Amy Klein Zeff, MA
Marriage and Family Therapist Lic # MFC 38532
22020 Clarendon Street, Suite 207, Woodland Hills, California 91367
818-591-8669 / Fax 818-591-2975

Minor Client Information Sheet

Client Name _____Today's Date_____

Date of Birth _____ Age ____ Gender_____ Ethnicity _____

Address _____

City_____Zip_____

Home Phone _____Cell Phone_____

Email
Address_____

Grade in School_____ School Attending_____

Guardian's Name _____Relationship _____

Date of Birth _____ Social Security Number _____
Address _____

City _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone_____ Fax #_____

Email Address_____

Gender _____ Marital Status _____Ethnicity_____

Education _____ Occupation _____

Guardian's Name _____Relationship _____

Date of Birth _____ Social Security Number _____
Address _____
City _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone_____ Fax #_____

Email Address_____
Gender _____Marital Status _____ Ethnicity _____

Education _____ Occupation _____

How were you referred to Amy Klein Zeff, MA, LMFT?_____

Emergency Contact_____

Phone #_____Relationship_____

We would like to receive blogs and educational emails, frequency about once per every six weeks (please circle) yes no

List Members of Child's Immediate Family and all Living in Child's Home(s):

Name	Age/Birth Date	Relationship	Occupation/School

Amy Klein Zeff, MA, Marriage and Family Therapist
MFC38532

Agreement For Service / Informed Consent to Treat a Minor

I_____ the parent of or legal guardian of

_____authorize Amy Klein Zeff,

MA, Licensed Marriage and Family Therapist to treat _____ in the context of individual /family/group psychotherapy. This agreement is created to outline terms and conditions of services provided by Amy Klein Zeff, MA, Marriage and Family Therapist for your minor child regarding the practices, policies, and procedures of Amy Klein Zeff, MA, Marriage and Family Therapist and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents should be discussed with Amy Klein Zeff, MA, LMFT prior to signing paperwork. _____ *initial*

I look forward to the opportunity of working with your child in psychotherapy. Your child's (and family's) commitment to the therapeutic process may afford him/her relief, insight, and change in the areas of his/her life that are bringing him/her into psychotherapy. Please know that there are times in the therapeutic process where people may feel worse before feeling better. _____ *initial*

About Amy Klein Zeff, MA, Marriage and Family Therapist

Amy Klein Zeff is passionate about her work as a Licensed Marriage and Family Therapist. She has been working with children and their families for over 16 years in many different settings. Amy Klein Zeff earned her undergraduate degree from Sarah Lawrence College and her graduate degree from Phillips Graduate Institute. In 1999 Amy Klein Zeff, MA, LMFT began working in Private Practice and founded *The Young Adult, Teen, and Family Program of the West Valley* which now encompasses individual psychotherapy for pre-teens, teens, and young adults; group therapy for pre-teens, teens, young adults, and parents; family counseling; parent consultation; and therapy for couples or parent(s) having questions concerning issues involving parenting and their children.. Amy Klein Zeff has been interviewed on the radio featuring topics such as parenting of adolescents and adolescent issues. She has also trained Los Angeles Unified School District school counselors on teen issues and how to help teens cope. Amy has

been asked to speak through out the Los Angeles area on parenting, adolescence, pre-teens, and "the college aged young adult" from a neuroscience prospective. Amy Klein Zeff, MA, LMFT has done a great deal of work with young children using art therapy and play therapy, and worked as psychotherapist with young mothers and mothers-to-be on issues concerning attachment, post-partum depression and from neuroscience prospective. If you would like more details concerns Amy Klein Zeff, MA, LMFT please go to her website www.amykleinzeff.com. If you are filing out this form on the website please go to the About Us page, thank you. _____*initial*

Confidentiality

I understand that Amy Klein Zeff, MA,LMFT, has an ethical and legal obligation to protect my child's confidentiality as a Licensed Marriage and Family. Amy Klein Zeff, MA, LMFT is a mandated reporter thus, confidentiality may be suspended and the proper authorities notified under the following circumstances:

- My child indicates suspicion to Amy Klein Zeff, LMFT of danger to him/ herself, another person, or property.
- I become gravely disabled.
- My child indicates suspicion to Amy Klein Zeff, LMFT regarding neglect, physical or emotional abuse of a minor, dependent adult, or an elderly adult.
- Amy Klein Zeff, MA, LMFT is subpoenaed by a court of law for records or to appear for deposition. _____*initial*

