New Client Information

Please provide the following information for our records. Leave blank any question you would rather answer with your therapist. Information you provide here is held to the same standards of confidentiality as therapy.

Name: _____
(Last, First, & Middle Initial)

Name of parent/guardian (if you are a minor): _____
(Last, First, & Middle Initial)

Address: _____
(Street and Number, City, State, Zip code)

Primary Phone: (____)_____ **Alternate Phone**: (____)_____

May we leave a message? □ Yes □ No

E-mail: _____ *May we email you?* □ Yes □ No
***Please be aware that email might not be confidential.*

Birth Date: ____ /____ /____ Age: _____ **Gender:** □ Male □ Female □ Transgender

Orientation: □ Gay □ Lesbian □ Bisexual □ Straight □ Questioning □ Other: _____

Relational Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Partner / Spouse: _____
(Names & Ages)

Children: _____
(Names & Ages)

Referred by: _____

Employment Status:

Employed working full time: ____ Employed working part time: ____ Retired: _____

Unemployed looking for work: _____ Medical Leave: ____ Long or Short Term Disability: ____

Military History: Are you currently active duty military: □ Yes □ No

Are you a Veteran: □ Yes □ No Are you a partner of Veteran: □ Yes □ No

Highest Level of Education:

Some High School (no diploma): □ Yes □ No High School Diploma or GED: □ Yes □ No

Some College or Technical School (no diploma / certificate): □ Yes □ No

College (or higher) Degree: □ Yes □ No

Raymond F. Cameron, M.A., Licensed Marriage & Family Therapist, Inc.
California State MFT License: MFC 38236
32605 Temecula Parkway, Suite 207, Temecula, CA 92592
Telephone: 951-970-6254
E-mail: rcameron.mft@gmail.com

New Client Information

Counseling, Psychotherapy, & Psychiatric History:

Have you ever received treatment for psychological, psychiatric, behavioral, or relationship problems:

□ Yes □ No If yes, Please describe: _____

Inpatient (hospital / treatment center): _____

Outpatient (counseling or other treatment): _____

_____

Dates of Treatment: _____

Name of Previous Therapist / Psychiatrist: _____ Phone: _____

Are you <u>currently</u> taking psychiatric medication? □ Yes □ No

If Yes, please list: _____

Reason for these medications: _____

If No, have you been <u>previously</u> prescribed psychiatric medication, please list: _____

_____

Client Medical:

Primary Care Physician: _____

(Please include address & phone)

Date of last physical exam: _____

Current & Past Medical Illness & Surgeries: _____

_____

Please list *<u>all</u>* current medications including over the counter medications, herbs, and supplements:

<u>Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Dates used</u>

Health and Social Information:

How is your physical health at present? (*please circle*)

Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

_____

_____

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New Client Information

Are you having any problems with your sleep habits? □ No □ Yes If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams

□ Other _____

How many times per week do you exercise? _____ Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? □ Yes □ No

If yes: □ Eating less □ Eating more □ Binging □ Restricting □ Purging

Have you experienced significant weight change in the last 6 months? □ Yes □ No

If yes, how much (gained / lost): _____

Alcohol and Drugs:

Have you ever used Drugs (street or Illicit) or Alcohol (please include experimentation): □ Yes □ No

Substances	Amount	Frequency	Dates Used

Have you ever received Alcohol or Drug Treatment: □ Yes □ No

If yes, when & where: _____

_____

_____

_____

Have you ever been arrested for being under the influence, possession, or D.U.I';s: □ Yes □ No

Do you drink coffee: □ Yes □ No How much: _____

Do you smoke or *vape*: □ Yes □ No How much: _____

Legal History:

Are you now, or have you been, court ordered to attend therapy: □ Yes □ No

Have you been arrested, on probation, or spent time in jail or prison: □ Yes □ No

If yes, please explain: _____

_____

_____

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New Client Information

Have You Ever Experienced: (please circle)

Extreme depressed mood	yes / no
Wild Mood Swings	yes / no
Rapid Speech	yes / no
Extreme Anxiety	yes / no
Panic Attacks	yes / no
Phobias	yes / no
Sleep Disturbances Hallucinations	yes / no
Unexplained losses of time	yes / no
Unexplained memory lapses	yes / no
Frequent Body Complaints	yes / no
Eating Disorder	yes / no
Body Image Problems	yes / no
Repetitive Thoughts *(e.g., Obsessions)*	yes / no
Repetitive Behaviors *(e.g., Frequent Checking, Hand-Washing)*	yes / no
Thoughts of wants to harm yourself (e.g. cutting, burning, etc)	yes / no
Thoughts of death / dying or suicide	yes / no
Thoughts of wanting to harm or kill others	yes / no

