Anna McQuinn PH.D.
Licensed Psychologist, PSY#12098
P.O. Box 226
San Carlos, Ca 94070

Date _____/_____/_____

Patient Information:

Name_____

Address_____

City_____State_____Zip_____

Home Phone____/_____ Work Phone____/_____ext_____

Cell Phone ____/_____ Email Address_____
*Please indicate your preferred telephone contact number.

Birth Date ____/_____/_____ Age_____

Social Security: _____/_____/_____ Marital Status _____

Employer_____Occupation_____

Spouse's Employer_____Occupation_____

Name of those living in household Relation to you Age
_____ _____ _____
_____ _____ _____
_____ _____ _____

Medical History Questionnaire:

How were you referred? _____

Have you had previous counseling?____ With Whom?_____When_____

Briefly describe the difficulties for which you are seeking help:

Current Health- On a scale of 1 (very poor) to 10 (excellent) how would you rate your present health? (Circle one) 1 2 3 4 5 6 7 8 9 10

Who is your Primary Care Physician:_____

What prescription medications are you currently taking and why?
_____ _____ _____

What non-prescription medications are you currently taking and why?
_____ _____ _____

Describe your alcohol consumption:

What kind_____

How frequently_____

How much_____

Has it changed recently? _____

Mental Health Questionnaire:
Please answer each of the questions below by circling the appropriate number or response appearing at the right side of the page. Each of the items should be answered according to how you currently feel.

1=Poor and 5=Very well
How well are you sleeping 1 2 3 4 5

Has your sleep pattern changed recently? Yes No

How would you describe your energy level 1 2 3 4 5

How high is your current level of stress 1 2 3 4 5

1=Hopeless and 5=Very bright
How does your future look to you? 1 2 3 4 5

1=Sad and 5=Happy
How would you describe your recent mood? 1 2 3 4 5

1=Disappointed and 5=Satisfied
How do you generally feel about yourself? 1 2 3 4 5

Do you worry a great deal? Yes No

Have you been very nervous or anxious recently? Yes No
How would you describe your relationship with:
1=Poor and 5=Excellent
Your spouse (or significant other) 1 2 3 4 5
Your family 1 2 3 4 5
Your friends 1 2 3 4 5

Do you have any trouble concentrating Yes No

Do you have any trouble making decisions? Yes No

Do you have any trouble remembering things? Yes No

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Client Information, Contract and Consent to Receive Services

This document contains important information about my services and business policies and it serves as your consent to receive services. Please read it carefully and note any questions you have so we can discuss them.

Consent to Treatment

Most people who participate in behavioral or mental health treatment benefit from it. Like most kinds of healthcare, this kind of treatment requires a very active effort on the individual's part. In addition, there may be certain kinds of risks involved. For example, the counseling process can be challenging and sometimes may involve experiencing some uncomfortable feelings, or engaging in difficult interactions, or facing difficult aspects of your life. Nevertheless, most people find the benefits outweigh any such risks. It is important that the individual participates in this treatment willingly. If you have any questions or concerns about this document, about the services being provided, or about the treatment options, please feel free to ask questions.

Services

I provide outpatient clinical psychology services to adults, ,children and families. This may include assessment, evaluation, consultation, psych-education, and family, couple, and group psychotherapy.

Initial Sessions

Our first session(s) will involve an evaluation of your situation and needs; that will include an interview and a review of your Background Information Questionnaire. After that, I will discuss with you my impressions and plan for what I believe may benefit you. As you proceed through the initial session(s) of therapy, you should evaluate whether you feel comfortable working with me. Therapy involves a commitment of time, money, and effort, so ft is important to select a therapist with whom you feel comfortable. If you have any questions at any time, we can discuss them whenever they arise.

Contacting Me

For routine matters, please call 650-508-1942. If I am available at that time, please leave a message, and I will return your call as soon as possible, if you are difficult to reach, please leave some times when you are available. If you cannot reach me directly and you feel that you have an emergency, you should telephone 911 or go the emergency room at your nearest hospital and ask for the psychologist or psychiatrist on call. If events arise between your therapy appointments and wish to speak with

me, please call. We will either discuss the situation briefly by phone, or schedule an additional office appointment to discuss the issue in depth.

