Date:_____ **Clarence Cisneros-Jones, LCSW 94006**

New Client Registration

YOUR NAME:_____ Social Security Number: _____-_____-_____

Date of birth: _____/_____/_____ Relationship status: _____Height: ____'____" Weight_____

Address:_____ City:_____ Zip:_____

Home Phone: (_____)_____ Work: (_____)_____

Cell Phone: (_____)_____ Other: (_____)_____

E-mail (print neatly!):_____ Alternate e-mail:_____

Occupation:_____ If employed, employer name:_____

If in relationship, how long? _____ Previously married? _____If so, how often, and how long?_____

SPOUSE OR SIGNIFICANT OTHER ***(complete even if s/he is not participating in therapy)***

Name:_____ Social Security Number: _____-_____-_____

Date of birth: _____/_____/_____ Relationship status: _____Height: ____'____" Weight_____

Address (if not living with you):_____ City:_____ Zip:_____

Home Phone: (_____)_____ Work: (_____)_____

Cell Phone: (_____)_____ Other: (_____)_____

E-mail:_____ Alternate e-mail:_____

Occupation:_____ If employed, employer name:_____

Previously married?_____ If so, how often, and how long?_____

Who else lives in your home? Name_____ Age:_____ Relationship:_____

Name_____ Age:_____ Relationship:_____

Name_____ Age:_____ Relationship:_____

Name_____ Age:_____ Relationship:_____

Any children who live outside the home? (give names and ages)_____

Insurance Plan:_____ **Full Name of primary insured**:_____

If primary insured is not you, give their date of birth: _____/_____/_____ **and their employer**:_____

Emergency Contact (not partner): _____ Phone:(_____)_____ Relationship:_____

Primary Doctor::_____ Phone: (_____)_____

Doctor's address:_____ City:_____

Psychiatrist (if any): _____ Phone: (_____)_____

Psychiatrist's address:_____ City:_____

Health Issues/Allergies: _____

_____

Medications and Over-the-Counter Drugs taken regularly (include dosages and why you take them):_____

_____

Alcohol: Average number of drinks per week_____ Average number of drinks when you drink:_____

Marijuana / other non-prescription drugs (drug you use, how much use, how often): _____

Has anyone ever been concerned about your alcohol or drug use?_____ If so, who?_____

Cigarettes: Average use per day:_____ Desire to quit?_____

Who referred you to my practice? _____ **Did you look at my website before coming?**_____

Word or sentence to describe your life or how you feel:_____

Clarence Cisneros-Jones, LCSW
Licensed Clinical Social Worker

4010 Moorpark Avenue #118, San Jose, California 95117
408.781-0525; cisnerosjoneslcsw@gmail.com

TREATMENT AGREEMENT

FEES: The fee per 50-minute session is $_150. This is payable at the time of our session, unless I am billing your insurance, in which case you must pay your copayment and/or deductible at the session.

CANCELLATION: Sessions are by appointment only, Tuesdays through Fridays. While I hate charging for missed sessions, I do reserve that time for you. Therefore, you will be charged $_50_ (not just a copayment) for missed sessions or for those cancelled without 24-hour notice, except in medical emergency. Insurance will not pay for missed sessions. If you must cancel, leave a voice mail and an email. Since your time is also valuable, if I forget a session, you get one session free.

INSURANCE: It is essential that you tell me about all possible insurance plans you have that might cover my services (ex. if you have Medicare in addition to a secondary policy, or coverage through your work and a family member's work). Please be aware that I will be required to provide a diagnosis on invoices and claims, and coverage may be limited to certain mental conditions. Even if you have coverage for unlimited sessions, health plans may review treatment, limit coverage, and request treatment notes. While I may check coverage for you, you are responsible for verifying and understanding the limits of your coverage. Although I am happy to assist your efforts in obtaining insurance reimbursement, I am unable to guarantee whether your health plan will provide payment for the services provided.

If I am a provider with your plan: I will submit claims for you, but at our session you must pay any copayment or coinsurance or any portion not covered by your plan. There may be a deductible (an amount you will need to pay out of pocket) before your plan begins coverings sessions. If insurance does not pay as expected, you remain responsible for the balance.

If I am NOT a provider for your plan: You will pay me in full at the session. I can give you an invoice if you wish to seek reimbursement from your plan, though many plans do not cover sessions with a provider who is not in their network.

PLEASE SIGN THE FOLLOWING IF USING YOUR INSURANCE OR EMPLOYEE ASSISTANCE PROGRAM:

"I authorize the release of any information necessary (including notes, treatment summaries and diagnosis) to process insurance or Employee Assistance claims, to prove medical necessity for treatment, to request additional sessions, or to comply with mandated quality control or administrative chart reviews from the insurance plan."