Family Mental Health History: Has anyone in your family (immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty:		**Family Member:**
Depression	yes / no	_____
Bipolar Disorder	yes / no	_____
Anxiety Disorders	yes / no	_____
Panic Attacks	yes / no	_____
Schizophrenia	yes / no	_____
Alcohol/Substance Abuse	yes / no	_____
Eating Disorders	yes / no	_____
Learning Disabilities	yes / no	_____
Trauma History	yes / no	_____
Suicide Attempts	yes / no	_____

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New Client Information

Please indicate how the problems you listed at the bottom of the last page are affecting the following areas of your life:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage/ Relationship						
Family						
Job / School						
Friendships						
Hobbies						
Financial Situation						
Physical Health						
Sexual Functioning						
Ability to Concentrate						
Ability to Control Anger or Temper						

Treatment Goals:

What are the reasons you have come to therapy: _____

_____

_____

How long has this been going on: _____

_____

What makes things better in your life? _____

_____

What do you hope will be different in your life by coming to therapy: _____

_____

_____

_____ _____

Client (or Parent/ Guardian) Date

_____ _____

Client (or Parent/ Guardian) Date

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New Client Consent For Treatment

Client Name: _____

(To be completed by the Parent/ Guardian if client is younger than 18 years)

Financial Agreement:

Many clients have insurance coverage for psychotherapy/ counseling services. As with all health care, the client or designated party is responsible for payment of service. **Until your insurance coverage is verified, you will be expected to pay for services at the time service is rendered.** Unless otherwise negotiated with **Raymond Cameron, M.A., MFT, Inc.**, payment of services is due in full at the time of service, and the standard fee for counseling services is **$135.00 per clinical session.** For those without health plan/ insurance coverage, payments arrangements should be made prior to your first counseling visit.

Client Initials: _____

If you have insurance coverage, you are still responsible for payment of the bill. This will include any deductibles or any amounts unpaid by the insurance coverage unless otherwise contractually agreed upon between **Raymond Cameron, M.A., MFT, Inc.** and your Insurance Company.

Client Initials: _____

Since many insurance companies will pay only a portion of treatment, a co-payment *may* be required and sometimes a deductible must be satisfied and is your responsibility. Any and all payment will be expected at the time of service.

Client Initials: _____

Clients whose costs are covered by insurance should be aware that coverage always requires a diagnosis. Some insurance companies require even greater information in order to complete treatment reports after a certain amount of counseling sessions.

Client Initials: _____

Out of Network and Secondary Insurance: It is the policy of **Raymond Cameron, M.A., MFT, Inc.**, that both secondary insurance and / or out of network benefits will *not* be billed. Upon request, **Raymond Cameron, M.A., MFT, Inc.** can provide a statement or "*superbill*" so that you may submit this to your insurance to request any potential reimbursement.

Client Initials: _____

If your *financial situation changes* affecting your ability to pay for sessions *or* if the *status of your insurance changes* (e.g., new insurance, change in insurance, termination of insurance) in any manner affecting payment for sessions, you are responsible to notify **Raymond Cameron, M.A., MFT, Inc.** immediately.

Client Initials: _____

It is assumed that by requesting the completion of an insurance form you are granting permission to fill out the necessary information concerning diagnosis and treatment. Questions regarding your insurance company's policies on confidentiality must be addressed directly to your insurance company.

Client Initials: _____

In some instances, to clients who are paying *without* Insurance benefits, ***Raymond Cameron, M.A., MFT, Inc.*** may offer a practice scholarship fund for clients and families who may not be able to seek services otherwise. The scholarship fund has been very successful, and the fund has varying slots based on client need, for example 15% slots, 25% slots, 40% slots, depending on which scholarship funding may be available at this time. If you are given scholarship fund to offset the costs of services, ***Raymond Cameron, M.A., MFT, Inc.*** requests that as you approach a time when you may no longer need the scholarship or require less of it, that you let us know so we can move you out of your slot and extend this portion of the scholarship funds to other clients who may need the assistance.

Client Initials: _____

- ☐ Your fee paid in full at the time of appointment is **$_____**
- ☐ If you are currently receiving a rate reduction through our Practice Scholarship Fund please enter your **new session amount here _____, this corresponds to a _____% discount.**
- ☐ Sessions will be covered by a combination of the client's insurance carrier and a co-payment provided by the client of $ _____ to be paid by the client at each appointment. ***Please note that your co-payment may change after treatment begins and through the course of treat as co-pays are determined by insurance***. Client understands that any portion of the fee not covered by the insurance carrier, including any deductibles, will be the sole responsibility of the client. *Client Initials*: _____

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New Client Consent For Treatment

Release of Information:
By signing this form, I authorize the release of information for claims, certification/ case management/ quality improvement, and other purposes related to benefits of my health plan [Releases of information to providers, family, etc., requires a separate form].

