CLIENT INFORMATION

SIGIL SOCIAL FOUNDATION

OFFICE USE	DX:	CN:	C#:

CLIENT INFORMATION

First Name	Middle	Last	Birth Date	Age	Sex

Street Address	City	State	Zip

Home Phone	Work Phone	Cell	Social Security #

Employer	Employer Address

INDIVIDUAL RESPONSIBLE FOR PAYMENT

First Name	Middle	Last	Birth Date	Age	Sex

Street Address	City	State	Zip

Home Phone	Work Phone	Employer	Social Security #

PRIMARY INSURANCE

Name of Insurance Company	Policy ID No.	Group #

Street Address	City	State	Zip

Name of Policy Holder	Date of Birth	Relationship to Insured

Employer Name/Address

SECONDARY INSURANCE COMPANY

Name of Insurance Company	Policy ID No.	Group #

Street Address	City	State	Zip

Name of Policy Holder	Date of Birth	Relationship to Insured

Employer Name/Address

Email Address

ASSIGNMENT OF BENEFITS

I understand that I am responsible for payment in full of all charges. I authorize payment of benefits from my insurance be paid directly to the Sigil Social Foundation.

I also authorize the Sigil Social Foundation to release to my insurance company any and all information necessary for the processing of insurance claims.

I understand there is a 24 Hour cancellation policy which requires that I cancel my appointment 24 hours in advance to avoid the full charge of the session.

Signature_____Date_____

SIGI SOCIAL FOUNDATION **Patient Questionnaire/Intake**

All files are held in strict confidence. If you are completing this form for your minor child, please fill out their information. Please skip questions that do not apply.

Full Name _____ Date_____
Address _____
Home phone _____ ☐ May we leave a message?
Work phone _____
E-mail _____☐ May we send a message?
Age _____ Date of birth _____

Marital status ☐Single ☐Engaged ☐Married
☐Separated ☐Divorced ☐Widowed

Sexual Orientation_____ Spirituality_____

Ethnicity ☐Asian/Pacific Islander ☐American Indian ☐Black
☐Hispanic ☐White ☐Other_____

Occupation _____ Educational level _____
Names and ages of children_____
_____
Name and age of spouse_____
Emergency contact information _____
Explanation of how patient may be contacted by therapist _____
_____

Please indicate who referred you to us:
☐Self ☐Friend ☐Advertisement ☐Therapist ☐Faculty
☐Family ☐Healthcare Provider ☐Other_____

Psychological History:
Have you ever received mental health treatment before? _____
When and for how long? _____
What was the focus of treatment? _____
Name of treating therapist(s), address(es), telephone number(s) _____
_____

Have you ever been subjected to one or more psychological tests? _____
If so, by whom? _____
Name of person(s) administered psychological tests, address(es), telephone number(s)
_____
_____

Have you ever been hospitalized for mental or emotional problems? _____
When and for how long? _____
Why were you hospitalized? _____

Name of treating therapist, address, telephone number _____

Are you currently taking any prescription medications (Name them)?
_____
Prescribed by whom? _____
How long have you been on the medications? _____
Have you ever taken any medications for a mental or emotional condition? _____
When and for how long? _____

Have you ever attempted suicide? _____
When? _____
Describe the circumstances that led to that attempt. _____
_____
_____
Are you currently having any suicidal thoughts? Please describe _____
_____
_____
Please describe your childhood. _____
Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.
_____
_____
_____
Have you ever been a victim of a violent crime? Please describe _____
_____
_____

Medical History
Have you ever been diagnosed with a serious illness? Please describe _____
_____
_____
Do you have any medical conditions that may affect your mental health treatment? _____
Please describe your overall health today. _____
_____
Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. _____
_____
_____
Have you ever been in a 12-step program? Please describe. _____
_____
Do you smoke? _____ How much? _____ For how long? _____
Do you drink alcohol? _____
On average, how much alcohol do you consume in a week?_____
Do you currently use illegal drugs? Please describe your use _____
_____
Have you ever used illegal drugs? Please describe. _____
_____

Please mark any of the following that apply:

Feelings

☐ Helpless ☐ Anxious ☐ Depressed ☐ Out of Control ☐ Shameful
☐ Afraid ☐ Angry ☐ Numb ☐ Guilty ☐ Relaxed
☐ Hopeless ☐ Happy ☐ Lonely ☐ Excited ☐ Sad
☐ Hopeful ☐ Stressed ☐ Unhappy ☐ Inferiority Feeling ☐ Mood Shifts
☐ Other_____

