Pilar Placone, Ph.D., LMFT
Lic # 29210
Phone: (619) 884.1966
Email: pmplacone@gmail.com

Personal Information

Name: _____ DOB: _____

Address: _____

City/State/Zip: _____

Primary Phone #: _____

Secondary Phone #: _____

CDL # _____ Employer: _____

Position: _____ ___ FT ___ PT

In Case of Emergency, please notify:
_____

Relationship: _____ Best Phone #: _____

How did you find me?

Referred By: _____

Internet: (circle one) Google/Web search San Diego Therapist Directory

Other_____

Primary Health Insurance:

Company Name: _____

Address: _____

Policy Holder: _____ Policy/Group #: _____

If you are not the policy holder please complete the following:

Your Relationship to Policy Holder: _____

His/Her Employer: _____

His/Her SS #: _____ His/Her DOB: _____

Medical Information:

Current Status of Health: ___Excellent ___Good ___Fair ___Poor

If you are currently under a physician's care, please complete the following:

Physician's Name: _____ Phone #: _____

Reason: _____

If you are currently under a physician's care, please complete the following:

Psychiatrist's Name: _____ Phone #: _____

Reason: _____

May I notify you're the doctor's mentioned above? ___yes ___no (If yes we will need to sign a Release of Information in session.)

If you are currently taking any prescription medications, please list them below:

	Name	Dosage
1.		
2.		
3.		
4.		
5.		

Counseling Problem & Goals:

Please describe the problem(s) for which you are seeking counseling:

How long has this been a problem?

What do you hope to obtain from counseling?

Have you had counseling in the past?

If so, was this counseling helpful? Please explain.

Is there anything else you wish me to know prior to our working together?

Current Symptoms

Please indicate below any of the following you are now experiencing or within the last six months:

__ Difficulty getting to sleep
__ Difficulty staying asleep
__ Excessive Sleeping
__ Feelings of sadness
__ Feelings of emptiness
__ Lack of interest in things
__ Significant weight loss or gain
__ Feeling of worthlessness
__ Increase/Decrease of appetite
__ Feeling of excessive guilt
__ Difficulty controlling drinking alcohol
__ Difficulty controlling drug use
__ Difficulty controlling gambling
__ Difficulty controlling spending money
__ Anorexia
__ Bulimia
__ Compulsive overeating
__ Very strong startle response
__ Excessive Fears
__ Difficulty expressing anger

__ Crying easily or frequently

__ Easily angered, irritable

__ Difficulty concentrative

__ Unusual indecisiveness

__ Recurrent thoughts of death

__ Plan to commit suicide

__ Suicide attempt

__ Feelings of helplessness

__ Excessive worries & anxieties

__ Fear of going crazy

__ Excessive Nightmares

__ Fear of socializing with people

__Sudden feeling of dizziness

__Sudden numbness or tingling

__ Sudden decreased need for sleep

__ Pressure to keep talking

__ Thoughts racing

__ Easily Distracted

__ Increased need to get things done

__ Recurrent & persistent intrusive thoughts

__ Repetitive behaviors which are difficult to stop

__ Tearfulness

__ Difficulty controlling anger

__ Sudden pounding of heart

__ Sudden sweating

__ Sudden trembling or shaking

__ Sudden feeling of shortness of breath

LIFE STYLE

__Hours of sleep on average

__ Bedtime

__ Wake time

__ Hours of weekly exercise or physical activity

__ Alcohol consumption per week

__Do you smoke (cigarettes, marijuana, other)

__Non prescribed drugs (cocaine, meth, ecstasy, oxycontin, other)

__ Minutes of Meditation/Reflective practice per week

__ Minutes of sunlight per day

__ Number of pleasurable experiences per week

__ Minutes of isolative activities per day (t.v., video games, reading)

RELATIONSHIPS:
Please indicate what applies to you by circling options given:

Marital history: Never Married once Married twice Married more than twice

Children, miscarriages (how many)

Abuse by parent: physical sexual emotional neglect

Abuse by partner: physical sexual emotional neglect

Abuse by healthcare professional or employer: physical sexual emotional

_____

Client Signature_____ Date _____

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COUNSELING AGREEMENT

Parties To The Agreement

This agreement is between Pilar Placone, Ph.D., LMFT and undersigned Client for counseling/psychotherapy sessions of Fifty five (55) minutes in length, unless otherwise discussed prior to session.

