Mcayla Sarno, Psy.D., L.M.F.T.

Licensed Therapist – Lic. LMFT 48323
27201 Puerta Real Suite 300 Mission Viejo, Ca 92691

Today's Date_______________________________

Referred by ________________________________

Client Patient Registration:
(Couples, please fill out own registration each)

NAME______________________________________SEX____________

AGE____________D.O.B____________ADDRESS___________________

CITY_________________________ST_________________ZIP____________

HOME PHONE:___________________ CELL_________________________

PERMISSION TO LV MESSAGE AT HOME? YES________NO______

PERMISSION TO LV MESSAGE ON CELL? YES ________NO______

DRIVER'S LICENSE # ______________________STATE ISSUED____

EMAIL (Print clearly)____

EMERGENCY CONTACT____

RELATIONSHIP TO CLT____

EMERGENCY CONTACT PHONE #___________________________

MARRIED___________DIVORCED__________ HOW LONG_____

EMPLOYED YES_______NO______OCCUPATION ______________

EMPLOYER____

STUDENT SCHOOL COLLEGE______________LEVEL__________

EDUCATION _______ H.S. GRADUATE ______________________

TRADE SCHOOL ______________SOME COLLEGE ___B.A._____

M.S./M.A. ________________PH.D. ____

UNEMPLOYED______DISABILITY________RETIRED___________

FINANCIAL RESPONSIBILITY IF DIFFERENT FROM ABOVE or PARENT TO MINOR ABOVE:

NAME__________________SEX_______________ AGE__________

DATE OF BIRTH_____________ ADDRESS ____________________

CITY ________________________ ST______ ZIP________________

HOME PHONE_______________CELL_________________________

PERMISSION TO LV MESSAGE AT HOME? YES_______NO______

PERMISSION TO LV MESSAGE ON CELL? YES _______NO______

DRIVER'S LICENSE ____________________STATE ISSUED_________

EMAIL (Print clearly)____

EMPLOYED YES________NO_______ OCCUPATION________________

EMPLOYER____

Current Concerns:

Patient/Client Information:

Please provide a brief description of the major concerns that led you to seek treatment/therapy at this time:

____

____

____

____

Previous Psychiatrist/Therapist:

Name of clinician Phone Number/Address Approximate Dates

____

____

____

____

Describe the problems for which you sought therapy in the past:

____

____

____

____

Your experience with previous therapy: Positive ___________________

Neutral _________Limited__________Negative___________________

Have you been hospitalized for psychiatric or substance abuse problems? No ___ If yes, please list:

Facility:_____________________________Dates:_________________

Reason:____

____

____

____

Do you have any history of suicide attempts or history of assault?

No _____ If yes, please describe below:

____

____

____

Medications:
Please list all current drugs/medications, including over-the-counter:

Name of medication Dose:________ Dates______________________

____

____

____

____

Please list any previous psychiatric drugs/medications:

____

____

____

____

Physical Health Status:
Do you have any existing medical problems or current physical symptoms of concern to you? If so, please describe below:

____

____

____

____

Please indicate any major illnesses, accidents, and/or hospitalizations within the last 5 years:

____

____

____

____

____

Date(s):____

Do you smoke? No______ Yes, (#) ____________ per day___________

Do you drink alcohol? No___ Yes, (# drinks)______ per week________

Do you engage in any other substance/drug use? No _______ If yes, please explain:

____

____

____

____

Do you exercise? Regularly____ Occasionally ____ Rarely ________

Never ______ How is your general food diet? Very healthy________

Questionably healthy________ Not very healthy_________________

Changes ____

How is your general health? Excellent _______ Good _____________

Fair ________ Poor _________

Family Background:
Have any family members had any moderate to severe psychological or medical problems? If so, please describe:

____

____

____

____

____

Please describe your family relationships:
____

____

____

____

____

Any history of family physical or sexual abuse:

____

____

____

____

____

Social/Occupational/Family Functioning:

Do you have a social network?_________ Have close friends_________

How often do you make contact with friends? ______________________

Are you currently in a romantic relationship? No____ Yes, it is:

Generally positive_______ Neutral _______ Problematic ___________

Are you able to talk to others about the concerns that bring you into therapy? No____ Yes____

What is you're living situation? Live alone________ Live with others, with whom?