Client Initials: _____

Canceled or Missed Appointments:
A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with **less than 48 hours notice**, the client will be billed the cancellation fee of ***$75.00*** for all sessions canceled less than 48 hours or missed appointments. *Client Initials*: _____

Session Time:
Counseling sessions are forty-five minutes in length. Sessions lasting longer than fifty minutes will be *prorated to the nearest quarter of an hour*, unless arrangements have been agreed upon by both counselor and client prior to the session.

Client Initials: _____

Telephone Contact:
Telephone contact is sometimes necessary to confirm appointments, change appointments, or convey brief information. For telephone contact lasting longer than ten minutes you will be charged at your regular session rate. Messages are checked weekdays from 9AM to 7PM. Telephone calls are usually returned within twenty-four hours.

Client Initials: _____

Reports, Letters, or Third Party Client Requested Communication:
Any written, e-mail, telephonic, or other form of authorized communication by **Raymond Cameron, M.A., MFT** with a designated third party at the request of the client will be charged at the following rates:

- *Written (paper, faxes, or electronic / e-mail) communication will be charged a rate of **$135.00 per hour** and prorated to the nearest quarter of an hour.*
- *Telephonic or in-person verbal communications will charged **$135.00 per hour** and prorated to the nearest quarter of an hour.*

Client Initials: _____

Secrets Policy:
It is the policy of **Raymond Cameron, M.A., MFT** to not hold secrets between couples, family members, or significant others involved in the counseling process even if such information is revealed without the presence of others or over the telephone.

Client Initials: _____

Emergencies:
If you are experiencing a crisis or a life-threatening emergency, please call ***911*** or the *Riverside County Crisis Line* ***Adults: (951) 686-4357*** & ***Adolescent: (800) 843-5200***

Client Initials: _____

Confidentiality:

- All information between **Raymond Cameron, M.A., MFT** and client is held strictly confidential unless:
- The client authorizes release of information with his/her signature.
- The client presents as a danger to self.
- The client presents a danger to others.
- Child abuse and/or neglect are suspected
- Elder and/ or dependent adult abuse and/or neglect are suspected.

In the *latter four instances*, **Raymond Cameron, M.A., MFT** may be required by law to break client confidentiality to protect client, inform any potential victims, and/ or contact legal authorities so that protective measures can be taken.

Client Initials: _____

Raymond Cameron, MFT is the owner of ***Raymond Cameron, M.A., MFT, Inc***., and he is currently renting office space to other treatment providers. Please note that other than renting space to other treatment providers, there is no business or clinical association or responsibility, supervisory obligation, or partnership between ***Raymond Cameron, M.A., MFT, Inc*** and any other provider in the office. *Client Initials*: _____

New Client Consent For Treatment

Consent for Treatment:
I further authorize and request that **Raymond Cameron, M.A., MFT** provide psychotherapy/ counseling services consisting of assessments, evaluations, diagnostic procedures, and treatments which now or during the course of my care as a client are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of counseling is designed to be helpful, it may at times be difficult and uncomfortable.

The nature of psychotherapy/ counseling services to be provided can vary from client to client, and in some cases it might be necessary to make referrals to other practitioners for more extensive psychological testing, medication evaluation, or medical and / or psychiatric treatment. Mostly, however, problems tend to arise in the context of relationships, and those problems can be diminished through evaluation of the problem cooperatively by the therapist and the client(s). Treatment may examine the client(s) current and past relationships with a myriad of people including but not limited to: family of origin, intimate/ romantic relationships, parent / child relationships, friends, co-workers, etc. Treatment orientation may include but is not limited to: Family of Origin, Bowen Family Systems, Cognitive, Behavioral, & Solution Focused theories and techniques. All of these treatment orientations examine the client(s) thoughts, feelings, and behaviors that may be involved in the presenting problem as well as give assistance to both the therapist and the client(s) in diminishing the presenting problems.

Client Initials: _____

Education & Clinical Experiences:
Raymond Cameron, M.A., MFT holds the following degrees from accredited institutions: Master of Arts in Marriage & Family Therapy from the University of San Diego (1996), & Bachelor of Arts, Cum Laude, in Philosophy from the University of California, San Diego (1994). **Raymond Cameron, M.A., MFT** has been working in the mental health field since June, 1996. **Raymond Cameron, M.A., MFT** is a Clinical Member of the *American Association for Marriage & Family Therapy* and a Clinical Member of the *California Association of Marriage & Family Therapist*.

I understand that **Raymond Cameron, M.A.** is a Marriage and Family Therapist licensed by the State of California Department of Consumer Affairs, Board of Behavioral Sciences (MFC 38236) to provide therapy to individuals, couples, children, families, and groups in accordance with the provisions of Division 2 Chapter 13 of the Business & Professionals Code.

