Corinne Hickson, Ph.D.
Complete Family Service
25550 Hawthorne Blvd. Suite 316
Torrance, CA 90505
Phone (310) 375-8665 · Fax (310) 375-8187

PATIENT INFORMATION FORM

DATE: _____

EMAIL ADDRESS: _____

IDENTIFYING INFORMATION

PATIENT FULL NAME:	AGE:	DATE OF BIRTH: / /

ADDRESS:	CITY:	STATE:	ZIP CODE:

PHONE # (HOME): ( )	(WORK): ( )	(CELL): ( )

MARITAL STATUS:
☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

NAME OF RESPONSIBLE PERSON(S) FOR PATIENT UNDER 18:
1.
2.

NAME OF FAMILY PHYSICIAN:	PHONE #: ( )
REFERRED BY:	

EMPLOYMENT INFORMATION (IF CHILD; PARENT OR INSURED'S INFORMATION)

OCCUPATION:	EMPLOYER:

ADDRESS:	CITY:	STATE:	ZIP CODE:

INSURANCE INFORMATION

NAME OF INSURED:	INSURED'S SS#:	INS.POLICY ID# AND GROUP #

INSURANCE COMPANY:	PHONE #: ( )	INSURED'S D.O.B. / /

INSURANCE COMPANY'S ADDRESS:	CITY:	STATE:	ZIP CODE:

NOTE: IF UNABLE TO KEEP YOUR APPOINTMENT, PLEASE GIVE 24 HOURS NOTICE OR YOU WILL BE CHARGED FOR THE TIME RESERVED. THANK YOU!

_____
SIGNATURE

Corinne Hickson, Ph.D.
Clinical Psychologist PSY 17257
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www.CompleteFamilyServices.com

POLICY AGREEMENT & CONSENT FOR TREATMENT

The following are important guidelines that apply to our work together and will be discussed during the initial visit.

CONFIDENTIALITY POLICY

Your therapist makes every effort to maintain either you or your child's participation in counseling confidential. There are additional circumstances where disclosure of personal health information is required or permitted by law.

California law establishes that your therapist is obligated to break confidentiality in the following situations:

- The therapist believes that the client may be a danger to self, another, or another's property, and that disclosure is necessary to prevent the danger. In the case of danger to another, the therapist is required to notify the police to take reasonable steps to warn the intended victim.
- There is reasonable suspicion of actual or potential neglect or abuse (sexual, emotional, or physical), in which case the therapist is required to contact the Children's Services Bureau (CSB).
- There is reasonable suspicion of physical abuse, financial abuse, abandonment, isolation, or abduction, neglect by others, and self-neglect of an elder or dependent adult.
- There is valid court order (e.g., legal subpoena) issued for a client's file.

California law establishes that your therapist may break confidentiality in the following situations:

- There is reasonable suspicion that a child has witnessed domestic violence, in which case the therapist is required to contact the Children's Services Bureau (CSB).
- Parents and guardians' legal right to know their child's progress.
- A therapist may not break confidentiality when a client discloses that she/he committed a crime unless the client sought therapy to aid in planning or committing the crime, or to escape detection or apprehension after committing the crime.
- The client files suit or complaint against their therapist related to services provided.
- There is reason to believe that a client, under the age of 16, has been the victim of a crime and that disclosure of confidential information is in the best interest of the client.

FINANCIAL POLICY

Payment for each visit is required at the time of service. Your therapist reserves the right to use all resources, including court or collection agency, if default in your payment occurs.

- You will be charged full fee for any appointments not cancelled within 24 hours of the scheduled visit.
- "No Shows" are defined as appointments that are missed with no notification for which you will be charged at full fee.
- You will be charged a $25.00 service charge for any returned check.

INSURANCE POLICY

Your therapist is not a provider for any insurance company. It is the office policy to bill your insurance carrier as a courtesy to you. Please realize that the processing of insurance claims can be lengthy with questionable outcome. The therapist cannot control this process. Please understand that you are responsible for the entire balance in full even though you may have insurance coverage.

PHONE CALLS, REPORT WRITING, & ADDITIONAL SERVICES

You will not be charged for brief phone calls. You will be charged for lengthy phone calls, telephone sessions, report writing, and extensive contact with insurance companies. Classroom observations and therapist attendance at IEP's will be charged at the regular session rate.

