Sharon D. Heaston, LMFT

EMAIL PREFERRED: PSYCHEVALSPCS@GMAIL.COM
Telephone: (909)-945-8894 | Facsimile: (909)-945-2855

Personal Information

Date: Referring Source:

Name: Birth Date: Age:

Home Phone: Work Phone: Cell Phone:

Address:

Marital History: (Select) Sex: (Select)

Children(s) Ages: Highest Level of Education: (Select)

Who do you live with?

Height: Weight:

Occupation: ☐Full Time ☐Part Time

Email Address: Are we free to contact you by: ☐Email ☐Text
(Please check the method of contact we are authorized to use)

Payment Information

If I am an in-network provider for your insurance company, I will be happy to bill them. Your debit/credit card will be used for your co-payment or any charges not covered by your insurance company. Please be sure to take a copy of the front and back of your insurance card and send it back to me with this packet.

Name of Insurance:

Name & ID Number on Card:

Co-Pay:

Form of payment: ☐ Visa ☐ American Express ☐ MasterCard ☐ Other:

Name on Card:

Credit Card Number:

Billing Zip Code: CVV#: Expiration:

Notice of Receipt of Privacy Practices

With your signature below, you acknowledge that you have received the HIPPA Notice of Privacy Practices. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full. My Notice of Privacy Practices is subject to change. If I change my Notice, you may obtain a copy of the revised Notice from me by contacting me at (909) 945-8894. If you have any questions about my Notice of Privacy Practices, please contact me at (909) 945-8894.

Client Signature Date

Client Signature Date

Sharon D. Heaston, LMFT
, Claremont, CA 91711 Telephone: (909) 945-8894 |
Facsimile: (909) 945-2855 www.sharonheaston.com
sheaston22@gmail.com

PLEASE KEEP THIS NOTICE OF PRIVACY PRACTICES FOR YOUR FILE
DO NOT RETURN

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 PHY, 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 release, 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 www.sharonheaston.com.

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 Heal 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 Treatments**. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For examples, I might send your PHI to your insurance

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 PHO 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 our consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

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

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

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

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

4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to a government official an adverse reaction that you have to 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 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 heal 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, 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 our 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 you 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 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 you PHI, but I know who does, I will tell you how to get it. I will respond to your request within 30 days of received 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 $0.25 per 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.

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 within 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. 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 VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

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

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: (909) 945-8894.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

Sharon D. Heaston, MFT

675 West Foothill Blvd., Suite 302
Claremont, CA 91711
Telephone: (909)-945-8894
Facsimile: (909)-945-2855

NON SUBPOENA AGREEMENT

This Contract is an agreement between the interested parties that no party shall attempt to subpoena my testimony or my records for a deposition or court hearing of any kind for any reason.

All parties acknowledge that the goal of psychotherapy is the amelioration of psychological distress and interpersonal conflict, and that the process of psychotherapy depends on trust and openness during the therapy sessions.

Therefore, it is understood by all parties that if they request my services as a Psychotherapist, they are expected not to use information given to me during the therapy process for their own legal purposes or against any of the other parties in a court or judicial setting of any kind.

Signed & Dated_____

Signed & Dated_____

Sharon D. Heaston, LMFT

Telephone: (909) 945-8894 | Facsimile: (909) 945-2855
www.sharonheaston.com

TELEMEDICINE INFORMED CONSENT FORM

I, (Name of Patient) hereby consent to engaging in telemedicine with Sharon D. Heaston, LMFT as part of my psychological evaluation, assessment and psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical mental information, both orally and visually, to health care practitioners located in California or outside California. I understand that I have the right to:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentially, including but not limited to: reporting child, elder and dependent adult abuse; expressed threats of violence towards ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent

(3) I understand that there are risk and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapists, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of any medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine-based services and care may not be as complete as face-to- face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some case even get worse.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction. Listed below please find my signature and the date:

Signature: Date:

Sharon D. Heaston, LMFT
Claremont, CA 91711
Telephone: (909) 945-8894 Facsimile: (909) 945-2855
sheastonlmft@gmail.com

PLEASE RETURN A SIGNED COPY

THERAPIST-CLIENT SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it, if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES
My Credentials: I am a licensed Marriage & Family Therapist, a Psychotherapist. I have been licensed since 1997. I hold a Master's Degree in Psychology form Azusa Pacific University. In 2015, I received training in EMDR which is very effective in treating trauma.

