Date:________________________

Kristin Cantella, MFT

New Client Registration

YOUR NAME:_________________________________ Social Security Number: _________-_________-_________

Date of birth: _____/_____/_______ Relationship status: ______________Height: ___'____" Weight__________

Address:_________________________________ City:______________ Zip:__________

Home Phone: (_______)_____________________ Work: (_______)_____________________

Cell Phone: (_______)_____________________ Other: (_______)_____________________

E-mail (print neatly!):_____________________ Alternate e-mail:_____________________

Occupation:_____________________ If employed, employer name:_____________________

If in relationship, how long? __________ Previously married? ______If so, how often, and how long?______________

SPOUSE, PARTNER, PARENT OR SIGNIFICANT OTHER ***(complete even if s/he is not participating in therapy)***

Name:_________________________________ Social Security Number: _________-_________-_________

Date of birth: _____/_____/_______ Relationship to client: ______________Height: ___'____" Weight__________

Address (if not living with you):_____________________ City:______________ Zip:__________

Home Phone: (_______)_____________________ Work: (_______)_____________________

Cell Phone: (_______)_____________________ Other: (_______)_____________________

E-mail:_____________________ Alternate e-mail:_____________________

Occupation:_____________________ If employed, employer name:_____________________

Previously married?______ If so, how often, and how long?_____________________

Who else lives in your home? (Give name, age, and relationship): _____________________

____

Any children who live outside the home? (give names and ages)_____________________

Insurance Plan:_____________________ **Full Name of primary insured:**_____________________

If primary insured is not you, give their date of birth: ____/____/_____ **and their employer:**_____________________

Emergency Contact (not partner): _____________________ Phone:(_____)__________ Relationship:__________

Primary Doctor::_____________________ Phone: (_____)_____________________

Doctor's address:_____________________ City:_____________________

Psychiatrist (if any): _____________________ Phone: (_____)_____________________

Psychiatrist's address:_____________________ City:_____________________

Health Issues/Allergies: _____________________

____

Medications and Over-the-Counter Drugs taken regularly (include dosages and why you take them):_____________________

____

Alcohol: Average number of drinks per week______________ Average number of drinks when you drink:__________

Marijuana / other non-prescription drugs (drug you use, how much use, how often, include history of use):

____

____

Has anyone ever been concerned about your alcohol or drug use?________ If so, who?_____________________

Cigarettes: Average use per day:_____________________ Desire to quit?_____________________

Who referred you to my practice? _____________________ **Did you look at my website before coming?**________

Word or sentence to describe your life or how you feel:_____________________

Kristin Cantella MFT
410 W. Arden Ave., Suite 201
Glendale CA 91203
Ph: 626-824-8572

TREATMENT AGREEMENT

CLIENT NAME:____

Please initial in each box on the left after reading the text to the right:

INITIAL BELOW	
	FEES: The fee per 50-minute session is $_______ (except for the first session, which is $______). Payment is to be paid via my website before each session, *unless I am billing your insurance, in which case you must pay your copayment and/or deductible before each session.* Website is www.kristincantella.com
	CANCELLATION: Sessions are by appointment only. While I hate charging for missed sessions, I do reserve that time for you. Therefore, you will be charged $ 90.00 (not just a copayment) for missed sessions or for those cancelled without 24-hour notice, including illness except in a medical emergency. Insurance will not pay for missed sessions.
	INSURANCE: If I am a provider with your plan: I will submit claims for you, but at our session you must pay any copayment or coinsurance or any portion not covered by your plan before the session. There may be a deductible (an amount you will need to pay out of pocket) before your plan begins covering sessions. If insurance does not pay as expected, you remain responsible for the balance. You have the right to waive using insurance, if desired and pay privately. **If I am NOT a provider for your plan:** You will pay me in full at the time of the session. I can give you an invoice if you wish to seek reimbursement from your plan. Many plans do not cover sessions with a provider who is not in their network.
	SECONDARY INSURANCE: It is your responsibility to tell me about all possible insurance plans that might cover my services (ex. if you have Medicare in addition to a secondary policy, or coverage through your work and a family member's work). If you do not, you may be responsible in full if claims are denied.
	DIAGNOSIS: Please be aware that if you use insurance I will be required to provide a diagnosis on invoices and claims, and coverage may be limited to certain mental conditions that are covered by your plan.
	LIMITS OF MEDICAL COVERAGE: Even if you have insurance coverage for unlimited sessions, health plans may review treatment for medical necessity, limit length of treatment or frequency of sessions, and request treatment notes. You are responsible for verifying and understanding the limits of your coverage. Although I am happy to assist your efforts in obtaining insurance reimbursement, I am unable to guarantee whether your health plan will provide payment for the services provided.
	CONFIDENTIALITY: What you say in therapy, your records, and your attendance are all confidential. Exceptions to confidentiality include when your records are subpoenaed for legal reasons, and when reporting is required or allowed by law. The law requires reporting of suspicion of child abuse or neglect; bullying; when there is downloading, streaming, or accessing material in which a child is engaged in an obscene or sexual act; danger to self; suspected elder abuse; and suspected danger to others. Other exceptions to confidentiality are when you give written permission to release information. See other exceptions outlined in my *Notice of Privacy Practices.*
	IN AN EMERGENCY: Contact me via e-mail and voicemail to inform me of your emergency. You may also go to the emergency room or dial 911.