I have read the above and I agree to accept treatment. Further, I agree to all conditions set forth and understand my responsibility. I also give my consent for any psychological testing necessary in the course of treatment.

_____ _____
Client Date

_____ _____
Client Date

_____ _____
Raymond Cameron, M.A., MFT Date

Consent for Treatment of Minors

Client Name: _____ Today's Date: _____
(*To be completed by Parent/ Guardian if Client is under 18 years old*)

Client Date of Birth: _____

Therapist: **Raymond F. Cameron, M.A., Licensed Marriage & Family Therapist**

This is to certify that I have given permission to the therapist named above for treatment of my child. This treatment may include individual, family or group psychotherapy. Psychological testing and assessment may also be a necessary part of treatment.

On occasion your therapist may consult with other professionals regarding your child. Consultation may be with teachers, educational psychologists, guidance counselors, physicians or psychiatrists.

California state law mandates the reporting of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse.

All actual or suspected acts of child abuse will need to be reported to the appropriate agency. In such an instance you may be referred to other State and County agencies for further counseling.

_____
Printed Name of Parent /Guardian

_____ _____
Signature of Parent /Guardian Date

_____
Telephone & Address

_____
Printed Name of Parent /Guardian

_____ _____
Signature of Parent /Guardian Date

_____
Telephone & Address

Assignment of Release of Benefits

I hereby authorize my insurance benefits to be paid directly to ***Raymond Cameron, M.A., MFT, Inc.***, the treatment provider, and acknowledge that I am financially responsible for all services *not covered or denied* by my insurance.

I authorize ***Raymond Cameron, M.A., MFT, Inc.*** to release any information required to my insurance company in regards to processing my claims and for quality assurance as necessary.

I acknowledge that ***Raymond Cameron, M.A., MFT, Inc.*** may file claims for treatment services through an *insurance claims clearinghouse* or *insurance claims billing service*, and I also authorize the release of any information required in regards to processing my claims.

_____ _____
Insured and/or client signature Date

_____ _____
Insured and/or client signature Date

_____ _____
Raymond Cameron, M.A., MFT, Inc. Date

Missed or Canceled Appointments

Policy Regarding Missed or Canceled Appointments

Please know that clients may cancel and reschedule appointments at any time as long as they provide at least **48 hours notice**. This cancellation policy is very important since the scheduling of an appointment involves the reservation of time specifically for you; therefore, a minimum of **48 hours notice** is required for re-scheduling or canceling an appointment. In the case of emergencies, exceptions to this cancellation policy may be considered on a case-by-case basis.

I acknowledge that it is my responsibility to notify **Raymond F. Cameron, M.A., Licensed Marriage & Family Therapist, Inc.** California State MFT License: MFC 38236 at 32605 Temecula Parkway, Suite 207 Temecula, CA 92592, by Telephone: 951-970-6254, or by email: rcameron.mft@gmail.com, at least **48 hours prior** to a scheduled appointment if, I am unable to keep the scheduled appointment.

I understand that I will be charged the **$75.00** in the event that I **miss an appointment** or **if I do not cancel at least 48 hours prior** to the scheduled appointment.

My signature below indicates that I have read, understand, and agree to the above policy regarding missed and less than forty-eight (48) hours notice for canceling appointments.

_____ _____

Client Signature *Responsible Party* (*If client is under 18 years old*)

_____

Raymond Cameron, M.A., MFT

_____

Date

Client Rights

Raymond Cameron, M.A., MFT is a private Licensed Marriage & Family Therapist providing comprehensive psychotherapy / counseling services to individuals, couples, families, adolescents, and groups.

Your rights as a client are to:

- Be treated with respect and honesty throughout your relationship with your therapist in a safe environment free from sexual, physical, and emotional abuse.
- Be provided with quality counseling services without bias to race, nationality, ethnicity, creed, gender, age, sexual preference, or socio-economic status.
- Be provided with quality counseling services as fits the best interest of your difficulties, or you will be referred in a timely manner.
- Request and receive full information about your therapist's professional capabilities including licensure, education, training, experience, as well as specializations and limitations.
- Know that counseling will be conducted in a lawful and ethical manner regardless if you are participating in individual, couple, family, child, or group counseling sessions. Counseling consists of face-to-face contact between the counselor and the person(s) in treatment focusing on the presenting problem(s) and the associated feelings, thoughts, and behaviors; assessing possible causes of the problem(s) and previous attempts to cope with it; and the possible alternative courses of action and their consequences.
- Refuse to answer any questions or disclose any information you choose not to reveal.
- Request and receive information from your therapist about your progress.
- Refuse a particular type of treatment, or end treatment without obligation or harassment.
- Know that you are expected to benefit from counseling, <u>but</u> there is **no** guarantee that you will. Outpatient treatment does not have significant risks for the client. Maximum benefits from counseling can occur with regular attendance; however, you may temporarily experience counseling, at times, to be difficult and/ or uncomfortable.
- Know that all information and records obtained during the course of counseling are held strictly confidential, and they will <u>not</u> be released without your written consent unless:
    a. The client authorizes release of information with his/her signature.
    b. The client presents a physical danger to self.
    c. The client presents a danger to others
    d. Child abuse and/ or neglect are suspected.
    e. Elder abuse and/ or neglect are suspected.
    f. Dependent adult abuse and/ or neglect are suspected.
- In the latter four instances, **Raymond Cameron, M.A., MFT** is <u>required by law</u> to inform the potential victims and legal authorities so that protective measures can be taken.

