

Christopher Carstens, Ph.D.  
Licensed Psychologist PSY 5654  
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7863 La Mesa Blvd., Suite 102 La Mesa, CA 91941

**For Patient Being Evaluated**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Soc. Security # \_\_\_\_\_  
Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_  
Marital Status \_\_\_\_\_ Referred By \_\_\_\_\_

**For Parents if Patient is a Child:**

Name of Father \_\_\_\_\_ Legal guardian? \_\_\_\_\_  
Address (if different from child) \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_

Name of Mother \_\_\_\_\_ Legal guardian? \_\_\_\_\_  
Address (if different from child) \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_

**Insurance Information (A copy of insurance card will be needed.)**

Insurance Carrier \_\_\_\_\_  
Address of Carrier \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Insured \_\_\_\_\_  
Insured's ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured's Soc. Security # \_\_\_\_\_ (Only if required for insurance)

The undersigned accepts responsibility for the cost of all services rendered to the patient and attests that the information above is true and correct.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Please answer for the patient being evaluated.**

Name: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Medical conditions (history, current condition, changes in condition);

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Current Medications (Drug, dosage, name of prescribing physician):

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Allergies / adverse reactions to treatment:

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Primary Care Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: \_\_\_\_\_

Please list the three main problems for which you are seeking assistance:

1) \_\_\_\_\_

Circle the number that indicates the severity of this problem.

1      2      3      4      5      6      7

**Not severe**

**Very severe**

How have you tried to solve this problem in the past? How helpful were those efforts?

2) \_\_\_\_\_

Circle the number that indicates the severity of this problem.

1      2      3      4      5      6      7

**Not severe**

**Very severe**

How have you tried to solve this problem in the past? How helpful were those efforts?

3) \_\_\_\_\_

Circle the number that indicates the severity of this problem.

1      2      3      4      5      6      7

**Not severe**

**Very severe**

How have you tried to solve this problem in the past? How helpful were those efforts?

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## AGREEMENT FOR PSYCHOLOGICAL SERVICES

This form explains how we will work together. If there is anything you do not understand, please ask me. I will answer your questions.

### SERVICES

I provide both therapy and testing. I work primarily children, adolescents and families. Who are you seeking services for? Check all that apply.

- Myself  My spouse or partner  
 My child or children  
(Please list names of children)

| Child's Name | Age | Grade |
|--------------|-----|-------|
|              |     |       |
|              |     |       |
|              |     |       |
|              |     |       |
|              |     |       |
|              |     |       |
|              |     |       |

### If services are for a child, are you the:

(Check only one)

- Parent, still married to child's other parent.  
 Parent, divorced from child's other parent  
 Parent, was not ever married to child's other parent  
 Step-Parent, married to child's biological parent  
 Adoptive Parent  
 Legal Guardian  
 Foster Parent  
 Caregiver, but not parent of child (ie, grandmother, relative, friend of family)

Does anybody living in your home have a social worker with CPS?  Yes  No

## **PERMISSION TO PROVIDE SERVICES FOR CHILDREN**

I need written consent to care for children under 18 years old. When parents are divorced, both mother and father must give permission for treatment, in writing, by signing this form. (Each may submit a separate copy.) When you sign this form, you give me consent to treat the child named on the first page.

✓ I have read and understand the above. Initials\_\_\_\_\_ Date\_\_\_\_\_

## **PARTICIPATION IN SERVICES IS VOLUNTARY**

Seeing me is voluntary. If you wish to change providers, I will help you find another therapist.

Even the court or a social worker has said you must get therapy, you can still ask to change therapists. If you are not clear about your rights, ask your attorney for advice.

You can ask questions at any point in our work together

✓ I have read and understand the above. Initials\_\_\_\_\_ Date\_\_\_\_\_

## **LIMITS OF SERVICES**

I do not guarantee results. I will do my best, but treatment results may not be what you hope for.

There are some risks in family or couples therapy. For example, you may come for services to improve a relationship, but one party may decide to end it. This can be partly as a result of therapy. I have no ability to foresee or prevent such possible outcomes.

I am not a physician. I do not write prescriptions or tell you about how to take medications your doctor has prescribed.

I work alone and am not part of a group. A machine often answers my telephone. I check my messages frequently, and strive to return calls quickly. If you cannot reach me in an emergency situation, please call 911 or go to the nearest emergency room.

If you have questions about the benefits and possible risks of psychological services, please ask them.

✓ I have read and understand the above. Initials\_\_\_\_\_ Date\_\_\_\_\_

## LIMITS OF CONFIDENTIALITY

Your records are private, and I keep them locked up. I will not talk with anybody about your case or release your records without written permission.

There are some exceptions to this general rule

1. The law requires that I report any child abuse.
2. If anyone in my care tells me about a plan to hurt another person, I must take steps to prevent it. If anyone in my care tells me about a plan to hurt themselves, I must take steps to prevent it.
3. If you give written permission, I will share information, but only with the people you name.
4. If the court ordered you to see me, I usually must tell your social worker when you come and whether or not you are making progress. I am often required to write a report to the court.

