# Douglas R. Keene, Ph.D.

Client Name _____

Address _____ City _____ Zip _____

Home Phone (___) _____ Mobile Phone (___) _____ Work Phone (___) _____
O.K. to leave message (circle for each)? Yes/No Yes/No Yes/No

Email Address _____ Sex M☐ F☐ Age____ Birthdate _____

Marital Status: Single☐ Married☐ Widowed☐ Separated☐ Divorced☐ Living Together☐

Employer/School _____ Occupation _____

Work/School Address _____

Whom may we thank for referring you? _____ Highest education (degree/years in school) _____

Notify in case of emergency: _____ Phone _____ Relationship to client: _____

Names, ages, and relationships of other persons living with you: _____

_____

Primary Care Physician _____ Address _____

Phone (___) _____ Date of most recent visit _____ Date of most recent physical _____

Describe any health problems _____

List all current medications, dosage, length of time taking it _____

_____

List any allergies to food or medication _____

Please list any previous mental health professionals you have seen, city where located, when and for what reason you saw him/her at that time _____

_____

Please describe the reason you are seeking services from Dr. Keene _____

_____

## INSURANCE INFORMATION

Responsible Party _____ Relationship to Client _____

Birthdate _____ Social Security # _____

Address (if different than above) _____

Employer _____ Occupation _____ Work Phone _____

Insurance Company Name _____ Insurance Company Telephone Number _____

Group/Contract # _____ Subscriber Insurance Identification # _____

PLEASE CONTINUE NEXT PAGE

## ADDITIONAL INSURANCE INFORMATION

***Please complete this section only if client is covered by a secondary insurance policy***

Responsible Party _____ Relationship to Client _____

Birthdate _____ Social Security # _____

Address (if different than above) _____

Employer _____ Occupation _____ Work Phone _____

Insurance Company Name _____ Insurance Company Telephone Number _____

Group/Contract # _____ Subscriber Insurance Identification # _____

## ASSIGNMENT OF INSURANCE BENEFITS

I certify that I (or my dependent) have insurance coverage through the company (s) listed herein, and assign directly to Douglas R. Keene, Ph.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Douglas R. Keene, Ph.D. or his representatives to release all information necesssary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that most insurance companies do not pay for sessions cancelled within 24 hours of the appointment time. I agree to pay full fee for any appointment not cancelled within 24 hours. I agree to pay all attorney's fees and collection expenses should this office need to institute any suit or action to secure the payment of this note. I understand there is a $30.00 fee for returned checks.

| Responsible Party Signature | Relationship to Client | Date Signed |
|---|---|---|

***In order to provide you with the most comprehensive service, I request that you authorize me to inform your primary care doctor that I am working with you. Most managed care companies insist that the psychotherapist closely coordinate with the client's doctor. If you have any questions or concerns about this, I welcome your discussing them with me.***

I authorize Douglas R. Keene, Ph.D. to release/receive/exchange information regarding my treatment with my primary care physician whose name I listed prior as well as any medical doctors and specialists who are presently treating me. I understand that my records are protected under Federal and State Confidentiality Regulations. This authorization may be withdrawn at any time in writing except to the extent the person or program which is to make this disclosure has acted in reliance on it. The authorization shall remain in effect for as long as I am in treatment with Dr. Keene unless I revoke it. Upon revocation of consent, further release of information shall cease immediately. File copy is considered equivalent to the original.

I acknowledge that the information to be released has been explained to me, and this consent is given of my own free will.

| Client Signature | Date Signed |
|---|---|
| Parent, Guardian or Authorized Representative | Witness |

PLEASE READ AND SIGN ATTACHED GUIDELINES

# DOUGLAS R. KEENE, PH.D.

License MFT 19528

## CLIENT INFORMATION AND AGREEMENT FOR SERVICE

### Introduction

This Agreement is intended to provide
(herein "Client") with important information regarding the practices, polices and procedures of Douglas R. Keene, Ph.D., MFT (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Client. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

### Risks and Benefits of Therapy

Psychotherapy is a process in which Therapist and Client discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Client can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Client may be experiencing. Psychotherapy is a joint effort between Client and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Participating in therapy may result in a number of benefits to Client, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Client, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Client's perceptions and assumptions, and offer different perspectives. The issues presented by Client may result in unintended outcomes, including changes in personal relationships. Client should be aware that any decision on the status of his/her personal relationships is the responsibility of Client. During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Client should address any concerns he/she has regarding his/her progress in therapy with Therapist.

**Professional Consultation**
Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Client.

**Records and Record Keeping**
Therapist may take notes during session, and will also produce other notes and records regarding Client's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any client. Should Client request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Client with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Client's records for ten years following termination of therapy. However, after ten years, Client's records will be destroyed in a manner that preserves Client's confidentiality.

**Confidentiality**
The information disclosed by Client is generally confidential and will not be released to any third party without written authorization from Client, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a client makes a serious threat of violence towards a reasonably identifiable victim, or when a client is dangerous to him/herself or the person or property of another.

**Client Litigation**
Therapist will not voluntarily participate in any litigation, or custody dispute in which Client and another individual, or entity, are parties. Therapist has a policy of not communicating with Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Client's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Client, Client agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of $150. .

**Psychotherapist-Client Privilege**
The information disclosed by Client, as well as any records created, is subject to the psychotherapist-client privilege. The psychotherapist-client privilege results from the special relationship between Therapist and Client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-client privilege. Typically,

the client is the holder of the psychotherapist-client privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-client privilege on Client's behalf until instructed, in writing, to do otherwise by Client or Client's representative. Client should be aware that he/she might be waiving the psychotherapist-client privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Client should address any concerns he/she might have regarding the psychotherapist-client privilege with his/her attorney.

**Fee and Fee Arrangements**

The usual and customary fee for service is $150 per 45 minute session. Sessions longer than 45-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Client will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with Therapist. The agreed upon fee between Therapist and Client is

From time-to-time, Therapist may engage in telephone contact with Client for purposes other than scheduling sessions. Client is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at Client's request and with Client's advance written authorization. Client is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. Clients are expected to pay for services at the time services are rendered. Therapist accepts cash and personal checks.

**Insurance**

Client is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. Client is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles. If Therapist is a contracted provider with Client's insurance company, then, Therapist has most likely agreed to a specified fee. If Client intends to use benefits of his/her health insurance policy, Client agrees to inform Therapist in advance.

**Cancellation Policy**

Client is responsible for payment of the agreed upon fee for any missed session(s). Client is also responsible for payment of the agreed upon fee for any session(s) for which Client failed to give Therapist at least 24 hours notice of cancellation. Cancellation notice should be left on Therapist's voice mail at (714) 838-7227. Client understands that most insurance companies do not cover missed appointments, and Client assumes full financial liability for that missed or cancelled appointment.

**Therapist Availability**
Therapist's office is equipped with a confidential voice mail system that allows Client to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

**Termination of Therapy**
Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Client needs are outside of Therapist's scope of competence or practice, or Client is not making adequate progress in therapy. Client has the right to terminate therapy at his/her discretion.

**Acknowledgment**
By signing below, Client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Client's satisfaction. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Client agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

| Patient Name (Please Print) | Date |
|---|---|

| Signature of Patient | Date |
|---|---|