IMTASIK
FAMILY COUNSELING SERVICES INC.
A 501 (c)(3) tax – exempt nonprofit organization

New Client Information

Date ____/____/____

Please Print

Name _____ Sex: ☐ M ☐ F
Last First Middle

Email Address _____

Address _____

City _____ State _____ Zip Code _____

Phone ( ) _____ Cell Phone ( ) _____

Date of Birth _____/_____/_____ Social Security # _____

Employer _____

Country of Origin _____

Marital Status: ☐ Single ☐ Married ☐ Divorced

Emergency Contact

Name _____ Phone ( )_____

Relationship _____

6809 Indiana Ave. Ste 205 Riverside, CA 92506 ❖ Imtasik.org
Ph: (951) 774 - 1367 ❖ Fax: (951) 231 - 1578 ❖ Email: ira@imtasik.org

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A $25 fee will be charged for any session missed or cancelled without 24 hour notice.

Late Cancellation & Missed Appointment Policy

At Imtasik Family Counseling Services Inc., Dr. Lake sees a fixed number of clients each week. Once you schedule an appointment with him, that time is reserved exclusively for you. In order to successfully operate his clinical practice, we need to be able to rely on these therapy appointments. Therefore, we have established the following policy for missed and canceled appointments. **For any appointment that is missed or cancelled with less than the required 24 hour notice, no matter what the reason, clients will be charged the $25.00 fee.**

I have been informed of the policies and procedures at Imtasik Family Counseling Services Inc.

Signature:_____ Date:_____

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Credit Card Authorization for Cancellation & Missed Appointment Fee

I, _____, authorize Imtasik Family Counseling Services Inc. to charge my credit card a $25.00 fee for cancellation of sessions not honoring the 24 hour cancellation policy as well as missed appointments.

_____ _____

Signature of cardholder Date

_____

Printed name of cardholder

Card Type: American Express
Mastercard
Visa
Other _____

Card Number: _____

Expiration Date: _____ Security Code: _____

Name as it appears on card: _____

Address: (where credit card bills are sent):

_____

_____

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Court and Legal Fees

Clients are discouraged from having their therapist subpoenaed or having him/her provide records for the purpose of litigation. Even though you are responsible for the testimony fee, it does not mean that my testimony will be solely in your favor. I can only testify to the facts of the case and to my professional opinion. Furthermore, if I see both a husband and wife separately or a child and parent separately, there is an obvious conflict of interest. I would rather not damage the trust I have built in the counseling relationship with each client especially if I am still seeing that person for
therapy.

If your therapist is to receive a subpoena, then the attorney or office staff will need to call his/her office and set up a time for the subpoena to be served during office hours.

He will request a minimum of 72 hour notice of any Court appearance so that schedule changes for his clients can be made within a reasonable time frame.

Please note: If a subpoena or notice to meet attorney(s) is received without a minimum of 72 hour notice there will be an additional $250 express charge.

When it comes to court action, the following fees are in effect:

1. Preparation Time (including submission of records): $200/hr

2. Phone calls: $200/hr

3. Depositions: $200/hr

4. Time required in Giving Testimony: $200/hr

5. Mileage: $0.40/mile

6. Time away from Office due to Depositions or Testimony: $200/hr

7. All attorney fees and costs that are incurred by the therapist as a result of the legal action.

If the therapist is subpoenaed and the case is reset with less than 72 business hours notice prior to the beginning of the day of the scheduled subpoena, trial, and/or the testimony is not given, then the client will
be charged $250.

All fees listed above are doubled if the therapist is scheduled to be going out of town.

Bills are presented to clients on a weekly basis and payment is expected upon receipt.

Your signature below indicates that you have read the information in this document and agree to its terms.

Signature of client Date

Signature of Parent or Guardian if client is a minor Date

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INFORMED CONSENT FOR TREATMENT AND/OR ASSESSMENT

Please read carefully and sign below before beginning your treatment. When you sign and give consent to treatment you agree to abide by the terms of this organization.

I, (print your name)

_____

- ☐ As the patient
- ☐ As the parent/legal guardian

(Print patient's name) _____

Agree and give consent to treatment/assessment as provided by Imtasik Family Counseling Services Inc. I agree to meet with Dr. Lake and/or other staff members for the purpose of pastoral care and counseling, which may include mediation, parenting classes/training, and assessment. I have discussed, understand, and agree to the fees based on the services provided.

I have read the above and fully understand its contents. I, therefore, give my authorization to conduct treatment. I also understand that any release of information will be done as set forth by California law.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

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Confidentiality Agreement

In general, the law protects the confidentiality of all communications between a client and a counselor/therapist and I can only release information about our work to others if you sign a written authorization form that meets certain legal requirements imposed by HIPPA. There are other situations that require only that you provide written, advance consent.

Your signature on this agreement provides consent for those activities, as follows:

❖ You should be aware that I regularly consult with and receive supervision with other mental health professionals. All mental health professionals are bound by the same rules of confidentiality. If I discuss your case, I will use your first name only and there will be no other identifying information. Again, if you do not object, I will not tell you about the supervision meetings in which I may discuss in your case.

❖ If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm him/herself, I may be required to seek hospitalization for the client, or to contact family members or others who can help provide protection. There are some situations where I am permitted to disclose information without either your consent or authorization:

❖ If you are involved in a court proceeding and a request is made for information concerning the professional services that I provided for you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization or a court order. If you are involved in contemplating litigation, you should consult with your attorney to determine whether a court order would be likely to order me to disclose information.

❖ If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

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❖ If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

❖ If I believe that a child, an elderly person, or a disabled person is being abused, I am required by California law to report the suspected abuse to the Department of Social Services

❖ If I believe a client presents an imminent danger to the health and safety of another, I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.

These situations are very unusual in my practice, but if such a situation should occur, I will make every effort to discuss it with you fully before taking any action and I will limit any discloser about you to what is necessary. While this written summary of exceptions to confidentiality should prove helpful n informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. As you might suspect, the laws governing these issues are quite complex and I am not an attorney. While I am happy to discuss these issues with you, should you want specific advice, formal legal consultation may be desirable.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signature of client Date

Signature of Parent or Guardian if client is a minor Date

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