Psychotherapy is collaboration between client and therapist to increase understanding and bring about change. There are many different clinical methods I may use to deal with the problems that you hope to address. Psychotherapy calls for a very active effort on your part and, for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

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. These troubled feelings are normal and will be temporary, depending on the depth of your emotional difficulties and distress. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions I feelings of distress. Although there are no guarantees of what you will

experience I will devote my attention to ensure we maintain a safe and respectful environment that can maximize the possibilities for you to achieve positive growth and healing.

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 / SESSIONS

I normally conduct an evaluation that will last from 2 to 4 sessions. 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, we will usually schedule one 50-minute session per week at a time we agree on. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours (1 day) advance notice of cancellation**. If it is possible, I will try to find another time to reschedule the appointment.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail that I monitor frequently. For quicker response, you may also **send an e-mail to sheaston22@gmail.com**. **Please note that I use calls/e-mails between sessions for scheduling and emergencies only**. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If your call is of a non urgent matter, please allow up to 48 hours to respond. If I will be unavailable for an extended time and you experience an emergency, please go to your closest Emergency Room or call 911.

EMERGENCY PROCEDURES

Because I am not available 24-hours, if an emergency situation occurs and you are at immediate risk and cannot reach me, please dial 911 or contact the nearest hospital emergency room. Also, call me and leave a message so that I will know what is happening and can get in touch with you as soon as possible.

PROFESSIONAL FEES

My fee for an initial Assessment is $150 each 50-minute session thereafter is $120. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

If I am called by another party to testify, because of the difficulty of legal involvement, I charge $375 per hour for preparation and attendance at any legal proceeding. I require a minimum of 4 hours and need 50% paid prior to my court appearance.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. I will ask you to leave a credit or debit card on file which I may use to charge each session. I don't accept personal checks. Payment schedules for other professional services will be agreed to when they are requested.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a psychotherapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- **Consultation**. I may occasionally find it helpful to consult other health and mental health professionals about my work with you. During this consultation, I would make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless it is important to our work together.
- **Insurance**. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- **Court order.** If you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by the psychotherapist-client privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- **Health Oversight**. If a government agency is requesting the information for health oversight activities, I am required to provide it for them.
- **Lawsuit.** If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- **Threat to self**. If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
- **Worker's Compensation.** If a client files a worker's compensation claim, I must, upon appropriate request, provide a copy of the client's record to the appropriate parties, the client's employer, the workers' compensation insurance carrier or the Labor Commission.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from hard and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

- **Child Abuse.** If I have reason to believe that a child has been or is likely to be subjected to incest, molestations, sexual exploitation, sexual abuse, physical abuse or neglect, the law requires that I immediately notify the Department of Child and Family Services or an appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information.

- **Vulnerable Adult Abuse.** If I have reason to believe that any vulnerable adult has been the subject of abuse, neglect, abandonment or exploitation, I am required to immediately notify Adult Protective Services intake. Once such a report is filed, I may be required to provide additional information.
- **Threat to other.** If a client communicates an actual threat of physical violence against an identifiable victim, I am required to take protective actions. These actions may include notifying the potential victim and contacting the police, and/or seeking hospitalization for the client.

While this written summary of exception to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

MINORS & PARENTS

Clients under 14 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records unless I decide that such access is likely to injure the child, or we agree otherwise. Since parental involvement in therapy is important, it is my policy to request an agreement between a child client between 14 and 18 and his/her parents allowing me to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services you insurance policy covers.

My practice is a fee for service practice, which means that your payment is expected at the end of each session.

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 heal 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 much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. 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. **By signing this Agreement, you agree that I can provide requested information to your carrier.**

ENDING THERAPY

Some clients benefit most from a brief involvement in therapy whereas others will find an extended length of time more valuable. Most people need at least 26 sessions to make significant progress. I am committed to working with you as long as the therapeutic process is productive and healthy. It is most productive if you can address the ending of your therapy over the course of several closure sessions.

If I do not have contact or communication from you for a period of 30 consecutive days, I will assume that you no longer intend to remain active in this therapy relationship and your case will be closed. You have the option, however, to contact me again any time in the future to continue psychotherapy with me.

If you don't give me 24 hour advance notice for two sessions, you will be taken off the schedule and referred back to your insurance company for another provider referral.

My (our) signature (s) below indicate that I (we) have received a copy of the Psychotherapist/Client Agreement and a copy of my HIPAA Notice of Policies and Practices to Protect the Privacy of Your Health Information document.