	E-MAIL/SOCIAL MEDIA: In general, e-mail is the quickest way to reach me. I use e-mail to arrange/change appointments. I do not do therapy by e-mail. When cancelling, please leave BOTH a voicemail and e-mail. Please do not e-mail me information related to your therapy, as e-mail is not completely confidential, and Important issues should be reserved for sessions. Be aware that e-mails between us become part of your legal record. I do not accept friend requests or contact requests from clients on social networking sites (Facebook, LinkedIn, etc.) out of concern for your confidentiality and my privacy. It may also blur the boundaries of our therapy relationship. *(continued)*

INITIAL BELOW	
	LEGAL MATTERS: If you become involved in legal proceedings that require my participation, you agree by signing this Agreement to pay me at my regular full fee of $ 130.00 per hour for any time I must spend on your case, including but not limited to time spent to appear in court or give depositions, and lost income for sessions I must miss.
	REFERRALS/GROUP: A referral to another provider may become necessary if it becomes clear in my opinion that your issues would be better treated by a professional with different expertise. It is unethical for me to practice beyond the level of my competence, education, training, or experience. I am not responsible for the care received from professionals to whom I refer you. Agreements made between you and I do not involve other professionals in the office suite, who each operate independent solo practices, and are not part of a group
	ENDINGS: If you are unhappy with any aspect of therapy, please I ask that you talk to me to see if we can work it out. Even if we can't, endings usually feel better this way. Of course, you may end therapy at any time, and I am happy to assist with referrals. It is my ethical duty to provide therapy only when I feel you are actively participating and benefiting from the sessions. I may end treatment if there have been repeated no-shows, late-cancellations or other treatment interruptions.
	PATIENT RIGHTS: You have the right to ask any questions about your treatment or refuse to participate in treatment at any time. This office does not discriminate in the delivery of health care services based on race, ethnicity, national origin, citizenship or immigration status, religion, gender/gender identity, age, mental or physical disability, medical condition, sexual orientation, or medical history.
	COMPLAINTS: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of Marriage and Family Therapy. You may contact the board online at www.bbs.ca.gov, or by calling 916-574-7830.
	PRIVACY PRACTICES: By initialing here and signing below, you are acknowledging receipt of my *Notices of Privacy Practices*. My *Notice of Privacy Practices* provides information about how I may use and disclose your private health information. I encourage you to read it in full. My *Notice of Privacy* Practices is subject to change. If I change my Notice, I will give you a revised Notice. If you have left treatment, you may obtain the revised notice from me at the above address and phone number

PLEASE SIGN THE FOLLOWING IF USING YOUR INSURANCE OR EMPLOYEE ASSISTANCE PROGRAM: *"I authorize the release of any information necessary (Including notes, treatment summaries and diagnosis) to process claims, to prove medical necessity for treatment, to request additional sessions, or to comply with treatment reviews or administrative chart reviews from the insurance plan. If my therapist is a network provider, I authorize payment of benefits to be made to him/her."*

(Sign here) :**X** ____________________

If second client participating, sign here: **X** ____________________

"I authorize payment of benefits to my therapist" (Sign here): **X** ____________________

By signing below, I acknowledge that I have read and understand the above rights and policies.

