

New Beginnings

Counseling Center

Susan M. Baker, MA, MFT
License #MFC36547

Welcome!

Please complete and sign the attached forms. You will be provided a copy of the information for your personal files.

Feel free to ask me any questions you may have regarding this information. Once you have finished, please attach your check, payable to Susan M. Baker, to the clipboard. Make yourself comfortable with some water if you wish, and I will be with you shortly.

I look forward to meeting with you.

Sincerely,



Susan M. Baker, MA, MFT

INSURED/INSURANCE INFORMATION

For Insurance Users Only
(Please present insurance card)

PRIMARY INSURANCE: _____

Insured _____ Gender: Female Male

Address _____

Authorization No. _____

Relationship to client: Self Spouse Other _____

Insured Date of Birth _____

SECONDARY INSURANCE: _____

Insured _____ Gender: Female Male

Address _____

Authorization No. _____

Relationship to client: Self Spouse Other _____

Insured Date of Birth _____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature _____ Date ____/____/____

I authorize payment of medical benefits to the undersigned physician or supplier for services described on claims.

Signature _____ Date ____/____/____

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Exceptions to Confidentiality

To Our Clients:

It is important to us that you understand that anything you tell your therapist is completely confidential. Unless we have specific written permission (a Release of Information form) signed by you, we tell no one that you come here or what you say.

There are several exceptions to this rule that we want to be sure you understand:

1. Your therapist is required to report any suspected child or elder abuse (either current or past) to local child protective or law enforcement officials within 24 hours. (Section 11161.5 - Cal. Penal Code) Abuse is defined as the willful cruelty to or the unjustifiable punishment of a child or elder person or endangering the life or health of either one. This includes sexual molestation, the willful infliction of physical pain or injury, willfully causing or permitting unjustifiable mental suffering, or the willful failure to provide necessary food, clothing, shelter and medical attention. (Section 273a - Cal. Penal Code) If any therapist fails to report, he or she may be both civilly and criminally liable.
2. If your therapist believes that you actually intend to do physical harm to someone else, he/she must notify the police and the intended victim.
3. If your therapist believes that you truly intend to harm yourself, he/she will make every effort to insure your safety. If he/she is unable to do this, he/she must (by law) notify the police.
4. If you are using your insurance to pay some or all of your therapy costs, it is important for you to know that your therapist may be required to make regular reports to the insurance company regarding you diagnoses and course of treatment. He/she may also use electronic methods (FAX) to communicate with your insurance company. While we make every effort in our office to protect your privacy by having our FAX machine in a separate room and using cover sheets on all FAXed material, we are not responsible for any problems that occur once information has left our office. If this creates issues for you, please discuss alternatives with your therapist.

Client's Signature

Date

Parent's Signature (if Client is under 18 years of age)

Date

Family Member's Signature

Date

Family Member's Signature

Date

Date: _____ Name: _____ Age: _____

Address: _____

For each of the following symptoms, please circle a number 0-5 for the difficulty you are having with each symptom, with 0 being no difficulty, 1 being little and 5 being severe difficulty. Please answer every question.

- | | | | |
|--|-------------|--|-------------|
| 1. Briefly describe the traumatic event or events:

_____ | | 21. Feeling defeated, inadequate,
can't do anything | 0 1 2 3 4 5 |
| | | 22. Feeling confused or fragmented | 0 1 2 3 4 5 |
| | | 23. Too much energy (hyperactivity) | 0 1 2 3 4 5 |
| | | 24. Impulses to run away | 0 1 2 3 4 5 |
| | | 25. Unable to feel weight of body | 0 1 2 3 4 5 |
| Date of Event(s) _____ | | 26. Feeling physically heavy-like
dead weight | 0 1 2 3 4 5 |
| 2. Feelings of helplessness and/or
powerlessness | 0 1 2 3 4 5 | 27. Constricted range of motion | 0 1 2 3 4 5 |
| 3. Lack of focus | 0 1 2 3 4 5 | 28. Feeling disconnected, lost,
"not here" | 0 1 2 3 4 5 |
| 4. Gaps in memory | 0 1 2 3 4 5 | 29. Trouble orienting time | 0 1 2 3 4 5 |
| 5. Disorientation | 0 1 2 3 4 5 | 30. Trouble orienting space | 0 1 2 3 4 5 |
| 6. Accident proneness | 0 1 2 3 4 5 | 31. Avoidance of triggers or
associations with events | 0 1 2 3 4 5 |
| 7. Feeling out of control | 0 1 2 3 4 5 | 32. Panic attacks | 0 1 2 3 4 5 |
| 8. Feeling frozen or paralyzed | 0 1 2 3 4 5 | 33. Free-floating anxiety | 0 1 2 3 4 5 |
| 9. Recurring dreams related to
traumatic event | 0 1 2 3 4 5 | 34. Nausea or vomiting | 0 1 2 3 4 5 |
| 10. Intrusive imagery related to
traumatic event | 0 1 2 3 4 5 | 35. Shame | 0 1 2 3 4 5 |
| 11. Flashbacks | 0 1 2 3 4 5 | 36. Self judgment/blaming self | 0 1 2 3 4 5 |
| 12. Disrupted sleeping patterns
Circle one: insomnia oversleeping both | 0 1 2 3 4 5 | 37. Electric or overcharged feeling
in body | 0 1 2 3 4 5 |
| 13. Lethargy, exhaustion, chronic
fatigue | 0 1 2 3 4 5 | 38. Obsessive review of incident | 0 1 2 3 4 5 |
| 14. Night terrors or abrupt awakening
with intense fear | 0 1 2 3 4 5 | 39. Disrupted eating pattern
Circle one: overeating under-eating both | 0 1 2 3 4 5 |
| 15. Extreme emotional shifts | 0 1 2 3 4 5 | 40. Recurring tension patterns in body | 0 1 2 3 4 5 |
| 16. Rage | 0 1 2 3 4 5 | 41. Chronic pain | 0 1 2 3 4 5 |
| 17. Over-cautiousness | 0 1 2 3 4 5 | 42. Hyper-vigilance | 0 1 2 3 4 5 |
| 18. Fear of being watched/followed | 0 1 2 3 4 5 | 43. Inability to cope | 0 1 2 3 4 5 |
| 19. Heightened startle response | 0 1 2 3 4 5 | 44. Isolation | 0 1 2 3 4 5 |
| 20. Feeling Overwhelmed | 0 1 2 3 4 5 | 45. Constriction, suppression,
shut down | 0 1 2 3 4 5 |

