

Ben Novell, MS, LMFT, LPCC  
 Marriage and Family Therapist  
 State License MFC25733



Janelle K. Novell, MA, LMFT, RPT-S  
 Marriage and Family Therapist  
 State License MFC32101

## Client Information Form

Client Name	Address
First:	Street:
Last:	City: State: Zip:

Check box for preferred call number

<input type="checkbox"/> Home Phone	<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Work Phone	Email Address
( )	( )	( )	

DOB	SSN	Driver's License #

Marital/Relationship Status	How long in current relationship?

Occupation	Employer/ School
Employer/ School Address	
Street:	City: State: Zip:
How long at current employer?	

Insurance
Insurance Address
Street: City: State: Zip:

List all family members living in your home	Age

# Client Information Form (cont'd.)

<b>Reason you are seeking counseling?</b>

<b>If you were referred here, who referred you?</b>

<b>Have you ever been seen by a Psychiatrist, Psychologist or Counselor?</b>		
Yes ( )	No ( )	If Yes:
<b>Who?</b>	<b>When?</b>	<b>Where?</b>
<b>For What Reason?</b>		

<b>In Case of Emergency Contact</b>		<b>Address</b>	
First:		Street:	
Last:		City:	State:
Zip:			
<b>Relationship</b>	<b>Home Phone</b>	<b>Cell Phone</b>	<b>Work Phone</b>
	( )	( )	( )

### Responsible Party

(If Client is a Minor or has Conservator)

<b>Name</b>		<b>Address</b>	
First:		Street:	
Last:		City:	State:
Zip:			
<b>Check box for preferred call number</b>			
<input type="checkbox"/> Home Phone	<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Work Phone	Email Address
( )	( )	( )	
<b>DOB</b>	<b>SSN</b>	<b>Drivers License #</b>	
<b>Occupation</b>		<b>Employer</b>	
<b>Employers Address</b>			
Street:			
City:		State:	Zip:
<b>Signature</b>		<b>Date</b>	

# Client Information Form (cont'd.)

## Additional Responsible Party

Name		Address	
First:		Street:	
Last:		City:	State:      Zip:
Check box for preferred call number			
<input type="checkbox"/> Home Phone	<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Work Phone	Email Address
(    )	(    )	(    )	
DOB	SSN	Drivers License #	
Occupation		Employer	
Employers Address			
Street:			
City:		State:	Zip:
Signature		Date	

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## General Client Information

We appreciate your interest in seeking professional help. We believe that a clear understanding of the practical aspects of your relationship with us, at the onset of treatment is in the best interest of therapy. It is with this in mind that we present the following information to you.

- THERAPY consists of face-to-face contacts between a qualified professional and the person(s) in treatment. The focus is on the present problem and associated feelings, assessing possible causes of the problem and possible alternative courses of action and their consequences. The frequency and type of treatment will be decided upon between you and your therapist. You are expected to benefit from therapy, but there is no guarantee that you will. Maximum benefits will occur with regular attendance, but you may feel temporarily worse while in treatment.
- NOVELL AND NOVELL COUNSELING SERVICE FEE SCHEDULE IS AS FOLLOWS:
  - The standard fee for counseling services is **\$150.00 per clinical session**. Occasionally, there is a need that requires the services of two therapists. The fee for this service is **\$300.00 per session**. **Clients are expected to pay for the service at the time the service is rendered, unless other arrangements have been made in advance with the administrator.** If you are in financial need we encourage you to discuss this with the administrator.
  - When there is a need for a **written report**, you will be billed at a rate of **\$100.00 per page**. Generally, **there will be no charge for correspondence of one page or less**. In the event that correspondence of lengthy duration is required, you will be billed at the rate of \$50.00 per page.
  - Occasionally, a need to communicate with your therapist may arise between sessions. No charge will be made for contact less than 10 minutes. **Contact in excess of 10 minutes will be prorated at the rate of \$150.00 per hour.** (Contact includes telephone, faxing and any electronic forms of communication).
  - **If you do not keep an appointment or do not cancel at least 24 hours in advance, you will be charged \$50.00 for your reserved time.** Adhering to this policy will be helpful for other clients and allow your therapist to make more efficient use of available time. We understand that emergencies do happen and we will take this into consideration.
  - **Payment is required at the time of service. We accept Master Card, Visa, debit cards and cash. A 15% APR service charge will be added to accounts that carry a balance. We do not accept checks.**

Initial Here \_\_\_\_\_

- INSURANCE REIMBURSEMENT:
  - Many insurance companies do reimburse for therapeutic treatment. If you have insurance we are willing to process forms for you. However, **until your insurance coverage is verified, you will be expected to pay for services at the time service is rendered.**
  - You must also understand that if you have insurance coverage, you are still responsible for payment of the bill. This will include any deductibles or any amounts unpaid by the insurance coverage unless otherwise contractually agreed upon between therapist and Insurance Company.
  - Since many insurance companies will pay only a portion of treatment, a co-payment will be required and sometimes a deductible must be satisfied and is your responsibility. Payment is required at the time of service.
  - If you have any questions regarding your financial responsibility, please speak with the billing manager or the administrator. We are interested in your success in treatment and are aware that this issue may become a source of conflict if not resolved prior to counseling.

