ROOTS & WINGS

INSTITUTE FOR PERSONAL GROWTH
AND FAMILY EXCELLENCE

A 501(c)(3) Non-Profit Organization Providing Evidence-Based Solutions for a Joyful Life
www.RootsnWings.org • hello@rootsnwings.org • 310-894-6597

INTAKE FORM for WOOLSEY FIRE EMOTIONAL HEALING PROGRAM

Name: _____ Intake Date: _____

The purpose of this questionnaire is to obtain a comprehensive understanding of your life experience and background. Completing these questions as fully and as accurately as you can will benefit you through the development of a treatment program suited to your specific needs. Please return this questionnaire when completed, or at your scheduled appointment.

Parent or Guardian (if client is a minor):_____

Address: _____ City: _____ Zip Code:_____

Phone: _____ Birthdate: _____ Age: _____

Occupation: _____ Work Phone: _____

Employer(s): _____

Work Address: _____ City: _____ Zip Code: _____

Relationship Status: _____ Name of Partner: _____

Names/Ages of all the people living in your house/apartment:

Name:	Age:
_____	_____
_____	_____
_____	_____

Emergency Contact:_____ Relationship: _____ Phone:_____

How were you impacted by the fires?

_____

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What difficulties are you experiencing following the events surrounding the fires?

_____

_____

_____

_____

Circle all of the following that apply to you:

Overeating	Suicide Attempts	Can't keep a job	Take Drugs
Compulsions	Insomnia	Vomiting	Smoke
Take too many risk	Odd Behavior	Withdrawal	Lazy
Drink too much	Nervous Tics	Eating Problems	Work too hard
Concentration Difficult	Aggressive Behavior	Procrastination	Sleep Disturbance
Crying	Impulsive Reactions	Phobic Avoidance	Temper Outburst
Loss of Control	Difficult Relationships	Anxious/Tense	School Problems

Please answer all of the following carefully. This will help us help you!

Have you ever been in therapy before? Please circle one: Yes No

If yes, was it helpful?:

_____

_

Reason for terminating therapy:

_____

INTAKE FORM for WOOLSEY FIRE EMOTIONAL HEALING PROGRAM

Have you ever attempted suicide? Please circle one: Yes No

Are you on any medication now? Please circle one: Yes No

If yes, please list:

_____

_____

Have you ever been hospitalized for an emotional illness?
Please circle one: Yes No

Location of Hospital(s):

_____
_

_____

Dates and reason for hospitalization(s):

_____
_

_____

Self-Description (Please complete the following):

A. I am a person who_____

B. All my life _____

C. Ever since I was a child _____

D. One of the things I feel proud of is _____

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E. It's hard for me to admit _____

F. One of the things I can't forgive is _____

G. One of things I feel guilty about is _____

H. One of the ways people hurt me is _____

I. Mother was always _____

J. What I needed from mother and didn't get was _____

K. Father was always _____

L. What I wanted from my father and I didn't get was_____

M. If I weren't afraid to be myself, I might_____

N. One of the things I'm angry about is _____

O. What I need and have never received from a woman (man) is _____

P. The bad thing about growing up is _____

Q. One of the ways I could help myself but don't is _____

R. I am proud of myself for_____

S. Some of my strengths are _____

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Authorization of Release of Information

In order for us to coordinate your treatment we may need to be in contact with your physician. If you are taking psychiatric medication you are be required to sign this *Authorization of Release of Information Form*. Your therapist will discuss this with you before contacting your physician.

I, _____ , authorize Roots & Wings and its therapists/staff to send/receive information about diagnosis and treatment planning from _____. The above information will be used for the following purposes:

__ Planning appropriate treatment or program
__ Continuing appropriate treatment or program
__ Determining eligibility for benefits or program
__ Case review
__ Updating files
__ Other (specify):_____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: __Self __Parent/legal guardian ___ Other (describe)_____

Client's Signature: _____

Printed Name: _____ Date: _____

Parent/guardian Signature: _____

Printed Name: _____ Date: _____

INTAKE FORM for WOOLSEY FIRE EMOTIONAL HEALING PROGRAM

Client Communication Guidelines

Protecting your privacy is important to us. In order to protect it, please provide a phone number and address where you can receive ***confidential*** voice messages and written communications, if necessary.

Address:_____ City/Zip:_____

Phone Number(s):_____

May we text you regarding appointment times (reminding you of your appointment, etc,)?
Please circle one: Yes No

Information that can be left in phone messages:
_____

COUNSELING / PSYCHOTHERAPY INFORMED CONSENT:

This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES
Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you hope to address. There are many different methods that may be used to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

INTAKE FORM for WOOLSEY FIRE EMOTIONAL HEALING PROGRAM

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, the therapist will be able to offer you some first impressions of what the work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with the therapist you were assigned. Likewise, at the end of the evaluation, your therapist will notify you if another therapist would be a better fit and will give you referrals to other practitioners.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about procedures, they should be discussed whenever they arise. If your doubts persist, we can help you set up a meeting with another mental health professional for a second opinion.

