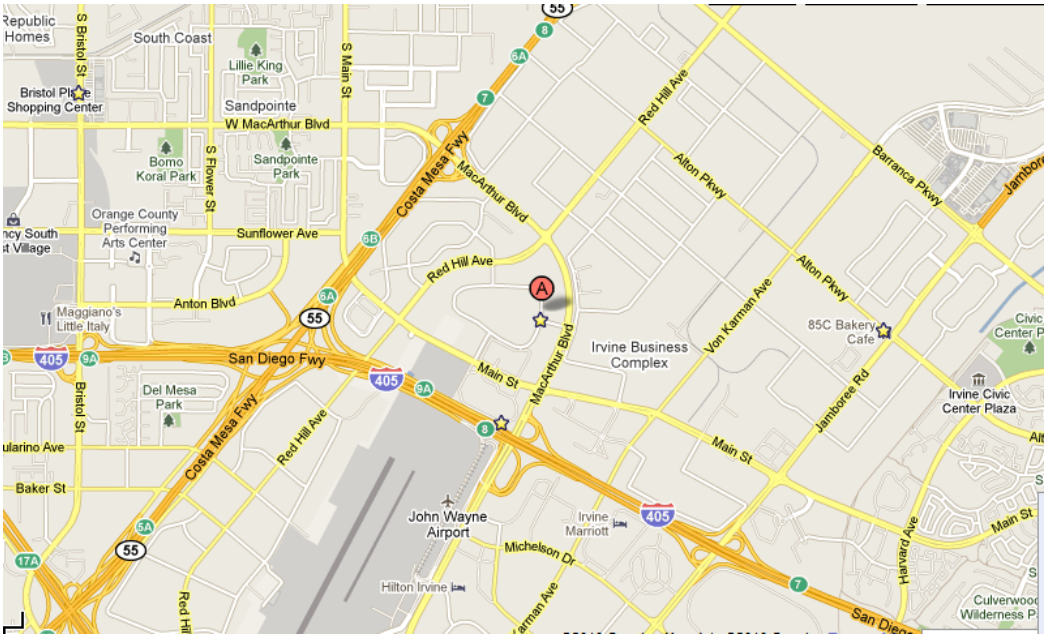
Welcome

Thank you for scheduling an appointment. Please print and fill out these forms.

If you have trouble printing the forms, there will also be a copy waiting for you when you arrive at my office. In that case, please arrive 20 minutes early to your scheduled appointment.

Directions:

My office is located at:
17752 Sky Park Circle, Suite 260
Irvine, CA 92614



From the 405 Freeway:
Exit MacArthur Blvd and turn right. About 1/2 mile later, turn left into Sky Park East. Turn right onto Sky Park Circle and the immediately left into the first driveway. I am upstairs in building 17752, in suite 260.

From the 55 Freeway:
Exit MacArthur Blvd. and turn West in the direction of John Wayne Airport. About 1 mile later, turn right into Sky Park East. Turn right onto Sky Park Circle and the immediately left into the first driveway. I am upstairs in building 17752, in suite 260.

I look forward to being of service.

Mark Pines

Client Information

Couples: Please use one form each.

Today's Date: _____

Name: _____
Date of Birth: _____
Guardian's Name (if a minor): _____

Email: _____ May I email your statements & newsletter? Yes ☐ No ☐

Cell Phone: _____ May I leave a message at this number? Yes ☐ No ☐

Home Phone: _____ May I leave a message at this number? Yes ☐ No ☐
Home Address: _____ May I write to you at this address? Yes ☐ No ☐
_____

Work Phone: _____ May I leave a message at this number? Yes ☐ No ☐
Work Address: _____ May I write to you at this address? Yes ☐ No ☐
_____
Employer: _____
Occupation: _____

Current Physician: _____
Current Psychotherapist: _____
Current Psychiatrist: _____
Medication/Drugs Currently Used: _____

Emergency Contact Name: _____
Emergency Contact's Telephone: _____

Please let me know the person or website where you learnt of my services?

