**Nick Barneclo, Ph.D.**
***Licensed Psychologist***
*nickbarneclo@gmail.com*
**nickbarneclo.com**
Cell Phone: (805) 910-8866 Fax (805) 419-6876

# INTAKE FORM
# (Child)

Today's Date_____

## Information about Child:

Name_____ Sex: ❑ Male ❑ Female DOB_____
Age_____Social Security#_____
Address_____City_____ State_____ Zip Code_____
Height _____Weight _____
Home telephone_____
Emergency contact_____ Relationship_____Telephone_____
School_____ Grade____ Teacher's Name_____Telephone_____

## Information about Mother:

Name_____ DOB_____ Age___ SS#_____
Address:_____City_____ State_____ Zip Code_____
Home telephone_____ Work Phone_____ Cell Phone_____
Years of School Completed__ Place of Employment_____
Type of Work_____ E-mail address_____
Marital Status_____ Number of Marriages__ Religion_____

## Information about Father:

Name_____ DOB_____ Age___ SS#_____
Address:_____City_____ State_____ Zip Code_____
Home telephone_____ Work Phone_____ Cell Phone_____
Years of School Completed__ Place of Employment_____
Type of Work_____ E-mail address_____
Marital Status_____ Number of Marriages__ Religion_____
***If Divorced with joint legal custody, Consent from both parents is needed***
**OTHERS IN THE HOME:**

| **Name** | **DOB** | **Age** | **Relationship** |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Even though we will ask to make a copy of your insurance card, we would appreciate if you would fill in the following information:

**PRIMARY INSURANCE COMPANY**

Name of Insurance Company_____ Policy#_____ Group#_____

Authorization or Referral Number_____

Name of Insured Person_____ DOB _____ Social Security#_____

Address, Phone Numbers and Place of Employment for Insured (if different from first page):

Address:_____City_____ State_____ Zip Code_____

Home telephone_____ Cell Phone_____

Place of Employment_____ Work Phone_____

**SECONDARY INSURANCE COMPANY**

Name of Insurance Company_____ Policy#_____ Group#_____

Authorization or Referral Number_____

Name of Insured Person_____ DOB _____ Social Security#_____

Address, Phone Numbers and Place of Employment for Insured (if different from first page):

Address:_____City_____ State_____ Zip Code_____

Home telephone_____ Cell Phone_____

Place of Employment_____ Work Phone_____

**Name of person who referred you to this office**_____

**Why are you seeking treatment now?** _____

Have you ever seen a therapist or counselor before ? ❑ Yes ❑ No

If yes, what was the name of therapist?_____

Dates and reason for therapy_____

_____

**PATIENT OR AUTHORIZED PERSON'S SIGNATURE**: I authorize the release of any medical or other information necessary to process insurance claims:

❑ Yes ❑ No

I authorize payment of medical benefits to Dr. Barneclo for services rendered:

❑ Yes ❑No

SIGNED: _____ DATE: _____

Has a referral been made to a psychiatrist/family doctor for medication evaluation?

❑ Yes ❑ No

For each item, below, please indicate your preference, provide your initials on the line to the left, and then sign below:

❑ Yes ❑ No I grant permission for Dr. Barneclo to speak with my primary care physician about my psychological and medical status.

❑ Yes ❑ No I grant permission for Dr. Barneclo to speak with *(other healthcare provider's name, address, and phone number)*:_____

_____

about my psychological and/or medical status.

❑ Yes ❑ No I authorize the release of any medical or other information necessary to process insurance claims:

❑ Yes ❑ No I authorize payment of medical benefits to Dr. Barneclo for services rendered:

**I have read Dr. Barneclo's practice and privacy policies, and consent to this patient-psychologist agreement.**

_____ _____

**Name (printed)** **Signature** **Date**

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# I. INFORMATION FOR NEW CLIENTS

The decision to begin counseling is an important one that can lead to major positive changes in a person's life, typically involving the reduction of problematic thoughts, feelings and behaviors, greater awareness of one's strengths and coping abilities, improved relationships, and general happiness. Although there can be no guarantee that everyone will achieve these results, greater understanding of how the counseling process works can facilitate such an outcome.

I am pleased that you are considering me for your therapist. It is my hope that with the following information you will be better prepared to make an informed decision about participating in this process.

When a client and a counselor agree to work together to defeat the problems affecting the client, it is important that the counselor have as much understanding as possible about the problems affecting the client. It is necessary, therefore, for me to listen very carefully to what has brought you to therapy. Often, I may ask questions to get to know you and the affect the problems have on you and your relationships. I will also want to listen intently to grasp your understanding of these problems. It is possible that this conversation may cause some discomfort, as we may delve into emotionally painful topics. Most often, this initial discomfort brings on a significant degree of relief in sharing these issues with a concerned professional. It will be important in our work together that you feel free to share your thoughts and feelings about our discussions.