Termination of Counseling

Client has the right to request a change of counselor or terminate counseling at any time. However, termination of counseling will not serve to nullify any of the above conditions. Client agrees to bring their account current within seven (7) days of termination.

Confidentiality

Conversations between Client and Therapist will not be disclosed without your written consent except for consultations with other clinicians, unless such disclosure is required or permitted by law, including without limitation: a disclosure pursuant to court order; or a disclosure pursuant to mandatory reportable instances involving suspected abuse or neglect or exploitation; or the disclosure is necessary to protect against an existing threat of life or of serious bodily injury.

Electronic Communication
Most people find it easier to correspond with me via texting and email as well Skype for long-distance therapy sessions. Because these are not considered "secure" to your confidentiality these forms of communication medias are not HIPPA approved. If you would like to be able to communicate using any of the electronic forms indicated below please put an "X" on the line next to the form of communication you approve.

"I understand that the following forms of communication with Pilar Placone, Ph.D., LMFT are not accepted by HIPPA as secure. Knowing this I am accepting the risk to my confidentiality and accept communicating with her by the following:"

Email _____ Text _____ Skype _____

Insurance (if applicable)

Client agrees that they are responsible for all insurance information given to Therapist and that Client is responsible for knowing the insurance requirements and eligibility for therapy/counseling services. Client further agrees to pay for each session at the time of appointment, therapist aggress to bill the insurance company monthly for reimbursement to client.

By signing below, Client acknowledges reading and understanding this agreement in its entirety and agreement to all foregoing terms and receipt of a copy of this agreement and Client also acknowledges receiving a copy of Notice of Privacy Practices.

Client Signature_____Date_____

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COUNSELING FINANCIAL AGREEMENT

Parties To The Agreement

This agreement is between Pilar Placone, Ph.D., LMFT and undersigned Client for counseling/psychotherapy sessions of fifty-five (55) minutes in length, unless otherwise discussed prior to session.

Fee for Services

The fee for the 55-minute sessions is $140. If additional time is requested, the fee for the additional time will be prorated at this rate. All fees are payable in full at the time of the session unless other arrangements have been mutually agreed upon in advance. Insurance is billed as courtesy for Clients, but it is the Client's responsibility to confirm eligibility of benefits and co-payments before the initial session.

Scheduling mistakes on the part of the therapist occasionally happen. If the therapist makes a scheduling mistake resulting in which the clients shows up for an appointment but the therapist has either double booked or is not there for the appointment, the therapist will NOT charge the client for the next scheduled appointment.

Missed Appointments or Cancellation of Counseling Sessions

Client agrees to pay the full fee of $140 for any and all missed sessions cancelled with less than 24 hours' notice. The client will not be charged under these circumstances if the appointment is rescheduled within the same workweek. For cancelations on a Friday the appointment must be rescheduled by Tuesday the following week.

Insurance companies do not pay for “no-shows” or late cancellations. Client agrees that this fee is due and payable within ten (10) days of the scheduled missed session or the fee will increase to $150.

Delinquent Payments

Client agrees to make all payments in a timely manner, as previously described. There will be a $20 late fee added to any balance not received or postmarked with in 30 days of the due date. Client further agrees that any payments not received With in 45 days of the date of service will be considered seriously overdue and will be assigned to a collection agency. There is a $25 fee for returned checks.

