# 2021 PATIENT REGISTRATION HTTP://www.drfoust.net

2201 Nn. Grand Ave #10433 Santa Ana, CA 92711 DRFOUST@DRFOUST.NET

**PATIENT INFORMATION** **DATE:_____**

**FIRST NAME:_____ INIT.:___ LAST:_____**

**STREET ADDRESS:_____ CITY:_____ST:____ZIP:_____**

**HOME PHONE:(____)_____-_____ WORK PHONE:(____)_____-_____**

**SOCIAL SECURITY #:_____-_____-_____ BIRTH DATE:_____-____-_____**

**MARITAL STATUS:_____EMAIL ADDRESS :_____REFERRED BY:_____**

**PATIENT'S RESPONSIBLE PERSON INFORMATION**

**[if different from above]**

**FIRST NAME:_____ MIDDLE INIT.:___ LAST: _____**

**RELATIONSHIP TO PATIENT:_____ HOME PHONE:(____)____-_____**

**ADDRESS:_____ CITY:_____ST.:_____ZIP:_____**

**EMAIL ADDRESS :_____EMPLOYER:_____PHONE:(___)___-_____**

**WORK ADDRESS:_____ CITY:_____ST.:_____ZIP:_____**

**DRIVERS LICENSE #:_____ STATE:_____DOB:____-____-_____**

**SOCIAL SECURITY #:____-____-_____ SPOUSE NAME:_____**

**SPOUSE'S OCCUPATION:_____SOCIAL SECURITY #:_____-_____-_____**

**EMPLOYER:_____ WORK PHONE:_____DOB:___-___-____**

***Credit Card # _____ exp:____ or co-pay amount _____***

**PATIENT'S INSURANCE INFORMATION**

**(OR COPY OF INSURANCE CARD)**

**PRIMARY COVERAGE:** **Authorization #** _____

**INSURANCE CO. NAME:_____ PHONE:_____**

**INSURED'S NAME:_____ RELATIONSHIP:_____**

**INS. ADDRESS:_____ CITY:_____ST./ZIP:_____**

**GROUP #:_____ MEMBER #:_____**

**SECONDARY COVERAGE:**

**INSURANCE CO. NAME:_____PHONE:_____**

**INSURED'S NAME:_____ RELATIONSHIP:_____**

**INS. ADDRESS:_____ CITY:_____ST./ZIP:_____**

**GROUP #:_____ MEMBER #:_____**

**IN CASE OF EMERGENCY THIS PERSON CAN BE CONTACTED:_____**

**WORK:(____)____-_____ HOME:(____)____-_____**

# MEDICAL HISTORY

Reason for today's visit
Present Medications: _____
ALLERGIES TO MEDICATION: _____

Allergies (E.G., ITCHIMESS OR HIVES) _____

OTHER PHYSICIANS CURRENTLY THEATING YOU: _____
PHONE NUMBER _____
PREVIOUS OR OTHER MEDICAL PROBLEMS: _____

LIST ANY PREVIOUS SURGERIES OR HOSPITALIZATIONS (INCLUDE NUMBER OF MISCARRIAGES AND LIVE BIRTHS) _____

FEMALES ONLY: ABE YOU PREGNANT, PLANNING A PREGNANCY OR NURSING A CHILD? ☐ YES
DO YOU SMOKE? ☐ NO ☐ YES ☐ CIGARETTES ☐ PIPE ☐ CIGARS NO.OF YEARS ☐
HOW MUCH _____
INTERESTED IN STOPPING ☐ YES ☐ NO DO YOU REGULARLY DRINK ALCOHOL? ☐ YES ☐ NO HOW MANY OUNCES/BEERS PER DAY? _____

DO YOU REGULARLY DRINK COFFEE? ☐ YES ☐ NO HOW MANY CUPS PER DAY? _____
ARE YOU UNDER A LOT OF PRESSURE AT WORK? ☐ No ☐ YES
PLEASE DESCRIBE _____

**Personal Medical History**

Have you ever had any of the following (check all that apply)

| | | |
|---|---|---|
| ☐ CHEST PAIN | ☐ ASTHMA | ☐ KIDNEY DISEASE |
| ☐ HYPERTENSION | ☐ DIZZY SPELLS | ☐ SHORTNESS OF BREATH |
| ☐ HEPATITIS | ☐ CANCER | ☐ TUBERCULOSIS |
| ☐ STROKE | ☐ DIABETES | ☐ ULCERS |
| ☐ HEAD ACHE | ☐ ARTHRITIS | ☐ SKIN DISORDERS |
| ☐ GLAUCOMA | ☐ HEARING LOSS | ☐ HEART ATTACK |
| ☐ ALLERGIES | ☐ CATARACTS | ☐ DIGESTIVE PROBLEMS |
| ☐ BLOOD IN STOOL | ☐ URINARY TRACT | ☐ OTHER _____ |