NOTICE REGARDING ONLINE SESSIONS: Occasionally, it may be necessary to conduct sessions over the phone or via video chat. You, as the client understand that phone and email sessions have limitations (as well as benefits) compared to in-person sessions, among those being the lack of "personal" face-to-face interactions, the lack of visual and auditory cues in the therapy process, the lack of total confidentiality usually assured by an office visit, and the fact that most insurance companies will not cover this type of therapy. You understand that telephone/online psychotherapy with me is not a substitute to medication under the care of a psychiatrist or doctor. You understand that online and telephone therapy may not be appropriate if you are experiencing a crisis or having suicidal or homicidal thoughts. If a life-threatening crisis should occur, you agree to contact a crisis hotline, call 911, or go to a hospital emergency room.

EMERGENCIES & CRISES

Every attempt is made to return phone calls within 24-48 hour, Monday through Friday. However, in the event that you are experiencing a clinical emergency that cannot await a returned phone call or that is experienced over the weekend you are directed to call 911 immediately.

NOTICE OF PRIVACY PRACTICES

I further acknowledge that I have received of the "Notice of Privacy Practices" which pertains to how medical information about myself or my child may be used and disclosed.

CONSENT FOR TREATMENT

I authorize and request Corinne Hickson, Ph.D. to conduct psychological assessments, treatments, and or diagnostic procedures, which now or during the course of my care are advisable. I understand that the administration of assessments will be conducted by: Megan Higinbotham, PhD, and Maddison Paul, Psy.D. (psychological assistants under the supervision of Corinne Hickson, PhD.)

I also understand that while the course of therapy is designed to be helpful, it may at times be emotionally difficult and uncomfortable.

I, _____, do hereby give my consent for (Myself) / (My child)
Print name of adult
_____, to be seen for psychological services. I understand and
Print name of child

agree to the limits of confidentiality and policies stated above pertaining to these psychological services.

_____ _____
Signature of Adult /Parent/ Guardian Date

AUTHORIZATION FOR RELEASE OF INFORMATION/RECORDS

Requesting Clinician: Corinne Hickson, Ph.D.
Licensed Psychologist, PSY17257
25550 Hawthorne Blvd., Suite 316
Torrance, CA 90505
Ph. (310) 375-8665 Fax (310) 375-8187

I, (name of patient) _____ DOB: _____
hereby authorize a mutual disclosure of information between Corinne Hickson, Ph.D., and the following individual or institution:

Name: _____

Address: _____

Phone: _____ Fax:_____

The disclosure of information/records authorized here is required for the following purpose:

_____

Such disclosure shall be limited to the following specific type of information:

- ☐ Clinical Evaluation
- ☐ Treatment
- ☐ Diagnosis
- ☐ Test Results
- ☐ Discharge Summary
- ☐ Educational Assessment & Behavioral Reports

Disclosure Authorization: This authorization shall become effective immediately and shall remain in effect for 90 days unless revoked by me in writing. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization. I understand that the requestor may not further disclose this information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. I understand that I may request a copy of this authorization and I may inspect or obtain a copy of the health information that I am being asked to use or disclose (as allowed by California Mental Health Laws). I understand that treatment will not be conditioned on my providing or refusing to provide this authorization and that I may refuse to sign. In this case the information will not be able to be obtained.

Date: _____ Time: _____ am/pm Signature: _____

If signed by someone other than the patient state legal relationship to the patient:

Witness Name: _____ Signature: _____

Clinical Approval Section: Required for Patient Access Only
The undersigned (licensed psychologist) who is in charge of the patient, hereby approves/disapproves the release of information and records to the party specified above. If disclosure is disapproved it must be based on the fact that release of the records would cause a substantial risk of significant adverse or detrimental consequences to the patient in seeing a copy of the mental health records requested. (Health & Safety Code 123115)

☐ Approves Release

☐ Disapproves Release/Include description of specific adverse/detrimental consequences anticipated.

Date: _____ Signature of Clinician: _____

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Billing Agreement

Payment is due at the time services are rendered and can be made in cash, check or credit card. If you do not remember to bring payment to your appointment, cancel without a notice of at least 24 hours, or do not come to a scheduled appointment, your credit card will be charged to cover the full-service fee. This also applies to payment for testing, school meetings, consultations, prolonged phone conversations and all other services provided by Complete Family Services, Inc.

I, _____ agree to comply with the above policy. I am aware that my credit card will be charged the full fee if unable to comply.

Credit Card Information:

Patient name: _____

Cardholder name: _____

Credit Card Account Number: _____

Expiration Date: _____

Security Code: _____

Cardholder Signature: _____ Date_____