Furthermore I understand that my child may discuss issues and activities with Amy Klein Zeff, MA, LMFT that I may not approve. Behavior that places my child in significant harm will be disclosed to me in the interest of protecting my child's safety.
In treating a minor it is especially important to create a working alliance with their family thus, I may be asked to meet with Amy Klein Zeff, MA, MFT separately or together with my child. Any contact I have with Amy Klein Zeff, MA, MFT is available to be shared with my child. _____*initial*

On occasion, Amy Klein Zeff, MA, MFT may consult with other professionals regarding my child's treatment. No identifying information will be revealed during these consultations, and confidentiality will be fully maintained. I understand that in in compliance with federal regulations (HIPAA, Healthcare Information Portability and Accountability Act 1996) my Patient Health information may be transmitted for the purposes of treatment, payment, and healthcare operations without my consent.

In order to assist your child, Amy Klein Zeff, MA, Marriage and Family Therapist, must insist on complete confidentiality, As such, you agree not to ask Amy Klein Zeff, MA, Marriage and Family Therapist to testify in any court proceedings. If Amy Klein Zeff, MA, Marriage and Family Therapist is called as a witness by anyone in regards to the therapist's care and treatment of the your child you agree to pay Amy Klein Zeff, MA, Marriage and Family Therapist $375.00 per hour for court testimony,

deposition, or consultation, $250.00 for preparation work including letter writing, and $200.00 per hour for travel time. All estimated costs of attendance at testimony or deposition and/or the consultation and preparation and travel will be due in advance of services rendered. _____ *initial*

Marriage and Family Therapist in the State of California must comply with codes and ethics set by the Board of Behavioral Sciences, The American Association of Marriage and Family Therapists, and the California Association of Marriage and Family Therapists. According to these codes and ethics, we who treat minors involved in custody, residence, or visitation actions may not perform forensic *evaluations* for the above mentioned matters regarding minors and adults. Treating Marriage and Family Therapists may provide a mental health professional performing the evaluation information only if proper legal documentation is signed about minor children. It is never the treating psychotherapist's role to make a recommendation to the court for purposes of domestic litigation. If you do not understand the above please ask for details.

*Sign that you read and agree to above*_____

Cancellation Policy and Payment

Therapy sessions are 45 to 50 minutes long. When your child is scheduled for session this time is specially reserved just for him/her. **A minimum of 24 hours notice is required for cancellation for an appointment. Sessions that are not cancelled prior to 24 hour notice will be charged at Amy Klein Zeff's customary fee per session of $200.00 per session.** Missed sessions can not be submitted to insurance. If you or your child are needing to speak with me on the phone between sessions phone calls up to 15 minutes are not charged. After 15 minutes calls will be charged at my regular hourly rate of $200 per hour. Payment for sessions, missed sessions, or phone calls are due at the start of each session thus if you are not accompanying your child to my office, please make arrangements for your child to bring payment with him/her to session. Payment for session is accepted in the form of check (made out to Amy Klein Zeff), cash, or Credit Card. You can make payment at the time your child comes to session or previous to session (please go to the Contact and Scheduling Tab at lifepaththerapy.com). I understand that I will be responsible for all bank fees incurred should a check be returned for non-payment plus a fee of $25.00 for processing fees to Lifepath Center for Counseling and Psychotherapy aka Amy Klein Zeff, MA, MFT Inc.

I have read and agree to the policies as outlined above.

Name (Please Print)

_____

*Signature*_____*Date*_____

Insurance

Amy Klein Zeff, Inc bills your insurance carrier *solely as a courtesy to you*. **You are responsible for the entire bill when services are rendered**. We require that arrangements for payment of your estimated share, if you are using insurance, or your total fee, if you are not using insurance be made at each session date. If your insurance carrier does not remit payment within 60 days the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining. All deductibles will need to be met prior to us being able to use available insurance mental health coverage with your insurance company. _____*initial*

As a courtesy to you we will also attempt to obtain authorization for sessions when your insurance plan deems necessary. Please understand this **it is your responsibility to know if you need an authorization prior to insurance activating** payments for sessions, and for tracking your sessions for re-authorizations. If a session is not covered by your insurance carrier due to lack of pre-authorization the payment of the session is your responsibility. If you have used you maximum number of visits per calendar year, **it is your responsibility** to track this not ours. You will be charged for any sessions that are not covered by insurance due to being over your allowed visits per year. _____ *initial*

If payment is made directly to you by your insurance company for services billed by Amy Klein Zeff, MA, MFT Inc you recognize an obligation to promptly remit same to Amy Klein Zeff, MA, MFT Inc. _____ *initial*

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, attorney fees, and any other fees incurred.

