Inspired Mind Counseling
Madeleine Burkhart, LMFT
3744 Mt. Diablo Blvd, Suite 206B
Lafayette, CA 94549
925-528-1363

Thank you for selecting me as your therapist. The purpose of this letter is to inform you of my credentials and to explain our professional relationship. Please feel free to ask questions whenever you would like clarification of the therapy process.

I am a Licensed Marriage and Family Therapist as designated by the California Board of Behavioral Sciences, the board who oversees and licenses therapists who have met the board's exigent standards for education, knowledge, and experience. I hold a Master's (M.S.) degree in Counseling Education: Couples, Marriage, and Family from Portland State University. Major coursework included human growth and development with emphasis on family systems. This graduate program is accredited by the Council on Accreditation of Counseling and Related Educational Programs.

Each person possesses the innate capacity to heal and find the unique and appropriate path to mental health, happiness, and wholeness. Sometimes discovering this capacity may take only a few sessions, while at other times, it may necessitate longer term counseling. I am fluent in English, French, and Spanish.

While I cannot guarantee any specific results from our counseling sessions, I am committed to rendering my services in a professional manner. As a Licensed Marriage and Family Therapist by the California Board of Behavioral Sciences, I abide by its Code of Ethics. They are located at 1625 North Market Blvd., Suite S200, Sacramento, CA 95834, phone (916) 574-7830. As my client you have the right:

1) To expect that a licensed therapist has met the minimal qualifications of training and experience required by state law;
2) To examine public records maintained by the Board and to have the Board confirm credentials of a licensed therapist;
3) To obtain a copy of the Code of Ethics;
4) To report complaints to the Board;
5) To be informed of the cost of professional services before receiving the services;
6) To be assured of privacy and confidentiality while receiving services as defined by rule and law with the following **exceptions**:
    a. Reporting suspected child abuse;
    b. Reporting imminent danger to yourself or others;
    c. Reporting information required in court proceedings or by your insurance company, or other relevant agencies;
    d. Providing information concerning licensed therapist case consultation or supervision;
    e. Defending claims brought by you against your licensed therapist.
7) To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

The fees for my services are $185 per 45 minute session payable at the start of each session. If you need to cancel or reschedule your appointment, please notify me by email, vmail, or text **at least 24 hours** in advance or you will be billed the full session fees.

If you need assistance outside of our sessions, please call me to schedule additional in-person or phone appointments. I will return your call as soon as possible during business hours M-F. If you need emergency assistance or are experiencing a mental health crisis, please call 911 or seek help at the emergency room of your local hospital. Alternatively, you may call the **Contra Costa County Crisis Hotline anytime 24 hours a day, 7 days a week at 800-833-2900.**

Client Name & Signature:_____Date:_____

Client Information Form

General Information Date: _____

Name (First, Middle, Last): _____

Address: _____City_____State_____Zip_____

Date of Birth: _____ Age: _____ Social Security #: ____XXX-XX-_____

Home Phone: _____ Cell phone: _____
Permission to leave a message? Y/N Permission to leave a message? Y/N

Work Phone: _____ Email: _____
Permission to leave a message? Y/N Permission to send a message Y/N

Occupation: _____ Employer: _____

Relationship Status: Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Widowed ☐

Spouse/Partner & Occupation: _____Date of Birth: _____

Children (Name & Age):_____

Other Members of Your Household (Name, Age, & Relationship):

_____

Emergency Contact: _____ Phone: _____

Relationship: _____ Permission to contact: Y / N

Whom may I thank for referring you to my practice? _____

Personal History

What is your Race/Ethnicity: _____

Please list any religious or spiritual affiliations: _____

What is your education? _____

Are you in school now? **Y / N** If yes, please explain: _____

Have you ever been in the military? **Y /N** If yes, please explain:

_____

Have you ever been arrested? **Y / N** If yes, please explain:

_____

Has anyone expressed concern about you being violent? **Y / N** If yes, please explain:

_____

Are you concerned about anyone being violent towards you? **Y / N** If yes, please explain:

_____

Family History

Briefly describe your childhood:

_____

_____

_____

_____

Sibling Information (Names, ages, birth order):

_____

_____

What is your relationship like with your family now?