**PREVIOUS PSYCHOLOGICAL CARE**

| DATE | WITH | OUTCOME |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**FAMILY HISTORY INFORMATION**

| | FATHER | MOTHER | FATHER'S PARENTS | MOTHER'S PARENTS | SIBLINGS |
|---|---|---|---|---|---|
| ALCOHOL | ☐ | ☐ | ☐ | ☐ | ☐ |
| DRUGS | ☐ | ☐ | ☐ | ☐ | ☐ |
| PRE. MEDS | ☐ | ☐ | ☐ | ☐ | ☐ |
| DEPRESSION | ☐ | ☐ | ☐ | ☐ | ☐ |
| GAMBLING | ☐ | ☐ | ☐ | ☐ | ☐ |
| LEGAL SYSTEM | ☐ | ☐ | ☐ | ☐ | ☐ |
| ANXIETY | ☐ | ☐ | ☐ | ☐ | ☐ |
| PANIC | | | | | |

# OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

**PSYCHOLOGICAL SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. If indicated, I may seek consultation with colleagues while maintaining your anonymity.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

**MEETINGS**

The initial session, and sometimes subsequent sessions will be devoted to evaluation. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although in some instances sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation.

**PROFESSIONAL FEES**

| SERVICES | FEES QUOTED PER SESSION |
|---|---|
| CONSULTATION\EVALUATION | $225.00 |
| INDIVIDUAL | $190.00 |
| FAMILY THERAPY OR COUPLE THERAPY | $225.00 |
| PSYCHOLOGICAL TESTING (+SCORING+REPORT WRITING) | $150.00 |
| GROUP THERAPY | $ 75.00 |

Consultations and psychotherapy sessions are scheduled for 50 minutes; group and family therapy sessions are scheduled for 90 minutes. **Sessions must be cancelled 24 hours in advance to avoid a charge being made.**

PAYMENT OF FEES

Full payment of fees is expected at the time services are rendered unless other arrangements have been made in advance. Co-payments are made at the time of the appointment or via a credit card on a monthly basis. Even though insurance coverage may pay all or a portion of the charges, you are responsible for the entire bill-not the insurance company. A finance charge of one and one-half percent per month may by added to all outstanding accounts in excess of thirty days (18% annually). A $15.00 service charge will be assessed for any checks that are returned by your bank.

INSURANCE

A monthly statement will contain all the information necessary for your insurance company. Attach your insurance claim form to the statement and submit it.

CONFIDENTIALITY

Written and spoken material from any and all sessions, including psychological testing, will be strictly confidential, unless you give written permission to release all or part of this information to a specified person or agency. **Exceptions** to this confidentiality involves situations where a licensed psychotherapist is mandated to report instances of child or elder abuse; imminent danger to you or others is present; or your mental health is used in your defense in litigation. In addition it should be understood that your therapist may ask for authorization to consult with other your psychiatrist or primary care physician.

DELINQUENT ACCOUNTS

If accounts become delinquent (past 30 days) our office may begin collection procedures. We will attempt to contact you directly, however if accounts remain delinquent (90 days) an outside collection agency or small claims court action may be pursued. In addition to a service charge, you are responsible for any legal fees, court costs and collection charges involved as a result of any collection activity. In such instances information of a non-confidential nature regarding this account may be released.

If any of the foregoing provisions are unsatisfactory please make alternative stipulations prior or during your fist appointment. Signing below indicates that you have read and understood these conditions.

_____ _____

Signature of client or guardian date

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, it is not uncommon for people to require care beyond benefit limits.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the

entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

For the aforementioned reasons stated and the intrusions and limitations I have withdrawn from many insurance panels.

**CONTACTING ME**

I am often not immediately available by telephone. Please appreciate that when I am with you I don't take calls, so when I am with someone else the same holds true. When I am unavailable, my telephone is answered by voice mail [that can page me if needed]. I will make every effort to return your call on the same day you make it, though it may be at the conclusion of my day 9:00 pm. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, when necessary. You may also communicate with me via email at drfoust@drfoust.net however; remember that the internet is not a confidential means of communicating.

# PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any time spent in preparing information requests. Records will be converted to electronic media for storage upon discharge and destroyed after ten years.

# MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. Your signature also signifies that you have been given copy of the form describing confidentiality exceptions, fee schedule and patient rights and responsibilities.

_____ _____

Signature date

# PATIENT RIGHTS AND RESPONSIBILITIES

## Patient Rights

- Be treated with dignity, respect and courtesy.
- Be treated without regard to race, gender, cultural background or religion
- Choose or change your caregiver.
- Participate in making your health care decisions by receiving appropriate information about your diagnosis, treatment options and prognosis.
- Request an interpreter or assistance for language translation or hearing problems, when needed
- Refuse treatment or tests and be made aware of the clinical consequences of such a Refusal.
- Submit either positive or negative comments concerning your care to any health care Provider.
- Be notified as soon as possible of a schedule change that requires a new appointment
- Expect privacy and confidentiality regarding your clinical records, except with your written permission.
- Refuse to participate in any proposed research project without jeopardizing your care.
- Have your guardian, next of kin or legal designees exercise these rights if you are unable to do so.
- Clear explanation of your benefit plan and how you can access services.
- Receive a copy of these rights and responsibilities.