My (our) signature(s) below also indicate that I (we) consent to treatment by Sharon D. Heaston, LMFT:

_____ _____

Client Signature Date

_____ _____

Client Signature Date

Sharon D. Heaston, LMFT
Claremont, CA 91711
Telephone: (909) 945-8894 | Facsimile: (909) 945-2855
www.sharonheaston.com
sheaston22@gmail.com

PLEASE KEEP THIS THERAPIST-CLIENT SERVICES AGREEMENT FOR YOUR FILE

THERAPIST-CLIENT SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it, if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES
My Credentials: I am a licensed Marriage & Family Therapist, a Psychotherapist. I have been licensed since 1997. I hold a Master's Degree in Psychology form Azusa Pacific University. In 2015, I received training in EMDR which is very effective in treating trauma.

Psychotherapy is collaboration between client and therapist to increase understanding and bring about change. There are many different clinical methods I may use to deal with the problems that you hope to address. Psychotherapy calls for a very active effort on your part and, for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

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. These troubled feelings are normal and will be temporary, depending on the depth of your emotional difficulties and distress. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions I feelings of distress. Although there are no guarantees of what you will

experience I will devote my attention to ensure we maintain a safe and respectful environment that can maximize the possibilities for you to achieve positive growth and healing.

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 / SESSIONS

I normally conduct an evaluation that will last from 2 to 4 sessions. 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, we will usually schedule one 50-minute session per week at a time we agree on. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours (1 day) advance notice of cancellation**. If it is possible, I will try to find another time to reschedule the appointment.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail that I monitor frequently. For quicker response, you may also **send an e-mail to sheaston22@gmail.com**. **Please note that I use calls/e-mails between sessions for scheduling and emergencies only**. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If your call is of a non urgent matter, please allow up to 48 hours to respond. If I will be unavailable for an extended time and you experience an emergency, please go to your closest Emergency Room or call 911.

EMERGENCY PROCEDURES

Because I am not available 24-hours, if an emergency situation occurs and you are at immediate risk and cannot reach me, please dial 911 or contact the nearest hospital emergency room. Also, call me and leave a message so that I will know what is happening and can get in touch with you as soon as possible.

PROFESSIONAL FEES

My fee for an initial Assessment is $150 each 50-minute session thereafter is $120. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

If I am called by another party to testify, because of the difficulty of legal involvement, I charge $375 per hour for preparation and attendance at any legal proceeding. I require a minimum of 4 hours and need 50% paid prior to my court appearance.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. I will ask you to leave a credit or debit card on file which I may use to charge each session. I don't accept personal checks. Payment schedules for other professional services will be agreed to when they are requested.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a psychotherapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- **Consultation**. I may occasionally find it helpful to consult other health and mental health professionals about my work with you. During this consultation, I would make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless it is important to our work together.
- **Insurance**. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- **Court order.** If you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by the psychotherapist-client privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- **Health Oversight**. If a government agency is requesting the information for health oversight activities, I am required to provide it for them.
- **Lawsuit.** If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- **Threat to self**. If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
- **Worker's Compensation.** If a client files a worker's compensation claim, I must, upon appropriate request, provide a copy of the client's record to the appropriate parties, the client's employer, the workers' compensation insurance carrier or the Labor Commission.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from hard and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

- **Child Abuse.** If I have reason to believe that a child has been or is likely to be subjected to incest, molestations, sexual exploitation, sexual abuse, physical abuse or neglect, the law requires that I immediately notify the Department of Child and Family Services or an appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information.

- **Vulnerable Adult Abuse.** If I have reason to believe that any vulnerable adult has been the subject of abuse, neglect, abandonment or exploitation, I am required to immediately notify Adult Protective Services intake. Once such a report is filed, I may be required to provide additional information.
- **Threat to other.** If a client communicates an actual threat of physical violence against an identifiable victim, I am required to take protective actions. These actions may include notifying the potential victim and contacting the police, and/or seeking hospitalization for the client.

While this written summary of exception to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

MINORS & PARENTS

Clients under 14 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records unless I decide that such access is likely to injure the child, or we agree otherwise. Since parental involvement in therapy is important, it is my policy to request an agreement between a child client between 14 and 18 and his/her parents allowing me to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services you insurance policy covers.

My practice is a fee for service practice, which means that your payment is expected at the end of each session.