Professional Fees. Billing and Payments

My services are provided for at the time of service. Individual psychotherapy, couples, family sessions are 50 minutes at a rate of $_____ per session. Payment is by cash/check at the beginning of your session. I do not take Insurance and I am not affiliated with any Insurance Company. Please note you are responsible for paying me directly, completing forms and obtaining reimbursement. You may wish to contact your insurance representative to ask about mental health coverage, out-of-network providers, and reimbursement rates. In addition to therapy sessions, I charge a fee (discussed as needed) for other-professional services you may require or request such as report writing, telephone conversations, attendance at meetings or consultations with other professionals which you have authorized, or the time required to perform other services you request. A 6% late fee will be added to your bill after 20 days of nonpayment. I may refer the overdue bill to a collection agency or small claim court.

Psychotherapy involving Legal issues

If you are seeking a therapist to support you with legal issues involved in therapy, e.g. divorce, child custody issues, disability claims, harassment claims, etc. Please note I do not have the training, education or experience to represent you. I will be glad to give you a referral to a competent therapist.

Please initial Here:

Cancellations and Missed Appointments

Your appointment time is reserved only for you and your commitment to therapy is fundamentally important to your progress. Consequently, once we agree on your regular meeting time, please notify me 72 hours prior to your appointment time, otherwise your will be charged for the missed session.

Confidentiality

In general, the confidentiality of all communications between a patient and a psychologist is protected by law and release of information about your treatment to others is only permitted with your written consent. There are however some exceptions when a psychologist is required by law to disclose confidential information. Some of these are:

1. If I have reasonable suspicion that a child, an elderly person, or a dependent adult is being abused or neglected, I am required by law to notify the appropriate authorities.

2. If I believe a client is threatening serious bodily harm to another, I am required to take

protective actions which may include: notifying the potential victim, notifying the police or other protective procedures.

3. If a client threatens or harms him/herself, I may be required to notify the police or other authorities for the purpose of protecting the client. I may seek hospitalization for the client or contact family members who can provide protection.

4. There are other times when I may be legally allowed or required to disclose confidential information (for example by court order). These are discussed in detail along with your rights in a separate document entitled California Notice Form that I give to clients at the outset of therapy. Additional copies are available anytime at your request.

Client's Consent

My signature below indicates that I have read and understand this Client Information Contract, and Consent to Receive Services Form. I also have received the California Notice Form describing privacy policies and practices. I have had the opportunity to ask questions and discuss to my satisfaction anything I have not understood. I willingly agree to the terms and conditions stated in the present document and I consent to receive the psychological services provided by Anna McQuinn, PH.D.

Termination of Therapy

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside the Therapist's scope of practice or competence, or Patient is not making adequate progress in therapy. Therapist will generally recommend that Patient participate in one or more termination sessions. These sessions are intended to facilitate a positive termination experience and I've both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals when appropriate.

By signing this agreement, I acknowledge that I have read this agreement, understood its terms, agree to be subject to its provisions, and voluntarily agree to the participation in the treatment.

Signature

Date

Anna McQuinn PHD
PSY 12098, California
Telehealth Consent Form

I, _____ hereby consent to engage in Telehealth with Anna McQuinn, PhD.

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in–person psychotherapy. The same mandatory and permissive expectations to confidentiality outlined in the informed consent form I received from my therapist also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
6. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above and had discussed it with my therapist, and I understand that I have the right to have all my questions regarding this information answer to my satisfaction.

_____ _____

Patient Signature Date

_____

Patients Printed Name

Verbal Consent Obtained

Therapist reviewed Telehealth consent form with patient, patient understands and agrees to the above advisement, and patient has verbally consented to receiving psychotherapy services from therapist via Telehealth.

_____	_____
Therapist Signature	Date