## Patient Responsibilities

- Know your benefit plan and adhere to the guidelines of your policy.
- Provide an accurate medial and social history. This includes granting a release of medical records from former caregivers.
- Respect the rights, privacy, and confidentiality of other patients and their families.
- Discuss any concerns you have about your treatment with your provider, including the refusal of treatment, this applies to you.
- Notify your health care provider when you expect to need to cancel with 24 hour notice.
- Telling your provider about your hopes and expectations of treatment.
- Ask questions regarding your illness or treatment.
- Co-payments are to be made at the time of the visit or via credit card on a monthly basis

## Fees

| SERVICES | FEES QUOTED PER SESSION |
|---|---|
| **CONSULTATION\EVALUATION** | **$225.00** |
| **Forensic / Legal.** | **$250.00** |
| **INDIVIDUAL** | **$190.00** |
| **FAMILY THERAPY OR COUPLE THERAPY** | **$225.00** |
| **HOME, SCHOOL OR HOSPITAL (TIME @ SITE+TRAVEL)** | **$260.00** |
| **PSYCHOLOGICAL TESTING (+SCORING+REPORT WRITING)** | **$150.00** |
| **GROUP THERAPY** | **$ 75.00** |

## CONFIDENTIALITY

Written and spoken material from any and all sessions, including psychological testing, will be strictly confidential, unless you give written permission to release all or part of this information to a specified person or agency. **Exceptions** to this confidentiality involves situations where a licensed psychotherapist is mandated to report instances of child or elder abuse; imminent danger to you or others is present; or your mental health is used in your defense in litigation. In addition it should be understood that your therapist may consult with other professionals associated with Anaheim Hills Psych. Center, or your referring physician, to ensure the highest quality of service.

DELINQUENT ACCOUNTS

If accounts become delinquent (past 30 days) our office may begin collection procedures. We will attempt to contact you directly, however if accounts remain delinquent (90 days) an outside collection agency or small claims court action may be pursued. In addition to a service charge, you are responsible for any legal fees, court costs and collection charges involved as a result of any collection activity. In such instances information of a non-confidential nature regarding this account may be released.

If any of the foregoing provisions are unsatisfactory please make alternative stipulations prior or during your fist appointment. Signing below indicates that you have read and understood these conditions. This page is yours to keep. Email:drfoust@drfoust.net and internet site is http://www.drfoust.net.The California Board of Psychology directs psychologists to inform patients that in the event we are unable to resolve any disputes, or if you have concerns about the treatment provided you may contact the Board at: 1422 Howe Avenue, Suite 22Sacramento, CA 95825-3200800-6332322 bopmail@dca.ca.gov

# PSYCHOLOGICAL/SOCIAL HISTORY

Name: SS#:
DOB:
Sex:

DIRECTIONS: Carefully read each question and circle your response.

1. What is your race?

| | | |
|---|---|---|
| Asian | Mexican | Caucasian |
| Pacific Islander | Latin American | Other |
| American or Alaskan Indian | African American | |

2. Who primarily raised you?

| | | |
|---|---|---|
| Biological parents | Father only | Mother only |
| Father and stepmother | Mother and stepfather | Adoptive parents |
| Foster parents | Institutional caretakers | Aunt and/or uncle |
| Brother and/or sister | Maternal grandparent(s) | Paternal grandparent(s) |

3. How would you characterize your childhood? (circle all that apply)

| | | |
|---|---|---|
| Happy | Dull | Painful |
| Frightening | Hard to remember | Regimented |
| Unhappy | Secure | |

4. Which descriptor(s) characterize your mother (maternal caretaker)? (circle all that apply) Please identify 5 adjectives.

| | | |
|---|---|---|
| Warm | Strict | Domineering |
| Distant | Rejecting | Abusive |
| Uncaring | Overprotective | Understanding |
| Others: | | |

5. Which descriptor(s) characterize your father (paternal caretaker)? (circle all that apply) Please identify 5 adjectives.

| | | |
|---|---|---|
| Warm | strict | Domineering |
| Distant | Rejecting | Abusive |
| Uncaring | Overprotective | Understanding |
| Others: | | |

6. How would you describe your parents' (or parent substitutes') relationship? (circle all that apply)

| | | |
|---|---|---|
| Close | Indifferent | Happy |
| Cold | Reserved | Loving |
| Hostile | Distant | Domineering/submissive |

7. How many brothers and sisters did you have?

| | | |
|---|---|---|
| None | Three | Six |
| One | Four | Seven |
| Two | Five | More than seven |

8. Which descriptors characterize you as a child (0 to 12 years of age)? (circle all that apply)

| | | |
|---|---|---|
| Outgoing | Shy | Active |
| Aggressive | Awkward | Happy |
| Friendly | Emotional | Irresponsible |
| Nervous | Rebellious | Serious |
| Stubborn | Unhappy | Calm |
| Temperamental | Selfconfident | Othe |