46. Distrust	0 1 2 3 4 5	71. Apathy, no energy for life	0 1 2 3 4 5
47. Little or no awareness of choices	0 1 2 3 4 5	72. Feeling dead or in "no man's Land"	0 1 2 3 4 5
48. Disinterest in life	0 1 2 3 4 5	73. Feeling blocked about finishing what you start	0 1 2 3 4 5
49. Generalized fear or anger (for example, believing <i>all</i> men, or <i>all</i> women are threatening, or <i>all</i> drivers are unsafe)	0 1 2 3 4 5	74. Starting many projects and not completing them	0 1 2 3 4 5
50. Excessive worrying	0 1 2 3 4 5	75. Hypersensitivity to sound or light	0 1 2 3 4 5
51. Disrupted relationships	0 1 2 3 4 5	76. Get feelings hurt easily	0 1 2 3 4 5
52. Alienation, believing no one can understand	0 1 2 3 4 5	77. Irritability, overreacting to things	0 1 2 3 4 5
53. Bonding with others through trauma	0 1 2 3 4 5	78. Checking everything you do	0 1 2 3 4 5
54. Sudden fearfulness for no apparent reason	0 1 2 3 4 5	79. Circle those that apply: Shouting, throwing objects, hitting or kicking, desire to have tantrum or scream	0 1 2 3 4 5
55. Fearlessness or dangerous situations	0 1 2 3 4 5	80. Everything seems too much trouble	0 1 2 3 4 5
56. Temper or outbursts	0 1 2 3 4 5	81. Feeling wear in body, collapsed joints	0 1 2 3 4 5
57. Desire to hurt self or others	0 1 2 3 4 5	82. Feeling doomed or as if something bad is going to happen	0 1 2 3 4 5
58. Loss of sexual interest	0 1 2 3 4 5	83. Restlessness	0 1 2 3 4 5
59. Dizziness	0 1 2 3 4 5	84. Heart pounding	0 1 2 3 4 5
60. Idea that someone can control your thoughts	0 1 2 3 4 5	85. Not remembering aspects of a traumatic event	0 1 2 3 4 5
61. Fear of being alone	0 1 2 3 4 5	86. Difficulty connecting or feeling close to others	0 1 2 3 4 5
62. Fear of being with others	0 1 2 3 4 5	87. Difficulty making decisions	0 1 2 3 4 5
63. Crying easily	0 1 2 3 4 5	88. Guilt	0 1 2 3 4 5
64. Inability to cry	0 1 2 3 4 5	89. Numbing	0 1 2 3 4 5
65. Fear of leaving home or familiar surroundings	0 1 2 3 4 5	90. Going blank	0 1 2 3 4 5
66. Adamant "everything fine" stance	0 1 2 3 4 5	91. Feelings of worthlessness	0 1 2 3 4 5
67. No sense of future	0 1 2 3 4 5	92. Feeling your life was threatened during the traumatic event(s)	0 1 2 3 4 5
68. Loss of creativity	0 1 2 3 4 5	93. Feeling your life is in danger Since the traumatic event(s)	0 1 2 3 4 5
69. Depression	0 1 2 3 4 5		
70. Shakiness	0 1 2 3 4 5		

Susan M. Baker, M.A., M.F.T.
CA License # MFC 36547
(805) 987-3162 ext. 2#

Professional Policies

Dear Clients:

The following information is meant to clearly communicate policies about my psychotherapy practice. Participation in psychotherapy can result in many benefits to you. These may include a better understanding of your personal goals, values, thoughts, and feelings, as well as improve relationships, change behavior, and resolution of the specific concerns that bring you here. This all requires effort on your part, which may involve emotional discomfort. Change occurs differently for each person, and is often slow and sometimes frustrating. There is, however, no guarantee that treatment will remove all emotional pain. I use many techniques as part of my practice, including: talking therapy, visualization exercises, art, trauma healing exercises, play therapy, and other standard psychotherapeutic methods. I welcome any questions you may have about the therapy process and practices, so please feel free to discuss these with me.

When working with clients under the age of 18 years, **I must have the consent of all parents/guardians who hold “legal custody”.** I will not treat children without this written consent. I prefer to involve all parents/guardians as much as is therapeutically appropriate. I will be glad to discuss how, when, and if this can be accomplished in your case.

Private Practice:

Although I am in an independent private practice, I work closely, whenever possible and appropriate, with my professional associates at New Beginnings Counseling Center. I also utilize professional consultations in order to continually improve my psychotherapy skills. From time to time, I may share some information with these professionals about our conversations so that I may better serve you in our work together. These professionals must also abide by the ethical rules of confidentiality. Please sign here that I have your permission to discuss your information in peer supervision or consultation, while keeping your identity confidential

Client(s) Signature _____ **Date:** _____

In our sessions together, we will spend a significant time talking with one another, exchanging ideas and perspectives. I shall want to know about you, to the degree that you are willing and able to share. A part of our work will involve me encouraging you to pay attention to those aspects of you that are beyond and beneath your words, namely your body, your senses, your feelings, and images. On occasion, and only with your agreement, I use Somatic Experiencing touch. Often the touch involves remaining in our chairs and experiencing ‘grounded touch’ like a foot touching a foot or a hand on a shoulder. At other times, I may invite you to use a table where I shall work with systems in your body in an attempt to open blocks and move energy. I do not manipulate but only support your body. Before any of this table work takes place, I shall inform you of what we are going to do and why, and ensure that you feel safe. I shall also always ask you permission before I place a hand on any area of your body.

