**Julia Rosengren, Psy.D.**

Licensed Clinical Psychologist PSY29240

5252 Balboa Ave Suite 803, San Diego, CA 92117

858.432.3919

**New Client Information Packet**

Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender:  Male  Female  Transgender  Other- Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Information:**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OK to contact? OK to leave message/text?

Telephone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes  No  Yes  No

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes  No  Yes  No

Personal Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes  No

Who referred you to me? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May I contact them to thank them for the referral?  Yes  No

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Basic Information:**

Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sexual Orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How religious or spiritual are you? (Circle the number that describes you best)

1 2 3 4 5 6 7 8 9 10

Very Somewhat Not at all

Relationship Status: (Check all that are true for you)

Single, not dating  Single and dating  Married  Divorced  Widowed

Committed Relationship(s)  Open Relationship/Marriage  Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parental Status:

No Children  Biological Parent (Number and ages of children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Step-parent/Co-parent  Foster Parent  Adoptive Parent  Grandparent

Highest Level of Education Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ College/High School Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financially Responsible Person’s Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from above) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Family and Living Situation:**

Please describe your current living situation (house, apartment, dorm room, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your parents still living?  Yes  No

Are they still married:  Yes  No If not, how old were you when they divorced \_\_\_\_\_\_\_\_\_\_\_

Do you have any brothers:  Yes  No If yes, how many?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any sisters:  Yes  No If yes, how many?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone in your family struggled with mental health difficulties or received mental health or substance use treatment?  Yes  No

If yes, please describe:

**Employment:**

Status:  Full-Time  Part-Time  Work as parent in the home  Student

Unemployed  Retired  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If employed, what is your employer or company’s name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If employed, what is your job title? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Military Experience:**

Have you ever been in the military?  Yes  No Are you active military?  Yes  No

If yes, please answer the following questions:

Branch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date entered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rank/Rate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time served overseas?  Yes  No Time served in combat?  Yes  No

**Health:**

Do you have health insurance?  Yes  No Name of insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any medical issues or serious injuries or illnesses:

Please list all current medications (i.e., name, dose, frequency, reason):

Please list any psychiatric medications you have taken in the past, but are no longer taking:

**Previous Counseling**

Have you ever seen a counselor or therapist in the past?  Yes  No

If yes, how long ago and why did your treatment end? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been admitted to a psychiatric hospital?  Yes  No

If yes, please describe the stay and reasons for it: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received a psychological or developmental evaluation?  Yes  No

If yes, by whom and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received a diagnosis for a psychological condition?  Yes  No

If yes, what was the diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any and all previous psychological services you have received (e.g., couple’s therapy,

anger management classes, parenting courses, pre-marital counseling):

**Coping Behaviors:**

Please describe your relationship to alcohol and drugs, if any:

Do you have any concerns about body image?  Yes  No

**Legal History:**

Have you ever been arrested?  Yes  No

As an adult, have the police or other law enforcement agents ever been called to your home?  Yes  No

Have you ever been on probation or parole?  Yes  No

If yes to any of the above questions, please describe the circumstances of the convictions below:

**Current Situation:**

What is your main concern you would like support with?

When did this problem start?

What is your reason for seeking support now?

Are there other issues you would like support with as well? If so, please describe them.

Is there any additional information that would be helpful for me to know?

**What are your main goals for therapy?**

1.

2.

3.

**Symptom Checklist:**

Please check all feelings and symptoms that apply:

Difficulty Sleeping  Crying Spells  Loss of Sex Drive  Memory Loss  Nausea

Anger Outbursts  Frustration  Rapid Heart Beat  Light Headed  Anger

Sense of Impending Doom  Loss of Appetite  Loss of Enjoyment  Panic Attacks  Fatigue

Difficulty Catching Breath  Stomach Aches  Tightness in Chest  Cultural Concerns  Sadness

Difficulty Concentrating  Headaches  Feeling Worried  Excessive Energy  Impulsive

Sleeping Too Much  Nervousness  Hopelessness  Problems at Work  Euphoria

Thoughts of killing yourself:

Are these thoughts happening now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicide Attempts?

