MANIFEST THE LIFE YOU WANT TO LIVE.

COUNSELING INTAKE FORM | FILE CODE: _____

TRACI MEDEIROS-BAGAN, MA, LMFT#86600, RYT200, COM | PASSIONATE REVOLT

Name (Used):	
Name (Legal, if different):	

Ethnicity:		Religious Preference:	
Gender Identity:		Relationship Identity:	
Ex. Genderqueer, Fluid, MTF, FTM, Agender, Transmasculine/feminine, Cis Male/Female, Other, etc		Ex. Monogamous, Polyamorous, Solo Poly, Open, Swinger, Married, Partner, Other, etc	
Pronouns:		Sexual/Romantic Orientation:	
Ex. Ze, They, She, He, Other, etc		Ex. Gay, Queer, Lesbian, Asexual/Panromantic, Omnisexual/Homoromantic, Bisexual/Heteromantic, etc	
Gender Identity:	Undisclosed	Out to Some	Out to Everyone
Sexual Orientation:	Undisclosed	Out to Some	Out to Everyone
Notes (Need support coming out, need support navigating transition services, etc):			

Phone:		Email:			
Address:					
City:		State:		Zip:	
DOB:		First Language Learned:			

Employer:		Monthly Income:		How Long:	

Emergency Contact Name:			
Phone:		Relationship:	
Alternative Plan Request:			

Insurance (Y I N) What Carrier:			
Primary Physician:		Primary Psychiatrist:	
Medications/Dosage:			

Last Physical:		Serious Health Issues:	Y I N (Circle One)
If yes, what?			
General Health (Circle):	Great	Fair	Poor
Special Dietary Restrictions:			
General Food Diet:	Healthy	Fair	Unhealthy
Eating History/Challenges:			
Do you exercise?	Y I N	Hours a Week:	
Activities:			
Need Support:	Y I N	Any Challenges:	Y I N
Feelings about your body?	Great	Neutral	Poor
Gender related? Y I N	Other important info you'd like to share:		

Do you know your HIV status?	Y I N	Results:	Positive I Negative
If positive, have you gotten support?	Y I N	Notes:	
Sexually Active:	Y I N	Notes (Monogamous, Polyfidelitous, Single Fluid Bonding, Number of Partners, etc):	
Practicing Safe Sex:	Y I N		
Communicating With All Partners:	Y I N		
Questions/Concerns:			

SUBSTANCE USE	Circle One / Fill In		Challenges (Previous/Current):
Do you smoke cigarettes?	No	Yes, # _____ Per Day I Week	Notes:
Do you drink alcohol?	No	Yes, # _____ Per Day I Week	Notes:
Do you use cannabis?	No	Yes, # _____ Per Day I Week	Notes:
Other: _____?	No	Yes, # _____ Per Day I Week	Notes:

Family Relationships and Psychological History			
Family Member	Relationship To You/ Name/Age	Good/Neutral/ Estranged/Etc	Serious Psychological/ Medical Problems
Parent 1			
Parent 2			
Other Parental Figures			
Sibling 1			
Sibling 2			
Sibling 3			
Sibling 4			
Other Significant Family Members			

Anything else important to share about your family:

Relationship to Partner(s):			
Name/Relationship (i.e. primary partner, bf, gf, spouse, etc)	Time Together	Living Together?	Good/Neutral/Negative/Abusive/Etc
1)		Y I N	
2)		Y I N	
3)		Y I N	
4)		Y I N	
Other Notes:			
How is the rest of your social network outside of your romantic relationships:			

How satisfied are you with?	Scale 1-10 (10 Most Satisfied)	Notes/Needs/Challenges/Etc
Primary Relationship		
Family		
Work		
School		
Living Environment		
Mental Health (General)		
Sleep Schedule		
Mood		
Anxiety		
Other Notes:		

Does anyone make you feel unsafe?	Y I N	Who/Why:
Any events you keep re-experiencing?	Y I N	What/Describe:
Thoughts about hurting yourself?	Y I N	What/Describe:
Have you ever hurt yourself?	Y I N	What/Describe:
Thoughts about suicide?	Y I N	What/Describe:
Have you ever attempted suicide?	Y I N	What/When/Describe:
Current thoughts about suicide?	Y I N	What/When/Describe:
Have you ever been hospitalized?	Y I N	When/Describe:
Anything else you'd like to share?		

