Sunah Kim, Psy.D. PSY24461
PO BOX 421
Patton, CA 92369
310-957-9569
skimpsyd@gmail.com
sunahkimpsyd.com

CLIENT INTAKE FORM
ADOLESCENT

NAME:______________________________________ DATE: ____________________________

SOCIAL SECURITY #: ____________________ DATE OF BIRTH: ______________________

ADDRESS : ____

City: __________________________ State: ________________ Zip code: ________________

TELEPHONE: (CELL)_____________________ (WORK) ______________________________

Okay to leave message? □ YES □ NO Okay to text? □ YES □ NO

EMAIL ADDRESS: ____

Okay to communicate via email? □ YES □ NO
Please note that email correspondence is not considered a confidential medium of communication.

MARITAL STATUS: Single _____ Married_____ Divorced_____ Widowed _____

Do you have children? □ Yes □ No How many? _____ Ages: __________________________

ETHNICITY: ____ GENDER: □ Male □ Female

RELIGIOUS BACKGROUND: □ Jewish □ Catholic □ Protestant □ LDS (Mormon) □ Unitarian

□ Muslim □ Atheist/Agnostic □ Other (please specify): _________________________________

EMPLOYER: ________________________ OCCUPATION: ____________________________
(of the parent/legal guardian if client is minor)

ADDRESS: ____

CITY: ________________________ State: ________________ Zip code: ________________

EMERGENCY CONTACT: ____
Name Relationship

Telephone:____

Who referred you? ____

Sunah Kim, Psy.D. PSY24461
PO BOX 421
Patton, CA 92369
310-957-9569
skimpsyd@gmail.com
sunahkimpsyd.com

INFORMED CONSENT FOR PSYCHOTHERAPY

PSYCHOLOGICAL SERVICES THERAPY I provide psychotherapy for individual, couple, and family. Individual therapy is offered for 50 minutes, and a 75- or 90-minute session is recommended for a family or couple. Therapy is a process of self-learning. While therapy may invoke intense feelings that are unpleasant or uncomfortable at times, it can help alleviate symptoms and develop more adaptive ways of handling current problems. ASSESSMENT I offer psychological assessment for various purposes, including a diagnostic clarification and treatment planning.

CONFIDENTIALITY I am dedicated to protecting your privacy to the best of my abilities. I will not reveal any information about you to anyone without your written permission. However, there are some important exceptions to this rule. I will have to break confidentiality if I assess you to be in imminent danger to yourself or others; or I suspect any child abuse or elderly abuse or neglect. When you file a worker's compensation claim or court mandates a release of information, I may need to break confidentiality.

PROFESSIONAL FEES Payment is expected to be made at the beginning of each session. In addition to regular appointments, I charge prorated amount of the hourly fee for other needed professional services (e.g., telephone calls lasting longer than 10 minutes, sessions longer than 50 minutes, collateral contacts, a review of documents, report writing per request etc.). Cash and checks are accepted forms of payment at this time. Should there be any problems clearing your check, there will a returned check fee of $25.00. THERAPY I charge $150 for a 50-minute session, if not other arrangements are made, and sessions that vary in duration are prorated. ASSESSMENT My hourly rate for assessment is $150. Assessment begins with an initial clinical interview which typically take 60 to 90 minutes. Shortly after the interview, I will notify you of the estimated hours for the completion of the assessment, which encompass all my professional services, including in-person testing hours, scoring and interpretation of test results, a review of relevant documents and collateral contacts (if necessary), report writing, and a feedback session. It is expected that you pay the half amount of the estimated fee at our second meeting; if not, I won't be able to proceed with further assessment. If the initial estimation is subject to adjustment based on my actual time spent for the evaluation, I will inform you before a feedback session. LEGAL If you are involved in legal proceedings that require my participation, you will be responsible for all my professional time, including preparation, transportation, and court appearance (including a wait time), and this applies even to occasions of me being called to testify by another party.

INSURANCE REIMBURSEMENT I am not currently contracted with any insurance providers, but per your request, I will gladly assist you as an "out of network" provider within my ability. Of note, most insurance companies require psychologists to provide them with certain information regarding their client's treatment (e.g., diagnosis, treatment plan, treatment summary).

CANCELLATIONS AND LATENESS If you wish to reschedule or cancel your appointment, it is important that you notify me at least 48 hours in advance to avoid being charged for a missed session or a late cancellation which amounts to a full fee for the scheduled appointment. For clients receiving assessment services, a fee of $150 will be charged for no show or late cancellations.