_____

In a sentence or two, please briefly describe your reason for coming in:

_____
_____
_____

Client Information for 2nd Person

Individual Clients: Please continue on next page

Today's Date: _____

Name: _____
Date of Birth: _____
Guardian's Name (if a minor): _____

Email: _____ May I email your statements & newsletter? Yes ☐ No ☐

Cell Phone: _____ May I leave a message at this number? Yes ☐ No ☐

Home Phone: _____ May I leave a message at this number? Yes ☐ No ☐
Home Address: _____ May I write to you at this address? Yes ☐ No ☐
_____

Work Phone: _____ May I leave a message at this number? Yes ☐ No ☐
Work Address: _____ May I write to you at this address? Yes ☐ No ☐
_____
Employer: _____
Occupation: _____

Current Physician: _____
Current Psychotherapist: _____
Current Psychiatrist: _____
Medication/Drugs Currently Used: _____

Emergency Contact Name: _____
Emergency Contact's Telephone: _____

Please let me know the person or website where you learnt of my services?
_____

In a sentence or two, please briefly describe your reason for coming in:
_____
_____
_____

Client Agreement

Welcome. This document provides important information about your treatment. Please read the entire document carefully and initial each page and sign at the end. Please feel free to ask me any questions before signing.

Fees
My fee for service is $175 for 50-minute sessions, and $280 for 80-minute sessions.

Fees are payable at the beginning of each session by cash, check or credit card. Cost of living increases may occur on an annual basis. Interest will be charged on accounts past due.

Other service:
If you need to talk me by phone, or ask me to prepare documents for you, the fees are as follows:

First 10 minutes:	Free
11 to 30 minutes:	Half of regular fee
31 to 50 minutes:	Full fee

Litigation Charges:
The focus of my work is treatment. I do not normally attend legal proceedings unless required to by law. My fee for attending depositions, hearings or other legal proceedings is $400 per hour. This includes my time at the legal proceeding, preparation and travel.

Insurance:
Full payment of my fees is required at each session. I do not accept health insurance. If you are covered by a PPO, it is possible that they will partially reimburse you my service. You will need to submit a claim to them. At your request I will provide you a bill to submit with your claim.

If you are unable to continue paying for your therapy, please let me know. I will do my best to provide you with appropriate options.

Cancelation Policy
In order to cancel or reschedule an appointment, you must notify me at least 24 hours in advance of your appointment. If you do not provide me with at least 24 hours notice, you are still responsible for full payment of the missed session. Exceptions may be made in cases of extreme illness or emergency.

Availability/ Emergencies
I am available for regularly scheduled appointment times. Dates of vacations and other exceptions will be given out in advance. Telephone contacts between office visits are welcome. However, they are best kept brief as important issues are better addressed in person.

You may leave a message for me anytime on my confidential voicemail. I am available to return messages Monday – Friday 10 AM to 5 PM. I do not offer emergency services. In the event of an emergency involving a threat to your safety or the safety of others, please call 911 or go to your nearest emergency room.

Initial Here: Client _____ Client (if more than one) _____ Parent/Guardian of minor _____

17752 Sky Park Circle, Suite 260 ▪ Irvine, CA 92614 ▪ Phone: (949) 288-3123

Confidentiality
State law and professional ethics require all communications between us to be held in strict confidence unless you provide written permission to release information about your treatment, or if the situation falls under one or more of the following exceptions to confidentiality:

1. If there is a suspected child abuse, elder abuse, or dependant adult abuse
2. If you are a danger to yourself or others.
3. If you are gravely mentally disabled.
4. If a judge required disclosure of records.

You can read my complete privacy policy including details of these and other exceptions in the separate privacy policy document included in this packet.

Couple's Therapy
I have a "no-secrets" policy in couple's therapy. This means that if you participate in an individual session with me while concurrently in couple's therapy, the information you reveal in your individual session may be used by me in your joint session. Please consider this carefully if you would like to reveal something in individual session that you would not like the other participant to know.

Minors
Communications between a therapist and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for the child's treatment are often involved with their treatment. Consequently, I, in the exercise of my professional judgment, may discuss the treatment progress of a minor client with the parent or the caretaker by providing a general summary, upon request.

The Therapeutic Relationship
Because of the nature of psychotherapy, the therapeutic relationship needs to be different from most relationships. It may differ in how long it lasts, in the topics we discuss, or in the goals of our relationship. It must also be limited to the relationship of the therapist and the client only. If we were to interact in other ways, we would then have a "dual relationship". Therapy professions have rules against such relationships to protect the client and therapist.

- I cannot be your supervisor, teacher, or evaluator
- I cannot be a therapist to my own relatives, friends or the relatives of friends, people I know socially, or business contact. I cannot have any other kind of business relationship with you besides the therapy relationship itself.
- I cannot give legal, medical, financial or any other type of professional advice.
- I cannot have any kind of romantic or sexual relationship with a former or current client, or any people close to a client.