Previous Therapy (Y I N) Outcome:	

Reason for Seeking Previous Therapy:	

Current Reason for Seeking Therapy:	

Anything Else You'd Like to Share:	

How did you fine me? (Web, referral, etc)	
Name of Referral? (If, applicable)	

I agree that the above is true, accurate, and I consent to treatment.	
Client Signature	Date

RIGHTS AND RESPONSIBILITIES

TRACI MEDEIROS-BAGAN, MA, LMFT#86600, RYT200, COM | PASSIONATE REVOLT

YOU HAVE THE RIGHT TO:

- Courteous and respectful treatment, with an appreciation of your dignity and right to privacy.
- Confidential treatment services in accordance with the Health Insurance Portability and Accountability Act (HIPAA).
- Prompt responses provided in a reasonable amount of time to questions and requests for services.
- Receive services in a safe manner and be reasonably protected from undue harm/ violence/harassment from a service provider or other clients.
- Access quality service/care regardless of and honoring of race, ethnicity, gender, sexual orientation, disability, religion, age, political beliefs or socio-economic status.
- Culturally sensitive services that are provided in a language and manner that is understandable.
- A fair and understandable grievance process.
- Request support around transfer to another service provider, if available and desired.
- Written informed consent for sharing of information and to receive services.
- Refuse services/referrals and receive an explanation of the effects associated with refusing services.

I understand that I have the right to file a grievance if I feel my client rights have been violated.

Initial:_____ Date: _____

IT IS YOUR RESPONSIBILITY TO:

- Notify/communicate to your provider any changes in health, needs, residency, income, etc., in a timely manner.
- Be considerate, cooperative and respectful of provider and other clients.
- Arrive promptly for scheduled appointments or notify the provider a minimum of 24 hours in advance if you must miss or change an appointment.
- Protect the confidentiality of other clients by keeping their identity and information confidential.
- Behave appropriately during visits, appointments and any other supportive group sessions or meetings.
- Not be under the influence of drugs and/or alcohol, and never bring drugs and/or alcohol to meetings, providers or other community events.
- Avoid abusive or threatening language.
- Avoid violence, threats of violence and possession of any weapons.
- Respect all providers and other client's personal and professional boundaries.
- Notify providers when there is dissatisfaction with services and utilize the grievance process when appropriate.
- Hear recommendations for complimentary/alternate care if needed and available.
- Be responsible for your physical and emotional safety and notify/call for appropriate support if the need arises.

I understand that a violation of any of the above listed client responsibilities will result in temporary or permanent termination of services.

Initial:_____ Date: _____

CRISIS CARE: I verify, by my signature below, that I understand my counselor does not provide crisis counseling and my counseling is limited to my scheduled appointments only. In case of life threatening emergency I will call 911. Messages can be left by phone/email and my counselor will respond within 24-48 hours except during weekends, holidays or as otherwise specified. A hotline list will be provided.

_____Client Initial

PAYMENT FOR SERVICES: Clients for services at the time they are rendered. Payments can be made by check (written out to Traci Medeiros-Bagan), cash (in correct change), or major credit card.

_____Client Initial

INSURANCE REIMBURSEMENT: This provider does not take insurance or bill insurance directly. However, the therapist will discuss diagnosis and provide an invoice for reimbursement at the client's request.

_____Client Initial

FORENSIC/LEGAL PROCEEDINGS: This provider is not a specialist in forensic or legal proceedings and does not offer this type of courtroom or legal support.