CONTACTING ME I may not be immediately available by phone and I do not offer crisis interventions. I check my voicemail on a regular basis and usually make a return call within 24 hours with the exceptions of weekends, holidays, and during pre-arranged trips. If you are in a life-threatening situation requiring immediate attention, please be sure to call 911 or proceed to your nearest emergency room immediately.

COMPLAINTS When you express your concern or complaint regarding my services, I will take your concern seriously and respond with care and respect. If you still feel that your concern is not properly received, or you believe that I have behaved unethically, you have the right to contact the California Board of Psychology (1422 Howe Ave, Suite 22 Sacramento, CA 95825, 1-866-503-3221).

BY SIGHNING ON THIS FORM, I ACKNOWLEDGE THAT I HAVE FULLY UNDERSTOOD THE ABOVE INFORMATION AND AGREE TO COMPLY WITH ITS TERMS.

____ __________________________________
Client Name Date

____ __________________________________
Parent/Representative Name Parent/Representative Signature

Sunah Kim, Psy.D. PSY24461
PO BOX 421 310-957-9569
Patton, CA 92369 skimpsyd@gmail.com
sunahkimpsyd.com

NOTICE OF PRIVACY PRACTICES

The Federal Health Insurance Portability and Accountability Act (HIPAA) requires mental health professionals to issue this official Notice of Privacy Practices. This notice describes how information about you is protected, the circumstances under which it may be used or disclosed and how you may gain access to this information. Please review it carefully.

Who Will Follow This Notice: Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g., a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

Uses and Disclosures for Treatment, Payment, and Health Care Operations: I may use or disclose your Protected Health Information (PHI), for treatment, payment, and health care operations purposes.

The following should help clarify these terms:
PHI refers to information in your health record that could identify you. For example, it may include your name, the fact you are receiving treatment here, and other basic information pertaining to your treatment.
• Use applies only to activities within my office and practice group, such as sharing, employing, applying, utilizing, and analyzing information that identifies you.
• Disclosure applies to activities outside of my office or practice group, such as releasing, transferring, or providing access to information about you to other parties.
• Authorization is your written permission to disclose confidential health information. All authorizations to disclose must be made on a specific and required form.
• Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. For example, with your written authorization I may provide your information to your physician to ensure the physician has the necessary information to diagnose or treat you.
• Payment Your PHI may be used, as needed, in activities related to obtaining payment for your health care services. This may include the use of a billing service or providing you documentation of your care so that you may obtain reimbursement from your insurer.
• Health Care Operations are activities that relate to the performance and operation of my practice. I may use or disclose, as needed, your protected health information in support of business activities. For example, when I review an administrative assistant's performance, I may need to review what that employee has documented in your record.

Written Authorizations to Release PHI: Any other uses and disclosures of your PHI beyond those listed above will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization at any time, in writing.

Uses and Disclosures without Authorization: The ethics code of the American Psychological Association, California State law, and the federal HIPAA regulations all protect the privacy of all communications between a client and a mental health professional. In most situations, I can only release information about your treatment to others if you sign a written authorization. This authorization will remain in effect for a length of time you and I determine. You may revoke the authorization at any time, unless I have taken action in reliance on it. However, there are some disclosures that do not require your Authorization. I may use or disclose PHI without your consent in the following circumstances:
• Child Abuse. If I have a reasonable suspicion that a child may be abused or neglected, I must report this belief to the appropriate authorities.
• Elderly Abuse. If I have a reasonable suspicion that an individual such as an elderly or disabled person has been abused, neglected, or financially exploited, I must report this to the appropriate authorities.
• Health Oversight Activities.
I may disclose your PHI to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
• Judicial and Administrative Proceedings.
If you are involved in a court proceeding and a request is made for information by any party about your treatment and the records thereof, such information is privileged under state law, and is not to be released without a court order. Information about all other psychological services (e.g., psychological evaluation) is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.
• Serious Threat to Health or Safety.
If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.
• Worker's Compensation.
I may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Sunah Kim, Psy.D. PSY24461
PO BOX 421 310-957-9569
Patton, CA 92369 skimpsyd@gmail.com

NOTICE OF PRIVACY PRACTICES
CONTINUED

Special Authorizations:
Certain categories of information listed as below have extra protections by laws, and thus require special written authorizations for disclosures.
• Psychotherapy Notes. • HIV Information. • Alcohol and Drug Use Information

Patient's Rights:
• Right to Request Restrictions –You have the right to request restrictions on certain uses/disclosures of PHI. However, I am not required to agree to the request.
• Right to Receive Confidential Communications by Alternative Means – You have the right to request and receive confidential communications by alternative means and locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.) • Right to Inspect and Copy – You have the right to request an amendment of PHI for as long as it is maintained in the record. I may deny your request. If so, I will discuss with you the details of the amendment process. • Right to an Accounting – You generally have the right to receive an accounting of all disclosures of PHI. I can discuss with you the details of the accounting process. • Right to a Paper Copy – You have the right to obtain a paper copy of the Notice of Privacy Practices from me upon request.