Initial Here \_\_\_\_\_

# General Client Information (cont'd)

- CONFIDENTIALITY RIGHTS:

- This is intended to inform you that, by law and by ethical standards, you are guaranteed confidentiality of your communication. Only if permission is given in writing will information be released. However by law, the following exceptions do exist:
- If you have intentions of harming yourself or another person.
- If you commit an act of abuse against a child.
- You may be reported for any criminal acts of violence and elder abuse.

Initial Here \_\_\_\_\_

- COMFORT OF CLIENTS AND GENERAL RULES:

- For the comfort of other clients, it is important that your children be under your control. Please supervise your children for their safety and comfort of others.
- Please, **NO** food or drink in the lobby. Please refrain from smoking in or near the office building for the comfort of all.
- This is a non-smoking facility. Smoking is not permitted anywhere on the property inside and outside of the building including the parking lot.
- Please wait in the lobby for your therapist. Do not walk past the receptionist window without assistance. This is important for client confidentiality and respect for other client's time with their therapist. If we are running behind please be assured that you will receive equal time and attention.
- Please check in at the window upon arrival. Not checking in may result in a delay of your session due to the therapist not being notified of your arrival.
- We are interested in your feedback. Please go to our website at <http://novellcounseling.org> to complete our satisfaction survey.

Initial Here \_\_\_\_\_

- EMERGENCY INFORMATION:

- In the event of an emergency, **please call 911.**

Initial Here \_\_\_\_\_

We hope that your relationship with us is helpful and profitable to you. If you have any further questions regarding these arrangements or other aspects of your relationship with us, please do not hesitate to discuss them with us.

**I HAVE READ THE ABOVE AND I AGREE TO ACCEPT TREATMENT. FURTHER, I AGREE TO ALL CONDITIONS SET FORTH AND UNDERSTAND MY RESPONSIBILITY. I ALSO GIVE MY CONSENT FOR ANY PSYCHOLOGICAL TESTING NECESSARY IN THE COURSE OF TREATMENT.**

\_\_\_\_\_  
Client or Responsible Party

\_\_\_\_\_  
Date

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## **Assignment of Release of Benefits**

I hereby authorize my insurance benefits to be paid directly to the provider and acknowledge that I am financially responsible for the non-covered services.

I also authorize the provider to release any information required, to my insurance company in regards to processing my claims and for quality assurance.

\_\_\_\_\_  
Insured and/or client signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



## Consumer Notice Of Rights and Responsibilities

### Dignity and Respect

- You have the right to be treated with consideration, dignity and respect – and the responsibility – to respect the rights, property and environment of all physicians and other health care professionals, employees and other patients.
- You have the right to access your own treatment records and have the privacy and the confidentiality of those records maintained.
- You are also entitled to exercise these rights regardless of gender, age, sexual orientation, marital status or culture; or economic, educational or religious background.

### Knowledge and Information

- You have the right to receive information about the organization's services and practitioners, clinical guidelines, and members' rights and responsibilities.
- You have the right – and the responsibility – to know about and understand your health care and coverage, including:
  - Participating with your physician and other healthcare professionals in decision making regarding your treatment planning. Having participated and agreed to a treatment plan, you have a responsibility to follow the treatment plan or advise your provider otherwise.
  - The names and titles of all healthcare professionals involved in your treatment.
  - Your clinical condition and health status.
  - Any services and procedures involved in your recommended course of treatment.
  - Any continuing health care requirement following your discharge from a provider's office, hospital, or treatment program.
  - How your health plan operates—as stated in your Policy and/or Certificate.
  - The medications prescribed for you—what they are for, how to take them properly and possible side effects.

### Continuous Improvement

- As a partner with your health plan and any health care professional who may be involved in your care, you have the right to:
  - Contact a Member Service Associate to address all questions and concerns as well as to make suggestions for improvement to the health plan and/or the members' rights and responsibilities policies.
  - Ask questions about any clinical advice or prescribed treatment if you need an explanation or want more information.
  - Appeal any unfavorable behavioral health care decisions by following the established appeal or grievance procedures of your health plan.