There are a number of other important areas that must be considered prior to initiating this professional relationship:

**Respecting your World View:**
An important component of any relationship is understanding and accepting differences in beliefs, customs, traditions, and ways of relating to others, all of which can be influenced by gender, ethnicity, race, sexual orientation, disability, family of origin, and a variety of other factors. As a result, an initial aspect of our work together may be acknowledging some of these differences. As a psychologist who values differences among individuals, I believe it is my responsibility to understand my own background, identity, biases, and beliefs, understand other cultures and acknowledge historical forces that have influenced the development of others, and provide therapy that is culturally appropriate. I encourage open discussion of any concerns along these lines.

**Working Together:**
It is important to me that you feel empowered to direct aspects of treatment and work with me to address the problems you are attempting to defeat. As a result, treatment goals will ideally be a

joint effort between the therapist and the client. Additionally, it might be common for the therapist to assign homework tasks, but it will similarly be important that such tasks are agreed upon and discussed together.

**Scheduled Sessions:**
Generally, I meet with a new client once a week for a 50-minute session. We will set up a mutually convenient appointment time for those meetings. Should you know of a pre-existing cause for missing a session, please contact me 24-hours prior to the meeting. Should you be unable to provide advanced notice about cancellation, the fee is $175 (Medical members may not be assessed any fees). My schedule is typically Monday through Friday from 8 AM to 5 PM, however, there may be temporary exceptions to this schedule.

**Confidentiality:**
Any information discussed in session must be held in strict confidence to maintain the trust of the client **unless**: the information reveals child abuse, abuse of a senior, or abuse of an individual without the capacity to properly care for him/herself; the information reveals a reasonable danger to the client or others; or information is requested in a court of law. Under such circumstances, only the minimum and essential information will be provided to the appropriate persons in an effort protect the individual and others. In addition, I may consult with other professionals from time to time thereby disclosing information about the individual, but I will provide few details with no demographic or identifiable information. This is performed only to receive assistance in providing effective and ethically sound services to the individual. Finally, minimal information is also shared with third party agencies when insurance is billed, but care is taken to protect your information based on HIPAA (please ask for a brief review of guidelines under HIPAA).

**Financial Arrangements:**
My fee is $175.00 per session. Unless you have made prior arrangement, payment is due at the end of each session. If you have health insurance that covers your therapy, I will be glad to complete any necessary paperwork, but the responsibility for payment remains with you. Some insurance plans dictate a fee that is different than my usual charge, and I will agree to accept that fee.

**Emergencies:**
If you are experiencing a mental health emergency, it is important that you let me know as soon as possible by phone. If the emergency occurs after hours or on weekends, you may contact 9-1-1, or you may go to the emergency room at a nearby hospital (which are open 24 hours a day). They will be able to assess your situation there and make appropriate recommendations.

**If you have any questions pertaining to our work together, please feel free to ask at any time.**

# NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. *Please Read Carefully.*

Treatment: Mental health providers do not disclose information to other health care professionals without your written consent.

Payment: Your health information may be used to seek payment from your health plan. For example, your health plan may request and receive information regarding your dates of service, services provided and the medical condition treated. Should your account become delinquent, your information may by used to seek payment through a collection agency.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities of this mental health practice. For example, information on the services you receive may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law Enforcement: Your mental health information may be disclosed to law enforcement when a legitimate subpoena or court order is presented. Further, information regarding physical, sexual or emotional abuse of a child or an elderly person and potentially imminent suicide and/or homicidal behavior, may be released to law enforcement without your knowledge.

Licensing Boards: Revelation that another mental health provider has engaged in a sexual relationship with a client must be reported to the licensing board for that provider. The client involved may remain anonymous in such a report.

Additional Uses of Information: Mental health professionals in this office do NOT mail appointment reminders. Your health information will not be used to provide you with information about treatments through the mail and will not be used for fundraising purposes.

Other Uses that Require Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Individual Rights: You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information.
2. The right to receive confidential communications concerning your medical condition and treatment.
3. The right to inspect and copy your protected health information.
4. The right to amend or submit corrections to your protected health information.
5. The right to receive an accounting of how and to whom your protected health information has been disclosed.
6. The right to receive a printed copy of this notice.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal or state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health Information: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. Nick Barneclo, Ph.D.
397 Mobil Avenue Camarillo, CA 93010

If you believe that your privacy rights have been violated, you should call the matter to my attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person: The name and address of the person you can contact for further information concerning our privacy practice is:

Dr. Nick Barneclo, Ph.D.
397 Mobil Avenue
Camarillo, CA 93010