****BY SIGNING I ACKNOWLEDGE THAT I HAVE READ AND& UNDERSTOOD THIS POLICY.**

_____ _____

Client Signature Date

Independent Marriage & Family Therapist

Please read the following statement regarding Independent Marriage & Family Therapist status:

Raymond F. Cameron, M.A., Licensed Marriage & Family Therapist, Inc. *California State MFT License: MFC 38236* at 32605 Temecula Parkway, Suite 207 Temecula, CA 92592 Telephone: 951-970-6254 is an independent Marriage & Family Therapist, and **Raymond Cameron, M.A., MFT** is ***not*** affiliated in any manner with, or responsible for, other independent licensed clinicians who may rent or lease office space in this office or in this building.

****BY SIGNING I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD THIS ABOVE STATEMENT**

_____ _____

Client Signature Date

_____ _____

Client Signature Date

_____

Raymond Cameron, M.A., MFT

Appeals and Grievances

Appeals Process:

I acknowledge my right to request reconsideration (an Appeal) in the case that outpatient visits are not authorized. I understand that I would request an Appeal from my Insurance's Behavioral Health Member Services Department or by submitting in my request in writing to my Insurance's Behavioral Health Member Services Department. I understand that my Therapist may submit a request for appeal on my behalf.

Grievances:

I also understand that I may submit a Grievance to my Insurance's Behavioral Health Member Services Department anytime to register a complaint about my care. I am aware that I may contact the Member Services Department of my Behavioral Healthcare Service to receive further information regarding the Appeals Grievances process.

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

_____ _____

Client (or Parent/ Guardian) Date

_____ _____

Client (or Parent/ Guardian) Date

Notice Of Privacy Practices

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
(Please note that this particular provision must be set forth in you notice privacy practices exactly as it is set forth here.)

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)
I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice. However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (if applicable). You can also request a copy of it in my office.

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 authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use disclose your PHI without your consent for the following reasons:

1. **For Treatment.** 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 case. For example, if you are being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care.
2. **To obtain payment for treatment.** I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
3. **For health care operations.** I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws.
4. **Other disclosures.** I may also disclose your PHI to others without your consent in certain situations. For example your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get 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 Uses and Disclosures Do Not Require Your Consent. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement.** For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
2. **For public health activities.** For example, I may have to report information about you to the county coroner.
3. **For health oversight activities.** For example, I may have to provide information to assist the government when it conducts an investigation or inspection of health care provider or organization.
4. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
5. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, I may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
6. **For specific government functions.** I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
7. **For workers' compensation purposes.** I may disclose PHI in order to comply with workers' compensation laws.
8. **Appointment reminders and health related benefits or services.** I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. **Disclosures to family, friends, or others.** I may provide your PHI to a family member, friend or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The Opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will ask for 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 Limits on Uses and Disclosures of PHI. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

B. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures I Have Made. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15,2003. I will respond to your request for an accounting of disclosures within 60 days of receiving your 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 of the disclosure, to whom 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 will charge you a reasonable cost based fee for each additional request.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in Writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My Written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

V. HOW TO COMPLAIN ABOUT MY 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 ***Raymond Cameron, M.A., MFT, Inc 951-970-6254***.

Appeals and Grievances Acknowledgement of Receipt of Notice of Privacy Practices

Client Name: _____ **Today's Date**: _____
(*To be completed by Parent/ Guardian if Client is under 18 years old*)

I, _____, *acknowledge receipt*
(Print name of client, subscriber, conservator, parent or legal guardian signing below)
acknowledge receipt of the Notice of Privacy Practices, which explains limits on ways in which ***Raymond F. Cameron, M.A., Licensed Marriage & Family Therapist, Inc.*** *may use or disclose personal health information (PHI) to provide service.*

_____ _____
Signature of Client (or Parent/ Guardian) Date

If not signed by client, indicate relationship: _____

NOTE: *Parent must have legal custody. Legal guardians and conservators must show proof.*

