If filling out on your computer, please download before filling out;
fill out the downloaded copy; and remember to SAVE periodically and after finishing.

MARINA BYSTRITSKY, Ph.D.
Clinical Psychologist

2171 Union St, #4 San Francisco, CA 94123
www.marinatherapysf.com (415) 458-2725

You have an appointment with Marina Bystritsky, Ph.D.

If you need to cancel this appointment, please give me **48 hours' notice.** Canceling with less notice will subject you to your full appointment fee. This must be paid before a change in this appointment can be made. I schedule 50 minutes for this appointment and last-minute cancellation keeps me from serving others who are waiting to see me.

I most kindly ask that you do not cancel this appointment without appropriate notice.

It is very important that you fill out and bring these forms with you. There is a fair amount of information needed and it may take a while to fill out all this information. If you have any other information about past evaluations, please bring a copy.

A credit card on file is required for all new patients.

If you are planning to use your insurance for reimbursement, please contact your insurance to find out your coverage for out of network providers. A credit card is required to guarantee payment and will not be needed on your first visit. I'm unable to see you without a credit card on file.

Thank you.

Marina Bystritsky, Ph.D.

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Confidential Client Information

Date of Initial Appointment _____

Client's Full Name_____

Address _____

City _____ State _____Zip _____

Home Telephone _____ Cell Number _____

Work Number _____ Email Address _____

Date of Birth _____ Gender F / M Social Security Number _____

If client is an adult, please complete the following information:

Marital Status _____ Spouse/Significant Other/Partner's Name _____

Occupation _____ Highest Level of Education _____

Do you have children? Y / N Names and Ages _____

If client is a child, please complete the following information:

Name of Parent(s) or Guardian(s) _____ Phone _____

Name of Noncustodial/Other Parent _____ Phone _____

Is the Other Parent/Guardian aware of and supportive of counseling? _____

Name of Siblings _____

Others in the House _____

Child's School and Grade Level_____

Emergency Information

Person to contact in case of emergency _____

Telephone number_____ Relationship_____

Referral Source

Who suggested you contact me? _____

If from another person, initial here _____ if it's okay for me to contact that person to thank them.

Medical History

Physician's name _____ Phone Number _____

Are you experiencing any health problems? Yes / No If yes, please describe:

Are you taking Medication? Y / N If yes, please describe _____

(If you are taking any psychotropic medication, please fill out Authorization to Release Information form to allow me to talk to the doctor who prescribes it for you)

Counseling History

Have you previously seen a counselor/therapist/psychologist/psychiatrist? If yes, please describe:

Name of therapist	Dates, duration	Reason for treatment	What type of therapy? Was it helpful?

Please check any of the following difficulties that apply:

Abuse/Neglect	Health Problems	Psychosis
Acting out Behaviors	Hyperactivity	Relationship Difficulties
Alcohol/Drug Use	Impulsivity	School problems/Poor Grades
Anger/Temper Issues	Insomnia/Sleep Difficulties	Self Control
Anxiety/Nervousness or Fears	Irritability	Sexual Problems/Sexuality
Career Difficulties	Legal Issues	Issues
Concentration Problems	Loneliness	Shyness
Depression	Low Self Esteem	Social Skills Deficits
Divorce/Separation	Memory	Stress
Domestic Violence	Nightmares	Suicidal Thoughts or Actions
Eating Problems/Disorder	Odd Behavior	Tiredness
Family Conflicts/Dysfunction	OCD	Thoughts of Hurting Others
Financial Difficulties	Panic	Trauma History
Gang Involvement	Parenting Difficulties	Truancy
Health Problems	Promiscuity	Other

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Psychological Services Contract

Welcome to my practice. I would like to thank you for the opportunity to serve your counseling needs. This document contains important information about my professional services and business policies. Please read it carefully and feel free to discuss any questions that you might have with me in our initial meeting. When you sign this document, it will represent an agreement between us.

INFORMATION ABOUT YOUR THERAPIST:

I am a licensed psychologist in the State of California (license PSY 18733). I received my Doctorate from the University of California Los Angeles. I also have Bachelor's degree from New York University.

THE PROCESS OF THERAPY AND SCOPE OF PRACTICE:

Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness. Always feel free to ask questions at any time. I will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly.

