Mehrzad Bazyar M.S. LMFT
California Board of Behavioral Science Registered
Licensed Marriage & Family Therapist (LMFT-108725)

INTAKE INFORMATION

Please be sure to legibly fill out the Intake Information Page completely

Date ____/____/_____ *Your Therapist's Name is:* Mehrzad Bazyar MS. LMFT (LMFT-108725)

CLIENT _____ Birth date ____/____/____

Address _____ Gender: ❑ Female ❑ Male

_____ Soc. Sec # _____

_____ Relationship Status: ❑ Single ❑ Married

Home Phone _____ ❑ Domestic Partner ❑ Divorced

Client's Occupation _____ ❑ Other _____

Employer or School _____ Work Phone _____Ext. _____

Address _____ Cell Phone _____

Who referred you? _____ E-Mail _____

Physician _____ Physician Phone _____

Date if Last Physical ____/____/____ Major Illness _____

Current Medications _____

History of Domestic Violence: Yes No History of Sexual Abuse: Yes No

Previous Psychotherapy? Yes No

If yes, when? _____, with whom? _____

OTHER FAMILY MEMBERS:

Name	*Gender*	*Birth date*	*Relationship*	*Living at home*
_____	M/ F	____/____/____	_____	yes / no
_____	M/ F	____/____/____	_____	yes / no
_____	M/ F	____/____/____	_____	yes / no
_____	M/ F	____/____/____	_____	yes / no

PERSON RESPONSIBLE FOR THE ACCOUNT _____

Address *(if different from above)* _____

Signature _____ Date ____/____/____

PERSON TO CONTACT IN CASE OF EMERGENCY:_____PH. #_____

I AUTHORIZE TREATMENT FOR THE MINOR CHILD(REN) UNDER MY CARE.

Signature _____ Date ____/____/____

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 there 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 or 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 intent to harm to yourself, he/she will make every effort to ensure 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 your 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 your 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.

5. Risk & Benefits: Counseling is a joint effort between the client and the therapist in which a wide range of issues can be discussed. Progress and success may vary depending upon the problem or issue being address and the involvement of the client in treatment as well.

_____ _____
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

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OFFICE POLICIES HIGHLIGHTS PAGE

Appointments are either 60 or 90 minutes.
Session Rates: $_____/Hour or_$_____/90 minutes, if insurance is not being used. Please pay your copay or fee at the beginnings of each session by check, visa, master card or cash.
There is a $25.00 service fee for any returned checks.
Once per year, your fee will be reevaluated and may be raised with a 30 days notice.

Cancellations: 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: (805) 906-1657. Otherwise, you will be charged for your missed session (charged to you, not your insurance company for the full fee). If we have set reoccurring appointments, you will be charged for the duration of two more schedule appointments without contact to cancel those appointments (see Termination section). If you had an extreme emergency, I will offer you an alternative date if possible to make-up for late cancelation within the same week. If that offer doesn't work for you, unfortunately you will be charged the full fee.

Telephone/E-mails and Text Messaging: Telephone/e-mail and text messaging time is limited to 10 minutes, beyond which I will bill you at my standard rate rounded to the next half hour. Payment will be expected at the next regularly scheduled appointment, or sooner by mail.

Treatment of minors: Children under the age of 18 years 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.

Limits to Confidentiality: Review thoroughly in the attached Therapeutic Contract/Informed Consent for Treatment the section called Limits to Confidentiality.

Court involved cases: By signing below you understand that All-In Health Foundation and your Therapist does not act as a witness in court cases, or report writing of any kind (except for providing evidences of attendance upon request). You agree that you will not request any of these services from All-In Health Foundation and your therapist.

Please read the attached Therapeutic Contract/Informed Consent for Treatment thoroughly. I have read and fully understand this Office Policies Highlights Page.

Signature _____ Date_____

Signature _____ Date_____

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Consent for Treatment

I hereby authorize the request Mehrzad Bazyar M.S. LMFT (LMFT-108725) to carry out psychological examinations, diagnostic procedures and/or treatment, which now or during the course of my care as a patient are advisable.

I understand that the purpose of any procedure will be explained to me and be subject to my agreement.

I have read and fully understand this Therapeutic Contract/Informed Consent of Treatment.

Would you like to receive our monthly Newsletter? YES ___ NO ___

Would you like to receive promotional deals on our services? YES ___ NO ___

Would you like to be notified of upcoming classes/groups/retreats? YES __ NO ___

Client's Signature ._____ Date _____

Client's Signature ._____ Date _____

Therapist Signature ._____ Date _____

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Acknowledgement

Federal law requires that all patients be given a copy of the California Notice Form. The Notice describes in detail how patient health information is used and shared with others. All reasonable efforts will be made to protect the privacy of patient health information, whether it is maintained on paper or electronically, regardless of how it is communicated.

I hereby acknowledge that I received the link to view online for the California Notice Form (Notice of Privacy Practices.): **http://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Notice-of-Privacy-Practices-English.pdf**

Name (Print): _____

Signature: _____

Date: _____ Date of Birth: _____

Name (Print): _____

Signature: _____

Date: _____ Date of Birth: _____

When the patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Name (Print): _____

Signature: _____

Date: _____ Relationship to Patient: _____

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ProfessionalCharges.com

Credit/Debit Card Payment Consent Form

Client Name _____
Print Last *First* *Middle Initial*

Name on Card if different _____

I authorize _____ **and ProfessionalCharges.com**
Provider Name

to charge my card for professional services for

the amount of $_____.

Type of Card: ☐ VISA ☐ MasterCard ☐ Discover Exp. Date _____

Card Number _____ - _____ - _____ - _____ CVV Number _____

Card Holder's Billing Address for Monthly Card Statements

_____
Street *City* *State* *Zip*

If I have questions about these charges, I agree to contact my provider and if necessary ProfessionalCharges.com via email (info@professionalcharges.com). I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

Card Holder Signature _____ Date ____ /____ /____

Charges may appear on your card statement as an abbreviation of **ProfessionalCharges.com** *usually* **ProfCharges.com**

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Consent to Obtain or Release Confidential Information

Information to be Released from:	Client Identifying Information:	Information to be Released to:
Mehrzad Bazyar M.S. LMFT **Counseling Services** **(805) 906-1657** **www.TheTherapist.Org**	**Name:** **Date of Birth:**	**Attention:**

I _____ , hereby consent to and authorized The Counseling Services, Mehrzad Bazyar M.S. LMFT, to: Obtain from the above named individual/agency and also release to the above named individual /agency the following specific types of information:

Admission/Psychological assessment, diagnose, entire record, social history, medication list, health history, lab tests, discharge summary, treatment plan, vocational testing, and other related therapeutic information for the purpose of facilitation of assessment and treatment.

This information might be provided in the following format: Written, verbal and audio &/or visual. This consent can be revoked by the undersigned at any time through a written notice addressed to the Counseling Services and Mehrzad Bazyar, and if not revoked earlier it shall terminate after a year from date signed.

_X_____ _X_____

Dated Signature

X_____ _X_____

Mehrzad Bazyar M.S. LMFT (10872 For Minor Clients: Parents, Guardian / Legal Rep.

See California Welfare and Institutional Code section 5328 and Evidence Code section 1014 for further information.

A faxed copy of the signed Consent to Release Information is valid as original