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 heal 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 much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. 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. **By signing this Agreement, you agree that I can provide requested information to your carrier.**

ENDING THERAPY

Some clients benefit most from a brief involvement in therapy whereas others will find an extended length of time more valuable. Most people need at least 26 sessions to make significant progress. I am committed to working with you as long as the therapeutic process is productive and healthy. It is most productive if you can address the ending of your therapy over the course of several closure sessions.

If I do not have contact or communication from you for a period of 30 consecutive days, I will assume that you no longer intend to remain active in this therapy relationship and your case will be closed. You have the option, however, to contact me again any time in the future to continue psychotherapy with me.

If you don't give me 24 hour advance notice for two sessions, you will be taken off the schedule and referred back to your insurance company for another provider referral.

My (our) signature (s) below indicate that I (we) have received a copy of the Psychotherapist/Client Agreement and a copy of my HIPAA Notice of Policies and Practices to Protect the Privacy of Your Health Information document.

My (our) signature(s) below also indicate that I (we) consent to treatment by Sharon D. Heaston, LMFT:

_____ _____

Client Signature Date

_____ _____

Client Signature Date

Sharon D. Heaston, LMFT[1]

Telephone: (909)-945-8894 | Facsimile: (909)-945-2855

BOURNE ANXIETY INDEX

Name: Marital Status: (Select) Age: Sex (Select)

Occupation: Education: (Select)

	Anxious Feelings	Not at All-0	Somewhat-1	Moderately-2	A lot-3
1.	Anxiety, nervousness, worry or fear	☐	☐	☐	☐
2.	Feeling that things around you are strange, unreal or foggy	☐	☐	☐	☐
3.	Feeling detached from all or part of your body	☐	☐	☐	☐
4.	Sudden, unexpected panic spells	☐	☐	☐	☐
5.	Apprehension or a sense of impending doom	☐	☐	☐	☐
6.	Feeling tense, stressed, uptight or on edge	☐	☐	☐	☐

	Anxious Thoughts	Not at All-0	Somewhat-1	Moderately-2	A lot-3
7.	Difficulty concentrating	☐	☐	☐	☐
8.	Racing thoughts	☐	☐	☐	☐
9.	Having your mind jump from one thought to the next	☐	☐	☐	☐
10.	Frightening fantasies or daydreams	☐	☐	☐	☐
11.	Feeling like you are on the verge of losing control	☐	☐	☐	☐
12.	Fears of cracking up or going crazy	☐	☐	☐	☐
13.	Fears of fainting or passing out	☐	☐	☐	☐
14.	Fears of physical illness, heart attacks or dying	☐	☐	☐	☐
15.	Concerns about looking foolish or inadequate in front of others	☐	☐	☐	☐
16.	Fears of being alone isolated or abandoned	☐	☐	☐	☐
17.	Fears of criticism or disapproval	☐	☐	☐	☐
18.	Fears that something terrible is about to happen	☐	☐	☐	☐

	Physical Symptoms	Not at All-0	Somewhat-1	Moderately-2	A lot-3
19.	Skipping, Racing or pounding of the heart	☐	☐	☐	☐
20.	Pain, pressure or tightness in the chest	☐	☐	☐	☐
21.	Tingling or numbness in the toes or in the fingers	☐	☐	☐	☐
22.	Butterflies or discomfort in the stomach	☐	☐	☐	☐
23.	Constipation or diarrhea	☐	☐	☐	☐
24.	Restlessness or jumpiness	☐	☐	☐	☐
25.	Tight or tense muscles	☐	☐	☐	☐
26.	Sweating not brought on by heat	☐	☐	☐	☐
27.	A lump in the throat	☐	☐	☐	☐
28.	Rubbery or "jelly" legs	☐	☐	☐	☐
29.	Feeling dizzy, light-headed or off balance	☐	☐	☐	☐
30.	Choking, smothering sensation or difficulty breathing	☐	☐	☐	☐
31.	Headaches or pains in the neck or back	☐	☐	☐	☐
32.	Trembling or shaking	☐	☐	☐	☐
33.	Hot flashes or cold chills	☐	☐	☐	☐
34.	Feeling tired, weak or easily annoyed	☐	☐	☐	☐

Bourne Anxiety Index Score: 0

Sharon D. Heaston, LMFT

Telephone: (909)-945-8894 | Facsimile: (909)-945-2855

BECK DEPRESSION INVENTORY

Name: Marital Status (Select) Age: Sex (Select)

