

Please note:

The following forms need to be completed prior to your meeting with Dr. Goodwin. Once you complete these forms, email them to Dr. Goodwin. If you prefer, you can complete the forms at home and print them and bring them with you to your initial appointment.

Instructions for emailing the forms:

Since the documents contain personal health information, you must protect the document. This is a Word document and so it is easy to do this. Please do the following:

- 1. Go to the “Tools” menu in Word.**
- 2. Choose “Protect Document.”**
- 3. Choose any password and type it in the “to open the document” box.**
- 4. Hit “enter”**
- 5. Re-type password into the box provided after you hit “enter.”**
- 6. Save the doc.**
- 7. Email the doc to Dr. Goodwin at DrG@DrAlanGoodwin.com**
- 8. Text Dr. Goodwin the password to enable him to open the document (Dr. Goodwin’s text line is 323-445-8900).**

Intake Form

(Please complete all sections prior to meeting with Dr. Goodwin)

Name: _____ Date: _____

Mailing address: _____
No. & Street
City
Zip Code

Telephone Numbers: Home: _____ Cell: _____

Is it O.K. to text a message to you about your appointment? Y N Birthdate: _____

Email: _____ o.k. to use to schedule? Y N

Occupation: _____

Physician: _____
Name
Phone

Psychiatrist: _____
Name
Phone

Education completed (✓all that apply)			
	High School		M.A./M.S.
	Assoc. Deg		J.D.
	BA/BS		M.D.
	M.A./M.S.		Other Doctorate

Emergency contact: _____
Name
Phone

Live with: Alone Partner Roommate(s) Family Kids Parents

Sexual Orientation: Bisex. Gay/Les. Hetero. Other Prefer not to say

Ethnic Identity: _____ (e.g., *African Amer., Amer. Indian, Asian, Euro-American/Cauc., Hispanic/Latino/a, Middle-Eastern, Pacific Islander, Other*)

If you'd like, state your Gender Identity: _____

Medications-past: _____
(please continue on back, if necessary)

Medications-current: _____

Who referred you to my practice? _____

**It is customary to thank the referring person. If you feel comfortable with me doing that, please sign, below. No other information will be disclosed. This is entirely voluntary.*

Signature: _____ Date: _____

Please list any emotional disorders you know of in your immediate family:

(Continued on back)

TIP Clinic, Inc.

Alan Goodwin, J.D., Ph.D.

Licensed Psychologist, PSY19421

Please list any significant life events you've experienced (deaths, divorce, traumas, etc.):

Please list any significant physical concerns you are confronting:

Please check any of the following that has occurred even once **during the past 4 weeks**:

- | | | |
|--|---|--|
| <input type="checkbox"/> thoughts of suicide | <input type="checkbox"/> drug use/abuse | <input type="checkbox"/> changes in appetite |
| <input type="checkbox"/> sadness | <input type="checkbox"/> low energy | <input type="checkbox"/> weight gain or loss |
| <input type="checkbox"/> angry outbursts/impulses | <input type="checkbox"/> low interest in activities | <input type="checkbox"/> muscle aches |
| <input type="checkbox"/> relationship difficulties | <input type="checkbox"/> sexual difficulties | <input type="checkbox"/> upset stomach |
| <input type="checkbox"/> conflicts with others | <input type="checkbox"/> persistent worries | <input type="checkbox"/> headaches |
| <input type="checkbox"/> sleep problems | <input type="checkbox"/> blurred vision | <input type="checkbox"/> poor concentration |
| <input type="checkbox"/> social isolation | <input type="checkbox"/> nightmares | <input type="checkbox"/> self-injury |

Please describe what is prompting you to seek psychotherapy at this time:

Thank you for providing this information.

When you finish, please be sure to switch the light switch on the wall to the "on" position, to let me know you have finished.

CONSENT FOR TREATMENT AGREEMENT

This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them prior to your signing this document. Once you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy (“talking therapy”), is most effective when it involves a collaboration between the client and therapist. Best outcomes occur when the client practices new behaviors between sessions and continues the process of gaining deeper insight into the issues discussed. Psychotherapy often helps people to build better relationships, find solutions to problems, and reduce feelings of distress. In the process of healing, psychotherapy sometimes uncovers unpleasant feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness.