9. What was your order of birth?
Oldest Only child Middle Other Youngest

10. What were problems for you as a child 0 to 12 years of age)? (circle all that apply)
None Getting along with sibling(s) Bedwetting Academic
Overweight Getting along with mother Getting along with peers Nightmares
Physical/medical problems Underweight Getting along with father Getting along with teachers
Excessive fears or worries Felt I was a burden to my parents Fear of failure
Fighting / Stealing

11. What did your parents (parental caretakers) argue about'? (circle all that apply)
Discipline of children Sex Not being a good provider Money
Drinking Not taking care of the home Other Relatives interfering
Jealousy Never argued

12. What was your father's (paternal caretakers) Occupation?
Service worker Unskilled worker Skilled worker Semiskilled worker
owner/manager owner/high level executive Professional (requires bachelor's degree)
Professional (requires advanced degree) Sales Not in labor force

13. What was your mothers (maternal caretakers) occupation?
Service worker Unskilled worker Skilled worker Semiskilled worker
Owner/manager owner/high level executive Professional (requires bachelor's degree)
Professional (requires advanced degree) Sales Not in labor force

14. How would you describe your mother's method of discipline?
Strict inconsistent Fair Lenient

15. How would you describe your father's method of discipline?
Strict inconsistent Fair Lenient

16. What fears did you have as a child 0 to 12 years of age)? (circle all that apply)
No significant fears Death Strangers Other Might fall
Might become seriously injured/ill Might be abandoned lose my parents Might be laughed at
Animals other children

17. How would you characterize your sexual experiences?
Pleasant Neutral Unpleasant

18. How much education has been completed?
Completed less than 6 grades Completed elementary school Completed junior high (9h grade)
Attended high school (no diploma) received a GED. Graduated high school
Vocational/business school training Attended college (did not graduate) Graduated collegefour year degree
Completed graduate level courses Earned a master’s degree earned a doctoral degree

19. How would you rate your intellectual ability? (1 answer)
Below average Average Above average Superior/gifted

20. Were you ever held back in school?
No Yes

21. In general, what grades did you make in school?
Many D's and F's Mostly C's and D's Mostly B's and A's Mostly A's

22. Which of the following describe your experiences in high school?
Does not apply None Suspended
Had to be disciplined Expelled Other
Frequently

23. Did you graduate from high school?

Yes | No, dropped out because of discipline problems | No, dropped out to work to support family | No, dropped out because of poor grades | No, dropped out because of drug | No, dropped out because of health problems | No, dropped out because you got pregnant | No, dropped out because girl friend got pregnant

24. What were your plans when you left high school?

Did not have any plans | Planned to get married | Join the armed service | Planned to continue education | Other

25. Did you ever get in trouble while in school?

No | Occasionally | Often

26. Did you have any problems learning to read?

No | Yes

27. Did you have any problems learning math?

No | Yes

28. Did your peers ridicule, tease or make fun of you more than other kids?

No | Yes

29. Rate your family's economic status during childhood and adolescence:

Poverty level (received welfare) | Working class | Middle class | Upper middle class | Wealthy

30. Who provided the main source of income for your family?

Mother | Father | A relative | Social service agencies | Other

31. Did your parents agree on how money should be spent?

Agreed most of the time | Disagreed | Disagreed frequently

32. Did your family experience any financial problems?

No | Occasionally | Often

33. Currently, how much money does your household earn?

Less than $8,000 | $8,000 $12,000 | $12,000 $15,000 | $15,000 $20,000 | $20,000 $30,000 | $30,000 $45,000 | More than $45,000

34. Have you had any major changes in income during the last 2 years?

No | Decreased significantly | Increased significantly

35. What is your family's primary source of income?

Earned income | my partner's earnings | Relatives | Disability payments | Unemployment | Welfare | Investments | Other | Child support

36. Is providing enough income for your family a big stress in your life?

No | Yes

37. Are you presently employed?

No | Yes

38. How long have you been working at this job?

Less than 6 months | 3 to 10 years | More than 20 years | 6 months to 1 year | 10 to 15 years | Does not apply | I to 3 years | 15 to 20 years

39. How many hours per week do you work?

Less than 10 20 to 30 More than 45
10 to 20 30 to 45 Does not apply

40. In general, how do you enjoy your work?
Enjoyable Neutral Unenjoyable Does not apply

41. Circle those that apply?
Laid off # of times Fired # of times

42. What is the longest period of time you held one job?
Less than 1 year 3 to 5 years More than 10 years
1 to 3 years 5 to 10 years

43. Since starting fulltime work, what is your longest unemployed period?
Less than 1 year 3 to 5 years More than 10 years

44. Do you have any problems at work?
No Yes

45. What kinds of work have you performed in the past? (circle all that apply)
Service worker Owner/manager Sales
Unskilled worker Owner/high level executive not in labor force
Skilled worker Professional (requires bachelor's degree)
Semiskilled worker Professional (requires advanced degree)