_____

*****This section to be filled out only by* ***Raymond F. Cameron, M.A., Licensed Marriage & Family Therapist, Inc.***

Client <u>did</u> receive the Notice of Privacy Practices, but <u>did not sign</u> this Acknowledgement of Receipt because:
- ❑ Client left office before Acknowledgement could be signed.
- ❑ Client did not wish to sign this form.
- ❑ Client cannot sign this form because: _____

Client <u>did not</u> receive the Notice of Privacy Practices because:
- ❑ Client required emergency treatment.
- ❑ Client declined the Notice and signing this Acknowledgement.
- ❑ Other:_____

_____ _____
Raymond Cameron, M.A., MFT Date

California State MFT License: MFC 38236
32605 Temecula Parkway, Suite 207, Temecula, CA 92592
Telephone: 951-970-6254
E-mail: rcameron.mft@gmail.com

"NO SECRETS POLICY"
Limitation on Confidentiality in Family Therapy and Couples Therapy

This written policy is intended to inform you, the participants in family therapy or couples therapy, that when I agree to work with a couple or a family, I consider that couple or family (the unit of treatment) to be the client. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-client privilege on behalf of the client (the treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the family or couple therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit –that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "*no secrets policy*" is intended to allow me to continue to treat the client (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

By signing this *No Secrets Policy* for Family Therapy and Couples Therapy Form, I understand and agree to all the above information and conditions.

_____ _____
Client (or Parent/ Guardian) Date

_____ _____
Client (or Parent/ Guardian) Date

_____ _____
Raymond Cameron, M.A., MFT Date

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Telephone: 951-970-6254
E-mail: rcameron.mft@gmail.com

ELECTRONIC COMMUNICATIONS

Email, Text Messaging, & Other Forms of Electronic Communication

Recently, some clients have expressed interest and preference for communicating with Raymond Cameron, M.A., MFT through various forms of Email, Text Messaging or other forms of Electronic Communication. Please read & sign this form regarding communication through Email, Text Messaging or other forms of Electronic Communication.

I understand that Email, Text Messaging and other forms of Electronic Communication are inherently an un-secure means of communication. Every effort will be made to treat these forms of communication confidentially. ***Raymond Cameron, M.A., MFT*** *may initiate contact with clients through Email, Text Messaging and other forms of Electronic Communication regarding availability of appointments, scheduling issues, & cancellation of appointments (e.g., due to illness or other unforeseen events) as appropriate and agreed to below.* ***Raymond Cameron, M.A., MFT*** *will not initiate contact with clients through Email, Text Messaging and other forms of Electronic Communication regarding clinical matters. If clients chose to initiate contact with* ***Raymond Cameron, M.A., MFT*** *regarding clinical issues from sessions,* ***Raymond Cameron, M.A., MFT*** *may respond to client Email, Text Messaging, and other forms of Electronic Communications by this same medium or as* ***Raymond Cameron, M.A., MFT*** *determines appropriate and consistent with the terms & conditions set forth in the Consent to Treatment Form previously signed.*

Please review the following options, check the box and Initial the lines that you would prefer as means of communication as they apply to you:

☐ I authorize communication via Email, Text Messaging or other forms of Electronic Communication.
Client Initials: _____

☐ I ***DO NOT*** authorize communication via Email, Text Messaging or other forms of Electronic Communication.
Client Initials: _____

☐ Please contact me through the following email address(es): _____

_____

Client Initials: _____

☐ Please contact me through the following telephone number(s) for Text Messaging: _____

_____

Client Initials: _____

☐ Please contact me through the following telephone number(s) for Voice Mail: _____

_____

Client Initials: _____

I have read the above and by **signing this *Electronic Communication Policy,* I understand and agree to all the above information and conditions.**

_____ _____
Client (or Parent/ Guardian) Date

_____ _____
Client (or Parent/ Guardian) Date

_____ _____
Raymond Cameron, M.A., MFT Date

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E-mail: rcameron.mft@gmail.com

Health Care Coordination Form

In order to coordinate care, I wish to inform you that your patient _____

was referred to me for treatment on _____/____/_____. The DSM-IV diagnoses code is _____.

