DMFC)** to charge my credit card for outstanding balances on my account due to late cancellations, no show appointments, returned checks, credit card charge backs and fees not collected from original time of service.

Print Client Name _____ Patient Signature _____ Date _____

Date Developed: 08/08/24 Initials _____

Date Reviewed: _____ Initials _____

Date Revised: _____ Initials _____

Clinician Signature _____ Date _____

Phone: 760-777-7720

www.desertmarriagefamily.com
43585 Monterey Ave STE 1
Palm Desert, CA 92260

Fax: 760-452-8532