During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or disappointed. There are no guarantees about what you will experience. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

During the course of therapy, I am likely to draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, cognitive, mindfulness, developmental (adult, child, family), or psycho-educational. I provide neither custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within my scope of practice. You are entitled to receive information from me about my methods and techniques used in therapy. Although it is difficult to predict the exact length of therapy, after first session I can give you an estimate of the average evaluation and treatment duration for conditions similar to yours. You have the right to know about alternative types of treatment. You may seek a second opinion or terminate treatment at any time.

CANCELLATION POLICY:

I will generally schedule one 45- to 50-minute session per week at a mutually agreed upon time, although sometimes sessions will be longer or more frequent. If you are unable to attend a scheduled session, **you must call 48 hours in advance to avoid being charged the full appointment fee.** Cancellations should be made during business hours (Monday through Friday 9am to 6pm). The appointment might be considered cancelled if you arrive more that 15 minutes late after the scheduled appointment time.

TELEPHONE & EMERGENCY PROCEDURES:

If you need to contact me between sessions, please leave a message at the answering service (415) 458-2725. I will make every effort to get back to you as quickly as possible. I check my messages a few times during the daytime only, unless I am out of town. If you are unable to reach me and are in crisis, please call 911 or proceed to your nearest emergency room. If I travel out of town or am unavailable for any reason, an announcement will be made on the outgoing message of my voicemail system. If I am unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

You may feel free to email me if you would like. Please only send e-mails regarding non-urgent matters, since several days may pass before the e-mail is retrieved and since some e-mails are returned undeliverable. In addition, please be advised to never send via e-mail any information that you would like to keep confidential. As is true of any e-mail, confidentiality can never be guaranteed. For all urgent matters and for any communication of confidential information, please only use telephone and voicemail.

PROFESSIONAL FEES AND PAYMENT POLICIES:

Clients are expected to pay agreed upon fee, due at the beginning of each scheduled session. Telephone conversations longer than 10 minutes, site visits, writing and reading of reports, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify me if any problems arise during the course of therapy regarding your ability to make timely payments. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or arrange for payment plan. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, I can provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement, if you so choose. As indicated in the section, *Health Insurance & Confidentiality of Records,* you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, I may use legal or other means (courts, collection agencies, etc.) to obtain payment.

TERMINATION:

As set forth above, after the first couple of meetings, I will assess if I can be of benefit to you. I don't accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals whom you can contact. If at any point during psychotherapy, I assess that I am not effective in helping you reach the therapeutic goals or that you are non-compliant, I am obligated to discuss it with you and, and if appropriate, to terminate treatment. In such a case, I would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. If, at any time, you want another

professional's opinion or wish to consult with another therapist, I will assist you with referrals, and, if I have your written consent, I will provide her or him with the essential information needed. I, also, may discontinue treatment if you neglect to make payments for the services delivered. You have the right to terminate therapy at any time. If you choose to do so, and if appropriate, I will offer to provide you with names of other qualified professionals.

CONFIDENTIALITY:

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

When Disclosure is Required or May Be Required by Law: Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to me that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by me. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I am authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client. Minors seeking therapy services should be aware that the law may provide parents the right to examine your treatment records. It is my policy to work with teens and their parents to come to an agreement about what information can be shared and what information the teen would prefer to keep private.

Emergency: If there is an emergency during therapy, or in the future after termination, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct me, only the minimum necessary information will be communicated to the carrier. I have no control over, or knowledge of, what insurance companies do with the information I submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to hacking and unauthorized access. Medical data has also been reported to have been legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position.

Litigation Limitation: 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 you nor your attorney(s), nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

Consultation: I consult regularly with other professionals regarding my clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

E–mails, Cell Phones, Computers, and Faxes: It is very important to be aware that computers and email communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Faxes can easily be sent erroneously to the wrong address. Emails, in particular, are vulnerable to unauthorized access due to the fact that Internet servers have unlimited and direct access to all emails that go through them. It is important that you be aware that emails, faxes, and important texts are part of the medical records. Additionally, my emails are not encrypted. My computers are equipped with a firewall, a virus protection, and a password and I also back up all confidential information from my computers on a regular basis. Please notify me if you decide to avoid or limit in any way the use of any or all communication devices, such as email, cell phone, or faxes. If you communicate confidential or private information via email, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters via email. Please do not use email or faxes for emergencies.