46. Have you ever served in the military?
No Yes
Air Force Army Navy
Marines Coast Guard does not apply

47. How long did you serve?
Less than 3 months 3 to 5 years More than 15 years
Less than 1 year 6 to 10 years does not apply
1 to 2 years 10 to 15 years

48. What kinds of problems did you experience while in the military?
Getting used to rules & regs Began using drugs had to do special duty (conduct) other
Went AWOL Taking orders Began using alcohol to excess did time in the stockade/brig

49. Were you stationed in a combat zone?
No Yes, for less than 3 months Yes, for 3 to 6 months Yes, for 6 months to 1 year
Yes, for 1 to 2 years yes, for 3 to 4 years yes, for longer than 4 years does not apply

50. What was the highest rank you attained?
Enlisted person Noncommissioned officer Officer does not apply

51. What were the terms of your discharge?
Nerves Was reprimanded for my conduct was courtmartialed none or does not apply
Still on active duty Honorably discharged (mental problem) Dishonorably discharged
Honorable discharge Honorably discharged (physical problem) Does not apply

52. Did you ever see a psychologist or psychiatrist while in the military?
No Was hospitalized for mental problems Does not apply
For evaluation only For evaluation & treatment (Out Patient)

53. Do you have a serviceconnected disability?
No Physical Mental
Physical and mental Does not apply

54. Which of the following have you used? (circle all that apply)
None Cocaine Barbiturates
Amphetamines Hallucinogenic Opium
Ecstasy Heroin Marijuana
Tranquilizers without prescription Ketamine PCP
Pain pills without prescription other:

55. Have you ever felt there was a time you drank too much alcohol?

No Yes, on one occasion Yes, on more than several occasions
Yes, on several occasions

56. On the average, how often do you drink alcohol?
Never Once or twice a year Once a month
Once a week Several times a week daily

57. Which of the following have you experienced? (circle all that apply)
None Lost a job due to drinking Missed work due to drinking
Were in fights because of drinking Were arrested for being drunk and disorderly
Had an automobile accident because of drinking Received a ticket for drinking and driving
Lost driver's license because of drinking Had arguments with friends or relatives because of drinking

58. Have you ever been involved in an alcoholism or drug treatment program?
No Yes

59. Did your parents have a problem with alcohol when you were a child?
No Mother only Father only
Both parents did The person who raised me did

60. Do you use any illegal drugs?
No Occasionally Daily
No, but did in the past Regularly

61. How long have you been using, or did you use, illegal drugs?
Does not apply Two years Five years
Less than one year Three years Over five years
One year Four years

62. Which of the following have you been treated for as an adult? (circle all that apply)
None Arthritis Cancer
Diabetes Epilepsy (seizures) Heart problems
Hypertension Low back pain Problems with lungs or breathing
Problems with digestive system Other

63. What are you currently being treated for? (circle all that apply)
Not being treated Arthritis Cancer
Diabetes Epilepsy (seizures) Heart problems
Hypertension Low back pain Problems with lungs or breathing
Problems with digestive system Other

64. Do you currently have any physical problems that are not being treated by a medical doctor, but should be? (circle all that apply)
No Chest pain Difficulty with breathing
Dizziness Loss of consciousness Pain
Stomach problems Vision problems Other

65. How many cigarettes a day do you smoke?
None, have never smoked None, but used to smoke Less than one pack per day
One pack per day More than one pack per day

66. How long have you been smoking (or did you smoke) cigarettes?
Have never smoked 5 to 10 years More than 15 years
Less than five years More than 10 years More than 20 years

67. Have any family members ever experienced mental illness?
No I have Mother
Father Sibling(s) (brother(sister(s)} Grandparent

68. Did you have any serious illnesses as a child? (e.g. hospitalizations)
No Yes

69. Have you had any significant accidents in the past 3 years? Head injuries?
No Yes

70. Have you had any major illnesses or hospitalizations in the past 3 years?
No Yes

71. Rate your general level of health:
Excellent Good Fair
Poor Extremely poor

72. Are you currently under the care of a physician?
No Yes

73. What medications are you currently taking? (circle all that apply)
None Pain pills Antibiotics
Antiinflammatory pills Anticonvulsant pills Heart pills
High blood pressure pills Tranquilizers Antidepressants
Vitamins Insulin Allergy pills
Stomach pills Other

74. Has there been a recent change in your weight?
No Yes, a weight gain Yes, a weight loss
Yes, a weight loss due to dieting

75. Has there been a recent change in your appetite?
No Yes, an increase in appetite Yes, a loss of appetite

76. What problems do you have with your sleep?
None Trouble getting to sleep Multiple awakenings
Don't get enough sleep Sleep too much Restlessness
Wake up too early in the morning Sleep enough, but don't feel rested Nightmares Other

77. Do you eat a balanced diet? No Yes

78. Do you participate in a regular exercise program?
No Yes

79. How would you characterize your size? (I answer)
Very thin Thin About average
A little overweight Overweight Very overweight

80. What is your marital status?
Never married First marriage Remarried
Divorced Widowed Cohabiting
Separated
81. Have you ever been divorced?
No Yes How many times?

