Terry Akhtarzad M.A, LMFT
Licensed Marriage and Family Therapist
#103315
1626 Westwood Blvd #103
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(310) 596-4300

TerryAkhtarzad@gmail.com

CONFIDENTIAL CLIENT INFORMATION
INTAKE AND CONSENT

GENERAL INFORMATION

Client's Name _____ Today's Date _____

Address _____City _____ Zip _____ Home Phone ( ) _____

Cell phone ( ) _____ Birth date _____ Age _____ MRN#

Education highest level _____

E-mail address: _____ Website _____

You have my permission to contact me on my __ Home Phone __ Cell Phone __ Work Phone __ E-mail

Driver's License #_____-
Insurance ID #

I found you via: ___Google ___ Therapist referral site (which): _____ ___ Person (who) _____

EMPLOYMENT

Occupation _____ Work Responsibilities _____ Work phone ( ) _____

Employer _____ Address_____ City _____Zip _____

PERSONAL / FAMILY INFORMATION

Marital Status _____ If married, anniversary date _____

Partner's Name _____ Partner's Age _____ Partner's Occupation _____

Length of current marriage/relationship _____ # of Previous marriage(s) ____ Length of each _____

Names/ages of children: this marriage _____ previous marriage(s) _____

Legal/physical custody? visitation arrangement? _____

Emergency Contact, if those in house cannot be reached:

Name _____ Relationship _____ Phone ( ) _____ Cell ( ) _____

Purpose for today's consultation: _____

Are you CURRENTLY involved in a legal procedure? _____ If so, does it concern your seeking counseling? _____

CONFIDENTIAL PSYCHOLOGICAL/MEDICAL HISTORY

Are you CURRENTLY seeing another psychotherapist or counselor? _____ If so:

Name _____ Phone ( ) _____

For how long? _____ For what purpose(s)? _____

Have you PREVIOUSLY been in psychotherapy or counseling? _____ If so: When? _____

For how long? _____ For what purpose(s)? _____ Results _____

If you have had difficulties with any of the following, **either current or past**, please explain:

_____ Alcohol, drug, or tobacco dependence or frequent use? _____

_____ Eating disorder(s)? _____

_____ Other addictive or compulsive behavior(s)? _____

_____ Depression or suicidal thoughts/attempts? ————————/-

———- Homicidal thought/attempt _____

_____ Anxiety or panic attacks? _____

_____ Major illness, surgery, or other physical problems)? _____

_____ Anger, arguments, domestic violence (current or childhood)? _____

_____ Marital, relationship, or family problems (current or childhood)? _____

_____ Learning disabilities/problems or ADD/ADHD? _____

List stressful situations in your life (accident, hospitalization, separation from loved ones, traumatic event, head injury)

_____

_____

What have you found has been helpful to you when you have felt depressed, anxious, etc.?

_____

In ONE word, please describe your current: relationship situation _____ sexual relationship(s) _____

In ONE word, describe how you are feeling in general lately: _____ how you feel today _____

Please list ALL prescription medications you are CURRENTLY taking:

_____

Please list any PREVIOUS medications you have taken for psychological purposes:

_____

Amount of CURRENT use: Tobacco _____ Alcohol _____ Caffeine (coffee/cola/chocolate) _____

Sugar _____ Other drugs (marijuana, cocaine, etc - specify) _____

Date of last medical exam _____ Doctor's Name _____ Phone ( )_____

Other useful information to assist in counseling: _____

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Psychotherapy is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

CONFIDENTIALITY:

All interactions with Therapy Services, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. No record of counseling is contained in any academic, educational, or job placement file. You may request in writing that Terry Akhtarzad release specific information about your counseling to persons you designate.
In case of insurance Terry Akhtarzad will ask you to sign a release to talk to your insurance company and third party biller.

EXCEPTIONS TO CONFIDENTIALITY:

- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety.

- California state law requires that if your therapist learns of, or strongly suspects, physical or sexual abuse or neglect of any person under 18 years of age must report this information to county child protection services. Furthermore, elderly abuse of any individual 65 years or older or any dependent adult will be reported.