Thoughts

☐ Confused ☐ Racing ☐ Unintelligent ☐ Obsessive ☐ Worthless
☐ Distracted ☐ Unmotivated ☐ Disorganized ☐ Unattractive ☐ Paranoid
☐ Unlovable ☐ Suicidal ☐ Confident ☐ Sensitive ☐ Worthwhile
☐ Honest ☐ Homicidal

Symptoms/Behaviors

☐ Eating Less ☐ Procrastinating ☐ Attempting Suicide ☐ Poor Concentration
☐ Crying ☐ Withdrawing Socially ☐ Skipping Classes ☐ Binge Drinking
☐ Injuring Self ☐ Compulsivity ☐ Career/Major Choice ☐ Acting Out Sexually
☐ Impulsivity ☐ Acting Aggressively ☐ Disorganization ☐ Recklessness
☐ Irritability ☐ Being Good To Yourself ☐ Drug Use ☐ Alcohol Use
☐ Passivity ☐ Sexual Problems ☐ Socializing ☐ Marital Relationships
☐ Nightmares ☐ Parent/Child Conflicts ☐ Spiritual Problems ☐ Dating Concerns
☐ Finances ☐ Lack of Ambition/Goals ☐ Poor Peer Relationships
☐ Worries About Body Image ☐ Other_____

Physical Symptoms

☐ Insomnia ☐ Tired ☐ Weight Gain or Loss
☐ Pain ☐ Dry Mouth ☐ Dizziness or Light Headedness
☐ Vomiting ☐ Headaches ☐ Rapid Heart Beat
☐ Eating Problems ☐ Loss of Memory ☐ Excessive Sleep
☐ Numbness or Tingling ☐ Tightness in Chest ☐ Other_____

Anything else you would like us to know about you:

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NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

OUR LEGAL DUTY: Sigil Social Foundation is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

USE AND DISCLOSURES OF HEALTH INFORMATION: Sigil Social Foundation uses your personal and health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provide you with. In addition, we may, from time to time, disclose your health information without prior authorization for public health purposes, audit purposes or research studies. In any other situation, Sigil Social Foundation will obtain your written authorization to release your information. You may later revoke that authorization to cease future disclosures at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Information Practices will be posted in the same area for public view. You may request a copy of our Notice of Information Practices at any time. The HIPAA Compliance Officer is Robin Paulson and she can be reached by calling this office.

PATIENT'S INDIVIDUAL RIGHTS: You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal health information for reasons other than for treatment, payment, or other related administrative purposes except when specifically authorized by you, when required by law, or in an emergency. Sigil Social Foundation will consider all such requests on a case-by-case basis. The company is not legally required to accept the requests.

CONCERNS AND COMPLAINTS: If you are concerned that Sigil Social Foundation may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the HIPAA Compliance Officer, Robin Paulson, at the office address and phone number listed below (951) 290-2997. You may also send a written complaint to the U.S. Department of Heath and Human Services.

Sigil Social Foundation
41715 Enterprise Circle N. #102
Temecula, CA 92590
951-290-2997

I am indicating I have read and fully understand the HIPAA Notice of Patient Information Practices for Sigil Social Foundation. I understand these practices may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Sigil Social Foundation will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Sigil's HIPAA Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ _____
Signature Date

_____ _____
Signature Date

SIGIL
SOCIAL FOUNDATION

CLIENT'S RIGHTS AND RESPONSIBILITIES

Welcome to Sigil Social Foundation. Our staff will be continually working to provide you with appropriate, high quality services. We believe that a client who understands and participates in his/her treatment may achieve better results. We have the responsibility to give you the best care possible, to respect your rights and recognize your responsibilities as a client.

YOUR RIGHTS

Right to Dignity and Respect

- You have a right to be treated with consideration, dignity and respect and to receive the same consideration and treatment as anyone regardless of your race, creed, culture, age, gender, marital status, economic status, educational background, religion, disability or sexual preference.

Right to Confidentially

- You have a right to confidentially, except in cases mandated by law. This means without your written permission no information will be shared with others.
- Exceptions are: child, disabled or elderly person suffering abuse or neglect. A court order, issued by a judge. If you pose a threat of harm to yourself to another person.

Right to Understand

- You have a right to understand why information requested about you is needed. In general, such information is used to determine whether you are eligible for services, to help us evaluate your needs for services and develop a plan to meet those needs, and to collect information from others, which will be helpful in developing an effective treatment plan.