By signing below, I acknowledge that I have read and understand the information presented in this document and that I give my consent for treatment to Marina Bystritsky, Ph.D. This consent shall remain in effect for the duration of my therapy or until I provide written revocation of my consent to Marina Bystritsky, Ph.D.
I further acknowledge that I have received a copy of this letter for my own records.

_____

Client/Guardian Name *(printed)*

_____ _____

Client/Guardian Signature Date

_____ _____

Marina Bystritsky, Ph.D. Date

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Informed Consent for Online Video Sessions and Teletherapy

Meetings via telephone or video chat offer an alternative to face-to-face therapy when in-person meetings are not possible. There are many potential benefits to this technology including continuation of therapy during client travel periods, flexibility of scheduling, and convenience. The same rules governing the confidentiality of our face-to-face meetings apply to all forms of teletherapy. All confidentiality rules will apply. In addition, all existing laws regarding patient access to medical information and copies of medical records apply.

However, there are certain limitations and possible hazards of therapy conducted in this manner. There are differences between teletherapy and traditional face-to-face therapy. Some of these differences include:

- Teletherapy may not work as well as face-to-face psychotherapy because of the lack of visual contact, especially if you are using voice only, and not picture-plus-voice video.
- Technical problems may interrupt or degrade the quality of sessions. I reserve the right to terminate any session if I feel that communication quality is inadequate.
- Teletherapy sessions will likely not be reimbursed by your insurance company.
- Confidentiality cannot be absolutely guaranteed, as breaches in online security are possible.

I will make my best effort to ensure the privacy of our communications by being in a secure, private office, similar to our in-person meetings. It should be understood that this is an adjunct to therapy – usually for the purpose of avoiding a break in treatment – not a replacement and in-person sessions are always preferable to online or telephone sessions when possible.

I'm typically not available for emergencies online or by telephone. Should you encounter an emergency, please contact the accepted emergency number for your location (usually 911 in the United States).

By signing the consent, you agree to

- Make every effort to ensure your privacy and the quality of our session by being in a private (not public) space
- When using Doxy, Skype, Zoom, iChat, Google Hangouts or similar video service, you make an effort to ensure a high-quality internet connection.
- Hold me harmless against any loss or damages due to someone listening in on our session.
-

You are free to withdraw this consent at any time without affecting the right to future treatment.

I have read this consent. I understand the contents. I have been provided the opportunity to ask questions.

_____

Name *(printed)*

_____ _____

Signature Date

MARINA BYSTRITSKY, Ph.D.
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Credit Card Payment Authorization
(Required, please fill Completely)

Name of Client _____ Date _____

This document authorizes Marina Bystritsky to automatically bill the credit card (below) for charges associated with my treatment or the treatment of the patient named above.

I_____(name of cardholder) hereby authorize Marina Bystritsky to keep my credit card information provided below on file and charge my credit card following office visits and phone consultations. In addition, I authorize Marina Bystritsky to charge my credit card fees for missed appointments or late cancelations. I understand that such amounts charged to my credit card will appear on my credit card statement.

Card Type: ○ Visa ○ MasterCard

Card Number _____ Exp. Date _____

Name on Card _____ Security Code _____

Billing Address _____

City _____ State _____ Zip _____

Email Address _____

Signature of Cardholder _____

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Authorization to Release and Exchange Information

If you have seen other professionals regarding this problem and would like me to co-ordinate with them, please provide me with this consent. For young patients, his or her pediatrician must be added.

Client's Name _____

Is Client over 18 years old? ◯Yes ◯No

If No, Guardian's Name _____

I'm requesting you to provide all pertinent information about the patient listed above to Marina Bystritsky, Ph.D. This information may be in electronic form such as a PDF file sent via email or by hard copy mailed to above address.

I'm giving my consent to both parties to share and exchange information as appropriate for the care of the patient.

Name of person or organization_____
Profession/Specialty _____
Address _____ City _____
State, Zip _____Phone _____Email _____

Name of person or organization_____
Profession/Specialty _____
Address _____ City _____
State, Zip _____Phone _____Email _____

Name of person or organization_____
Profession/Specialty _____
Address _____ City _____
State, Zip _____Phone _____Email _____

Name of person or organization_____
Profession/Specialty _____
Address _____ City _____
State, Zip _____Phone _____Email _____

_____
Name *(printed)*

_____ _____
Signature Date
Relationship to client (if other than client) _____