Mike Zukowski, M.A.
Licensed Marriage and Family Therapist LMFT#52629
8371 Church St., Gilroy, CA 95020
Phone: 408-430-3312 email: gilroycounseling@gmail.com

Name: _____ Today's Date: _____
Address: _____ City_____
Zip_____ Email _____
Age: _____ Birth date:_____
Home phone _____ Work Phone _____ Cell _____
Employed By: _____
Person responsible for referral:_____
May I call your work #? Yes /No Initial here _____
In Case of Emergency Notify: Name: _____Phone _____

FOR MINOR CLIENTS

Mothers' Name: _____ Father's Name:_____

Phone_____ Phone: _____

Birthdate:___/___/___ Birthdate ___/___/___

For divorced parents, indicate custody arrangement:
_____

HISTORY AND BACKGROUND

Marital Status: _____How long? _____Number of previous marriages: Self _____ Spouse_____
Spouse/Partner
Name: _____ Occupation: _____
Number of children: Self: _____ Partner: _____ Legal custody: Yes/No

List children and others living in your household:
Name: _____ Age: _____
_____ Age: _____
_____ Age: _____

Faith (religious orientation):_____
Previous Psychotherapy: Yes/No W/Whom?_____

Physician's Name: _____ Phone: _____

Currently under medical care? Yes/ No
Reason: _____

Major Accidents, Illnesses, Injuries and Dates:
_____

Current Medications:

Significant family mental health and substance abuse
history:_____

Do you authorize release of information to your Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication?
Do you further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to your health plan and coordination of care? Yes/ No Initial here _____

I authorize my insurance carrier to directly pay my practitioner.
Yes/No Initial here _____

Circle any of the following that apply to you:

Headaches	Panic attacks	Heart palpitations	Appetite change
Trouble sleeping	Sexual difficulties	Fearful or shy	Memory problems
Bingeing/Purging	Early a.m. waking	Tension & Anxiety	Paranoid ideas
Drugs & Alcohol	Blackouts	Lack of Joy	Poor self image
Depression	Irritability	Frequently tired	Trouble concentrating
Low energy	Obsessions/Compulsions		Poor anger control
Apathy	Frequent nightmares		Compulsive Pornography

How much alcohol do you drink? _____Day/ Week
How much alcohol does your Spouse/Partner Drink? _____Day/Week
How much marijuana do you use?_____Day/Week
Drug use history:
_____

Have you ever attempted suicide? Yes/No Date(s):
_____

Are you currently experiencing suicidal thoughts? Yes/No Explain
_____

Past or present thoughts or attempts to harm others? Yes/No
Explain_____

Current legal or administrative action pending against you? Yes/No Explain
_____

Have you ever been convicted of a Crime? Yes/No
Explain_____

When you are under stress, or unhappy, what do you do to feel better:

Shop	Gamble	Exercise	Faith	Alcohol
Art	Work	Hobbies	Talk w/friends	Sex
Drugs	Eat	Groups	Other?_____	

Who do you turn to for support?
_____
_____

Why are you coming to counseling? (Please be specific):
_____
_____

What do you hope to accomplish from our time together? What goals would you like to work towards?
_____
_____

Mike Zukowski LMFT MFC#52629
8371 Church Street
Gilroy, California

Treatment Payment Agreement

I, _____ (client name), am signing this agreement to indicate that I am seeking treatment with Mike Zukowski LMFT and that I understand that I will not be covered by my health plan, _____ (insurance plan's name). This treatment starting on _____ (date), will not be paid for by my Insurance plan because:

_____ I am choosing not to use my insurance benefits

_____ is no longer covered, as my benefits to see this provider for this service have been exhausted or terminated

other:_____

If this is the result of a decision by my health plan, I have been informed about the reason, am aware of my plan's formal clinical appeal process, and have elected not to appeal, or am in the process of appealing this decision. Instead, and/or in the meantime, I have chosen to continue treatment with my provider on a self-pay basis starting _____ (date), which is no earlier than the date I have signed on this form.

I agree to pay the full amount of **$180.00 (individual) / $300.00 (couples)** (amount) for counseling sessions on an out- of-pocket basis, and I understand I will not be reimbursed by my insurance unless I am successful on appeal.

I agree that the provider may bill and collect charges for the proposed services at his full fee-for-service rate, or at the rate of **$180.00/$300.00** per session. Plan provider discounts and the plan maximum that applies to medically necessary covered services will not apply and will not limit the amount I may become obligated to pay for the proposed services.

This self-pay agreement applies only to the services listed above. If I move to another level of care, authorization may need to be obtained or another self-pay agreement signed.