Psychologist's Duties: • I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. • I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. • If I revise my policies and procedures, I will notify you at our next session, or by mail at the address you provided me. Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Effective Date, Restrictions, and Changes to Privacy Policy: This notice will go into effect on October 1, 2016 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

Patient's Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been given a copy of Dr. Kim's Notice of Privacy Practices. We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving psychological services.

____ ________________________________
Client Name Date

____ ____
Parent/Representative Name Parent/Representative Signature

Sunah Kim, Psy.D. PSY24461

PO BOX 421
Patton, CA 92369

310-957-9569
skimpsyd@gmail.com
sunahkimpsyd.com

NEW CLIENT QUESTIONNAIRE

**If you run out of space when answering any questions, please use the back of this sheet or add a new sheet.*

DATE: ___________________________________

NAME:_________________________________ DOB: _______________________________

Please describe your main complaints that brought you here.

____

____

____

____

Please describe goals that you would like to achieve through therapy/assessment.

____

____

____

____

EDUCATIONAL/MILITARY BACKGROUND

Do you have any knowledge of your mother having complications or difficulties during pregnancy?

□ Yes □ No (If yes, explain.) ____

Any drugs or alcohol consumed pregnancy? □ Yes □ No

Did you reach developmental milestones (e.g., rolling, walking, talking) age-appropriately? □ Yes □ No

Did you have any issues as a child in any of these areas below?

□ speech/language □ motor skills □ cognitive/intellectual □ sensory □ behavioral □ emotional □ social

(If yes, explain.) ____

____

What is the highest school degree you have earned? ______________________________________

Are you in school now (If yes, provide detail)? □ Yes □ No ______________________________

____

During school, did you receive any: □ special education □ diagnosis of learning disabilities □ diagnosis of ADHD □ tutoring □ alternative schooling □ disciplinary actions

Have you ever serviced in the military? □ Yes □ No (If yes, please specify.)

Date of services: __________________________ Type of discharge: __________________________

Combat experiences? ____________________________ Highest rank: ________________________

MENTAL HEALTH HISTORY

1. Have you received any mental health services, including psychological assessment prior to coming here? Please mark all that apply.

□ None □ Partial care □ Other 24-hour care □ Substance abuse rehab/detox center

□ outpatient therapy □ inpatient care □ psychological assessment

If yes, please list the name(s) of facility or treatment/service provider, the date/duration of service, and the purpose of service.

____

____

____

____

____

2. Have you been diagnosed with any psychiatric disorders? □ Yes □ No

If yes, please specify: ____

____

3. Have you been on any psychotropic medications? □ Yes □ No

If yes, please specify: ____

____

4. Are you currently on any psychotropic medications? □ Yes □ No

If yes, please specify (Name, dosage, and reason for taking):

____

____

____

____

Who is currently monitoring your psychotropic medications? ______________________________

6. Current physician/psychiatrist (Name, contact number)

____

____

May I contact your physician/psychiatrist? □ Yes □ No

(If yes, I'll ask you to fill out the form of authorization to release information later.)

7. Have you experienced any of the following problems within the recent month period? (Please mark all that apply): □ depression □ extreme mood swings □ social isolation □ no/little appetite □ significant weight change □ difficulty concentrating □ overeating □ always tired □ sleep problems □ nightmares □ anger/hostility □ suicidal thoughts □ anxiety □ feeling panicky □ obsessions □ gambling □ feeling tense □ worried excessively □ job problems □ financial problems □ relational problems □ family conflicts □ unusual thoughts or beliefs □ overwhelming crisis □ self-inflicted injury or pain □ feeling people are out to get me □ hearing or seeing things that other people don't □ low self-esteem

8. Have you recently used alcohol or illicit drugs (□ marijuana, □ methamphetamines, □ cocaine, □ party drugs, □ LSD □ heroine, or □ hallucinogens), or □ misused prescribed medications

If yes, please elaborate the average amount at a time, and the frequency per week:

____

____

____

____

9. Have you ever tried to cut down on your use of alcohol or drugs? □ Yes □ No

10. Has anyone gotten angry at you or expressed serious concerns about you because of your alcohol or drug use? □ Yes □ No

11. Have your ever felt guilty or worried about your use of alcohol or drugs? □ Yes □ No

12. Have you experienced significant life changes or stressful events recently?

If yes, please explain: ____

____

13. Do you have any history of □ criminal activities/incarceration (If yes, mark all that apply:

□ arrest/ assault □ arrest/other* □ DUI □ restraining/protective order(s) □ child protective services

□ divorce/custody □ disability claim(s) □ other: ______________________________________)

□ aggression/violence □ domestic violence □ alcohol or drug abuse □ gambling □ self-injurious behavior

□ child abuse (If yes, mark all that apply: □ physical □ emotional □ verbal □ sexual

□ neglect □ abandonment; by who?____

When?____)

□ suicidal attempt (If yes, how many times? _____________ when? _____________________________,

what methods? ____)

14. Are you currently involved in legal proceedings? □ Yes □ No

If yes, explain: ____

____

15. Who do you live with? (Ages and relationships to you)

____

____

16. Any familial history of mental illness? (Who and what diagnosis?)

____

____

MEDICAL HISTORY

1. Have you seen a physical or other health care professional within the last six months for reasons other than a physical checkup? □ Yes □ No

If yes, please specify reason(s): ____

____

2. Please mark any of the following that you have experienced:

□ headaches □ dizziness □ fainting spells/blackouts □ severe or prolonged nausea

□ seizures or convulsions □ memory loss □ allergies □ asthma □ ulcers □ high blood pressure

□ chronic pain □ nerve pain □ arthritis □ diabetes □ hypoglycemia (low blood pressure)

□ heart disease □ gastrointestinal issues □ traumatic head injury (if yes, when? ______________ concussion? □ Yes □ No Unconsciousness? □ Yes □ No Hospitalized? □ Yes □ No)

□ any other medical conditions (specify:____)

3. Please list a history of major illnesses, traumatic brain injury, surgeries, and/or serious injuries with dates of the applicable incident(s): ____

____

____

____

Thank you for completing this form!

Sunah Kim, Psy.D. PSY24461
PO BOX 421
Patton, CA 92369
310-957-9569
skimpsyd@gmail.com
www.sunahkimpsyd.com

AUTHORIZATION TO EMAIL/TEXT PROTECTED HEALTH INFORMATION

Client Name: ____ DOB: _______________________________

Electronic mail and text messaging are forms of communication that may be utilized between Sunah Kim, Psy.D. and you. Please note that email and text communication are not secure communications. I cannot encrypt text massages, but I will send sensitive health information via encrypt email. Of note, encryption is the process of making information unreadable unless you have password to decrypt the information.

ALERT: If you elect to communicate from your workplace computer, you should be aware that your employer and its agents may have access to email communications between us. Email and text communications may become a part of your medical record. Email communication should never be used in the case of an emergency or for urgent requests for information.

□ I authorize Sunah Kim, Psy.D. to text me to remind me of upcoming appointments and/or care coordination activities. I understand that she will limit information via text to the minimum necessary.
□ I authorize Sunah Kim, Psy.D. to communicate with me via email, excluding my treatment/assessment records and other sensitive health information.
□ I authorize Sunah Kim, Psy.D. to communicate with me and send me attachment files including sensitive health information via encrypt-emailed email (skimpsyd@protonmail.com). I understand that file names will not include identifiable information, and files are encrypted and unmodifiable.
□ I authorize Sunah Kim, Psy.D. to communicate with a third party and send my health information via encrypt-enabled email (skimpsyd@protonmail.com). I understand that file names will not include identifiable information, and files are encrypted and unmodifiable.
  * The written form of authorization to release information should be signed by me prior to this authorization.

EXPIRATION OF THIS RELEASE
Date: ____
If no date is indicated, the authorization will expire upon termination of services provided by Sunah Kim, Psy.D.

____ ____
Parent/Representative Name Parent/Representative Signature

____
Date

NOTICE: Sunah Kim, Psy.D. and many other organizations and care providers are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, state or federal confidentiality laws may no longer protect your health information.
YOUR RIGHTS: The authorization to release information is voluntary. This authorization may be revoked at any time. The revocation must be in writing, signed by you or you/guardian/or representative, and delivered to Sunah Kim, Psy.D. The revocation will take effect immediately upon the recipient of your signed form. You are entitled to receive a copy of the authorization.