The first few sessions of psychotherapy involve an evaluation of your needs. By the end of the evaluation, I will describe my initial impressions of the work that I believe would be beneficial. It is vital that you evaluate this information and decide whether you will choose to work with me. Therapy involves commitments of time, money, and energy. In making these commitments, it is best that you exercise care. If you have questions about my procedures, we should discuss them thoroughly. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional who can provide you a second opinion.

MY PARTICULAR TREATMENT

There are many types of psychotherapy treatment. **I may not be the right provider to help you to address your current treatment needs.** Please read the following section to assist us to assess whether my treatment is appropriate for you at this time. If I am not an appropriate choice given your current needs, I will assist you to find a provider whose services better suit your current needs.

My particular treatment involves ONLY reserved meeting times. I am typically NOT available to assist you when you have not reserved my time.

Crisis Response

In assessing whether my practice will suit your needs, please note that **I am NOT able to provide emergency response assistance unless the crisis occurs during a psychotherapy session.** My practice operates independently of a medical center and is therefore not designed with the expectation of responding to crises as a normal course of practice.

Psychological crises are not entirely predictable but we can make a reasonable effort to assess their likelihood. In order for my practice to be a good fit for your treatment needs, the following will be true:

1. It is reasonable to expect that a future psychiatric hospitalization is unlikely, AND
2. Individuals who live locally are willing and able to assist you in a psychiatric emergency, AND

3. Any past intensive psychiatric treatment was voluntary.

As a condition of our treatment agreement, it is necessary that you agree to inform me of any past mental health crises you have experienced, including psychiatric hospitalizations. It will also be necessary that you agree to promptly inform me if you believe the likelihood you will experience a mental health crisis has increased. Complete transparency on this subject is necessary.

Please note: I do not provide emergency assistance in response to a telephonic or text message.

For your own safety, in an emergency occurring outside of my office, you should not seek my immediate assistance. Instead, see instructions, below.

EMERGENCIES

For immediate help during a mental health emergency you should **call 911, 1-800-SUICIDE (a daily, 24-hour line), or any resources listed on the Emergency Resources sheet I provided you with this consent form, prior to your initial appointment.** You may also contact your health insurer's 24-hour care line, your local police department, other phone lines dedicated to emergency response, or the nearest emergency room (ask for the psychologist or psychiatrist on call).

AFTER you, or a person helping you, has secured emergency help and the crisis has passed, please inform me via a text message at 323-445-8900. To preserve your privacy, simply send a brief message such as "please call asap." I will respond as soon as I am able.

MEETINGS

Psychotherapy sessions are typically 45 minutes but they may be longer, by prior arrangement. Sessions are generally weekly. The frequency of appointments and the length of individual sessions vary from person to person and may vary during the course of treatment. We make decisions in this regard together, during the collaborative treatment process.

MISSED APPOINTMENTS

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide **48 hours of advanced notice** of the cancellation, **regardless of the reason for the cancellation.** This policy **includes sudden illnesses, accidents** that are no fault of your own, **weather conditions, and issues caused by nature or other people.** This policy is not intended to represent a punishment. This is simply a means of enabling me to account for a time when I was present for you and was therefore unable to work with a different person.

PROFESSIONAL FEES

The fee for a 45 minute psychotherapy appointment is \$250.00. There are a limited number of spaces in my practice dedicated to Medicare-funded psychotherapy. Also, I dedicate some of my time to providing psychotherapy to reduced fee clients. These spaces are generally reserved for those clients who do not have family resources to assist them and/or for those who are confronting multiple health-related challenges or work-related crises that are impacting on their ability to pay. **The charge for other professional services you may request of me is \$250.00 per hour,** which will be charged by the quarter hour. Other services include **report writing, telephone conversations** lasting longer than ten(10) minutes, attendance at

meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you, instead. Professional records can be misinterpreted by untrained readers. If you wish to see your records or to have them sent to someone, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time I spend responding to information requests.

