

LA CBT DBT Psychological Services  
 Jennifer L. Taitz, Psy.D., ABPP  
 License 25222, NPI 1396058335

## PERSONAL INFORMATION QUESTIONNAIRE

Name:	Date:		
Address:			
Date of Birth:			
<b>Contact information</b>	<b>May we contact you here/ leave a message?</b>		
Mobile phone:	Yes	No	
Home phone:	Yes	No	
Email address:	Yes	No	
Emergency contact -- name, number, and relationship to you:			
Relationship status:	Single	In a relationship	Cohabiting
	Married	Separated	Divorced
			Widowed
Children (names and ages):			
Education:			
Occupation:			
Religious Denomination:			

How do you identify yourself ethnically or culturally?
Do you speak any other languages at home besides English?
What is your sexual orientation?
How did you hear about LA CBT DBT?
<b>Insurance information</b> <b>(Please note: I do not accept insurance and am not a Medicare provider)</b>
Do you have insurance coverage?
Carrier and percentage of coverage per session:
Do you have Medicare?
<b>Psychiatric and Medical History</b>
Are you currently seeing another therapist or a psychiatrist?
If so, please list the therapist or psychiatrist's name and contact information:
May I reach out to your other treatment provider to collaborate?
Names and dates of previous therapists:
Name:                                  Start Date:                                  End Date:
Name:                                  Start Date:                                  End Date:
Are you currently taking medication? Please list the names, dosage, and dates of each medication:

Please list any psychiatric diagnoses that describe your current experience:
When was the last time you had a physical exam and what was the outcome?
Physician Name:
Please describe any medical problems:
<b>Goals and Psychological History</b>
What are your hopes for therapy?
If therapy proves remarkably effective, what would we accomplish?
What qualities do you find most helpful in a therapist?

Please highlight any problems you would like help with:			
Anxiety	Suicidality	Anger	Decision Making
Depression	Assertion	Aggression	Violence
Fear	Loneliness	Hopelessness	Problem solving
Work	Shyness	Meeting people	Insomnia
Overeating	Under eating	Alcohol	Substance use
Obsessing	Sexual	Panic	Procrastination
Self-criticism	Self-harm	Hopelessness	Relationships
Pain/medical	Legal	Attention span	Fatigue
Other:			
If you've ever faced a trauma or loss, can you describe?			
Do you avoid situations because of anxiety? If yes, please list what you avoid:			
What type of exercise do you do and how often?			
Do you have a history of struggling with eating disorders?			

What substances do you use and how often?

Have you had a problem with substances?

Have you ever had a period of mania?

Have you ever engaged in self-harm behaviors?

Do you feel suicidal or have you ever wanted to die or attempted to end your life?

What do you do like to do in your free time?

**Family Background**

Please list the names, ages, and occupations of your parents and siblings. If anyone in your family struggles with a psychiatric problem, please provide details.



### **Mission**

Welcome to LA CBT DBT, I am a clinical psychologist and aim to provide evidence-based therapy in a compassionate setting. My hope is for us to work collaboratively toward building/enhancing a life that's meaningful to you. To best accomplish this, we'll try to understand what might be getting in the way and practice tools (based on researched therapies including CBT, DBT, and ACT) to face challenges effectively. It takes courage to seek services and I feel honored to have the opportunity to meet you. I value your time and believe that change is possible. In working with you, I value your input and look forward to hearing what feels helpful and what might not be working.

To start, we'll meet for an initial consultation to get a better sense of whether we might be a good team and to ensure that my experience meets your therapy goals. If we decide that it makes most sense to pursue another approach, I will provide you with referral recommendations.

Before we begin, I want to give you logistical information on what to expect as a patient. These forms are meant to address potential questions, though I am happy to discuss any concerns you have now or in the future.

### **Therapy Time**

Once you start therapy, you can reserve a consistent time with me. If you need to cancel or reschedule your appointment please do so 48 hours in advance or you will be billed the full amount of the session. If you are sick and do not want to come to session, you may use your scheduled time for a phone session. Unfortunately, if you are late, that time will be lost from that session to prevent interfering with time set aside for other clients.