Outpatient care is being delivered and the treatment plan consists of the following modalities:

❑ *Individual Psychotherapy* ❑ *Couples Psychotherapy* ❑ *Family Psychotherapy* ❑ *Group Psychotherapy*

❑ Other_____

Medication(s) are being managed by Dr. _____

Known Medications and Dosages:

1) _____ 3) _____

2) _____ 4) _____

If you need additional information, please feel free to contact me at **(951) 970-6254.**

Respectfully,

_____

Raymond Cameron, M.A., MFT

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN (PCP)

Client Name: _____ DOB: _____ Member ID Number: _____

I hereby authorize the release of medical information listed below which pertains to my medical history, mental or physical condition, or treatment, including information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis and treatment to my primary care physician:

_____

Physician Name Phone Number Fax Number

_____

Address

❑ ***Please send to my PCP*. I understand that the release of this information is to permit my primary care physician to monitor my health status and to coordinate all the care, which I may receive from specialists. This authorization becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance hereon. If not earlier revoked, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized recipient only. Additional information may be provided to this recipient only with signed consent from me. I further understand that I have the right to receive a copy of this authorization upon my request.**

❑ ***Do not send to my PCP*.**

❑ ***I have no current PCP*.**

_____ _____

Signature of Patient or Legal Guardian **Date**

Child/Adolescent Development History

Client Name: _____ **Today's Date**: _____

(*To be completed by Parent/ Guardian if Client is under 18 years old*)

Were medications taken during pregnancy?

❑ Yes; specify _____

❑ No ❑ Unknown

Did the birth mother consume alcoholic beverages or abuse any street drugs during pregnancy?

❑ Yes; specify _____

❑ No ❑ Unknown

Did the birth mother experience any physical or emotional problems during pregnancy?

❑ Yes; specify _____

❑ No

Was delivery normal?

❑ Yes ❑ Unknown

❑ No; specify _____

What was the child's birth weight?

_____ lbs. _____ oz.

❑ Unknown

Did the baby experience any problems immediately after birth?

❑ Yes; specify

❑ No

❑Unknown

Has the child ever required hospitalization?

❑ Yes; specify _____

❑ No ❑ Unknown

Is there any history of physical, sexual or emotional abuse?

❑ Yes; specify _____

❑ No

❑ Unknown

At what age did your child do the following?
(italicized areas reflect normal development)

_____ smiled *(6 months)*

_____ sat alone *(6 to 10 months)*

_____ talked in sentences *(30 to 36 months*)

_____ walked by self *(12 months)*

_____ held head up (*3 to 4 months)*

_____ fed self *(2yrs)*

_____ crawled *(6 to 10 months)*

_____ rode a bike *(6 yrs)*

_____ rolled over *(6 months)*

_____ talked in single words *(18 to 24 months*)

_____ pulled up *(6 to 10 months)*

_____ established toilet training*(2 ½ to 4 yrs)*

How would you describe your child's approach to new situations?

❑ Positive, jumps right in

❑ Withdrawn, tends not to participate

❑ Slow to warm up; cautious

How would you generally describe your child's over all mood?

❑ Positive (happy, laughing, upbeat, hopeful)

❑ Negative (depressed, cranky, angry, hostile)

❑ Mixed but more positive, than negative

❑ Mixed but more negative than positive

Which school is your child currently attending?

_____

Is the child expected to pass this school year?

❑ Yes

❑ No

Is the child currently receiving special services in this school?

❑ Yes; specify _____

❑ No

Has the child ever failed a class or been held back for academic reasons?

❑ Yes; specify grade: _____

❑ No

Comments: _____

_____

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DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

Routine Brief Screening for Intimate Partner Violence & Abuse

Because abuse and violence are common in many people's lives & relationships, it is important to ask all persons attending therapy if abuse and violence is, or has been, present in their lives & relationships to determine how abuse and violence may have affected them and their relationships, work to end the violence and abuse, & to work towards healing from these experiences. ***Your answers will not be reviewed in session if you request this at the bottom of the next page.***

Name: _____ **Date**: _____

Please look over the following questions. Think about how you are being treated and how you treat your partner. Remember, when one person scares, hurts or continually puts down the other person, its abuse.

Does Your Partner (or Parent)....

____Embarrass or make fun of you in front of your friends or family?
____Put down your accomplishments or goals?
____Make you feel like you are unable to make decisions?
____Use intimidation or threats to gain compliance?
____Tell you that you are nothing without them?
____Treat you roughly - grab, push, pinch, shove or hit you?
____Call you several times a night or show up to make sure you are where you said you would be?
____Use drugs or alcohol as an excuse for saying hurtful things or abusing you?
____Blame you for how they feel or act?
____Pressure you sexually for things you aren't ready for?
____Make you feel like there "is no way out" of the relationship?
____Prevent you from doing things you want - like spending time with your friends or family?
____Try to keep you from leaving after a fight or leave you somewhere after a fight to "teach you a lesson"?

Do You...

____Sometimes feel scared of how your partner will act?
____Constantly make excuses to other people for your partner's behavior?
____Believe that you can help your partner change if only you changed something about yourself?
____Try not to do anything that would cause conflict or make your partner angry?
____Feel like no matter what you do, your partner is never happy with you?
____Always do what your partner wants you to do instead of what you want?
____Stay with your partner because you are afraid of what your partner would do if you broke up?