I have read and understand this agreement. By signing this agreement, I know that I am creating a binding contract that is legally enforceable against me by this provider. The agreement is in effect only from the date I sign it, until or unless it is rescinded, the agreement may never be retroactive.

_____

Signature of participant Date

_____

Signature of therapist Date

Mike Zukowski, MA LMFT #52629

8371 Church St., Gilroy, CA 95020 Phone: 408-430-3312 Fax: 408-848-3354

TREATMENT DISCLOSURES

All information between practitioner and client is held strictly confidential. There are legal exceptions to this:

1. The client authorizes a release of information with signature.
2. The client's condition becomes an issue in a lawsuit.
3. The client presents a physical danger to him/herself.
4. The client presents a danger to others.
5. Child or elder/dependent adult abuse or neglect is suspected. This now includes viewing or downloading underage child/minors pornography or photos (sexting) AB1775.

In the latter measures can be taken. All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency.

INITIAL HERE_____

Financial Terms

Fee arrangements will be made directly with the practitioner. Unless otherwise arranged, payment in full is due at the time of each session. The client is ultimately responsible for 100% of the fee.

INITIAL HERE_____

Insurance Coverage and Co-payments

You are responsible for obtaining prior authorization for treatment from your insurance carrier. The billing personnel will bill your insurance as a courtesy if you request it. If there is a co-payment, it is due at the time of each session. Any portion of the fee that your insurance does not cover, you are responsible to pay.

INITIAL HERE_____

Legal Proceedings

I agree to not to involve my therapy session or therapy notes in court proceedings. I understand that my therapist will not be asked to participate in any court proceeding on my behalf. (see Litigation Limitations)

INITIAL HERE_____

Cancellation and Missed Appointments Policy

Scheduled appointment times are reserved especially for you. If an appointment is missed or is cancelled with less than **48 hours notice,** you will be billed according to the scheduled fee. Insurance plans do not pay for these fees and you will remain responsible for them.

INITIAL HERE _____

Emergency Access

This practitioner cannot guarantee availability after hours. He will make every effort to answer an emergency call as soon as possible. In the event of an emergency ***do not wait for his call*.** When immediate intervention is required, you can call: Life threatening danger, **call 911** or go to your nearest Emergency Room
Crisis Line 1 (855) 278-4204 or Child Protective Services (408) 683-0601.

Consent for Treatment

I authorize and request my practitioner to carry out psychological treatment and/or diagnostic procedures, which, now or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me**.**

INITIAL HERE _____

PATIENT SIGNATURE_____DATE_____
WITNESS SIGNATURE_____DATE _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it in effect. This Notice takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For Example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operation. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that there is child, elder, or spousal abuse. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

To Avoid Harm: We may disclose your health information to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public. We may also be compelled or permitted to disclose by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $2.00 for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-mont period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in and emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or a t alternative locations, you may complain to **Mike Zukowski.** You also may submit a written complaint to the U.S. Dept. of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We support you right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Dept of Health and Human Services.

I herby acknowledge that I have received and have been given an opportunity to read a copy of Mike Zukowski's Notice of Privacy Practices.

_____ Date _____
Signature of Client

_____ Date _____
Signature of Parent, Guardian, or Personal Representative (Please State)

_____ Client Refuses to Acknowledge Receipt

Signature of Privacy Officer _____ Date _____

Address: 8371 Church St., Gilroy, CA 95020
This form is educational only, does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of March 27,2002. Subsequent law changes may require Form revision.)

Reminders and Payment

Thank you so much for being a part of my clinical practice. I am excited to integrate some new services to make things run even more smoothly for you! The new system will give us the option of setting up automated e-mail, text, or phone reminders if you would prefer them.

The system is completely private and HIPAA compliant and will provide additional safeguards beyond what a traditional paper file can provide.

At this stage, I am asking clients to think about the following questions: (Choose one)

Would you like automated **phone/voice** reminders? Y/N

If so, include the number here _____

Would you like **text** reminders? Y/N

If so, include your mobile number **:** _____

Would you like **e-mail** reminders? Y/N

If so, include the e-mail you would like to use here: _____

I will also be offering bank-card and credit card billing as part of the new service. (Which means no more having to waste time in session messing with checks or swiping cards).

Include the credit card you would like placed on file below. Please note: I will enter this information and immediately shred this document. As per the informed consent, my rates are $180 individual/$300 couples per 50 minute session and my cancellation policy is 48 hour notice or a session fee will be collected.

Credit card information: (circle one)
Mastercard/ Visa/ AMEX/ Discover

Card #_____ Exp Date:_____

3 digit code:_____ Zip Code: _____

Name on Card:_____

Signature: _____

Insurance Information- Mike Zukowski LMFT MFC#52629

If you plan to use your insurance benefits to obtain treatment please provide the following information in order to process the claim. It is advised that you speak with your insurance carrier to verify coverage prior to your first visit. Thank you.