_____Client Initial

CANCELLATIONS: A minimum of 24 hours notice is required for rescheduling or cancellation of your appointment. The full fee will be charged for missed sessions without notification.

_____Client Initial

CONFIDENTIALITY: All information disclosed within sessions and in the client's records is confidential and may not be revealed to anyone without your written permission except where disclosure is required by law. Disclosure may be required under the following circumstances: Where there is suspicion of child abuse, elder abuse, adult dependent abuse, or if you're thought to be a harm to yourself or others. Disclosure may also be required pursuant to a legal proceeding.

_____Client Initial

CONSENT FOR TREATMENT: I understand that psychotherapeutic services are to help facilitate self-exploration and growth. Psychotherapy services provided are not medical advice, treatment is not time limited, outcomes are dependent on compliance with treatment, and will, also, vary by individual.

_____Client Initial

BY SIGNING THIS FORM I AGREE TO THE ABOVE AND CONSENT TO TREATMENT		
Client Name Printed	Client Signature	Date
Therapist Name Printed	Client Signature	Date

HOTLINE	SPECIFICS/INFO	NUMBER
Alcoholics Anonymous	24 Hours	714-556-4555
California AIDS Hotline	M-F 9am-5pm	800-367-2437
Domestic Violence Hotline	24 Hours	714-992-1931 800-978-3600
OC Human Relations	M-F 8:30am-5pm	714-567-7470
Crisis Counseling Hotline of S. California		714-894-4242
Legal Aid Society Hotline	M-F 9am-4:30pm	800-834-5001
PFLAG Helpline	*Message	714-997-8047
Suicide Hotline	New Hope Counseling-Religious	714-639-4673
Suicide Prevention Center OC	24 Hours	877-727-4747
Suicide Prevention Center OC	24 Hours	310-391-1253
Sexual Assault Victim Assistance Hotline	24 Hours	714-834-4317 714-957-2737
Women Alive	Women living with HIV	323-965-1564
Youth Crisis Line	24 Hours	800-784-2432
Suicida	Spanish Suicide Hotline	800-784-2432
Warmline	M-F 9am-3am Sat-Sun 10am-3am	714-991-6412 877-910-9276
Trevor Project	24 Hours	866-488-7386

IN CASE OF A LIFE THREATENING EMERGENCY CALL 911

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.

MY DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION.

Protected health information (PHI) refers to information in your health record that could identify you. It is individually identifiable information about your past, present or future health or condition, the provision of health care to you, or payment for the health care. Examples of PHI include your name, address, birth date, age, phone number, diagnosis, medical records and billing records.

I am required by applicable federal and state law to maintain the privacy of your protected health information, and to give you this Notice of Privacy Practices that describes my privacy practices, my legal duties and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect. This notification takes effect April 14, 2003 and will remain in effect until replaced.

I reserve the right to change my privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before I make a significant change in my privacy practices, I will change this Notice and make the new Notice available upon request.

You may request a copy of my Notice of Privacy Practices at any time. For more information about my privacy practices or for additional copies of this Notice, contact me.

HOW I MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its HIPAA Privacy Rule (Rule), I am permitted to use and/or disclose your PHI for a variety of reasons. Except in specified circumstances, I am required to use and/or disclose only that minimum amount of your PHI necessary to accomplish the purpose for the use and/or disclosure. Generally, I am permitted to use and/or disclose your PHI for the purposes of treatment, the payment for services you receive, and for my normal health care operations. For most other uses and/or disclosures of your PHI, you will be asked to grant your permission via a signed Authorization. However, the Rule provides that I am permitted to make certain other specified uses and//or disclosures of your PHI without your Authorization. The following information offers more descriptive examples of my potential use and/or disclosure of your PHI:

1. **Uses and/or Disclosures of PHI for Treatment, Payment, and Health Care Operations That Do Not Require Authorization.**

   Treatment: I may use or disclose your health information to a physician or other healthcare provider providing treatment to you or for the management of healthcare and related services. This also includes but is not limited to consultations and referrals

between one or more providers. For example, an insurance company may contact a provider on your behalf to facilitate your access to mental health treatment.