Right to Consent or Refuse

- You can be treated without consent only if there is an emergency and in the opinion of your therapist failure to act immediately would jeopardize your health. Otherwise, you may refuse treatment and change your mind at any time.
- You have a right to end you therapy at any time, providing you accept responsibility and the consequences of such a decision. Discuss your objections with your therapist. Try to be sure of what you do or do not want.

Right to a Safe Environment

- No weapons are allowed on the premises. For safety purposes no child should be left unattended on the premises.

Right to Access Your Records

- You have a right to request in writing access to and may obtain a copy or summary of your records. Your therapist can deny your request only if he/she has a substantial belief the information is harmful to you.

YOUR RESPONSIBILITIES

1. Keep your scheduled appointments and let your therapist know as soon as possible if you cannot keep on.
2. Be as honest and open as possible with your therapist.
3. To know your therapist. You are entitled to ask your therapist what his/her training is, where it was received and if he/her is licensed or an Intern/Trainee.
4. To understand your treatment plan. You are responsible to actively participate in the development of your treatment plan, your ideas on what you need to do are as important and your therapists.
5. Between sessions, think through the concerns you are addressing in therapy.
6. Follow through on treatment recommendations and complete your therapy homework assignments.
7. We ask that you end your work with us in a termination session, rather than not keeping your appointment. This way you can share and discuss with your therapist what was useful and what could have been improved.
8. To be responsible for your own valuables, both on your person, as well as in your car and your car itself. Sigil Social Foundation cannot be held responsible for loss or damage to your property on the premises.
9. You are responsible to notify your therapist or Sigil Social Foundation of any change in your address, telephone number (home, cell and work), and insurance coverage.

_____	_____	_____
Print Client Name	Client Signature	Date
_____	_____	_____
Print Parent/Guardian Name	Parent/Guardian Signature	Date
_____	_____	_____
Print Therapist Name	Therapist Signature	Date

SIGIL SOCIAL FOUNDATION

Appeals and Grievances

Appeals Process

I acknowledge my right to request reconsideration (an Appeal) in the case that outpatient visits are denied authorization. I understand that I would request an Appeal from my Behavioral Healthcare Member Service Department, or by submitting in my request in writing to my Behavioral Healthcare Service. I also understand that my practitioner may submit a request for appeal on my behalf.

Grievances

I also understand that I may submit a grievance to my Behavioral Health Care Service Member Associate at anytime to register a complaint about my care. I am aware that I may contact the Member Services Department of my Behavioral Healthcare Service to receive further information regarding the Appeals and Grievances process.

The California Department of corporations is responsible for regulating health care service plans. The department's Heath Plan Division has a toll free telephone number (1-800-400-0815) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free numbers (1-800-735-2939(TTY) or 1-888-877-5378(TTY)) to contact the department. The department's Internet website (http://www.corp.ca.gov) has complaint forms and instructions online. If you have a grievance against your health plan, you should contact the plan and use the plans grievance process. If you need the department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by the plan, or a grievance has remained unresolved for more than sixty (60) days you may call Health Plan Divisions' toll free telephone number. The plan's grievance process and Health plan Divisions' toll free telephone number. The plan's grievance process and Health Plan Division's complaint review process are in addition to any other dispute resolution procedures that may be available to you and your failure to use these processes does not preclude your use of any other provided by law.

_____

Signature of Patient, Legal Guardian/Legal Representative

_____

Name (Printed)

_____

Relationship to Client/Patient

_____

Patient Name (If different from above)

_____

Date

SIGIL
SOCIAL FOUNDATION

Notice of Privacy Practices

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 lNFORMATION (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 (if applicable). 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 sigilsocial.org.

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 written 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 use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. 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 a psychiatrist is treating you, I can disclose your PHI to your psychiatrist 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 use and 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 my accountant, attorney, consultants, or others to further my health care operations.

4. Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. 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 Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.

3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.

4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. 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.

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 need your written authorization before using or disclos- ing 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 Restrictions on My Uses and Disclosures. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. The Right to Choose How I Send PHI to You. You have the right to request that I send confidential 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 it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI. In most cases, you have the right to inspect and receive a copy of the PHI that I that I have on you, but you must make the request to inspect and receive a copy of such information 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 your request 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 Receive a List of the Disclosures I Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003.

I will respond to your request for an Accounting of Disclosures within 60 days of receiving such 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 the disclosure was made, to whom the 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 may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend 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 Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

V. HOW TO COMPLAIN ABOUT OUR 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 Vl 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 our 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 us at 951-290-2997.

VlI. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on May 1, 2013.