(Sign here) :**X** _____

(If applicable, second client sign here): _____

"I authorize payment of benefits to Clarence Cisneros-Jones, LCSW

(Sign here): **X** _____

CONFIDENTIALITY: What you say in therapy, your records, and your attendance are all protected and kept confidential. Exceptions include when your records are subpoenaed for legal reasons, when reporting is required or allowed by law (ex. suspected child abuse or neglect, extreme danger to self, suspected elder abuse, or danger to others), when you give written permission to release information, and other exceptions outlined in my *Notice of Privacy Practices.*

IN AN EMERGENCY: Contact me via e-mail and voicemail, then call my 24-hour answering service at 650-398-4557. Tell them it is an emergency; the service will try to reach me or a licensed therapist. You may also go to the emergency room or dial 911.

E-MAIL/SOCIAL MEDIA: In general, e-mail is the quickest way to reach me. I use e-mail to arrange/change appointments. You can also schedule a session at my online calendar at www.calendly.com/barbgris. I do not do therapy by e-mail or video. When cancelling, please leave BOTH a voicemail and e-mail. Please do not e-mail me information related to your therapy, as e-mail is not completely confidential, and Important issues should be reserved for sessions. Be aware that e-mails between us become part of your legal record. I do not accept friend requests or contact requests from clients on social networking sites (Facebook, LinkedIn, etc) out of concern for your confidentiality and my privacy. It may also blur the boundaries of our therapy relationship.

ENDINGS: If you are unhappy with any aspect of therapy, please don't just leave – I ask that you talk to me to see if we can work it out. Even if we can't, endings usually feel better this way. Of course, you may end therapy at any time, and I am happy to assist with referrals. It is my ethical duty to provide therapy only when I feel you are actively participating and benefiting from the sessions. I may end treatment if there have been repeated no-shows, late-cancellations, repeated treatment interruptions, or for lack of payment.

REFERRALS/GROUP: A referral to another provider may become necessary if it becomes clear in my opinion that your issues would be better treated by a professional with different expertise. It is unethical for me to practice beyond the level of my competence, education, training, or experience. I am not responsible for the care received from professionals to whom I refer you. Agreements made between you and I do not involve other professionals in the office suite, who each operate independent solo practices, and are not part of a group.

PATIENT RIGHTS: A list of your client rights is posted in the waiting room. You have the right to ask any questions about your treatment or refuse to participate in treatment at any time. This office does not discriminate in the delivery of health care services based on race, ethnicity, national origin, citizenship or immigration status, religion, gender, gender identity, age, mental/physical disability, medical condition or history, sexual orientation, evidence of insurability, or payment source.

By signing below, you acknowledge you have read this Agreement, and you acknowledge receipt of my *Notices of Privacy Practices*. My *Notice of Privacy Practices* provides information about how I may use and disclose your private health information. I encourage you to read it in full. My *Notice of Privacy* Practices is subject to change. If I change my Notice, I will give you a revised Notice. If you have left treatment, you may obtain the revised notice from me at the above address and phone number.

If you have any questions about the Notice, or any of the above, please feel free to ask.

X_____ **X**_____ **X**_____

Signature | Printed Name | Date

_____ _____ _____

Signature, second client (if applicable) | Printed Name, second client (if applicable) | Date

Clarence Cisneros-Jones, LCSW
Licensed Clinical Social Worker

4010 Moorpark Avenue #118, San Jose, California 95117
408.781-0525; cisnerosjoneslcsw@gmail.com

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 REVIEW IT CAREFULLY.

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. **For your treatment**. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.
2. **To obtain payment for your 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 to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.
3. **For health care operations**. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization.

1. **Psychotherapy Notes**. I do not keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501; rather, I keep a record of your treatment and you may request a copy of such record at any time, or you may request that I prepare a summary of your treatment. There may be reasonable, cost-based fees involved with copying the record or preparing the summary.
2. **Marketing Purposes**. As a psychotherapist, I will not use or disclose your PHI for marketing purposes**.**
3. **Sale of PHI**. As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations mandated by law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including**,** ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

(continued on back)

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.

YOUR RIGHTS YOUR REGARDING YOUR PHI

You have the following rights with respect to your PHI:

1. **The Right to Request Limits on Uses and Disclosures of Your PHI**. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. **The Right to Choose How I Send PHI to You**. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. **The Right to See and Get Copies of Your PHI**. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you.
   I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.
5. **The Right to Get a List of the Disclosures I Have Made**.
   You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. 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. 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.
6. **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 from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. **The Right to Get a Paper or Electronic Copy of this Notice**. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice, and my address and telephone number are: _____.

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
2. Calling 1-877-696-6775; or,
3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on _____.