Please sign here to verify that you have read and understood the above information.

Client(s) Signature _____ **Date:** _____

Therapy Time and Standard Fee:

1. Sessions are generally 45 minutes in length.
2. If you need to cancel a session, please remember **I require 24 hour notice**. You can leave a message on my voice mail 24 hours a day, 7 days a week. Otherwise, you will be charged for your missed session (charged to you, not your insurance company for the FULL fee).
3. If you are late, we will meet for the remainder of your scheduled session. If you are more than 20 minutes late and I have not heard from you, I will assume you aren't coming and may leave the office.
4. Telephone time is limited to 5-10 minutes, beyond which I will bill you at my standard rate at 15 minute intervals. Payment will be expected at the next regularly scheduled appointment, or sooner by mail.

_____ (Initial)

Accessibility and Emergencies:

I have a voice mail system which can be accessed 24 hours a day, 7 days a week. I check my messages periodically during normal business days/hours. On weekends and holidays I check messages occasionally. I return business calls during normal business hours. In case of a crisis or urgent situation, you can choose to call me at (805) 231-1331. I will then respond as soon as possible. If I cannot be reached, or do not respond, you may contact one of my associates at NBCC, or other agencies/authorities equipped to deal with serious emergencies. A crisis is a situation in which you feel you are in danger of being emotionally overwhelmed. If you have tried all your coping skills and they are not enough, and the situation cannot wait until your next appointment, please call.

Vacations and Holidays:

When I will be unavailable, I will try to let you know in advance. If you have an emergency when I am gone you may contact your primary physician or psychiatrist, or ask to speak with any of my NBCC associates who cover for me in my absence.

Terminations:

Termination from therapy is an important process which can be of benefit to clients and therapists. This is an important opportunity to reflect on progress, or lack of, and the process of where you are now and where you hope to be going. I encourage my clients to partake with me in this process of finding out what was helpful and that could have been more helpful. It is your right to terminate therapy at any time. If you choose to terminate, I will be glad to provide referrals to qualified professionals. As your therapist, I have the right and duty to terminate therapy under the following circumstances: when I assess that treatment is no longer helpful or beneficial to you, if I determine that another professional would better serve your needs; if you have not paid for the last two sessions (unless a special arrangement has been made); or if you have failed to show up for your last two sessions without the required 24 hour notice of cancellation. In all cases I will be happy to provide you with the resources and referrals as necessary.

Financial Policy:

1. Fees can be paid in the following manner:
 - a. You pay in full each session; you may send my bill to your insurance (does not apply to HMO and managed care). Please request a billing statement.
 - b. You pay your assigned co-payment required by your insurance company or mental health benefits, I bill your insurance for the remaining balance (you may still be liable for balance if your insurance does not pay).
2. A physician referral may be required by your insurance company for mental health benefits. If required, please obtain this promptly as you will be responsible for all charges until you do.

3. **I do not bill secondary insurance.** I can, upon request, provide a billing statement which you can submit to your secondary carrier for reimbursements to you.
4. A charge will be assessed for reports requested by the client(s) (for court, attorneys, work, etc).
5. **A \$25.00 late fee** is assessed on overdue accounts for each month delinquent.
6. **Please remember, all charges are ultimately your responsibility. It is your responsibility to maintain insurance coverage, update me regarding any changes and keep informed as to your deductibles or changes in co-payments.**

Additional Charges:

Additional charges may be incurred for the following: letter writing at clients request, court reports or documentation requested by attorneys (authorized by the client), sessions which take place at someplace other than this office, special meetings. Time outside this office is usually charged door to door. Any additional charges will be discussed in advance and agreed upon. I charge for extensive telephone calls (see above). These charges are calculated on my regular hourly fee and are not covered by insurance.