### **Insurance and rates**

I do not accept insurance though will provide you with a receipt you may submit to your provider for potential reimbursement. It is up to you to clarify if your insurance will cover treatment. My fee is \$250/45 minutes. You may pay by check, credit card (Visa or MasterCard), or cash, at the time of session or your card on file will be charged. In the unlikely event that bills are not paid within 60 days, past dues are placed in collections. Fees may be changed with at least 4 weeks advance notice. The rate for DBT group is \$100/group.

### **Expectations for Communication**

If there is an emergency and you need help urgently, please call 911 or go to your nearest emergency room. If you need to reach me between sessions for a non-urgent matter, I will generally try my best to get back to you within 1-2 business days.

### **Email, voicemail, and text messaging**

There are security risks associated with email and voicemail messages (e.g. delivery to a mistaken email or phone number, electronic communication may not be received, unintended broadcasting of information may occur). While LA CBT DBT Psychological Services/Jennifer L. Taitz, Psy.D., ABPP, will use reasonable measures to protect the security of your information, LA CBT DBT/Jennifer L. Taitz, Psy.D., ABPP, cannot completely guarantee the security of your information. LA CBT DBT/Jennifer L. Taitz, Psy.D., ABPP, will not assume liability for information that is disclosed that is not caused by intentional misconduct. You can check off if you will allow electronic communication of your personal information in the personal information questionnaire. I do not use text messaging as a form of contact with prospective, current, or former clients. I only use email for scheduling. If you need help between sessions, please call by phone so we can talk.

### **Consulting/letter writing fee**

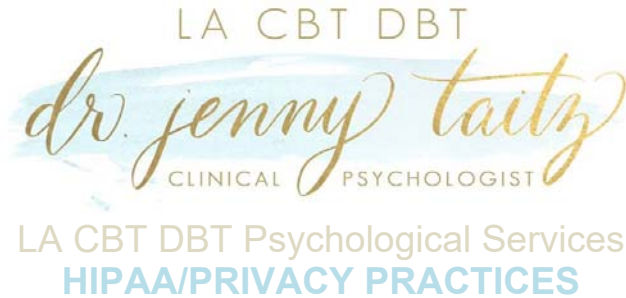
In the event that you need me to write letters on your behalf (e.g. academic accommodations or custody considerations) or connect with outside professionals (e.g. academic counselors or attorneys), if these efforts take more than 15 minutes, you may be billed on a prorated basis for this time.

### **Ending therapy**

You may end therapy at any time, though if you choose to end therapy, I hope we might be able to talk through your decision so I might be able to offer recommendations. If you want to end therapy and I believe that in doing so you are at risk, I will provide you with recommendations or referrals to continue your care. If you want to restart therapy with me, you're welcome to reach out and I will try my best to accommodate you. If I believe I cannot help you, your balance is significantly overdue, or it is in your best interest for our work to end, I will recommend alternative options.

### **Your rights**

You have every right to ask me about my training experiences and credentials. Given how important this time is, you have the right to know what the goals of therapy are and how those will be measured. At any time, you can suggest changes in goals and in your treatment plan. I am open to negative and positive feedback about our work.



**Confidentiality: This describes how medical information about you may be used and disclosed. Please review if carefully and contact me with any questions.**

I am required by federal and state law to maintain the privacy of your health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) also requires that I give you this notice about my legal duties, my privacy practice, and your rights concerning your health information. I am required to follow the privacy practices in this notice while it is in effect.

*I may use or disclose your protected health information (PHI), information that could identify you, for treatment, payment, and health care operations. To define these terms, treatment includes coordinating with another treatment provider (e.g. physician or another psychologist). Payment is when I obtain reimbursement for your health care or to determine eligibility or coverage. Health care operations relate to the performance and operation of my practice, such as quality assessment and improvement activities, business matters like audits and administrative services, and case management and care coordination. Use applies only to activities within my practice, such as sharing, examining and analyzing information that applies to you. Disclosure applies to activities outside of my practice, such as releasing, transferring, or providing information about you to other parties.*

**Uses and disclosures requiring authorization:** I may use or disclose PHI for purposes outside of treatment, payment and health care operations when your authorization is obtained. An *authorization* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization, or release of information form, from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *Psychotherapy notes* are notes I have about our conversations during a private, group, joint, or family counseling session, which I have kept separate from the rest of your chart. These notes are given a greater degree of protection than PHI. It is my policy not to keep separate psychotherapy notes. All documentation we keep is a part of your clinical chart.