82. How long have you been with your current partner?
Does not apply Less than 1 year Number of years

83. How many children do you have?
None 3 6
1 4 7
2 5 More than 7

84. How would you describe your partner? (circle all that apply)
Warm Unhappy Distant
Uncaring Happy Frustrating
Enjoyable Abusive Faultfinding
Understanding Unforgiving Tense
Argumentative Boring Affectionate Does not apply

85. Are you having problems with your child(ren)'s behavior?
No Yes Does not apply

86. Check all the problems which trouble you.
Being uncomfortable with opposite sex Being afraid of sexual diseases

Having a sexually transmitted disease Being gay Worrying about sexual performance
Having unsatisfactory sexual relationship Thinking about sex too often Disliking sex
Being troubled by unusual sexual behavior Other

87. Is the frequency of sex a problem for you?
No Yes

88. Is the frequency of sex a problem for your partner?
No Yes

89. Which is true about your sex life?
Prefer not to answer I am interested in sex, but not active at this time
Have an active sex life Have an active sex life Have no interest in sex

90. Has there been a recent change in your interest in sex?
Prefer not to answer Yes, a decrease in interest No

91. What are your living arrangements?
Living with relatives in their home Living with friends in their home Renting a home/apartment Living in a dorm Own my home Boarder

92. How often do you and your partner argue?
Never Once a week Several times a day Rarely
Several times a week Does not apply once a month Daily

93. Has your relationship ever been threatened by an affair?
No Does not apply Yes, my affair Yes, my partner's affair

94. Which of the following have you experienced in the last 5 years? (Circle all that apply)
Not having any religious beliefs Not having good philosophy of life Not being able to get to church
Work interfering with religious practices Being rejected by church Being confused about religious beliefs Failing in religious beliefs Feeling abandoned by God Worrying about being accepted by God

95. What is your religious affiliation?
None Jewish Atheist Protestant Muslim Agnostic Catholic Buddhist Other

96. Are any of the following problems occurring or about to occur? (Circle all that apply)
Needing legal advice Being someone's guardian Not receiving child support Having legal problem with neighbors
Custody battle Being sued Being on parole Not receiving alimony Not having retirement funds Being legally disowned by family Facing criminal charges No Legal problems

97. Which of the following have you experienced in the past year? (Circle all that apply)
None Marriage spouse or partner being seriously ill or injured
Death of spouse or partner Child being seriously ill or injured Parent being seriously ill or injured
Other Separation Birth of child financial problems Serious illness or injury
Spouse or partner losing job Spouse or partner changing jobs Divorce
Death of child Death of a parent Change of jobs Loss of job

98. How would you rate your ability to cope with life?
Very good Good Average

99. How would you describe yourself? (Circle all that apply)
Quiet Unassertive Shy
Active Aggressive Temperamental
Selfconfident Carefree Stubborn
Friendly Smart Impatient Happy
Responsible Rebellious Serious Depressed
Worried Unenthusiastic Regretful Scared

100. How would you describe your mental state? (Circle all that apply)
Tense Sad Angry Disappointed Calm Nervous Troubled
Forgetful Fearful Confused Irritable Hyperactive Distrustful Concerned

101. What is the primary problem bothering you? (1 answer)

| | | |
|---|---|---|
| Marriage | Family | Loneliness |
| Moodiness | Depression | Anxiety |
| Selfconfidence | Physical (ill/tired) | Alcohol |
| Drugs | Sex | Memory |
| Work | Other | Self-esteem |

102. How long ago did you begin to be troubled by this problem? (1 answer)

| | | |
|---|---|---|
| Within the past month | Between 1 and 2 years | Over 10 years |
| Between 1 and 6 months | Between 2 and 5 years | 'All my life |
| Between 6 and 12 months | Between 5 and 10 years | Does not apply |

103. Rate the degree to which this problem has affected your life. (1 answer)

Very little A good deal A little A great deal

104. How often do you experience this problem? (1 answer)

| | | | |
|---|---|---|---|
| Many times a day | Several times a week | Monthly | Several times a day |
| Once a week | Several times a year | A fair amount | |
| Does not apply | Daily | Several times a month | Less than once a year |

105. What other kinds of problems are bothering you? (Circle all that apply)

| | | | |
|---|---|---|---|
| Marriage | Moodiness | Selfconfidence | Drugs |
| Work | Family | Depression | Physical (ill/tired) |
| Sex | Other | Loneliness | Anxiety |
| Alcohol | Memory | Does not apply | |

AAI questions

1. Could you start by orienting me to your early family situation, where you lived, and so on? If you could start with where you were born, whether you moved around much, what your family did for a living at various times.

2. I'd like you to try to describe your relationships with your parents as a young child. If you could start from as far back as you can remember.

3. To which parent did you feel closest and why? Why isn't there this feeling with the other parent?

4. When you were upset as a child, what would you do?

5. What is the first time you remember being separated from your parents? How did you and they respond? Are there any other separations that stand out in your mind?