Privacy Policy:

1. Your client record, or PHI (Personal Health Information) is confidential. Client information can only be released by the person legally in charge. I will presume I have your permission to call/contact you (at the telephone numbers you provided on the intake sheet) in those circumstances which may require this, unless you specifically request on your intake form that this is not acceptable. **If a minor child is my client, I require the signature of all parents/guardians who have legal custody and the child's signature** before I will release any information, and in some cases may not be able to release information at all. If your child is my client, it is my job to protect your child's therapeutic interests.
2. If you have insurance which is being billed for professional services, some information regarding you may be requested by the company. The amount of information varies depending upon the kind of plan you have (HMO's, for example, often want written reports sent and contact with provider physicians). Insurance plans may make use of, and/or require electronic communications (FAX, computer, etc.). I make every effort, in this office, to protect your privacy, but am not responsible for any problems which occur once information has left this office. If you have any questions about this and your particular plan, please discuss with me any alternatives.
3. ***NOTE:** These are **EXCEPTIONS TO CONFIDENTIALITY** for which I am legally bound to adhere to, these include:
 - a. if you threaten **serious and imminent harm** to another person, I am required by law to notify that person and appropriate law enforcement agencies.
 - b. If you reveal information about active **child abuse, elder abuse, or dependent physical abuse**, I must report this to authorities. If I have reasonable suspicion that a perpetrator of child abuse may be still abusing minors, I must also report this information.
 - c. If I believe that you **imminently** intend to do **serious/life threatening harm yourself**, I will make every effort to ensure your safety. This may include notification of necessary authorities.
 - d. If I receive a legal subpoena for information about you I need your written authorization to release information, and/or an order from a judge. I will make reasonable efforts to notify you, in advance, to discuss this. Without an order from a judge your records will remain confidential unless you provide written authorization to release them. Any subpoena to appear in court and/or subpoena for records when a child is my client must be accompanied by written permission of **BOTH LEGAL PARENTS** before I can testify in a court of law.

I have read, understand, and agree to the above, including Privacy Practices policy and information regarding client Protected Health Information (PHI). I may request a printed copy of my rights under the Health Insurance Portability and Privacy Act (HIPPA).

Client(s) Signature _____ **Date:** _____

Date: _____

Date: _____

Date: _____

Parent/Guardian Signature (if client is under 18 years of age)

Date: _____

Date: _____

Therapist's Signature _____ **Date:** _____

09-07

New Beginnings Counseling Center

Consent to E-mail Communication

I _____, request to have access to my therapist, Susan M. Baker, M.A., MFT, via electronic communications, including e-mail via the internet. I understand that any such communication with my therapist will be for the purpose of scheduling appointments or communicating information to my therapist and **not** for the purpose of receiving internet psychotherapy. I also understand that my therapist had taken reasonable steps to protect my privacy and confidentiality with the use of a computer firewall and password protection and other safety measures. However, I know there are risks to my privacy in using this method of communication that I accept. My therapist agrees only to respond to my internet communication with her/him and will *not initiate* any internet dialogues. For underage minors all parents/guardians with legal authority must provide signature(s).

Signature(s) of clients and legal guardian(s):

Date

Therapist:

Susan M. Baker, M.A., MFT

License No. MFC 36547

CLIENT BILL OF RIGHTS

You, the client have the right to:

- Receive respectful treatment that will be helpful to you.
- Receive a particular type of treatment or end treatment without obligation or harassment.
- A safe environmental, free from sexual, physical, and emotional abuse.
- Report unethical and illegal behavior by a therapist.
- Ask questions about your therapist.
- Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specializations, and limitations.
- Have written information about fees, methods of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies before beginning therapy.
- Refuse electronic recording, but you may request it if you wish.
- Refuse to answer questions or disclose any information you choose not to reveal.
- Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose your case.
- Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
- Request, and in most cases receive, a summary of your file, including the diagnosis, your progress, and type of treatment.
- Request the transfer of a copy of your file to any therapist or agency you choose.
- Receive a second opinion at any time about your therapy or therapist's methods.
- Request that the therapist inform you of your progress.

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Office: (805) 987-3162 ~ Email: sbaker.mft@verizon.net
155 Granada Street ~ Suite N ~ Camarillo, CA 93010