____

____

____

____

How do you feel about (select one) work? N/A____ Pleased____ Mostly

Satisfied____ Mixed____ Mostly dissatisfied_______________________

Unhappy________________ How do you feel about (select one) school?

N/A____ Pleased_____________Mostly satisfied____ Mixed_________

Mostly dissatisfied____________ Unhappy ________________________

Any major dissatisfaction with: Work______ School______

Marriage______ Family________________Friends_________________

If so, please explain:

____

____

____

____

Any history of physical or sexual abuse from non family members?

No_____ Yes______ Please describe any hobbies or recreational or enjoyable activities:

Any history of physical or sexual abuse from non family members?

No_____ Yes______

Please describe any hobbies or recreational or enjoyable activities:
____

____

____

____

____

____

Mcayla Sarno, Psy.D., L.M.F.T.

California Licensed EMDRIA Certified Therapist – Lic. LMFT 48323

27201 Puerta Real Suite 300 Mission Viejo, CA 92691

Self Pay Agreement:

Patient:____________________________Date:__________________

Patient Attests to one of the Following:

a) I do not have or have exhausted my insurance coverage _______

b) I have insurance coverage but choose not to use it, and understand that in doing so I am waiving any right to reimbursement_______

c) I have insurance coverage but understand that Dr. Sarno's services are not covered by the plan ________

Patient Signature:______________________________ Date:_________

Provider Signature:_____________________________Date:_________

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Cancellations, Illnesses, Electronic Communications & Therapist Availability Cancellations:

Since scheduling an appointment involves the reservation of time specifically for you, a minimum of 24 hours' notice is requested to avoid full session fee. This is a typical custom in the mental health profession. If you cancel outside of 24 hour notice please be advised a credit card is placed on file and will be automatically charged for any cancellation or missed appointment outside of 24 hour notice. If a cancellation needs to be made, please notify therapist ASAP by email at: Operations@DrMcayla.com Initials __________

Credit Card: ____

Expiration Date: ________________________ CVC Code: _____________

Signature: _____________________________Zip Code:________________

Please note: Insurance companies do not reimburse for missed sessions therefore your insurance company cannot be billed for missed appointments. Therapist will not be able to give you a Super Bill to bill your insurance company Initials __________

Electronic Communication:

Due to confidentiality, emailing, texting, and faxing is not secure and does not meet the HIPPA compliance regulations for privacy and confidentiality. Therefore, all emailing, texting, and/or faxing is strictly limited to administration communication such as appointments, cancelations, requests, etc. No clinical information between client or therapist is to be emailed, texted, or faxed. Initials _________

Therapist Availability:

Therapist's cell phone allows client/patient to leave a message at any time. Therapist will make every effort to return calls within 24 hours Monday to Friday (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Client/Patient is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room. If you need to call to talk to someone, call the National Suicide Hotline at 800-273-8255.
Initials _________

Thank you for your cooperation regarding the above.

Signature of ClientPatient:_____________________________________

(Minors: 12 yrs or older please sign as well)

Signature of Mother/Guardian: ____________________Date:________

Signature of Father/Guardian: _____________________Date:________

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Fee Agreement

All payments to psychotherapy/counseling sessions are tax deductible as medical services received.

Session Time Structure:
Length of sessions (CPT Codes) are stipulated by current national guidelines governing the profession of psychiatry/psychotherapy.

Fee Scale:
Session fee is determined by what is reasonable and customary in Southern California for mental health providers. Fees may vary somewhat per individual provider.