Appointment Scheduling/Reminders: Unless you request that I contact you by other means, the Privacy Rule permits me to contact you by phone/voice mail to schedule appointments and to leave appointment reminders.

Payment: I may use or disclose your health information to obtain reimbursement for your healthcare. For example I may disclose your PHI to your health insurer to determine eligibility or coverage for psychotherapy. Or, I may disclose PHI when I obtain reimbursement from your health insurer for your healthcare.

Healthcare Operations: I may use or disclose your health information in healthcare operations. For example, I may disclose your PHI to your health insurer for care coordination or case management.

2. **Uses and/or Disclosures of PHI Requiring Authorization**

You may give me written authorization to use your health information or to disclose it to anyone for any purpose. If you give me authorization, you may revoke it in writing at any time. Your revocations will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give me a written authorization, I cannot use or disclose your health information for any reason except those described in this Notice.

Psychotherapy Notes: I will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes I have made about our conversation during an individual, group, conjoint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection that PHI.

3. **Uses and/or Disclosures Not Requiring Your Authorization or Consent**

The HIPAA Privacy Rule provides that I may use and/or disclose your PHI without your Authorization in the following circumstances.

- **When required by law:** I may use and/or disclose your PHI when existing law requires that I report information including each of the following areas:
- **Reporting abuse, neglect or domestic violence:** I may disclose your PHI to appropriate authorities if I reasonably believe that you are a possible victime of abuse, neglect, or domestic violence or the possible victim of domestic violence or the possible victim of other crimes.
- **Child abuse:** Whenever I, in my professional capacity, have knowledge of or observe a child I know or reasonably suspect, has been the victim of child abuse or neglect, I must immediately report such to a police department or sheriff's department, county probation department, or county welfare department. Also, if I have knowledge of or reasonable suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, I may report such to the above agencies.

- **Adult and domestic abuse:** If I, in my professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these or if I reasonably suspect such, I must report the known or suspected absue immediately to the local ombudsman or the local law enforcement agency. I do not have to report such an incident told to me by an elder or dependent adult if (a) I am not aware of any independent evidence that corroborates the statement that the abuse has occurred; (b) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and (c) in the exercise of clinical judgment, I reasonably believe that the abuse did not occur.
- **To avert a serious threat to health or safety:** I may use and/or disclose your PHI in order to avert a serious threat to health or safety. If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.
- **Public health activities:** I may use and/or disclose your PHI to prevent or control the spread of disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food, dietary supplements, product defects and other related problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether or not you have a work related illness or injury, in order to comply with Federal or state law.
- **Health oversight activities:** I may use and/or disclose your PHI to designated activities and functions including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs.
- **Judicial and administrative proceedings:** I may use and/or disclose your PHI in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process.
- **Law enforcement activities:** I may use and/or disclose your PHI for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death.
- **Relating to decedents:** I may use and/or disclose the PHI of an individual's death to coroners, medical examiners and funeral directors.
- **For specific government functions:** I may use and/or disclose the PHI of military personnel and veterans in certain situations. Similarly, we may disclose the PHI of inmates to correctional facilities in certain situations. We may also disclose your PHI to governmental programs responsible for providing public health benefits, and for workers' compensation. Additionally, we may disclose your PHI, if I required, for national security reasons.