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (please describe):

**Please Rate And Comment On Your Satisfaction In These Life Areas:**

|  |  |
| --- | --- |
| **Work/Career**  1 2 3 4 5 6 7 8 9 10  Extremely Dissatisfied Very Satisfied | Comments: |
| **Romantic Relationship**  1 2 3 4 5 6 7 8 9 10  Extremely Dissatisfied Very Satisfied | Comments: |
| **Family Relationships**  1 2 3 4 5 6 7 8 9 10  Extremely Dissatisfied Very Satisfied | Comments: |
| **Friends/Social Support**  1 2 3 4 5 6 7 8 9 10  Extremely Dissatisfied Very Satisfied | Comments: |
| **Exercise/Fitness**  1 2 3 4 5 6 7 8 9 10  Extremely Dissatisfied Very Satisfied | Comments: |
| **Relationship with Food**  1 2 3 4 5 6 7 8 9 10  Extremely Dissatisfied Very Satisfied | Comments: |
| **Body Image**  1 2 3 4 5 6 7 8 9 10  Extremely Dissatisfied Very Satisfied | Comments: |
| **Sex**  1 2 3 4 5 6 7 8 9 10  Extremely Dissatisfied Very Satisfied | Comments: |
| **Spirituality**  1 2 3 4 5 6 7 8 9 10  Extremely Dissatisfied Very Satisfied | Comments: |
| **Life Goals**  1 2 3 4 5 6 7 8 9 10  Extremely Dissatisfied Very Satisfied | Comments: |

**Checklist of Difficult Life Events**

Below is a list of life events that many people have experienced. Please place check marks next to the events that you have experienced in your life.

Your parent(s) died when you were a child.

Your own child died.

Your heterosexual partner/spouse died.

Your same-sex partner/spouse died.

You were robbed.

You were physically assaulted by an opposite sex stranger.

You were physically assaulted by a same-sex stranger.

You were a victim of a hate crime.

You witnessed your parents physically fighting when you were a child.

You were sexually harassed at school or work by a member of the opposite sex.

You were sexually harassed at school or work by a member of the same sex.

You were sexually assaulted by a member of the opposite sex.

You were sexually assaulted by a member of the same sex.

Your parent(s) was/were addicted to drugs/alcohol.

You were sexually abused as a child.

You were physically abused as a child.

You were removed from your parents’ home by the authorities.

Your parent was placed in jail.

You were arrested.

You were placed in jail.

You witnessed street violence or a violent crime.

You were forced to leave your country (refugee).

You had an abortion.

You were diagnosed with a life-threatening illness.

You tested positive for HIV.

You got a heterosexual divorce.

You were separated or divorced from your same-sex life partner.

Your partner was diagnosed with a life-threatening illness.

Your partner tested positive for HIV.

You were addicted to drugs/alcohol.

You sexually assaulted someone.

You physically assaulted someone

Your parents divorced.

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**\_\_**

**CONSENT TO TREATMENT AND PSYCHOTHERAPY**

**Psychotherapy**

We will be working together collaboratively, using empirically supported approaches. Your full participation as the client will determine much of the benefit you receive from therapy. It is important to participate openly in the process of describing problems and issues of concern. This includes asking questions and expressing agreement or disagreement with anything that happens in our sessions. While therapy can help you to feel stronger, provide insight, and create motivation for change, it may also sometimes feel frustrating and painful. This is a natural process that may occur when you are examining uncomfortable emotions and situations. While there are no guarantees about therapy outcomes, the best results occur when you bring up and discuss any and all reactions you may have to therapy.

I am not a physician and I do not prescribe medications. However, if you need a referral for a medication evaluation, I will be glad to suggest some options. I am also open to collaborate with any physician and psychiatrist who may already prescribe for you.

**Telephone and Emergency Procedures**

To reach me for between sessions, call 858-432-3919 between the hours of 8:00 A.M. and 8:00 P.M. Calls after business hours will often be returned the next day.

For emergency situations, please call 911. If your situation is urgent and you need to speak to a mental health professional but cannot reach me, call the Crisis Line at 800-479-3339 where counselors are always available to take urgent calls. **Please call me, but not email or text me in urgent situations.** If I will be unavailable for an extended period of time or if a unforeseen emergency occurs, Erica Wollerman, Psy.D. will be your point of contact and have access to your record. Her contact number is 858-342-1304.

**Confidentiality**

Psychotherapy sessions are confidential, meaning this information will not be revealed to anyone without your written permission, except as required by law. California law states there are exceptions to confidentiality, which are:

1. Reasonable suspicion of child abuse (physical, sexual, possibly emotional) or neglect, I am required to make a report to child welfare services and/or notify law enforcement. This includes child pornography or a child as the perpetrator of abuse, such as sexting.
2. Reasonable suspicion of elder or dependent adult abuse, will require a report to authorities.
3. If I assess that you are an imminent danger of killing yourself or that you are unable to take care of yourself (gravely disabled), I may be required to contact the appropriate authorities,

seek appropriate hospitalization, and/or take other steps such as contacting your emergency contact.