Estimated patient payment_____

Please Print Name _____

Parent /Guardian Signature_____Date_____

Estimated coverage information is provided as a courtesy to you. It is only an estimate at this time.

Payment

Responsible Party for Payment

_____

Address

_____

City_____ State_____Zip Code_____

Work Phone #_____ Home Phone # _____

Cell Phone # _____ Fax #_____

Email Address _____

Social Security # _____ Date of Birth _____

Relationship to Patient

_____

Insurance: Without all information filled in we can not help you with your insurance

Primary Ins Co _____

Phone # _____ (On Back of Card)

Address_____

_____

Primary Insured's Name_____

Primary Insured's Date of Birth_____

Primary Insured's Social Security # _____

Group#/Name_____

Policy # _____

Relationship to Patient _____

Amy Klein Zeff, MA, Marriage and Family Therapist
MFC38532

CLIENT INFORMATION SHEET

Full Name_____Today's Date_____

Date of your child's last medical exam?_____Name of pediatrician_____

List any medical conditions your child is being treated for_____

List of any medications or drugs your child is currently taking (including supplements):

_____

_____

Has your child ever received psychiatric, psychological help, or counseling or any kind before? _____

If so please explain:

_____

Please circle or put an x in front of any of the following that apply to your child (please go over the list with your child):

Nervousness	Sadness	Suicidal Thoughts
Feelings of Anxiousness	Divorce	Social Skills
Panic	Feeling Down	Friends
Shyness	Alcohol Use	Unhappiness
Separation	Depressed	Tiredness
Anger	Disinterest in Activities	Concentration
Sleep	Self-Control	Making Decision
Irritability	Stress	Ambition
Relaxation	Headaches	Health Problems
Drug Use	Memory	Motivation
Energy	Insomnia	Flash Backs
Temper	Inferiority Feelings	My Thoughts
Legal Matters	Career	Self Harm
Academic Issues	Nightmares	Gender Identity
Stomach Problems	Eating Issues	Work
Peers	Parent	Sexual Issues
Education	Fears	Body Image
Loneliness	Appetite	Feeling Stuck
Rather Be Alone	Guilt	Feel like a Bad Person
Loss of Interest in Usual Interests	Feel like running away	In a Difficult Situation
Difficulty Carrying Out Life Tasks	Very Emotional	Relationship(s)
Trust	Transition	Support

Other:_____

Please let me know if this in your child's words or your words:
What is bringing you to therapy?

_____

_____

What would you like to gain from therapy?

_____

_____

_____

Is there anything else I should know?

_____

Circle all the apply to you (if you are coming with a partner please put your initials inside your circle).

1. In the last seven days have you felt:

Great Sad Hopeful Anxious Afraid Irritable Lonely Empty Bored

2. Over the last two years have you felt:

Great Sad Hopeful Anxious Afraid Irritable Lonely Empty Bored

3. How has your concentration been in the last month:

Good Fair Poor Can't Read Can't Watch TV Can't Write Can't Relax

Your child's psychotherapy session is reserved especially for him/her. This is time just put aside for them. All sessions that are not cancelled prior to 24 hours of your child's session will be charged at my standard psychotherapy fee of $200.00 per session. Missed sessions or late cancelled sessions can not be billed to insurance. It is your responsibility for fees due to a missed or late cancelled session to be remitted either at your child's first appointment after a missed or late cancelled appointment, immediately by mail, or payment through use of the website www.amykleinzeff.com continue to Contact and Schedule page.

Please make all changes regarding appointments via telephone at my office number 818-591-8669. Text messages, emails, and other forms of

communication may not be received 24 hours in advance and might cause you to be charged for a missed or late cancelled session.

As a reminder, all payments for sessions are due at the time of session unless you have a written agreement stating otherwise with Amy Klein Zeff or her biller.

Welcome to Lifepath. We look forward to our work together.

You are agreeing to all that is stated above by signing this form. You are stating that all information you have filled out is true.

*Name*_____

*Signature*_____ *Date*_____

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 INFORMATION (PHI)

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

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (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 (insert website address, if applicable).

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 yourconsent 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 disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request 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 my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please

contact me at: _____818-591-8669_____.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

Please sign that you have been informed concerning your privacy rights _____.