Signature	Printed Name	Date
Signature, second client (if applicable)	Printed Name, second client (if applicable)	Date

Kristin Cantella, MFT
410 W. Arden Ave, Suite 201
Glendale CA 91203
626-824-8572

CLIENT NAME_______________________________

TELEHEALTH (VIDEO/PHONE) COUNSELING AGREEMENT

The purpose of this form is to obtain your consent to participate in telemental health, which involves counseling by video or phone.

Benefits include:

1. It's more convenient. It can decrease the time commitment of therapy since there is no travel time
2. I can see you even if you are unable to get to my office (ex. transportation issues), if you are home sick, or when you are home caring for an ill family member
3. I can see you when you travel within the state, or even when you move within the state
4. You can always choose to schedule a face-to-face session, when desired

Limitations/Risks include:

1. There is a greater chance of misunderstanding -- due to technology limits, I might not see some of your body language or hear subtle differences in your tone of voice that I could easily pick up if you were in my office. And you might not pick up mine.
2. If we meet in-person, I have more control of interruptions. With video, I can't control your setting.
3. Internet connections could cease working or become too unstable to use
4. The telehealth platform or our computers/smartphones can have sudden failure or run out of power
5. You may feel more emotional distance related to the lack of in-person contact and presence.
6. I cannot guarantee the privacy/confidentiality of conversations held via phone, as these can be intercepted accidentally or intentionally. I cannot guarantee that hackers will not access video calls.
7. I cannot immediately intervene in-person if you are in crisis.

Logistics

1. If we are connecting by video, I will send you a link to sign in to my secure and HIPAA-compatible video platform. You don't need to set up an account of any kind in advance. It is OK to "arrive" early -- I will connect with you at the time of the session. If we are connecting by phone, I will call you at our scheduled time.
2. I will be in a private location where I am alone in the room. You also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where others can hear you, I cannot be responsible for your confidentiality.
3. At the start of the session, I may verify your location (street address). This enables me to send help, if needed, and to verify that you are in-state. I can only provide therapy to you while you are in the state where I am licensed. If I do not ask, please be sure to tell me if you are not at your home.
4. Do not invite others to join us for any part of the session without discussing this with me in advance.
5. Please be sure to have a cell phone with you or be near a phone, in case video gets cut off.

(continued)

(Telehealth Consent, continued)

CLIENT NAME______________________________

You may have a better experience if you:

1. Use a computer or tablet instead of a cell phone so that you can see me better.
2. Make sure your device is fully charged.
3. Utilize Chrome to connect to the video platform
4. Wear a two-ear headset with microphone (this can help us hear each other)
5. Close other applications or programs on your computer.
6. Make sure you have strong internet connection -- you may need to be near your modem.
7. Consider how you will reduce interruptions (ex. talking to family in advance about your need for privacy during that hour, using a "do not disturb" sign on your door, etc.)
8. Find a location where your face will be well-lit so I can see your facial expressions clearly.

Connection Loss:

- **For video sessions:** If we lose our video connection during our session, please quit and restart your search engine (or computer), and sign in again to the video platform. If you can't reconnect, call my office number (see first page of this agreement), If I do not hear from you within 5 minutes, I will call and email you. I will *remain available during the time of our scheduled session, so we can reconnect and continue, if possible.*
- **For phone sessions:** If we lose our phone connection during our session, I will call you again from my office phone or an alternate number, which may show up as restricted or blocked -- please be sure to pick up the phone. After 5 minutes if you have not heard from me, you may also attempt to call me at my office number (see first page). I will remain available during the time of our scheduled session, so we can reconnect and recontinue, if possible.
- **Billing for a disrupted session:** If the disconnection is due to my service or equipment, I will not charge you for the session, or will prorate it for what time we talk. If the disconnection is due to your service or equipment, you will be charged in full for the session (not just a copayment).

  Best Phone Number to reach you if video or phone connection is lost: ______________________

Security

- I utilize video software and hardware tools that adhere to security best practices and legal standards for the purposes of protecting your privacy.
- It is not recommended that you communicate using a public wireless network.
- You represent that you are not using someone else's device or your employer's computer, since employers have the right to monitor their equipment and networks, which could compromise your privacy.
- You have the sole responsibility for security and privacy of your devices, equipment, and internet connection.

Recording of Sessions:

- No sessions will be recorded by me, and the telehealth platform I use states that there is no recording of the session, no information collected, and no digital record saved afterwards. Please note that recording or screenshots of any kind of any session are not permitted, and are grounds for termination of the client-therapist relationship.