_____

_____

Please list anyone in your family who may suffer from mental health and/or substance abuse issues:

_____

_____

Health History

Physician Name: _____ Phone: _____

Please list any medical issues you are currently being treated for:

_____

_____

Please list any medications prescribed or OTC that you are currently taking:

_____

_____

Please describe alcohol and drug use (frequency and amounts):

_____

Please list any family history of medical conditions that you are aware of:

_____

_____

If applicable, please tell me about you or your partner's pregnancy history (# of pregnancies, children, miscarriages, infertility issues): _____

Symptoms

Symptom	Past	Present	N/A	Symptom	Past	Present	N/A
Depressed Mood	☐	☐	☐	Difficulty concentrating	☐	☐	☐
Low Energy	☐	☐	☐	Hyperactivity	☐	☐	☐
Eating Problems	☐	☐	☐	Nightmares	☐	☐	☐
Mood Swings	☐	☐	☐	Flashbacks	☐	☐	☐
Anger/Aggression	☐	☐	☐	Paranoia	☐	☐	☐
Irritability	☐	☐	☐	Hallucinations/Delusions	☐	☐	☐
Hopelessness	☐	☐	☐	Relationship problems	☐	☐	☐
Worthlessness	☐	☐	☐	Work or school problems	☐	☐	☐
Guilt and/or Shame	☐	☐	☐	Financial Difficulties	☐	☐	☐
Sleep problems	☐	☐	☐	Substance abuse	☐	☐	☐
Thoughts of Suicide	☐	☐	☐	Learning disability	☐	☐	☐
Suicide Attempts	☐	☐	☐	Developmental disability	☐	☐	☐
Self-harming behaviors	☐	☐	☐	Family/Parenting Problems	☐	☐	☐
Anxiety/Fears	☐	☐	☐	Other _____	☐	☐	☐
Panic Attacks	☐	☐	☐	Other _____	☐	☐	☐

Please describe any history of suicide attempts or self-harming behaviors: _____

_____

_____

Please describe any history of psychiatric hospitalizations: _____

_____

Please describe any past or current substance abuse issues: _____

_____

Please describe any past or current gambling problems: _____

_____

Have you ever been physically, sexually, or emotionally abused? **Y / N** If yes, please explain:

_____

_____

Please list any other significant trauma that you have experienced that you feel may be impacting your functioning today:

_____

_____

_____

Lifestyle

How many hours a week do you spend at work? _____
What do you enjoy doing most in your present life? _____
Please describe your exercise habits: _____
From whom can you seek support? _____

What areas of your life are being affected by the issue(s) for which you seek counseling?

☐ Work	☐ Marriage/Relationship	☐ Family	☐ Friendships
☐ Finances	☐ General Mood	☐ Sleep	☐ Relaxation
☐ School	☐ Joy/Enjoyment	☐ Physical Health	☐ Spirituality

Therapy

What led you to seek counseling at this time? _____

_____

_____

What do you hope to gain from counseling? _____

_____

_____

Have you sought counseling in the past? **Y / N** If yes, please explain whom you saw and

how it was helpful or not helpful: _____

_____

_____

Is there anything else you would like me to know? _____

_____

_____

Thank You!

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Credit Card Authorization

Name of Client: _____

Name of Cardholder (as it appears on card): _____

Billing Address: _____

City, State, Zip: _____

Telephone Number: _____ Cell phone ☐ Home Phone ☐

Credit Card Type: Visa ☐ Master Card ☐ American Express ☐ Discover ☐

Credit Card Number: _____ Exp.: _____ CSC: _____

Authorization:

☑ Missed Appointments/Late Cancellations: I hereby authorize Madeleine Burkhart, LMFT to charge the above credit card for missed appointments or late cancellations as outlined in the Informed Consent I signed on _____. This authorization shall remain in force until cancelled by me in writing. All such transactions are processed through Square, Inc. or IVY Pay.

☐ Recurring Billing: I hereby authorize Madeleine Burkhart, LMFT to charge the indicated credit card on a periodic basis for the amount due under the Informed Consent Agreement dated _____. This Recurring Payment Authorization/Periodic Charge shall remain in force until cancelled by me in writing. All such transactions are processed through IVY Pay.

Please list what the credit card authorization is for: _____

Authorization:

I hereby authorize Madeleine Burkhart, LMFT to charge the indicated credit card. I agree that this is either a missed appointment/late cancellation or recurring payment/periodic charge that will be made as indicated above. To terminate the recurring charge process, if selected, I understand that I must cancel in writing. I will not dispute Madeleine Burkhart, LMFT's recurring billing with my credit card issuer so long as the amount in question was for service rendered prior to my canceling my account in the manner required. I guarantee and warrant that I am the legal card holder for this credit card and that I am legally authorized to enter into this one time or recurring billing agreement with Madeleine Burkhart, LMFT.