Adapted form http://www.ncadv.org/learn-more/what-is-domestic-violence/do-you-think-you-re-being-abused

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California State MFT License: MFC 38236
32605 Temecula Parkway, Suite 207, Temecula, CA 92592
Telephone: 951-970-6254
E-mail: rcameron.mft@gmail.com

Routine Brief Screening for Intimate Partner Violence & Abuse

1. Have you ever been called *names, put-down, or degraded* by your partner or someone important to you? ***YES*** ***NO***

If YES, by whom? _____ How often:_____

2. Have you ever been *screamed or sworn at, threatened, or intimidated* by your partner or someone important to you? ***YES*** ***NO***

If YES, by whom? _____ How often:_____

3. Within the last year, have you been *hit, slapped, kicked, grabbed, pushed, etc* by your partner or someone important to you? ***YES*** ***NO***

If YES, by whom? _____ Total number of times:_____

4. Since you've been *pregnant* (when you were *pregnant)*, have you been *hit, slapped, kicked, grabbed, pushed, etc* by your partner or someone important to you? ***YES*** ***NO***

If YES, by whom? _____ Total number of times:_____

5. Have you ever been *forced or coerced* to participate in *sexual activities* against your will? ***YES*** ***NO***

If YES, by whom? _____ Total number of times:_____

6. Are you currently, or have you ever been, in a relationship where you are, or were made to feel, *afraid* of your partner or someone important to you? ***YES*** ***NO***

If YES, by whom? _____ How often:_____

*****IMPORTANT,** Please initial here _____ if you would like to discuss these questions with your therapist in private **without** your child, partner, or family member present!*

Raymond F. Cameron, M.A., Licensed Marriage & Family Therapist, Inc.
California State MFT License: MFC 38236
32605 Temecula Parkway, Suite 207, Temecula, CA 92592
Telephone: 951-970-6254
E-mail: rcameron.mft@gmail.com

Raymond F. Cameron, M.A., Licensed Marriage & Family Therapist, Inc.
California State MFT License: MFC 38236
Address: 32605 Temecula Parkway, Suite 207, Temecula, CA 92592-6839
Telephone: 951-970-6254
E-mail: rcameron.mft@gmail.com
Website: www.raymondcameronmft.com

Dear Client

Welcome to the practice of **Raymond Cameron, M.A., MFT, Inc**. This letter is intended to inform you of current billing procedures. Please feel free to discuss the information in this letter in your upcoming session.

Forms of Payment:
To offer clients a range of payment options, our practice accepts the following forms of payment: **Visa Card, MasterCard, and Discover Cards**. Please indicate your preferred form of payment on the **Electronic Payment Authorization Form**.

Our practice's policy is to securely store a form of payment on file for all your sessions. We are deeply committed to the therapeutic climate and want your therapeutic experience to be focused on you and your treatment goals. By allowing you to use a credit or debit card, we can avoid taking time away from your therapeutic work to check you in and process payment. Each month you will receive an automated statement by email. Statements will show what you have paid for your services and are ready for you to forward to your insurance company if you wish to seek reimbursement.

The **Electronic Payment Authorization Form** will be securely stored in your file, and may be updated at any time. Please be aware that all transactions may read '**Raymond Cameron, M.A., MFT, Inc**.' or '**Therapy Partner Corporation**' on your bank or credit card statement. Therapy Partner is the merchant who processes our credit card and transactions.

Monthly Statements:
You will receive monthly statements via email for all sessions attended within a calendar month. You can use these statements to seek reimbursement from your insurance company if you are taking advantage of your out-of-network benefits.

Please feel free to discuss any billing matters with your therapist in your next session.

Respectfully,

Raymond F. Cameron, M.A.,
Licensed Marriage and Family Therapist (MFC 38236)

ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the Debit / Credit card you wish to use for all services rendered through this practice. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept: Visa, MasterCard and Discover.

Client Information:

Name_____

Address: _____ City_____ State: _____ Zip: _____

Home Number: _____ Mobile Number: _____

Email: _____

Billing Information: Please indicate the information associated with the debit / credit card you wish to use.

Name_____

Address: _____ City_____ State: _____ Zip: _____

Home Number: _____ Mobile Number: _____

Email: _____

Debit / Credit Card Information:

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one): Visa MasterCard Discover

Card Number: _____ **Expiration Date**: _____

Please enter the **CVV code** _____ (last three digits on back of card)

I authorize all service fees to be deducted from the card ending in _____ (last four digits of the card)

I authorize the use of this card for all services and fees at the time they are rendered for the following parties:

Full Name(s) of Client(s): _____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

_____ _____

Signature of Client, Legal Guardian, or Card Holder **Date**

** Payments are processed by Therapy Partner. Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

Please return this form to your therapist