There are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions. A therapist offers you choices and helps you consider what is best for you. Also when therapy is complete, I am not able to continue meeting you in a friendship relationship.

Please note that from time-to-time we may run into one another in public or in the parking lot outside my office. If this happens, I will not initiate contact in order to preserve your confidentiality.

Initial Here: Client _____ Client (if more than one) _____ Parent/Guardian of minor _____

17752 Sky Park Circle, Suite 260 ▪ Irvine, CA 92614 ▪ Phone: (949) 288-3123

About the Therapy Process
It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

The benefits of therapy may include reduced stress and anxiety, a decrease in negative thoughts and self-defeating behaviors, improved relationships, increased comfort in social, school and/or family settings, increased self-confidence, and a more hopeful attitude towards life.

The risks of therapy may include recalling or recounting painful memories and experiences, discomfort in analyzing current distress and problems, and the possibility of experiencing strong feelings of sadness, anger, fear or other difficult emotions. As your therapist, I may from time to time challenge your assumptions or perceptions and offer a different perspective.

Changes in your perspective, thoughts or feelings may have unintended outcomes, including changes in personal relationships. During the course of therapy, it is often the case that you will feel worse before you feel better; this is natural and expected in any healing process.

There is no guarantee that therapy will yield any or all of the benefits listed above. Neither is there any certainty that the risks listed above will be encountered during the course of our work together. Therapy is an open and dynamic process, and its course is dependent upon our mutual willingness to collaboratively continue the process and, to a certain extent, upon life events that cannot be foreseen.

Termination of Therapy
The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. We will discuss a plan for ending therapy as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If it is determined that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referrals, changing your treatment plan, or terminating your therapy.

Commitment
Therapy is a significant investment of time and money. I encourage you to make a commitment to getting the most from your sessions by attending regularly and being open to the experience of making a change in the direction of your goals. Please ask any and all questions you may have.

Initial Here: Client _____ Client (if more than one) _____ Parent/Guardian of minor _____

I have read this informed consent completely and have raised any questions I might have about it with Mark Pines. I have received full and satisfactory response and agree to the provisions freely and without reservations. I understand that my therapist is responsible for maintaining all professional standards set forth in the ethical principles of his professional association, as well as the laws of the state of California governing the practice of psychotherapy and that he is liable for infractions of those standards. This agreement constitutes our professional contract. Any changes must be signed by both parties. I have also received Mark Pines' full privacy policy (included in this packet). I have a right to keep a copy of this contract.

Client Signature

Printed Name: _____

Signature: _____ Date: _____

Client Signature of Second Client (if applicable)

Printed Name: _____

Signature: _____ Date: _____

Parent/Guardian Signature (if applicable)

Printed Name: _____

Signature: _____ Date: _____

Statement of the Therapist This document was discussed with the client and any questions were discussed. I have assessed the client's mental capacity and found the client capable of giving an informed consent at this time.

Signature: _____ Date: _____

Debit/Credit Card Authorization

In order to maximize the time available to us, payment is done electronically by credit or debit card (debit card preferred). Please fill in the form below. You may also pay by cash or check.

Credit Card Information:

Card Type : Visa ☐ MasterCard ☐ Discover ☐ American Express ☐

Card#: (please print clearly) _____

Expiration Date: _____

Name on Card: _____

By signing below, I authorize Mark Pines MA LMFT to process all applicable charges to this credit card in accordance with the Client Agreement.

Signature:_____ Date:_____

Privacy Policy

I. 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.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website http://www.orangecountycounseling.com/privacy/ . You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at http://www.orangecountycounseling.com/privacy/ .

III. HOW I MAY USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. **For treatment.** I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care.
2. **To obtain payment for 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 or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
3. **For health care operations.** I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm com-plying with applicable laws.
4. **Other disclosures.** I may also disclose your PHI to others with-out your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Uses and Disclosures Do Not Require Your Consent. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement**. For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. **For public health activities.** For example, I may have to report information about you to the county coroner.
3. **For health oversight activities.** For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
5. **To avoid harm.** In order to avoid a serious threat to the PHI to law enforcement personnel or persons able to prevent or lessen such harm.
6. **For specific government functions.** I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
7. **For workers' compensation purposes**. I may provide PHI in order to comply with workers' compensation laws.
8. **Appointment reminders and health related benefits or services.** I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

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

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.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

B. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures I Have Made.

You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.

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. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. 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.

E. 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, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Mark Pines, 17752 Sky Park Circle, Suite 260, Irvine, CA 92614

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on January 1, 2008.