I will also obtain an authorization from you before using or disclosing PHI in a way that has not been described in this notice.

I will not use your PHI for marketing or sales purposes under any conditions.

**Uses and disclosures with neither consent nor authorization:** I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse:* If in my professional capacity, I have reasonable cause to believe that a minor child is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk or harm to the child's health or welfare (including sexual abuse), or from neglect, including malnutrition, I must immediately report such a condition to the Department of Children and Families.
- *Adult and Domestic Abuse:* If I have reasonable cause to believe that an elderly person (age 60 or older) is suffering or has died as a result of abuse, I must immediately make a report to the Department of Elder Affairs.
- *Health Oversight:* The Board of Registration that applies to my particular license to practice has the power, when necessary, to subpoena relevant records should I be the focus of an inquiry.
- *Judicial or Administrative Proceedings:* If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release information without written authorization from you or your legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the court evaluation is court ordered. I will inform you if this is the case.
- *Serious Threat to Health or Safety:* If you communicate to me an explicit threat to kill or inflict serious bodily injury upon an identified person and you have the apparent intent and ability to carry out the threat, I must take reasonable precautions. Reasonable precautions may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. I must also do so if I know you to have a history of physical violence and I believe there is a clear and present danger that you will attempt to kill or inflict bodily injury upon an identified person. Furthermore, if you present a clear and present danger to yourself and refuse to accept further appropriate treatment and I have a reasonable basis to believe that you can be committed to a hospital, I must seek said commitment and may contact members of your family or other individuals if it would assist in protecting you.
- *Workers Compensation:* If you file a worker's compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division of Worker's Compensation.

## Patient's Rights:

- *Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and Alternative Locations:* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address).
- *Right to Inspect and Copy:* You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have the decision reviewed. On your request, I will discuss with you the details of the amendment process.
- *Right to Amend:* You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting:* You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy:* You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.
- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket:* You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket or in full for my services.
- *Right to Be Notified if There is a Breach of Your Unsecured PHI:* You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

## Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in the notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and

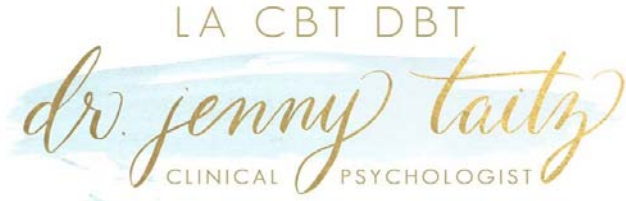
procedures, I will notify current clients and post the new policies in the waiting area.

**Questions and Complaints:**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me at 310-270-5401. You may also send a written complaint to my office. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

**Effective Date and Changes to Privacy Policy:**

This notice will go into effect on November 1, 2016. I reserve the right to change the terms of the notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by either distributing it to you in the office or mailing it to your home address.



LA CBT DBT Psychological Services  
**CREDIT CARD AUTHORIZATION**

All clients are required to have a current credit card on file. Payment is due at the time of service. In the event you are unable to attend an appointment, please cancel 48 hours in advance. If you miss an appointment and don't cancel 48 hours prior, a "no show" fee will apply.

Please indicate how you would like to render payment:

I would like to use my card on file to regularly pay for my session. Sessions will be billed the week of your scheduled appointment.

I prefer to pay by cash or check for scheduled payments. I understand I will be charged for sessions if I don't furnish payment at the time of service.

Name on credit card: \_\_\_\_\_

Relationship to cardholder: \_\_\_\_\_

Credit card billing address: \_\_\_\_\_

Email: \_\_\_\_\_

Credit card number: \_\_\_\_\_

Security code: \_\_\_\_\_

Expiration: \_\_\_\_\_

By signing or electronically signing below, I authorize LA CBT DBT Psychological Services/ Jennifer L.Taitz, PsyD., ABPP to charge the above credit card for services provided and in accordance with the terms of the cancellation and fee policies agreement.

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Name

Signature

Date



Acknowledgement and agreement for consent for treatment.

I have read and understand this consent for treatment form. In the event I type my name in the spaces provided, I agree that my electronic signature is the legally binding equivalent to my handwritten signature.

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Name	Signature	Date
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Acknowledgement of receipt of notice of privacy practices:

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Name	Signature	Date
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