-Attorney involvement and Litigation-

Please note: I will gladly provide you with records of our work together, should you ever ask me for that. Due to my identity as a licensed attorney, in order to prevent role conflicts, it is my policy to focus exclusively on my role as a treatment provider, as opposed to being an advocate or an independent assessor. As a result, I resist voluntarily participating in any legal dispute involving a client. I have a policy of no communication with a client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in a legal matter unless I am compelled to do so by an appropriate legal document. I will generally not provide records or testimony to anyone other than you unless I am compelled to do so. Should I be subpoenaed or ordered by a court of law to appear as a witness in a legal matter involving you, even if I am called to testify by another party, you agree to reimburse me for any time spent for preparation, travel, or other time during which I made myself available for the appearance, at an hourly rate of \$400. In this circumstance, you agree to reimburse me for these services ahead of time in the form of a \$3,000.00 retainer for each day I am asked to appear in the service of litigation. Any unused portion of the retainer will be refunded to you promptly. The retainer is to be paid at least 5 working days prior to the day I am requested to serve in a court-related function.

BILLING AND PAYMENTS

Payment for each session is due by the start of the session or prior to it. Payment schedules for other professional services will be agreed upon when they are requested. If, for some reason, a balance develops in your account, and your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I may secure payment by other means. This may involve hiring a collection agency or going through small claims court. If legal action is necessary, its costs will be included in the claim. In collection situations, I would release only information needed for collection purposes (generally a patient's name, contact information, the general nature of services provided, and the amount due).

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate the resources you have available to pay for your treatment. Health insurance often provides some coverage for out-of-network mental health treatment. To assist you in making a claim, I will provide at no charge a monthly statement listing our sessions that you may submit for reimbursement. It is best if you request this via text in advance of the day you would like me to provide you the statement. You would be responsible for identifying which

mental health services your insurance policy will reimburse and the amount of reimbursement you can expect. You will also be responsible for finding and submitting the forms for reimbursement.

If insurance coverage is important to you, it is best that you call your plan administrator to clarify coverage limits prior to our commencing work. Please be mindful that any information I am required to provide to the insurance company regarding our work will become part of the health record your insurance company retains. I will provide you with a copy of any report I submit to your insurer, if you request it. Please also be aware that if you seek insurance reimbursement for psychotherapy, most insurance companies require me to provide them with a clinical diagnosis. In addition, they may require clinical information such as treatment plans or summaries, or even copies of an entire treatment record.

CONTACTING ME

***The quickest and best way to send me a NON-URGENT message is via TEXT to my office line (323-445-8900).**

Please note that this line is a cell phone and therefore it is not a confidential line. I urge you to only leave messages involving scheduling our meetings rather than anything personal. **I monitor text messages multiple times each day.** I am often not immediately available to talk on the telephone. When I am unavailable, my telephone is on silent mode and calls are answered by an automated system. **I generally do not monitor voice messages daily.** I will make every effort to return your call promptly. It is best to inform me of some times when you will be available to receive my call.

MINORS

If you are under eighteen(18) years of age but are twelve(12) years of age or older, California law likely gives you the authority to consent to your treatment without your parents' permission. It is my policy to ask for contact information for your parents. Unless there is a reason why it would be inappropriate for me to inform your parents that we are working together, California law requires that I do that. I normally would do that, with your permission, and provide them only with general information about our work. Normally, this is done only at the beginning and end of our work together, unless I feel at some point that there is a high risk that you will seriously harm yourself or someone else. In that case, I would notify them of my concern immediately.

CONFIDENTIALITY

The privacy of your psychotherapy is protected by law. I can only inform others about our work with your written permission. But there are some exceptions. Two exceptions involve when a judge might order my testimony in child custody proceedings or in any legal matter in which your emotional condition is considered relevant.

Another exception involves circumstances in which I am legally obligated to take action to protect a person from harm. For example, if you provide information that causes me to believe that a child, elderly person, or person with a disability is being abused, I must file a report with the appropriate agency (note that this includes possession of child pornography in electronic or print form). If I believe a patient is threatening serious bodily harm toward any person (including themselves), I must take appropriate actions such as notifying the potential victim, contacting the police, seeking hospitalization for the threatening patient, or contacting family members or others who can help provide emergency protection.