Occupation: Education (Select)

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past wo weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
   - ☐ 0 I do not feel sad
   - ☐ 1 I feel sad much of the time
   - ☐ 2 I am sad all the time
   - ☐ 3 I am so sad or unhappy that I can't stand it.
2. Pessimism
   - ☐ 0 I am not discouraged about my future
   - ☐ 1 I feel more discouraged about my future than I used to be
   - ☐ 2 I do not expect things to work out for me
   - ☐ 3 I feel my future is hopeless and will only get worse
3. Past Failure
   - ☐ 0 I do not feel like a failure
   - ☐ 1 I have failed more than I should have
   - ☐ 2 As I look back, I see a lot of failures
   - ☐ 3 I feel I am a total failure as a person
4. Loss of Pleasure
   - ☐ 0 I get as much pleasure as I ever did from the things I enjoy
   - ☐ 1 I don't enjoy things as much as I used to
   - ☐ 2 I get very little pleasure from the things I used to enjoy
   - ☐ 3 I can't get any pleasure from the things I used to enjoy
5. Guilty Feelings
   - ☐ 0 I don't feel particularly guilty
   - ☐ 1 I feel guilty over many things I have done or should have done
   - ☐ 2 I feel quite guilty most of the time
   - ☐ 3 I feel guilty all of the time
6. Punishment feelings
   - ☐ 0 I don't feel I am being punished
   - ☐ 1 I feel I may be punished
   - ☐ 2 I expect to be punished
   - ☐ 3 I feel I am being punished
7. Self-Dislike
   - ☐ 0 I feel the same about myself as ever
   - ☐ 1 I have lost confidence in myself
   - ☐ 2 I am disappointed in myself
   - ☐ 3 I dislike myself
8. Self-criticalness
   - ☐ 0 I don't criticize or blame myself more than usual
   - ☐ 1 I am more critical of myself than I used to be
   - ☐ 2 I criticize myself for all of my faults
   - ☐ 3 I blame myself for everything bad that happens
9. Suicidal thoughts or Wishes
   - ☐ 0 I don't have any thoughts of killing myself
   - ☐ 1 I have thoughts of killing myself, but I would not carry them out
   - ☐ 2 I would like to kill myself
   - ☐ 3 I would kill myself if I had the chance
10. Crying
    - ☐ 0 I don't cry any more than I used to
    - ☐ 1 I cry more than I used to
    - ☐ 2 I cry over every little thing
    - ☐ 3 I feel like crying, but I can't

Subtotal Page 1
0

BECK DEPRESSION INVENTORY, Continued

11. Agitation
    - ☐ 0 I am no more restless or wound up than usual
    - ☐ 1 I feel more restless or wound up than usual
    - ☐ 2 I am so restless or agitated that it's hard to stay still
    - ☐ 3 I am so restless or agitated that I have to keep moving or doing something
12. Loss of Interest
    - ☐ 0 I have not lost interest in other people or activities
    - ☐ 1 I am less interested in other people or things than before
    - ☐ 2 I have lost most of my interest in other people or things
    - ☐ 3 It's hard to get interested in anything
13. Indecisiveness
    - ☐ 0 I make decisions about as well as ever
    - ☐ 1 I find it more difficult to make decisions than usual
    - ☐ 2 I have much greater difficulty in making decisions than I used to
    - ☐ 3 I have trouble making any decisions
14. Worthlessness
    - ☐ 0 I do not feel I am worthless
    - ☐ 1 I don't consider myself as worthwhile and useful as I used to
    - ☐ 2 I feel more worthless as compared to other people
    - ☐ 3 I feel utterly worthless
15. Loss of Energy
    - ☐ 0 I have as much energy as ever
    - ☐ 1 I have less energy than I used to have
    - ☐ 2 I don't have enough energy to do very much
    - ☐ 3 I don't have enough energy to do anything