# Consumer Notice Of Rights and Responsibilities (cont'd)

## Accountability/Autonomy

- As a partner in your own health care, you have the right to refuse treatment – providing you accept responsibility and the consequences of such a decision – and the right to refuse to participate in any medical research projects.
- You have a responsibility to participate, to the degree possible, in understanding your behavioral health problems and developing mutually agreed-upon goals.
- You also have the responsibility to:
  - Provide your current provider with previous treatment records, if requested, as well as provide accurate and complete medical information to any other health care professionals involved in the course of your treatment.
  - Be on time for all appointments and to notify your provider's office as far in advance as possible if you need to cancel or reschedule an appointment.
  - Receive all non-emergent or urgent care through your assigned behavioral health provider and obtain preauthorization of service from your behavioral health plan.
  - Notify your Behavioral Health Care within 48 hours – or as soon as possible – if you are hospitalized or receive emergency care.
  - Pay all required co-payments and deductibles at the time you receive behavioral health care services.
- You have the right at any and all times to contact a member service associate for assistance with issues regarding your behavioral health plan.
- It is your right to have all the above rights apply to the person you have designated with legal authority to make decisions regarding your health care.

**If you have any questions or complaints regarding your rights, contact your Behavioral Healthcare Service Member Associate.**

Patient or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Practitioner Signature \_\_\_\_\_ Date \_\_\_\_\_



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## POST ADOPTION THERAPY GROUP CONTRACT

I, \_\_\_\_\_, hereby agree to participate in a 90 minute, Post Adoption Therapy Group. I have read and agree to abide by the following requirements:

### GROUP FEES & ATTENDANCE REQUIREMENTS:

Attendance fees are \$50 per group session. Fees for the group are due and payable in full prior to beginning the group.

### ASSIGNMENTS:

Participation and completion of assignments in and out of group is expected and required. Participants may have material fees to pay. The group leader will inform of the costs prior to each group session.

### MEETINGS:

Each session shall begin at **9:00 am on the 2<sup>nd</sup> Sat of each month**, (In the event of a holiday. The administrator will advise as to an alternate date.), with the first class beginning on \_\_\_\_\_. I shall arrive at least 10 minutes prior to the beginning of each class to assure a timely beginning of the class for all members. Any late arrival of more than five (5) minutes will result in non-admission to the class for that day.

### CONFIDENTIALITY EXPECTATIONS:

Because of the nature of this program many clients disclose personal information during the class. It is required that any information discussed or disclosed by other class members be kept confidential. No discussion of any individual or information about that individual is to be discussed outside of the class session. If you violate another member's confidentiality, you will be immediately discharged from the class and not allowed to return.

**Program Administrator: Janelle K. Novell, LMFT, RPT-S (951) 694-0695.**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## Appeals and Grievances

### Appeals Process

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

### Grievances

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

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

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Signature of Patient, Legal Guardian, Legal Representative

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Printed Name

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Relationship to Patient

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Patient Name (if different from above)

---

Date



## Notice Of Privacy Practices

- 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.
- WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).  
We are legally required to protect the privacy of your PHI, which includes information that can be used to identify you that we have 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. We must provide you with this notice about our privacy practices, and this notice must explain how, when, and why we will “use” and “disclose” your PHI. A “use” of PHI occurs when we share, examine, utilize, apply, or analyze it within our practice. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure was made. And, we are legally required to follow the privacy practices described in this Notice.
- However, we reserve the right to change the terms of this Notice, and our privacy policies at any time. Any changes will apply to all PHI already on file. Before we make any important changes to the privacy policies, we will promptly change this notice and post a new copy in our office and on our website. You can also request a new copy of this notice in our office at any time.
- HOW MAY WE USE AND DISCLOSE YOUR PHI.  
We will use and disclose your PHI for many different reasons. For some of these uses or disclosures, we will need your prior authorization, for others however, we do not. Listed below are the different categories of our uses and disclosures along with some examples of each category.
  - USES AND DISCLOSURES RELATING TO TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS DO NOT REQUIRE YOUR PRIOR WRITTEN CONSENT. We can use and disclose your PHI without your consent for the following reasons:
    - FOR TREATMENT. We can use and 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 case. We can disclose your PHI to your physician in order to coordinate your care.
    - TO OBTAIN PAYMENT FOR TREATMENT. We can use and disclose your PHI to bill and collect payment for the treatment and services provided to you. For example, we might send your PHI to your insurance company or health plan to get paid for the health care we have provided to you. We may also provide your PHI to our business associates, such as billing companies, claim processing companies, and others that process our health care claims.
    - FOR HEALTH CARE OPERATIONS. We can use or disclose your PHI to operate our practice. For example, we 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. We may also provide your PHI to our accountants, attorneys, consultants, and others to make sure we are complying with applicable laws.
    - OTHER DISCLOSURES. We may also use or disclose your PHI to others without your consent in certain situations. For example your consent is not required if you need emergency treatment, as long as we try to get your consent after treatment is rendered, or if we try to get your consent but you are unable to communicate with us (such as if you are unconscious or in acute pain) and we believe you would consent to such treatment if you were able to do so.
  - CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR CONSENT. We can use and disclose your PHI without your consent or authorization for the following reasons:
    - WHEN DISCLOSURE IS REQUIRED BY FEDERAL, STATE, OR LOCAL LAW; JUDICIAL OR ADMINISTRATIVE PROCEEDINGS; OR LAW ENFORCEMENT. For example, we may make a disclosure to applicable officials when a law requires us to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
    - FOR PUBLIC HEALTH ACTIVITIES. For example, we may have to report information about you to the county coroner.
    - FOR HEALTH OVERSIGHT ACTIVITIES. For example, we may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
    - FOR RESEARCH PURPOSES. In certain circumstances, we may provide PHI in order to conduct medical research.
    - TO AVOID HARM. In order to avoid a serious threat to the health or safety of a person or the public. We may need to provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
    - FOR SPECIFIC GOVERNMENT FUNCTIONS. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
    - FOR WORKERS COMPENSATION PURPOSES. We may disclose PHI in order to comply with workers’ compensation laws.
    - APPOINTMENT REMINDERS AND HEALTH RELATED BENEFITS AND SERVICES. We may use PHI to provide appointment reminders or give you information about treatment alternatives or other health care services or benefits we offer.
  - CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.
    - DISCLOSURES TO FAMILY, FRIENDS, OR OTHERS. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your case 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.