4. USES AND/OR DISCLOSURES REQUIRING YOU TO HAVE AN OPPORTUNITY TO OBJECT

I may disclose your PHI in the following circumstances if I inform you about the disclosure in advance and you do not object. I may use or disclose health information to notify or assist the notification of (including identifying or locating) a family member, your personal representative or another person responsible for our care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, I will provide you with an opportunity to object to such use or disclosure. However, in the event of your incapacity or emergency circumstances and you cannot be given and opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests. I will disclose only health information that is directly relevant to the person's involvement in your healthcare. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

The HIPAA Privacy Rule grants you each of the following individual rights:

Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. (If you request copies, I will charge you $1.00 per page to locate and copy your health information, and postage if you want the copies mailed to you.) I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Request an Amendment: If you believe that your PHI is incorrect or incomplete, you may ask me to amend the information. This request must be made in writing, and it must explain why the information should be amended. You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. A request for a restriction must be put in writing. However, I am not required to agree to a restriction you request. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make. If I do agree to your request, I will put these limits in writing and abide by them except in emergency situations.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another to another address.) You must make your request in writing. It must specify how and/or where you wish to be contacted. I will accommodate all reasonable requests.

Right to an Accounting: You generally have the right to receive a list of disclosures of PHI for which you have neither authorization nor consent (see above for this section.) This accounting will begin on 4/15/03 and disclosure records will be held for six years. On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy: You have the right to obtain a paper copy of this Notice of Privacy Practices from me upon request.

QUESTIONS AND COMPLAINTS

If you want more information about my privacy practices or have questions or concerns, please contact me.

If you are concerned that I may have violated your privacy rights, or you disagree with a decision I made about your access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have me communicate with you by alternative means or at alternative locations, you may complain to me using the contact information listed at the end of this notice. You may also submit a written complaint to the Secretary U.S. Department of Health and Human Services. Upon request I will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. Any complaint you file must be received by me, or filed with the Secretary, within 180 days of when you know, or should have known, the act or omission occurred.

I support your right to the privacy of your health information. I will not retaliate in any way if you make a complaint.

EFFECTIVE DATE: THIS NOTICE OF PRIVACY PRACTICES IS EFFECTIVE APRIL 14, 2003.

CONTACT INFORMATION

Traci Medeiros-Bagan, MACP, LMFT#86600
224 W Maple Ave, Suite A, Orange, CA 92866
email: compassionaterevolt@gmail.com
telephone: 657.333.2396

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

TRACI MEDEIROS-BAGAN, MA, LMFT#86600, RYT200, COM | PASSIONATE REVOLT

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____ (PRINT),
HAVE RECEIVED A COPY OF TRACI MEDEIROS-BAGAN'S NOTICE OF PRIVACY PRACTICES.

_____ _____

(SIGNATURE) (DATE)

FOR OFFICE USE ONLY

TRACI MEDEIROS-BAGAN, LMFT#86600 ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF HIS/HER/THEIR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

_____ INDIVIDUAL REFUSED TO SIGN

_____ AN EMERGENCY SITUATION PREVENTED THEM FROM OBTAINING THE ACKNOWLEDGEMENT.

_____ OTHER (SPECIFY)

_____

_____

_____

AUTHORIZATION FOR CREDIT CARD BILLING

TRACI MEDEIROS-BAGAN, MA, LMFT#86600, RYT200, COM | PASSIONATE REVOLT

AMOUNT:

_____

CARD NUMBER:

_____

EXPIRATION: _____

SECURITY CODE: _____

BILLING ZIP: _____

NAME:

_____

ADDRESS/EMAIL:

_____

I HEREBY AUTHORIZE TRACI MEDEIROS-BAGAN TO BILL THE CREDIT CARD LISTED ABOVE FOR ALL SERVICES PROVIDED, INCLUDING LATE CANCELLATIONS AND MISSED APPOINTMENTS, CONSISTENT WITH OFFICE POLICIES OUTLINED IN MY CONSENT FOR TREATMENT. NOTE, CHARGES WILL APPEAR ON YOUR ACCOUNT AS BILLED UNDER COMPASSIONATE REVOLT HEALING.	
Signature	Date