1. If I assess that you have intent to harm someone, I may be required to take protective actions, which may include notifying the potential victim, notifying law enforcement, and/or seeking appropriate hospitalization.
2. If you are involved in any legal proceeding, there is always a chance the records could be subpoenaed and with a valid court order I may have to provide information.
3. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential.

**Text and Email Communication**

All emails and texts sent and received will be included in your legal record. I use email and text communication only with your permission and for administrative purposes unless we have made another agreement. That means that email exchanges should be limited to things like setting and changing appointments, billing matters and other administrative issues. Limiting the information that you include in emails will help to limit intrusions on your privacy. If you send clinical information via text and email, you are doing so at the risk of your privacy and have been warned.

**Social Media**

I do not communicate with, contact, or accept any friend/contact requests with any of my clients through social media platforms. If I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant privacy risks for you and may impact the therapist-client relationship. You may find my psychology practice on sites for users to rate their providers and add reviews. If you should find my listing on any of these sites, please know that my listing is not a request for a testimonial, rating, or endorsement from you as my client. If you choose to post an online review about me either while you are in treatment or afterwards, please keep in mind that you may be revealing confidential information about your treatment.

None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like.

**Termination**

You have the right to terminate therapy with me at any time without any financial, legal, or moral obligations other than those you have already incurred. If you are no longer able to participate in therapy due to financial concerns, I will work with you to establish a payment plan, or help you ease into therapy with another qualified professional who offers services at a lower fee. If either party decides to terminate therapy, it is recommended we meet for at least one session to review our work together, our goals and accomplishments, any further work to be done, and our options. This process is intended to facilitate a positive termination experience and give both parties the opportunity to reflect on the work that has been done.

**Client Litigation**

I will not voluntarily participate in any litigation, or custody dispute in which you and another individual, or entity, are parties. I have a policy of not communicating with attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in a legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law to appear as a witness, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made ourselves available for such an appearance at the rate of $400 per hour. Time spent in court or being deposed will be billed at $450 per hour.

Please sign below to indicate that you understand and agree to the above and consent to treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Julia Rosengren, Psy.D.**

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**Fee and Financial Agreement**

**Standard Fees: Initial Appointment: $150**

**Individual/Couples/Family Psychotherapy, per session: $150**

**Other services provided, per hour: $150**

By signing below, I agree to pay a fee of $150 per 50 minutes to Julia Rosengren, Psy.D. for services provided. There will be a $20 surcharge for each returned check. I understand that this fee is subject to change, and that any change in fee will be as mutually agreed upon. I understand that my fee is subject to periodic review, particularly if my financial situation changes and I am paying a reduced fee. I agree to pay for services at the time they are provided, or as frequently as mutually agreed upon. I understand that my health insurance cannot be billed for missed appointments. I agree to pay my full session fee for appointments missed without providing **24 hours notice**, emergencies excepted. I may waive the late cancellation for good cause at my sole discretion. This is not considered a waiver for next time and any waiver shall not be considered a waiver for future occurrence.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed on, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or attorney or going to small claims court which will require disclosure of otherwise confidential information. In most collection situations, the only information released regarding a client’s treatment is the name, the nature of services provided, and amount due. (If such legal action is necessary, its costs will be included in the claim).

**Credit Card Information**

A current credit card number of the financially responsible person must be on file at all times (provided below). Your credit card will only be used to pay for missed appointments, late cancellations, and unpaid balances. Payment by cash, credit card, or check is due at the time of your appointment.

The credit card to remain on file is:

Please check one:  MasterCard  Visa  American Express

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_ Security Code: \_\_\_\_\_\_\_\_\_

Name as it appears on the card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number, Street City, State, Zip Code

I authorize Julia Rosengren, Psy.D. to charge my credit/debit card for any missed appointment fees, late cancellation fees, and/or unpaid balances. I understand that I am responsible for all charges.

**Signature of cardholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**CALIFORNIA NOTICE FORM**

**Notice of Psychologists’ Policies and Practices to Protect the Privacy of Your Health Information**

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice conforms to the Federal Health Insurance Portability and Accountability Act (HIPAA) effective April 14, 2004. It also conforms to the Health Care Privacy Laws of California.

**I. Disclosures for Treatment, Payment, and Health Care Operations:** I may use or disclose your protected health

information (PHI), for certain treatment, payment, and health care purposes without your authorization. In certain circumstances, I can only do so when the person or business requesting your PHI gives me a written request that includes certain promises regarding protecting the confidentiality of your PHI.

To help clarify these terms, here are some definitions:

* **“PHI”** refers to information in your health record that could identify you.