6. Did you ever feel rejected as a young child? Of course, looking back on it now, you may realize that is wasn't really rejection, but what I'm trying to ask about here is whether you remember ever having felt rejected in childhood.

7. Were your parents ever threatening with you in any way - maybe for discipline, or maybe just jokingly?

8. How do you think these experiences with your parents have affected your adult personality? Are there any aspects of your early experiences that you feel were a set-back in your development?

9. Why do you think your parents behaved as they did during your childhood?

10. Were there any other adults with whom you were close as a child, or any other adults who were especially important to you?

11. Did you experience the loss of a parent or other close loved one while you were a young child?

12. Have there been many changes in your relationship with your parents since childhood? I mean from childhood through until the present?

13. What is your relationship with your parents like for you now as an adult?

14. Is there any particular thing which you feel you learned above all from your own childhood experiences?

15. What would you hope your child might learn from his/her experiences of being parented?

# Authorization form

Michael H. Foust, Ph.D.

**Patient Authorization for Use and Disclosure of Protected Health Information for insurance.**

By signing, I authorize Michael H. Foust, Ph.D. to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits Michael H. Foust, Ph.D. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

The Practice will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Michael H. Foust, Ph.D. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:
Michael H. Foust, Ph.D. 540 Golden Circle Dr., Suite 211, Santa Ana, CA 92705

Signed by: _____ _____

Signature of Patient or Legal Guardian  Relationship to Patient

_____ _____

Print Patient's Name  Date

_____

Print Name of Patient or Legal Guardian, if applicable

# Notice of privacy practices

**Effective date: _____**

***Michael H. Foust, Ph.D.***

**Notice Of Privacy Practices**

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.**
**Please review this notice carefully.**

**A. Our commitment to your privacy:**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

**The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.**

**B. If you have questions about this Notice, please contact:**

Michael H. Foust, Ph.D. at 714 834 9222.

**C. We may use and disclose your PHI in the following ways:**

The following categories describe the different ways in which we may use and disclose your PHI.

**1. Treatment**. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
**2. Payment**. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
**3. Health care operations**. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
**4. Optional Appointment reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment.
**5. Optional Treatment options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
**6. Optional Health-related benefits and services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
**7. Optional Release of information to family/friends.** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.
**8. Disclosures required by law**. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

**D. Use and disclosure of your PHI in certain special circumstances:**
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

**1. Public health risks**. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,

- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

**2. Health oversight activities**. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

**3. Lawsuits and similar proceedings**. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

**4. Law enforcement**. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

**5. Optional Deceased patients.** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

**6. Optional Organ and tissue donation.** Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

**7. Optional Research.** Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of

the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

**8. Serious threats to health or safety**. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

**9. Military**. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

**10. National security**. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

**11. Inmates**. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

**12. Workers' compensation**. Our practice may release your PHI for workers' compensation and similar programs.

**E. Your rights regarding your PHI:**

You have the following rights regarding the PHI that we maintain about you:

**1. Confidential communications**. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Michael H. Foust, Ph.D. at 540 Golden Circle Dr. #211, Santa Ana, CA 92705 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

**2. Requesting restrictions**. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Michael H. Foust, Ph.D. at 540 Golden Circle Dr. #211, Santa Ana, CA 92705. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

**3. Inspection and copies**. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not

including psychotherapy notes. You must submit your request in writing to Michael H. Foust, Ph.D. at 540 Golden Circle Dr. #211, Santa Ana, CA 92705 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

**4. Amendment**. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Michael H. Foust, Ph.D. at 540 Golden Circle Dr. #211, Santa Ana, CA 92705. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

**5. Accounting of disclosures**. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Michael H. Foust, Ph.D. at 714 834 9222. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

**6. Right to a paper copy of this notice**. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Michael H. Foust, Ph.D. at 714 834 9222.

**7. Right to file a complaint**. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Michael H. Foust, Ph.D. at 714 834 9222. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

**8. Right to provide an authorization for other uses and disclosures**. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care. Again, if you have any questions regarding this notice or our health information privacy policies, please contact Michael H. Foust, Ph.D. at 714 834 9222.

**INFORMED CONSENT FOR TELEHEALTH DURING AND AFTER THE CORONAVIRUS (COVID-19) PANDEMIC**

This Informed Consent for Telehealth contains important information focusing on providing healthcare services using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

**Benefits and Risks of Telehealth**

Telehealth refers to providing mental health psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of Telehealth is that the patient and clinician can engage in services without being in the same physical location. This can be helpful particularly during the Coronavirus (COVID-19) pandemic in ensuring continuity of care as the patient and clinician likely are in different locations or are otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telehealth, however, requires technical competence on both our parts to be helpful. Although there are benefits of Telehealth, there are some differences between in-person treatment and Telehealth, as well as some risks. For example:

- Risks to confidentiality. As Telehealth sessions take place outside of your [insert discipline]'s office [clinic], there is potential for other people to overhear sessions if you are not in a private place during the session. On my end, I will take reasonable steps to ensure your privacy. It is important; however, for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact Telehealth. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in Telehealth with clients who are currently in a crisis situation requiring high levels of support and intervention. We may not have an option of in-person services presently, but in a crisis situation, you may require a higher level of services. Before engaging in Telehealth, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our Telehealth work.