Finally, I may occasionally find it helpful to consult other professionals about our work together. I avoid revealing your identity and the consultant is also legally bound to keep information confidential. If you don't object, I will not tell you about these consultations unless I believe it is important to our work together.

While this written summary of exceptions to confidentiality should help inform you about potential problems, and I will be happy to discuss these issues with you, the laws governing confidentiality are quite complex. Formal legal advice may be needed. Although I am an attorney, I cannot act as your attorney, including providing brief legal advice.

COMPLAINTS REGARDING PRIVACY RIGHTS

If you believe your privacy rights have been violated, you may file a written complaint with me, or with an independent mental health professional, or with the U.S. Department of Health and Human Services, 50 United Nations Plaza, Room 322, San Francisco, CA, 94102. You will not be penalized for filing a complaint.

OTHER QUESTIONS/CONCERNS/COMPLAINTS

The California Department of Consumer Affairs' Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. You may contact them by calling 1-866-503-3221, at www.psychboard.ca.gov, or by writing to the Board of Psychology, 1422 Howe Avenue, Suite 22, Sacramento, CA 95825.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. You have the right to retain a paper copy of this document, and you will be offered one when you sign the original. I reserve the right to change the policies as outlined in this document-- if they change, you will be informed of that change and will be provided with a copy of the updated form.

Printed Client Name

Client Signature

Date

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**Authorization to permit coordination of treatment with your
primary Physician and/or Psychiatrist**

I authorize Dr. Alan Goodwin to use the following physicians' contact information to coordinate psychotherapy treatment with my other medical care. In providing this information, I realize that, if I am utilizing Medicare to pay for my psychotherapy, I am authorizing Dr. Goodwin and any holder of medical information to release any information needed to determine medical benefits and to process claims for psychotherapy services. I understand that Dr. Goodwin has affirmed his compliance with all privacy protection guidelines propounded by the Health Insurance Portability and Accountability Act (HIPAA).

Client Name: _____

Physician's Name: _____ Tel: _____

Psychiatrist's Name: _____ Tel: _____

Permitted Disclosure: Verbal Info. Treatment Summary Letter Records

Limitations on disclosure: _____

Client Signature: _____ Date: _____

_____ **I DECLINE TO AUTHORIZE.**

YOUR RIGHTS: This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization, except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) solely to create health information to provide to a third party.

*This Authorization may be revoked at any time. The revocation must be in writing, signed by you or by your representative, and delivered to Dr. Alan Goodwin at the address listed on the front of this form. The revocation will take effect when Dr. Goodwin receives it. You are entitled to receive a copy of this Authorization.

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(Please use this additional sheet, and attach any more you would like, to provide any additional information you would like me to have.)

TIP Clinic Client Emergency Resource List

Your safety and successful recovery is of great concern to me. Since I cannot be available to you when I am out of my office, to help ensure your health and safety, please read the following document carefully and keep it in an easily accessible place in your home, in case an emergency arises.

CRISIS RESOURCES

For immediate help, call:

1. **911**
2. **1-800-SUICIDE**
3. Didi Hirsch **Suicide Prevention Center** at **877-727-4747**
4. **1-800-900-3277 (Kaiser Permanente** 24-hour care line, for Kaiser members only)
5. your local **POLICE** department [Van Nuys station: **(818) 374-9500**)
6. any telephone line dedicated to emergency response (search “crisis response” or “suicide” or “suicide prevention,” for example).
7. Your family physician
8. Go to the nearest **EMERGENCY ROOM**

AFTER you or a person helping you has secured emergency help, please inform me of the situation via a text message at 323-445-8900. I will respond as soon as I acquire the message. Please remain mindful that **I do not provide emergency response assistance** because my practice cannot provide the collateral support needed for that.

I cannot help you, without your help.

Please remember:

As a condition of our treatment agreement, you agreed to inform me promptly if you are experiencing a psychological crisis, or if you believe the likelihood you will experience a future psychological crisis has increased.