# Notice Of Privacy Practices (Cont'd)

- OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION.  
In any other situation not previously described in this section we will ask for your written authorization before using or disclosing 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 we haven't already taken any action in reliance on such authorization).
- WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.  
You have the following rights with respect to your PHI.
  - THE RIGHT TO REQUEST LIMITS ON USES AND DISCLOSURES OF PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request, but we are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.
  - THE RIGHT TO CHOOSE HOW WE SEND PHI TO YOU. You have the right to ask that we send information to you at an alternative address (such as sending information to your work address rather than your home address) or by alternate means (such as email rather than regular mail). We must agree to your request so long as we can easily provide the PHI to you in the format and method you have requested.
  - THE RIGHT TO SEE AND GET COPIES OF YOUR PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we do not have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.
  - If you request copies of your PHI, we will charge you not more than \$25.00 for electron transmission of records. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.
  - THE RIGHT TO GET A LIST OF THE DISCLOSURES WE HAVE MADE. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list will also not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures prior to April 15<sup>th</sup>, 2003.
  - We will respond to your request for a list of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide this list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost-based fee for each additional request.
  - THE RIGHT TO CORRECT OR UPDATE YOUR PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and the reason for the request in writing. We will respond within 60 days of receiving your request to correct or update your PHI. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done so, and tell others that need to know about the change to your PHI.
  - THE RIGHT TO GET THIS NOTICE BY EMAIL. You have the right to get a copy of this notice by email. Even if you have agreed to receive this notice via email, you also have the right to request a paper copy of it.
- HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.  
If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed below. You may also 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. We will take no retaliatory action against you if you file a complaint about our privacy practices.
- PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.  
If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact our Office Manager at 951-694-0695.

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## Acknowledgement Of Receipt Of Notice Of Privacy Practices

Patient or Subscriber Name: \_\_\_\_\_  
(Please print patient or subscriber name)

I, \_\_\_\_\_,  
(Print name of patient, subscriber, conservator, parent or legal guardian signing below)

acknowledge receipt of the Notice of Privacy Practices, which explains limits on ways in which Novell & Novell Counseling Services may use or disclose personal health information (PHI) to provide service.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If not signed by patient, indicate relationship: \_\_\_\_\_  
NOTE: Parent must have legal custody. Legal guardians and conservators must show proof.

\*\*\*\*\*  
THIS SECTION TO BE FILLED OUT BY NOVELL & NOVELL COUNSELING SERVICES STAFF

Patient did receive the Notice of Privacy Practices, but did not sign this Acknowledgement of Receipt because:

- Patient left office before Acknowledgement could be signed.
- Patient did not wish to sign this form.
- Patient cannot sign this form because: \_\_\_\_\_

Patient did not receive the Notice of Privacy Practices because:

- Patient required emergency treatment.
- Patient declined the Notice and signing this Acknowledgement.
- Other: \_\_\_\_\_

Name: \_\_\_\_\_  
(Print name of provider or provider's representative)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of provider or provider's representative)