Name of Client _____ ID# _____

Name of Insurance Company _____

Claims and Billing address for your insurance (where do we send the bills?)

_____

Name of Insured (if not client) _____ ID#_____

Relationship of Insured to client (i.e. self, spouse, child, etc)_____
Client's date of birth: _____/_____/_____

Insured's date of birth: _____/_____/_____

Insured's Employer:_____

Insurance phone number (on back of card, may say "MH/SA Benefits", "Eligibility and Benefits", "for preauthorization" or "customer service") _____

What is your co-payment for sessions?_____

Deductible- Yes/No If yes, amount met to date (i.e. $350 of $500)_____

Do you know how many sessions are allowed per calendar year?_____

We will gladly bill your insurance for you and typically are able to confirm payment and coverage within a few weeks after service. Finding out the above information and whether or not your insurance accepts Mike Zukowski LMFT as an "in-network" or "out of network" provider will help you to avoid any surprises in the amount due. It is our goal to help you use your benefits wisely and effectively to help meet your counseling needs.

GOOD FAITH ESTIMATE from Mike Zukowski, LMFT

Pursuant to the No Surprises Act (HR133, Title 45 Section 149.610), this form is used to provide a current or prospective client with a "Good Faith Estimate" (GFE) of expected charges for services to be provided. This template is a hybrid of ones recommended by several therapist professional associations.

Client Name:	Client Date of Birth:
Client Address:	
Client Phone #: ( )	Client Email:
Diagnosis Codes (if known):	
Services Requested (Type and Codes): CPT 90837, 90834, 90847, 90871	

Provider Name: Mike Zukowski, LMFT	License #:LMFT 52629
Provider Address: 8371 Church St., Gilroy, CA 95020	
Provider Phone #: (408) 430-3312	
Provider Tax ID: 46-1695728	Provider NPI #:1477899854

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider listed, nor does it include any services that may be recommended during treatment to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

The fee for a 45-50 minute individual psychotherapy visit (in person or via telehealth) is $170. For couples/conjoint visits a 45-50 minute session is $200. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs. Based on the per visit fees cited above, the following are expected charges of psychotherapy services:

Number of Weeks	Total estimated charges for 1 session per week	Total estimated charges for 2 sessions per weeks
1 Week of Service	$180	$360
12 Weeks of Service (Approx. 3 Months)	$2160	$4320
24 Weeks of Service (Approx. 6 months)	$4320	$8640
36 Weeks of Service (Approx. 9 months)	$6480	$12960
48 Weeks of Service (Approx. 12 Months)	$8640	$17280

You have a right to dispute a bill if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges). Initiating the dispute process will not adversely affect the quality of services rendered to you. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call HHS at (800) 368-1019. Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Date of this Estimate _____

NOTICE TO CLIENTS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

LITIGATION LIMITATIONS (Cost of involving Mike Zukowski LMFT in legal proceedings)

Due to the nature of the therapeutic process, and the fact that it often involves making a full disclosure with regard to many matters, which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither the patient nor the patient's attorney(s), nor anyone else acting on the patient's behalf will call on the therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

Patient understands that Mike Zukowski LMFT, has a strict policy that he will not prepare, write, or administer statements, letters, or positions on behalf of the patient or the patient's agent or representative such as lawyer, employer, or parole officer. **Any such request from the patient shall be denied.**

By entering into a professional relationship with the therapist, the patient indicates his/her understanding of this limitation and agrees not to introduce the treatment, evaluation, diagnosis, or other information pertaining to our professional relationship into any legal proceeding. If the patient chooses to do so, he/she agrees not to hold the therapist or anyone with whom the therapist is associated responsible for the outcome or effects of the patient's disclosure of his/her information.

In the event the patient becomes involved in legal proceedings and the therapist is required to participate by law, or any other situation that requires what is considered to be legal work of any kind on the part of therapist, this work shall be billed at the rate of $750.00 per hour **with a four-hour minimum** ($3,000) for any legal appearances, including court appearances, depositions, or attorney-meetings. There is a retainer fee of $7,500.00, which must be paid **PRIOR** to the commencement of any work related to the legal proceeding on behalf of the patient, and needs to be replenished each time it is exhausted. Legal work requires extra time, special care, and outside professional consultation to ensure that proper procedure is followed. Therefore, this higher fee applies to all legal work performed, including but not limited to future therapy sessions, telephone calls, reviewing documents, preparing reports, consultation with legal representation, and appearing in court.

I, the patient, understand the above:

Signature: _____ Date: _____