Often I see two or more people in a family. Whatever I am told in private remains private. For example, I will not tell a wife what her husband tells me when we meet alone.

✓ I have read and understand the above. Initials\_\_\_\_\_ Date\_\_\_\_\_

## PARENT'S RIGHTS TO CHILDREN'S RECORDS

(If no children are to be receiving services, skip to next page.)

In general, parents have the right to information about the services their children receive. I will tell you whether or not the child is participating and making progress. I will not show you my records. I will not share what the child says in private, without the child's permission.

At times I may refuse to provide parents, or any third parties acting on the request or authorization of parents, with information and records pertaining to a child's mental health evaluation or treatment, if it is my opinion that such disclosure would negatively impact the child or the child's evaluation or treatment. Your initials below and your signature on this form constitute a release from any and all liability from my good-faith refusal to disclose your child's information or records.

If you have any questions, please ask them before initialing this section.

✓ I have read and understand the above. Initials\_\_\_\_\_ Date\_\_\_\_\_

## OPINIONS REGARDING CUSTODY

Based on my best understanding of the ethical standards of my profession, it is my practice never to form or state an opinion regarding the custody or time-sharing plan for a child who is or has ever been in my care as a psychotherapy patient.

✓ I have read and understand the above. Initials\_\_\_\_\_ Date\_\_\_\_\_

## APPOINTMENTS

**Sessions usually last 50 minutes. If you cancel an appointment with less than 24 hours notice, you will be charged the full fee, not just your copay. Your insurance company will not pay this fee, and it will be your personal responsibility. (Does not apply to government contracts.)**

✓ I have read and understand the above. Initials\_\_\_\_\_ Date\_\_\_\_\_

## FINANCIAL AGREEMENT

My fee is **\$125 per 50-minute session** for therapy services performed in the office, and **\$125 per hour** other services. **As a rule, you should expect to pay your fee or co-payment at the beginning of each session.** Any change in this fee policy must be negotiated in advance.

Your insurance may pay for all or part of my fee for therapy. If you are planning to use your insurance, be sure to call **THE INSURANCE COMPANY FOR AUTHORIZATION BEFORE YOUR FIRST VISIT**. In case your insurance company does not pay, the fee remains your responsibility.

Some government programs, such as Medi-Cal, pay the entire cost of treatment. If you are covered by such a plan, claims will be sent directly to the program, not to you.

Monthly statements or insurance claims will be sent to you, or to your insurance carrier. Insurance claims include information about your diagnosis and treatment services. You must give permission to release that information to your insurance carrier before I can submit a claim.

Sometimes you may request that I prepare a letter or report for your attorney. Such reports require very careful attention, and I will bill you for my time at \$125 per hour. Fees for preparation must be paid before I send out the letter or report. **THESE FEES ARE NEVER COVERED BY INSURANCE, AND YOU WILL BE REQUIRED TO PAY FOR THE LETTER OR REPORT.**

You should feel free to discuss any questions regarding fee policy. If there is a problem, let me know, so we can arrange a payment plan.

Should financial situations change or fees be changed with fair notice, this form may be changed with accompanying initials.

Finally, if you do not pay your bill, legal steps for collection of the bill may be taken. The only information that will be given to the court, a collection agency or an attorney will be your name, address, the dates of your appointments, and the amount due.

✓ I have read and understand the above. Initials\_\_\_\_\_ Date\_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY:**

I authorize the release of any medical or other information necessary to process insurance claims related to this care. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I have read and understand the above. Initials\_\_\_\_\_ Date\_\_\_\_\_

**Please sign below when you have read and understood all of the agreement.**

I have read and understood this Agreement for Services. I have had a chance to ask questions and my questions have been answered. I understand this agreement fully, and voluntarily sign:

\_\_\_\_\_  
 Patient  Parent  Other\_\_\_\_\_Date

\_\_\_\_\_  
 Patient  Parent  Other\_\_\_\_\_Date

## Consent to use and disclose your health information

This form is an agreement between you and Christopher Carstens, Ph.D. When we use the word “you” below, it will mean your child, relative, or other person if you have written his or her name here \_\_\_\_\_.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices, which you have been given, explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

We may use your information to bill you, your insurance, or others to be paid for the treatment we provide to you. We may contact your insurance company to check on exactly what your insurance covers. We may have to tell them about your diagnoses, what treatments you have received, and what we expect as we treat you. We will need to tell them about when we met, your progress, and other similar things.

### **If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.**

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. The full notice is posted on my website at [www.drcarstens.com](http://www.drcarstens.com) . You can also get a copy by calling me at (619) 698-9525, or by email at [contact@drcarstens.com](mailto:contact@drcarstens.com).

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

\_\_\_\_\_  
Signature of client or his or her personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client or personal representative

\_\_\_\_\_  
Relationship to client

\_\_\_\_\_  
Description of personal representative’s authority