JULIA FITTON, L.M.F.T.
1910 W. SUNSET BLVD., STE 440, LOS ANGELES, CA 90026
(310) 895-4157 – JULIA@JULIAFITTON.COM

Client Information Sheet

The information requested on this form is completely confidential.

CLIENT **Today's Date:**_____

Name: _____

Primary Residence: _____

City: _____ State: _____ Zip: _____

Mobile _____ Email: _____

*Please indicate which phone number or email is your preferred method of communication; Is it is okay to leave confidential messages at this number or address? Yes No (circle one)

Birth date: _____ Birthplace: _____

PARENT/LEGAL GUARDIAN

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

*Telephone numbers: home _____ work _____ mobile _____

Email address(es): _____

Employer: _____ Occupation: _____

PARENT/LEGAL GUARDIAN

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone numbers: home _____ work _____ mobile _____

Email address(es): _____

Employer: _____ Occupation: _____

FAMILY HISTORY

Father: ___Living ___Deceased Current age / age at time of death: ____ Cause of death: _____

Mother: ___Living ___Deceased Current age / age at time of death: ____ Cause of death: _____

Number & Age of Siblings (if any) please list in birth order: _____

Please Indicate Applicable Custody Status

Married___ Joint Physical Custody _____
Sole Legal Custody _____ Joint Legal Custody____
Sole Physical Custody _____ Custody Schedule _____

PSYCHOTHERAPY AND MEDICATION HISTORY

Has the Client ever been in therapy? Yes No (circle one)

If so, when? _____ For how long? _____

Please list any medications Client is currently taking: _____
_____

IN CASE OF EMERGENCY, PLEASE CONTACT: _____

Phone: _____ Relationship to self: _____

REFERRED TO THIS OFFICE BY: _____

FEES AND INSURANCE

Payment is requested at the beginning of each session. Checks should be made payable to ***Julia Fitton****. Checks returned for insufficient fees are assessed a service charge of $25.00 per check. In an effort to keep my fees affordable, I ask that you use debit or credit cards only when without other options as processing fees are quite high. Further, sliding scale fees are assessed on an individual, as-needed, basis. All fees below the current rate will be subject to yearly review.*

Initial here: ____

Those clients who wish to utilize health insurance benefits will be provided with a monthly statement reflecting service provided and payments made. This statement should be submitted directly to the insurance company for reimbursement, attached to a claim form. Since your insurance policy is a contract between you and your insurer, you are advised to understand its provisions. As the insured, you are entitled to an explanation if your insurer rejects your claim for any reason. Rejection of your claim does not, however, relieve you of your obligation to pay for services provided.

Do you require a monthly statement to seek insurance reimbursement? Yes No (circle one)

CANCELLATION POLICY

To avoid being charged for a cancelled session, the session ***must be cancelled at least 24 hours*** *in advance by leaving a message at (310) 895-4157. Sessions cancelled with any less than 24 hours notice will be charged at the full fee. By law, insurance providers may not reimburse patients for fees paid for cancelled sessions.*

Initial here: ____

PROFESSIONAL RECORDS

I keep professional, written records. You may request a summary of your records. There is a charge of $160 per hour for any time spent responding to this request. I recommend that we review the summary together so that we may discuss the content.

Initial here: ____

POLICY AND LAWS REGARDING CONFIDENTIALITY

Communications between you and me are private and protected by law. I can only release information about our work to others with your written permission. The exceptions to this are the following:

A. *State law requires all mental health providers to report suspected child or elder abuse, or abuse of a dependent adult.*
B. *If you make a serious threat to harm another or their property, I am legally obligated to take steps to protect third parties. This may include reporting to the authorities and/or warning the intended victim(s). If you present a serious danger to yourself, I may be required to break confidentiality in order to keep you safe. In most cases, I will make every effort to discuss this with you prior to taking such actions.*
C. *In some court proceedings involving child custody and those in which your emotional condition is an important issue, a judge may determine my testimony or your records are required for fair finding.*
D. *I cannot guarantee the privacy of communication through electronic means such as text message or email. I strongly advise that you limit such communications to scheduling and other material not therapeutically sensitive.*

Initial here: ____

MINORS AND CONFIDENTIALITY

Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are encouraged to be involved in their treatment. Consequently, parents will be informed of therapeutic progress but, unless otherwise agreed upon by the minor, no details of minor's therapy will be provided. The exception to this is if minor's disclosures lead me to believe that he or she is in substantial danger of serious and immediate harm or death.

Initial here: ____

I have read the foregoing and my signature below attests to my understanding of these policies and laws.

_____ _____

Parent/Guardian Signature ***Date***

_____ _____

Client Signature ***Date***

JULIA FITTON, L.M.F.T.
1910 W. SUNSET BLVD., STE 440, LOS ANGELES, CA 90026
(310) 895-4157 – JULIA@JULIAFITTON.COM

Client Copy

FEES AND INSURANCE

Payment is requested at the beginning of each session. Checks should be made payable to ***Julia Fitton****. Checks returned for insufficient fees are assessed a service charge of $25.00 per check. In an effort to keep my fees affordable, I ask that you use debit or credit cards only when without other options as processing fees are quite high. Further, sliding scale fees are assessed on an individual, as-needed, basis. All fees below the current rate will be subject to yearly review.*

Those clients who wish to utilize health insurance benefits will be provided with a monthly statement reflecting service provided and payments made. This statement should be submitted directly to the insurance company for reimbursement, attached to a claim form. Since your insurance policy is a contract between you and your insurer, you are advised to understand its provisions. As the insured, you are entitled to an explanation if your insurer rejects your claim for any reason. Rejection of your claim does not, however, relieve you of your obligation to pay for services provided.

CANCELLATION POLICY

To avoid being charged for a cancelled session, the session ***must be cancelled at least 24 hours*** *in advance by leaving a message at (310) 895-4157. Sessions cancelled with any less than 24 hours notice will be charged at the full fee. By law, insurance providers may not reimburse patients for fees paid for cancelled sessions.*

PROFESSIONAL RECORDS

I keep professional, written records. You may request a summary of your records. There is a charge of $160 per hour for any time spent responding to this request. I recommend that we review the summary together so that we may discuss the content.

POLICY AND LAWS REGARDING CONFIDENTIALITY

Communications between you and me are private and protected by law. I can only release information about our work to others with your written permission. The exceptions to this are the following:

A. *State law requires all mental health providers to report suspected child or elder abuse, or abuse of a dependent adult.*
B. *If you make a serious threat to harm another or their property, I am legally obligated to take steps to protect third parties. This may include reporting to the authorities and/or warning the intended victim(s). If you present a serious danger to yourself, I may be required to break confidentiality in order to keep you safe. In most cases, I will make every effort to discuss this with you prior to taking such actions.*
C. *In some court proceedings involving child custody and those in which your emotional condition is an important issue, a judge may determine my testimony or your records are required for fair finding.*
D. *I cannot guarantee the privacy of communication through electronic means such as text message or email. I strongly advise that you limit such communications to scheduling and other material not therapeutically sensitive.*

MINORS AND CONFIDENTIALITY

Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are encouraged to be involved in their treatment. Consequently, parents will be informed of therapeutic progress but, unless otherwise agreed upon by the minor, no details of minor's therapy will be provided. The exception to this is if minor's disclosures lead me to believe that he or she is in substantial danger of serious and immediate harm or death.