In Office Psychotherapy:

Session: 90mins = $300 (Usual and Customary Session Time)

Initials _________

Session 2hr = $450 (recommended for Couple or Family Therapy)

Initials _________

Skype/Online:

Skype Online Coaching 1hr = $225

Initials _________

(**Reports or letters)** (written or read): $150 per/hour and $75 per 1/2 hour. If the therapist is running late, therapist will make up the time that session, however, if client, is running late, the session will not be made up and charges will be for the full session originally scheduled for.
Initials _________

Credit Card, Cash, or Check Accepted for payment in full (if credit card payment is used, there will be an additional $9.50 charge for transaction fee) **Returned check fee is $25.00**. Initials _________

I understand that Mcayla Sarno, Psy.D, LMFT, is a mandated child and elder abuse/neglect reporter by the state of California and must report any suspicion or reported child or elder abuse/neglect to the appropriate authorities. I also understand that if I am at risk of harming myself (Suicide) or others (homicide), Dr. Sarno is also mandated to report me for psychiatric crisis intervention to the appropriate authorities to protect myself from harm.

Sessions may be longer (see above fee schedule) if agreed upon between therapist and client. The fee is due at the beginning of each session. If I have concerns about the fee or payments, I will discuss them at the beginning of the session or call/email Dr. Mcayla prior to my session.

Client Self Pay: Dr Mcayla does not belong to any HMO provider panels. PPO may reimburse however, it is the clients own responsibility to bill their insurance carrier.

I also understand that I will pay my session in full at the time of the Session and that Dr Mcayla will provide to me an Insurance Super Bill after each session in order for me to bill my insurance company directly. Dr Mcayla will fill out any appropriate clinical information that is needed on each Insurance Super Bill for client to submit to their insurance company for possible reimbursement. I also understand that there is no guarantee that my insurance company will reimburse me for said services. Initials _________

NOTE: I understand no statements are sent out. Checks, Credit Card Payments Receipts, and/or Insurance Super Bills (if requested) are my proof of sessions and payments made.

Initials _________

If I have forgotten my checkbook, I will pay my session by credit card.

Initials________

Print Name (Client or Parent(s) responsible for payment) ___________

Client Signature ____

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Basic Rights In Psychotherapy

1. You have the right to decide not to receive psychotherapy from me. If you wish, I shall provide you with the names of other qualified psychotherapists. ______ Initials

2. You have the right to end therapy at any time without any moral or legal obligations, or without incurring any further financial obligations. ______ Initials

3. You have the right to ask any questions about the techniques, methods, approaches, and/or procedures used during therapy. ______ Initials

4. You have the right to prevent the use of certain therapeutic techniques, methods, approaches, and/or procedures. I shall inform you of my intention to use any techniques, methods, approaches, and/or procedures and shall describe any risks involved. _____ Initials

5. You have the right to prevent electronic recording of any part of the therapy sessions; permission to record must be granted by you in writing on a form that explains exactly what is to be done and for what period of time. Should I request to record our sessions, I shall explain my intended use of the recordings and provide a written statement to the effect the recordings will not be used for

any other purpose. You have the right to withdraw your permission to record at any time. ______ Initials

6. You have the right to review your records in the file at any time. ______ Initials

7. One of the most important rights involves confidentiality. You hold the legal privilege to all the information presented during therapy. Information is held in the strictest confidence and will not be revealed to any other person or agency without your written permission, within certain limits (see below # 8). ______ Initials

8. You should know that there are certain situations in which, as a psychotherapist, I am mandated by law to reveal information obtained during therapy to other persons or agencies without your permission.