**Electronic Communications**
You may have to have certain computer or cell phone systems to use tele-psychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in Telehealth.

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, and do not respond immediately, therefore, these methods **should not** be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, and if you need immediate attention, contact your family physician or the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence, if necessary.

**Confidentiality**
I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of Telehealth services. The nature of electronic communications technologies, however, is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for Telehealth sessions and having passwords to protect the device you use for Telehealth).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent still apply in telehealth. Please let me know if you have any questions about exceptions to confidentiality.

**Appropriateness of Telehealth**
During this time, it may not be possible to engage in in-person sessions to “check-in” with one another. I will let you know if I decide that Telehealth is no longer the most appropriate form of treatment for you. If you decide Telehealth is not optimal for you, it is important to let me know. We will discuss options of engaging in referrals to another professional in your location who can provide appropriate services.

**Emergencies and Technology**

Assessing and evaluating threats and other emergencies can be more difficult when conducting Telehealth than in traditional in-person treatment. To address some of these difficulties, we will create an emergency plan before engaging in Telehealth services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as technological connection failure, and you are having an emergency, do not call me back; instead, call 9-1-1, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-connect you via the Telehealth platform on which we agreed to conduct treatment. If I do not connect via the Telehealth platform within two (2) minutes, I will call your cell phone. If I am unable to connect this way then call me on the phone number 7148349222.

**Fees**

The same fee rates will apply for Telehealth as apply for in-person therapy. Some insurers are waiving co-pays during this time. It is important that you contact your insurer to determine if there are applicable co-pays or fees which you are responsible for. Insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic therapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in Telehealth sessions in order to determine whether these sessions will be covered.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

**Records**

The Telehealth sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

**Informed Consent**

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our treatment together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

_____ _____

Patient Date

**In the event of treament concluding or Dr. Foust becoming incapacitated:**

**Michael H. Foust, Ph.D.**
**540 Golden Circle Drive, Suite 211**
**Santa Ana, CA 92705**

**Release of Information for Outpatient Psychotherapy Records/Information**
**Continuity of Care**
***

I, _____ (Name of Patient)
authorize **Michael H. Foust, Ph.D.** (Dr. Foust) to release my complete medical chart, inclusive of my contact information, chart notes, and prescription records to a licensed mental health profession associated with Practice-Legacy Programs™ (P-LP) upon Dr. Foust's death, or other event, that renders him unable to practice as a my psychologist.

II. I understand that the confidential information provided to P-LP will not be used for any purpose other than its intended use: To aide in the continuity of my mental health care and treatment to a referral psychologist previously agreed upon between me and Dr. Foust

III. Dr. Foust is not authorized to disclose any of my confidential information to any other person or entity without my consent.

**Continuity of Care Provision**

IV. I have been informed by Dr. Foust of his participation with P-LP which ensures the continuity of my mental health care/therapy in case of an unanticipated or emergency situations rendering Dr. Foust unable to continue with my care, therapy, or treatment.

I hereby authorize and consent that the contents of my mental health chart maintained by Dr. Foust, upon his inability to practice, be made available to a licensed mental health professional associated with P-LP, upon the termination of Dr. Foust's practice. That individual will review, assess, and ensure my referral to another qualified mental health professional, of my choosing, without further written consent on my part.

I understand that by signing this Continuity of Care Provision that I am knowingly, intelligently, and voluntarily waiving my patient-therapist right of confidentiality to enable the continuity of my care. This release applies only to a licensed mental health professional associated with P-LP.

Please select preference below that can be changed at any time.

V. ____ I understand that I may revoke this authorization, in writing, in whole or in part, at any time.

VI. ____ I choose to take possession of my record.

FINAL DISPOSITION OF THE MEDICAL RECORDS BY WAY OF DESTRUCTION

I, _____ intend that my complete mental health medical chart, in the possession of Michael H. Foust, Ph.D. be destroyed when Dr. Foust's psychology practice closes due to his inability to practice as my psychologist.

It is also my express intention that no person, other than Dr. Foust, has my consent to read or otherwise extract any information from any record or data maintained, by Dr. Foust, about me in our patient-doctor relationship.

I understand that I may contact Practice-Legacy Programs LLC,[1] the company that will administer the closing of Dr. Foust's healthcare medical practice: www.Practice-Legacy.com 925-263-2835 or 760-908-3227, to ensure that my chart, and its contents, is destroyed in concert with my express intentions.

Name (printed): _____

Signature: _____

Date: _____

Witness : [print name] _____ Signature: _____

[1] California LLC [12/10/13], primary place of business: 324 S. Eagle Nest Lane, Danville, CA 94506