**“Treatment and Payment Operations”**

* + **“Treatment”** is when I provide or another healthcare provider diagnoses or treats you. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist, regarding your treatment.
  + **“Payment”** is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  + **“Health Care Operations”** is when I disclose your PHI to your health care service plan (for example your health insurer), or to your other health care providers contracting with your plan, for administering the plan, such as case management and care coordination.
* **“Use”** applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
* **“Disclosure”** applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.
* **“Authorization”** means written permission for specific uses or disclosures.

**II. Uses and Disclosures Requiring Authorization:** I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment and payment operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke or modify all such authorizations (of PHI or psychotherapy

notes) at any time; however, the revocation or modification is not effective until I receive it in writing.

**III. Uses and Disclosures with Neither Consent nor Authorization:** I may use or disclose PHI without your consent or authorization in the following circumstances:

1. **Child Abuse:** Whenever I, in my professional capacity, have knowledge of or reasonably suspect that a child has been the victim of child abuse or neglect, I must immediately report such to Children Protection Services (CPS). Also, if I have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional wellbeing is endangered in any other way, I may report such to CPS as well.
2. **Elder or Dependent Adult Abuse:** If I, in my professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these or if I reasonably suspect such, I must report the known or suspected abuse immediately to Adult Protective Services (APS) or the local law enforcement agency.

**I do not have to report such an incident if:**

i. I have been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect;

ii. I am not aware of any independent evidence that corroborates the statement that the abuse has occurred;

iii. the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court ordered conservatorship because of a mental illness or dementia; and

iv. in the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

1. **Health Oversight:** If a complaint is filed against me with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.
2. **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services that I have provided you, I must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; or 3) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides me with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified me that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.
3. **Serious Threat to Health or Safety:** If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.
4. **Workers’ Compensation:** If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of your initial examination, and at subsequent intervals as may be required by the administrative director of the Worker’s Compensation Commission in order to determine your eligibility for worker’s compensation.

**IV. Patient’s Rights and Psychologist’s Duties:**

1. **Patient’s Rights:**
   1. **Right to Inspect and Copy:** You are entitled to receive a copy of your medical record unless I believe that receiving that information would be emotionally damaging. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records or receive a copy of your records, I require written notice to that effect, and I would expect to discuss your request with you in person. If I deny you access to your records, you can request to speak with an independent colleague of mine about your request. Your request for independent review of your request should also be made in writing. If you are provided with a copy of your medical record information, I may charge a fee for any costs associated with that request.
   2. **Right to Amend:** If you believe that the information I have about you is incorrect or incomplete, you may ask me to amend that information. It is my practice to accept this sort of request in writing, and that any information you may wish to add to your record also be provided to me in written form.
   3. **Right to an Accounting of Disclosures:** You have the right to request an "Accounting Of Disclosures." This is a list of the disclosures I have made of medical record information. That information is listed on the Authorization To Release Information, and will be provided to you at your written request.
   4. **Right to Request Restrictions:** You have the right to privacy, and to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. As noted above, I will not release your confidential information without your written permission. Any restrictions to your Authorization To Release Information should be specified on the Authorization.
   5. **Right to Request Confidential Communications:** You have the right to request that I communicate with you only in certain ways. For example, you can ask that I not leave a telephone message for you, or that I only contact you at work or by mail.
   6. **Complaints Regarding Privacy Rights:** If you believe your privacy rights have been violated, you may file a written complaint with me, or with an independent colleague of mine, or with the U.S. Department of Health and Human Services, 50 United Nations Plaza, Room 322, San Francisco, CA, 94102. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

You have the right to a paper copy of this document, and you will be offered one when you sign the original for your medical record. I reserve the right to change my policies as outlined herein. If they change, you will be informed of that change and will provided with a copy of the current document if desired.

1. **Psychologist’s Duties:**
   1. I am required by law to maintain the privacy of your PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
   2. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
   3. If I revise my policies and procedures, I will provide you with a revised notice either in person or by mail.

**V. Agreement to Arbitrate:** It is understood that any dispute as to psychological malpractice, that is as to whether any psychological services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. All claims for

monetary damages exceeding the jurisdictional limit of the small claims court against the psychologist and the psychologist’s partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including claims for loss of consortium, emotional distress or punitive damages.

A demand for arbitration must be communicated in writing to all parties. Each party to the arbitration shall pay such party’s pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party’s own benefit. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**I do hereby acknowledge receipt of this office’s Notice of Psychologists’ Policies and Privacy Practices.**

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Signature Printed Name Date