   Also, I am not required by law to inform you of my actions in this regard. These situations are as follows; (a) if you threaten grave bodily harm or death to another person, I am required by law to inform the intended victim and the appropriate enforcement agencies; (b) if a court of law issues a legitimate subpoena, I am mandated by law to provide the information specifically described in the subpoena; (c) if you are in therapy or being tested by order of a court of law, the results of the treatment or tests ordered must be revealed to the court of law; (d) if there is sufficient evidence presented in therapy to suspect that a child is being abused, either by neglect, assault, battery, or sexual molestation, I am required by law only to report the “reasonable suspicion” of such abuse. I have no authority nor responsibility to investigate the case; (e) if there is sufficient evidence presented in therapy to suspect that an elder and/or dependent adult is being abused I am required by law to report the “reasonable suspicion” of such abuse; (f) in the case of potential suicide, I am allowed by law to inform the necessary individuals and/or agencies to prevent harm; (g) if you are billing your insurance company for reimbursement for your therapy

sessions, I may be required to give your insurance company certain information regarding your diagnosis, prognosis, and treatment plan should they request it. ______ Initials

9. If you request it, any part of your record in the files can be released to any person or agencies that you designate. I shall tell you, at the time, whether or not I think making the record public will be harmful or potentially harmful to you. ______ Initials

I have read and understand all of the above, and all of my questions have been answered to my satisfaction. My signature below attests to this.

Patient Name (please print):_________________________________Date:___________

Signature of Client/ Patient:____________________________________Date:________

(If Client/Patient is 12 yrs or older)

Signature of Mother/ Guardian:_______________________________________Date:_______

Signature of Father/ Guardian:_______________________________________Date:______

Mcayla Sarno, Psy.D., LMFT

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HIPPA: 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.
Effective Date: 01/01/2017

If you have any questions about this notice, please contact Dr. Mcayla at Operations@DrMcayla.com

Our Obligations:

- We (health care providers) are required by law to:

- Maintain the privacy of protected health information
  Give you this notice of our legal duties and privacy practices regarding health information about you

- Follow the terms of the notice that is currently in effect

How we may use and disclose health information:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to Mcayla Sarno, Psy.D.

For Treatment:

We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment:

We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received.

For Health Care Operations:

We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our clients receive quality care and to operate and manage our office. For example, We may consult with colleagues to make sure the care you receive is of the highest quality. We also may share information with other entities that have a relationship with you for their healthcare operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services:

We may use and disclose Health Information to contact you to remind you that you have an appointment. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care:

When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research:

Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Special Situations:

As Required by Law:

We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety:

We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates:

We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services

on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Military and Veterans:

If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation:

We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.

Public Health Risks:

We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities:

We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes:

We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes:

If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors:

We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities:

We may release Health Information to authorized federal officials for intelligence, counter intelligence, and other national security activities authorized by law.

Protective Services for the President and Others:

We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody:

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures that require us to give you an opportunity to object or opt out:

Individuals Involved in Your Care or Payment for Your Care:

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief:

We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Your written authorization is required for other uses and disclosures:

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information:

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy:

You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Mcayla Sarno, Psy.D. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to Get Notice of a Breach:

You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend:

If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Mcayla Sarno, Psy.D.

Right to an Accounting of Disclosures:

You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Mcayla Sarno, Psy.D.

Right to Request Restrictions:

You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Mcayla Sarno, Psy.D. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments:

If you paid out-of-pocket in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications:

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Mcayla Sarno, Psy.D. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice:

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at anytime. To obtain a paper copy of this notice, contact Mcayla Sarno, Psy.D.

Changes to this notice:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

Client signature
____

Date
____

Mcayla Sarno, Psy.D., LMFT

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Please print your name in the first space, then sign, print, and date below to indicate that you understand what you have read.

I agree to the process of EMDR therapy. I understand that I will have all choices at all times and can start and end the process at anytime. I understand that EMDR therapy can provide assistance in resolving problems and changing thought processes and negative core beliefs. I agree to continue any current medication as prescribed by my attending physicians and understand that EMDR therapy is not a substitute for medical care.
If my symptoms progress I agree to seek medical attention. In the event of a medical emergency or if I feel suicidal, I will call 911 or other emergency help. I understand that the methods of EMDR therapy may include relaxation, deep breathing, creative visualization and other techniques of producing physical and emotional responses. I am over age 18, and consent to EMDR therapy services offered by Dr. Mcayla Sarno

Signature: ____

Print Name: ______________________________________

Date: ____