Payment for Services:

Payments for services must be made prior to our session or the day of the session via my website at www.kristincantella.com If you have insurance and I am on your insurance provider list, I will bill insurance on your behalf, but you remain responsible for any portion they do not pay.

(continued)

Session Cancellations:

Phone/video sessions are treated as in-office sessions when it comes to late cancellations and no-shows -- 24-hour advance notice is required, otherwise you will be charged the full session fee (not just a copayment), except for cases of unforeseen medical emergency. Cancellations should be communicated via email and phone.

Emergencies and Confidentiality:

Since you will be at a distance, please list an emergency contact for you:

____

Full Name *Relationship* *Phone Number(s)*

If you do not expect to be at home for sessions, please give the location you expect you will be:

Street Address____

Emergency (continued):

If you are outside the area that I practice at the time of our session, I will identify emergency resources in your area and document that in your chart. If you are in crisis and we get disconnected, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline at 800-784-2433 if you cannot reach me.

Please share with me if you have severe feelings of helplessness, hopelessness, or wanting to hurt yourself or others. There are many steps I can take to help, even at a distance. However, if I have extreme concerns about your safety at any time during a phone session, we may need to have you come to the office, or I may need to call your support system or emergency services to keep you safe.

Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.

Consent to Participate in Telehealth Sessions

By signing below, you agree that you have read and understand all of the above. You give permission for me to communicate with your emergency contact if client is concerned about your safety. You agree that you have had the chance to ask questions, that you understand the limitations associated with participating in telehealth sessions and consent to attend sessions under the terms described in this document.

Signature: ____

Printed Name: ____

Date: ____

Kristin N. Cantella, MFT
410 West Arden, Suite 201
Glendale, CA 91203

Life Status Questionnaire

Name: ______________________________ Date: __________

This questionnaire is designed to describe a wide range of situations, behaviors and emotions that are common to adults. You may find that some do not apply to your current situation. If this is the case, please check the "Never" category. Please respond to these questions based on your mood and behavior in the past month.

	Never	Rarely	Sometimes	Frequently	Always
1) I feel sad or blue					
2) I feel nervous, jittery or uneasy					
3) I don't participate in activities I used to enjoy					
4) I have trouble falling asleep or staying asleep.					
5) I feel hopeless about the future					
6) I feel easily annoyed or agitated					
7) I feel bad about myself					
8) I worry and cant get thoughts out of my mind					
9) I use alcohol					
10) I have a hard time sitting still and focusing					
11) I have a hard time trusting others					
12) My emotions are strong and change quickly					
13) I have stomachaches or headaches					
14) I think about suicide					
15) I have trouble maintaining friendships					
16) I feel lonely and feel like I don't have friends.					
17) I isolate myself					
18) My heart races when im nervous.					
19) I cut myself or harm myself physically					
20) I get angry easily and yell.					
21) I have a hard time finishing projects.					
22) I get along with my family members					
23) I get along with my coworkers					
24) I feel there is something wrong with me.					
25) I oversleep					
26) I take drugs					

Kristin Cantella, LMFT
Licensed Marriage & Family Therapist
410 W. Arden Ave, Suite 201, Glendale CA 91203
kristincantella@gmail.com, 626-824-8572

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 law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. **For your treatment**. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.
2. **To obtain payment for your treatment**. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.
3. **For health care operations**. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization.

1. **Psychotherapy Notes**. I do not keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501; rather, I keep a record of your treatment and you may request a copy of such record at any time, or you may request that I prepare a summary of your treatment. There may be reasonable, cost-based fees involved with copying the record or preparing the summary.
2. **Marketing Purposes**. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. **Sale of PHI**. As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations mandated by law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

(continued on back)

Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others**. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

YOUR RIGHTS YOUR REGARDING YOUR PHI

You have the following rights with respect to your PHI:

1. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. **The Right to Choose How I Send PHI to You**. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. **The Right to See and Get Copies of Your PHI.** Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you.
   I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.
5. **The Right to Get a List of the Disclosures I Have Made.**
   You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable *cost-based fee for each additional* request.
6. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. **The Right to Get a Paper or Electronic Copy of this Notice**. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice, and my address and telephone number are: ____.

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
2. Calling 1-877-696-6775; or,
3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on ____________________.