Sunah Kim, Psy.D. PSY24461
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CLIENT INTAKE FORM
COUPLES

DATE: ____________________________

1. NAME:__________________________________ DOB: _______________________

GENDER: □ Male □ Female SOCIAL SECURITY #: _____________________________

MARITAL STATUS : Single ___ Married____ Divorced____ Widowed ____

ETHNICITY: ___________________ RELIGIOUS BACKGROUND: ________________________

ADDRESS : ____

PHONE: (CELL)___________________________ (WORK) ______________________________

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

EMAIL ADDRESS: ____

EMPLOYER (Name & Address): ____

____

2. NAME:__________________________________ DOB: _______________________

GENDER: □ Male □ Female SOCIAL SECURITY #: _____________________________

MARITAL STATUS : Single ___ Married____ Divorced____ Widowed ____

ETHNICITY: ___________________ RELIGIOUS BACKGROUND: ________________________

ADDRESS : ____

PHONE: (CELL)___________________________ (WORK) ______________________________

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

EMAIL ADDRESS: ____

EMPLOYER (Name & Address): ____

____

EMERGENCY CONTACT :

NAME______________________________ RELATIONSHIP__________________________

PHONE____

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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.

COUPLES/FAMILY In couples or family therapy, the couple or family unit, rather than any one individual, is the client, and relational issues are to be addressed. If you would like to schedule an individual session during the course of therapy, I am happy to do so as long as you agree that what you share in such a session can be brought up during couples or family sessions. Confidentiality is not kept within participants of the couples or family therapy.

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 full fee for missed sessions or late cancellations. 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.

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**INFORMED CONSENT FOR PSYCHOTHERAPY
CONTINUED**

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 Print Name	Client Signature	Date
______________________________	_________________________________	___________________________
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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,

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NOTICE OF PRIVACY PRACTICES
CONTINUED

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.

Special Authorizations: Certain categories of information have extra protections by laws, and thus require special written authorizations for disclosures. • Psychotherapy Notes. I will obtain a special authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during private, group, joint, or family counseling session as well as notes obtained from clinical interviews for assessment. I keep these separate from the rest of your record. These notes are given a greater degree of protection than PHI. • HIV Information. Special legal protections apply to HIV/AIDS related information. I will obtain a special written authorization from you before releasing information related to HIV/AIDS. • Alcohol and Drug Use Information. Special legal protections apply to information related to alcohol and drug use and treatment. I will obtain a special written authorization from you before releasing information related to alcohol and/or drug use/treatment. You may revoke all such authorizations (of PHI, Psychotherapy Notes, HIV information, and/or Alcohol and Drug Use Information) at any time, provided each revocation is in writing, signed by you, and signed by a witness. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

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 November 1, 2016 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

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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 Print Name	Client Signature	Date
______________________________	__________________________________	___________________________
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COUPLES THERAPY INTAKE FORM

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

DATE: ____

NAME: ____

PARTNER'S NAME: _______________________________

Please describe your main complaints that brought you to couple therapy.

____

____

____

____

What do you hope to accomplish through psychotherapy?

____

____

____

What have you already done to deal with difficulties?

____

____

____

How long have you and your partner been together? (e.g., dating, living together, married)

____

____

What initially attracted you to your partner?

____

____

____

If there were any significant events that you feel relevant to the development of current conflicts, what would they be?

____

____

What do you do when there is conflict between the two of you? What does your partner do?

What strengths and weaknesses do you have in resolving conflict? What would you say about your partner's strengths and weaknesses in resolving conflict?

Please rate your current level of relationship difficulties by circling the number that corresponds with your current feelings about the relationships (0 being not at all; and 10 being extremely difficult):

0 1 2 3 4 5 6 7 8 9 10

What is the area or topic that it is most difficult for you to open with your partner about? Why?

When do you feel most content in your relationship? When do you feel most unhappy or frustrated?

Have you received prior couples therapy? □ Yes □ No

If yes, please detail when, where, how long, for what issues, and by home.

Have you been in individual psychotherapy before? □ Yes □ No

If yes, please detail when, where, how long, for what issues, and by whom.

____

____

____

Are you currently using any substances (e.g., alcohol, prescribed and/or illicit drugs) to intoxication?

□ Yes □ No   If yes, please detail kinds of substances, amount, and how often.

____

____

____

Have you and your partner stuck, physically restrained, used violence or aggression against or injured the other person? □ Yes □ No

If yes, please detail incidents including the number of occurrence, date, and what happened.

____

____

____

Has either of you threatened to separate or divorce as a result of the current relationship problems?

□ Yes □ No   If yes, who? □ Me   □ Partner   □ Both of us

Do you feel that either you or your partner has withdrawn from the relationship? □ Yes □ No

□ Yes □ No   If yes, who? □ Me   □ Partner   □ Both of us

Pleas rate the level of your commitment to your relationship.

0 1 2 3 4 5 6 7 8 9 10

Please rate the level of your feelings of security in your relationship.

0 1 2 3 4 5 6 7 8 9 10

Please rate the level of your closeness or intimacy toward your partner.

0 1 2 3 4 5 6 7 8 9 10

Please rate the level of your perceived closeness or intimacy from your partner.

0 1 2 3 4 5 6 7 8 9 10

Please rate the level of trust in your relationship.

0 1 2 3 4 5 6 7 8 9 10

How open are you in expressing your innermost feelings, desires, and thoughts to your partner?
(0= totally closed, 10=totally open)

0 1 2 3 4 5 6 7 8 9 10

How often do you engage in sexual relations with your partner?

____

How enjoyable is your sexual relationship? (0= not at all, 10= extremely)

0 1 2 3 4 5 6 7 8 9 10

How satisfied are you with the frequency of your sexual relations? (0= not at all,10= extremely)

0 1 2 3 4 5 6 7 8 9 10

Lastly, please a draw a graph indicating your level of relationship satisfaction beginning with when you met your partner. Not pivotal/significant events in your relationship (e.g., one of you moved out, one of you cheated etc.)

◄When you began dating Current►

THANK YOU FOR COMPLETING THE FORM!

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◄When you began dating Current►

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