By signing below, Client acknowledges reading and understanding this agreement in its entirety and agreement to all foregoing terms and receipt of a copy of this agreement and Client also acknowledges receiving a copy of this Counseling Financial Agreement

_____ _____

Client Signature Date

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH

INFORMATION FOR PURPOSES REQUESTED BY PROVIDER

Type of information to be disclosed:

I hereby authorize Pilar Placone, Ph.D., LMFT to use and/or disclose the following protected health information: All information required by client's third-party payer (Insurance Company).

Purpose and use and/or disclosure:

- To determine insurance benefits coverage and eligibility for insurance benefits
- Processing claims with your insurance company
- Reviewing services provided to you to determine medical necessity
- Utilization review activities

Recipient of protected health information:

_____

Name of Health Insurance Company

Revocation; Redisclosure

It is my understanding that this authorization can be revoked at any time, except to the extent that substantial action may have already been taken in reliance on this authorization, including provision of health care services requiring subsequent disclosure to effectuate payment. Unauthorized redisclosure by recipient is a potential risk.

Duration

If not previously revoked, this authorization will expire upon termination of therapy and full payment of all claims. Except as to third-party payers, this authorization does not include disclosure for future health care services received more than ninety (90) days from date of last signature.

This authorization covers protected health information of:

_____

Name of Health Insurance Client

The signature below authorizes use and/or disclosure of protected health information in accordance with the foregoing from the date of the signature (initial or renewal). I understand that I have the right to refuse to sign this authorization.

_____

Client Signature _____Date _____

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NOTICE OF PRIVACY PRACTICES

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.

I am required by applicable federal and state law to maintain the privacy of your health information, I am also required to give you this Notice about my privacy practices, legal obligations, and your rights concerning your health information

("Protected Health Information" or "PHI"). I must follow the privacy practices that are described in this Notice (which may be amended from time to time).

For more information about my privacy practices, or for additional copies of this Notice, please contact me directly.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures without Your Written Authorization I may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section It, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. Treatment: I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In

addition, I may disclose PHI to other health care providers involved in your treatment.

2. Payment I may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, I may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

3. Health Care Operations: I may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. Required or Permitted by Law: I may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition t may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law Include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law

[Note: HIPAA allows you to do many things that we have not included here. These include disclosures for purposes of reminding clients of their appointments, sending them information about treatment alternatives or other health related services, disclosures to family members or other persons involved in a client's care or in the event you intend to contact a client for fund raising purposes. If you intend to do any of these things, you must include these disclosures in both your NPP and policies and procedures. You must also include an explanation of the client's right to object to such disclosures. In addition, the foregoing descriptions of permissible uses and disclosures must be modified to the extent state law is more protective of client health information (e.g., "State law requires me to obtain your authorization to disclose your health information for payment purposes."). Finally, you may choose to modify the provisions in this section to reflect your individual practices that may be more restrictive than what federal and state law allow.]

B. Uses and Disclosures Requiring Your Written Authorization

1. Psychotherapy Notes: Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

[Note: HIPAA requires psychotherapy notes to be "separated from the rest of the individual's medical record." In addition, if you operate a federally assisted substance abuse program, or obtain HIV/AIDS testing, or other highly sensitive information protected by state law, applicable authorization requirements should be added here.]

2. Marketing Communications: I will not use your health information for marketing communications without your written authorization.

3. Other Uses and Disclosures: Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical record and billing records maintained by me in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, I may deny access to your records. I may charge a fee for the costs of copying and sending you any records requested. (Note: State law may regulate such charges.) If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record will not be accessible to you. [Note: Examples should be included consistent with state law (e.g., records related to mental health, drug treatment, or family planning services)].

B. Right to Alternative Communications. You may request, and I will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. I am not required to agree to any such restriction you may request.

D. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by me after August 1, 2010. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. Right to Request Amendment. You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.

G. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that I have violated your privacy rights, you may file written complaints with the Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint with the Office for Civil Rights or myself.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on August 1, 2010.

B. Changes to this Notice. I may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the waiting area of my office. You may also obtain any revised notice by contacting the Privacy Officer.