Signature of Cardholder (Required): _____ Date: _____

EAP Information & Financial Responsibility

Employee Assistance Program (EAP) Information:

Name of EAP:	
Address:	
EAP Policyholder:	DOB:
Employer:	
Authorization # (if applicable):	
Number of sessions covered:	
Number of missed or late cancellations covered:	

I understand and fully accept that it is my responsibility to verify all insurance benefits and coverage. I authorize Inspired Mind Counseling (**IMC**) as my agent in helping me to obtain payment from my EAP/health insurance provider. Included in this authorization is for the release of any medical or other information necessary to process these claims and for payment to be made directly to **IMC**. I also will permit a copy of this authorization to be used in place of this original. **Ultimately, I am solely responsible for payment to IMC for services rendered and for any missed appointments or late cancellations.**

The following consequences might occur if I refuse to sign this authorization: (1) If the authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it; and (2) If the authorization is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to authorize disclosure of certain psychotherapy notes.

Print Name: _____

Signature: _____ Date: _____

Authorization to Use and Disclose Protected Health Information

This authorization must be written, dated and signed by the consumer or by a person authorized by law.

Client Name: _____ **Birthdate:** _____ **Social Security#:** _____

Street Address: _____**City:** _____ **State:** _____ **Zip:** _____

I authorize **Inspired Mind Counseling (IMC)** to: Release information only [ ] Receive information only [ ]
Both release & receive information [ ]

To/from the following:

_____

(Person/Agency) (Address) (Phone/Fax)

For the purpose of:
[ ] Assessment & Diagnosis
[ ] Coordination of care (treatment plan, medication, consultation, continuity of care)
[ ] Other: _____

By initializing below, I specifically authorize the release/receipt of the following mental health/medical records:

_____ Mental Health and/or Medication Information _____Alcohol & Drug Information

_____HIV/AIDS information _____Other specific information_____

Any specific information you **DO NOT** want disclosed includes:
_____

Federal or state law may require that HIV/AIDS, mental health, and drug/alcohol information not be re-disclosed. It is possible, however, that the person or organization who receives the information may re-disclose it. The information being shared will be the minimum amount necessary to accomplish the purpose of this authorization. I understand that this information may be shared via phone, fax, mail, email, in written form, or in person. This authorization is not required. Refusal to sign this will generally not affect your ability to access health services. I understand that information disclosed may be protected under state and federal confidentiality regulations (42 CFR, Part 2) and cannot be re-disclosed without my written consent unless otherwise provided in the regulations. I understand that **IMC** cannot guarantee that the recipient of this information will not re-disclose my health information to another party.

I understand that I may revoke this authorization either in writing or verbally at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described on this form. If **IMC** already used or disclosed information because of this authorization, that cannot be undone.

Unless revoked, this authorization will remain in effect for the duration of my treatment with **IMC** or until this date: _____.

I have read this authorization and understand it.

_____ _____
Signature of Client Date

_____ _____
Madeleine Burkhart, LMFT/ Inspired Mind Counseling Date

Inspired Mind Counseling

HIPAA: Notice of Privacy Practices. Your Information. Your Rights. Our Responsibilities.

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. Effective Date of this Notice: February 1, 2017

Your Rights You have the right to:	**Your Choices** You have some choices in the way that we use and share information as we:
• Get a copy of your paper or electronic medical record	• Tell family and friends about your condition
• Correct your paper or electronic medical record	• Provide disaster relief
• Request confidential communication	• Include you in a hospital directory
• Ask us to limit the information we share	• Provide mental health care
• Get a list of those with whom we've shared your information	• Market our services and sell your information
• Get a copy of this privacy notice	• Raise funds
• Choose someone to act for you	
• File a complaint if you believe your privacy rights have been violated	

Our Uses and Disclosures We may use and share your information as we:
• Treat you
• Run our organization
• Bill for your services
• Help with public health and safety issues
• Do research
• Work with a medical examiner or funeral director
• Address workers' compensation, law enforcement, and other government requests
• Respond to lawsuits and legal actions
• Comply with the law
• Respond to organ and tissue donation requests

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877- 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to share information with your family, close friends, or others involved in your care:

- Share information in a disaster relief situation
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- Treat you: We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
- Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. **For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

- Help with public health and safety issues
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- Do research: We can use or share your information for health research.
- Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests: For workers' compensation claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We never market or sell personal information. Unless in response to a court or administrative order or in response to a subpoena, we will never share treatment records without your written permission.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office and on our web site.

This Notice of Privacy Practices applies to the following organizations: the private practice of Inspired Mind Counseling, Madeleine Burkhart, LMFT #94533, 3744 Mt. Diablo Blvd, Suite 206B, Lafayette, CA 94549, Confidential Phone: 925-528-1363.

Client Name & Signature: _____Date: _____