- A court order, issued by a judge, may require Terry Akhtarzad to release information contained in records and/or require her to testify in a court hearing.

Cancellation policy

We appreciate prompt arrival for appointments. Please notify me if you will be late. Twenty-four hour notice of cancellation allows me to use the time for every client. Hence you will be charged in full for any cancellations without the 24 hr notice. We will start and end the session on time. If you are late to session we will still stop at ten minutes prior to the hour as to be courteous to the next Client.
Please note that your insurance will not pay for your cancellation fee and that you are responsible to pay the provider out of pocket. The client is responsible to notify the provider for insurance coverage and eligibility and to pay the co-pay directly to the provider. You will need to put your credit card information via paper or IVY pay a HIPPA compliant company for late cancellation or unpaid balances.

***Returned checks will be charged $ 30.00 plus the amount of the check. In an attempt to collect any debt due to the therapist, the therapist exercises the right to send the account to the collection agency.

Communication

I will try and return your phone calls within 24 hours unless on leave which you will have ample notice. Texting is for appointments and for cancellation only . If you need to speak to me please text me the time you are available and I will try to call you back by the end of the day.

Insurance

The full fee is paid in advance. The therapist will Provide the Client a super bill as courtesy. The client is responsible to ask the insurance company if their session will be covered, the amount of their copay and of their deductible has been met. If your deductible has not been met you are responsible to pay the provider out of pocket. In case you use insurance, your record will be shared with the insurance company, and the third party Biller.

For couple (relational) sessions,
Please note that most insurances do not cover it and you will need to find out from your insurance. I will need to collect the full fee of 150.00/ 50 Minute session in advance unless we have arrangement for sliding scale due to financial hardship.

In cases where you need two sessions back to back please note that is is 100 minute

Couples

There is a "no secret " policy for couples. If one of the couple calls the therapist in between session, the therapist will encourage them to bring up the issue in session. Exception to this rule will be crisis, safety and health protected item covered under HIPPA.

Please note: I will not testify or be an expert in any court proceedings , If there is an unavoidable case or situation I will have additional charges up to $400.00/ hour which I will discuss if it becomes necessary.

If you need me to fill out any forms including leave of absence from work I will charge you $200.00/ hour even if you are no longer my client.

SOCIAL MEDIA

I Terry Akhtarzad use Facebook, LinkedIn, Instagram for purposes. This may be where you first learned of my practice.
While I value the opportunities for information and connection that social media provides, I also want to ensure your privacy and confidentiality to the degree possible. Therefore, I do not accept "friend" requests or similar connection requests from clients. Commenting or direct messaging through social media is not an appropriate way-to contact me, and I will not acknowledge or respond to client communication attempts through these channels. I apologize if this may at first appear to be cold; it is designed to protect your interests and your privacy.
To reach me, please call 3105964300 or email me at terryakhtarzad@gmail.com if you wish.
I do not provide client contact information to any social media platforms. However, you still may find that these platforms present some risk to your confidentiality. They are known to match people using descriptions like "People You May Know" simply if you and the other person share the same contact

in your phone, and have given the social media site access to your contacts. If you have “Liked,” commented on, or otherwise attempted to respond to any of my posts in the past, this information may also be used by social media platforms to connect you to me – and may result in you being connected to others who have connections with me in various ways. As such, you may be suggested as a potential contact for other clients, and other clients may be suggested as a potential contact for you. I have no ability to control or alter how social media platforms use information about you or me that I did not share.

I have read and discussed the above information with my therapist. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of the Counseling Services.

_____ _____

Signature of Client. *Date:* *Signature of Therapist.*

TERRY AKHTARZAD LMFT#103315

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I ———— - ——————authorize my therapist **Terry Akhtarzad LMFT** to disclose/exchange specific information and records obtained in the course of

my counseling with My insurance and third party biller for the purpose of claims and Billing.

This disclosure of information and records authorized herein is required for Communication and shall be limited to the following specific types of information Billing and collaboration ; and will remain valid until the date:

I understand that any cancellation or modification of this authorization must be in writing
Client name
DOB
Parent or legal Guardian Name
DOB
signature