Subtotal Page 2
0
Subtotal Page 1
0
Total
0

16. Changes in Sleeping Pattern
    - ☐ 0 I have not experienced any change in my sleeping pattern
    - ☐ 1 I sleep somewhat more than usual
    - ☐ 1 I sleep somewhat less than usual
    - ☐ 2 I sleep a lot more than usual
    - ☐ 2 I sleep a lot less than usual
    - ☐ 3 I sleep most of the day
    - ☐ 3 I wake up 1-2 hours early and can't get back to sleep
17. Irritability
    - ☐ 0 I am no more irritable than usual
    - ☐ 1 I am more irritable than usual
    - ☐ 2 I am much more irritable than usual
    - ☐ 3 I am irritable all the time
18. Changes in Appetite
    - ☐ 0 I have not experienced any change in my appetite
    - ☐ 1 My appetite is somewhat less than usual
    - ☐ 1 My appetite is somewhat greater than usual
    - ☐ 2 My appetite is much less than before
    - ☐ 2 My appetite is much greater than usual
    - ☐ 3 I have no appetite at all
    - ☐ 3 I crave food all the time
19. Concentration Difficulty
    - ☐ 0 I can concentrate as well as ever
    - ☐ 1 I can't concentrate as well as usual
    - ☐ 2 It's hard to keep my mind on anything for very long
    - ☐ 3 I find I can't concentrate on anything
20. Tiredness or Fatigue
    - ☐ 0 I am no more tired or fatigued than usual
    - ☐ 1 I get more tired or fatigued more easily than usual
    - ☐ 2 I am too tired or fatigued to do a lot of the things I used to do
    - ☐ 3 I am too tired or fatigued to do most of the things I used to do
21. Loss of Interest in Sex
    - ☐ 0 I have not noticed any recent change in my interest in sex
    - ☐ 1 I am less interested in sex than I used to be
    - ☐ 2 I am much less interested in sex now
    - ☐ 3 I have lost interest in sex completely

Sharon D. Heaston, LMFT

Telephone: (909)-945-8894 | Facsimile: (909)-945-2855

MICHIGAN ALCOHOLISM SCREENING TEST

Name: Marital Status: (Select) Age: Sex: (Select)

Occupation: Education: (Select)

Please answer Yes or No to the following questions.

IF YOU DO NOT DRINK PLEASE ACKNOWLEDGE SO WITH YOUR SIGNATURE BELOW. YOU DO NOT HAVE TO COMPLETE THE QUESTIONNAIRE.

I do not consume alcohol.

Signature: Date:

1. Do you feel you are a normal drinker? ("normal" is defined as drinking as much or less than most other people) ☐ Yes ☐ No
2. Have you ever awakened the morning after drinking the night before and found that you could not remember a part of the evening? ☐ Yes ☐ No
3. Does any near relative or close friend ever worry or complain about your drinking? ☐ Yes ☐ No
4. Can you stop drinking without difficulty after one or two drinks? ☐ Yes ☐ No
5. Do you ever feel guilty about your drinking? ☐ Yes ☐ No
6. Have you ever attended a meeting of Alcoholics Anonymous (AA)? ☐ Yes ☐ No
7. Have you ever gotten into physical fights when drinking? ☐ Yes ☐ No
8. Has drinking ever created problems between you and a near relative or close friend? ☐ Yes ☐ No
9. Has any family member or close friend gone to anyone for help about your drinking? ☐ Yes ☐ No
10. Have you ever lost friends because of your drinking? ☐ Yes ☐ No
11. Have you ever gotten into trouble at work because of drinking? ☐ Yes ☐ No
12. Have you ever lost a job because of drinking? ☐ Yes ☐ No
13. Have you ever neglected your obligations, family, or work for two or more days in a row because you were drinking? ☐ Yes ☐ No
14. Do you drink before noon fairly often? ☐ Yes ☐ No
15. Have you ever been told you have liver trouble, such as cirrhosis? ☐ Yes ☐ No

Sharon D. Heaston, LMFT

Telephone: (909)-945-8894 | Facsimile: (909)-945-2855

MICHIGAN ALCOHOLISM SCREENING TEST, Continued

16. After heavy drinking, have you ever had delirium tremens (DTs), severe shaking, visual or auditory (hearing) hallucinations? ☐ Yes ☐ No

17. Have you ever gone to anyone for help about your drinking? ☐ Yes ☐ No

18. Have you ever been hospitalized because of drinking? ☐ Yes ☐ No

19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward? ☐ Yes ☐ No

20. Have you ever gone to any doctor, social worker, clergyman, or mental health clinic for help with any emotional problem in which drinking was part of the problem? ☐ Yes ☐ No

21. Have you been arrested more than once for driving under the influence of alcohol? ☐ Yes ☐ No

22. Have you ever been arrested, or detained by an official for a few hours because of other behavior while drinking? ☐ Yes ☐ No