MEETINGS
Evaluations last from 2 to 4 sessions. During this time, we can both decide if your therapist is best person to provide the services you need in order to meet your treatment goals. If you agree to begin psychotherapy, you will usually be scheduled one 60 minute session per week, at an agreed upon time, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, if you are paying a fee, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. [If it is possible, I will try to find another time to reschedule the appointment.] If you are not paying a fee and miss two sessions without notifying us, you will no longer be eligible for free sessions.

EMDR Consent

EMDR involves the use of bilateral stimulation to help you process stored memory information from one area in the nervous system to another. According to the psychologist who discovered and developed the EMDR particles, Dr. Frances Shapiro, when a disturbing event occurs, it can get locked into the brain with the original pictures, sounds, thoughts, feelings and body sensations. EMDR seems to stimulate the information and allows the brain to process the experience. That may be what is happening in REM or dream sleep;, the eye movement (tones, tactile) may help to process the unconscious material. It is your own brain that will be doing the healing and you are the one in control.

EMDR is used to address the experiences that contribute to your current struggle with anxiety, depression, trauma symptoms, etc. EMDR involves eight phases of treatment. These include: a detailed history from you, preparation phase for EMDR, assessment of targeted memories, desensitization- reprocessing the targeted memory network, installation of positive/adaptive ways of thinking about the event and associated events, body scan- reprocessing any residual stored memories within the body, closure, and revaluation.

INTAKE FORM for WOOLSEY FIRE EMOTIONAL HEALING PROGRAM

There are some important things to know before starting EMDR treatment. First, if you have been a victim of a crime or witnessed a violent crime and are called to testify in court, EMDR can result in loss of detailed recall. Memories that are no longer emotionally charged will fade or disappear. You may no longer exhibit high emotions when recounting the events. More information may be recalled but may not be necessarily accurate. These are important considerations to talk over with your legal counsel before beginning treatment.

EMDR may cause you to experience very intense levels emotions or unexpected memories to occur while processing. It is helpful to process intense emotions when they arise if possible. It is important that you practice relaxation exercises and visualizing a safe space daily. This is an extremely important safety protocol to help you manage these things should they arise.

If you are currently abusing drugs or alcohol or recently have stopped abusing them, please inform the clinician. There are some drugs that EMDR is contraindicated for safety reasons.

EMDR is contraindicated if you have serious neurological conditions or medical conditions that impair your ability to process information. If you have a medical illness that is exacerbated by stress, it is important to discuss this with the clinician and obtain a release from your doctor to proceed with EMDR treatment.

There is no guarantee that EMDR will help you. Evidence strongly suggests that it helps improve people's quality of life, but each individual is different and different forms of treatment may be necessary to help you achieve your goals. Sometimes therapy can cause problems in relationships or make your symptoms worse before they get better. It is important to be patient and continue to work with the clinician. If you feel, for any reason that therapy is becoming too overwhelming or you need to slow it down, contact the therapist to discuss this. Don't just stop treatment.

By signing this document you are indicating that you have read through this document, understand its contents, have discussed it with the therapist and are agreeing to and consenting to the use of EMDR in your treatment. You can stop the treatment at any time.

PROFESSIONAL FEES

Fees vary based on your circumstances. If you lost your home in the Woolsey fire and we still have availability in our allocated hours from the Malibu Foundation grant, there is no charge. If you were displaced from your home from the Woolsey fire, you are eligible to receive a sliding-scale fee that you and your therapist can discuss beginning at $30 (for those at the most extreme financial hardship), to $45 to those with some financial hardship, to $60 for those with moderate financial hardship, to $75 to $100.

INTAKE FORM for WOOLSEY FIRE EMOTIONAL HEALING PROGRAM

Normal fees for those without financial hardship start at $150 per session and vary from therapist to therapist. If you meet more than the usual time, you will be charged accordingly. In addition to weekly appointments, this same hourly rate will be charged for other professional services you may need, though we will prorate the hourly cost if we work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service requested. If you become involved in legal proceedings that require our participation, you will be expected to pay for any professional time spent on your legal matter, even if the request comes from another party.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you are receiving complimentary therapy. Payment schedules for other professional services will be agreed to when such services are requested. In circumstances of unusual financial hardship, fee adjustment or payment installment plans are available.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information we will release regarding a client's treatment is his/her name, the dates, times, and 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 what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will provide you with a Superbill to submit to your insurance for possible reimbursement; however, you (not your insurance company) are responsible for full payment of my fees. It is important that you find out exactly what mental health services your insurance policy covers.

Due to the rising costs of healthcare, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek

approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow us to provide services to you once your benefits end. If this is the case, we will try to assist you in finding another provider who will help you continue your psychotherapy.]

You should also be aware that most insurance companies require that we provide them with your clinical diagnosis. Sometimes we have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any records we submit, if you request it. *You understand that, by using your insurance, you authorize Roots & Wings to release such information to your insurance company. We will try to keep that information limited to the minimum necessary.* It is important to remember that you always have the right to pay for your therapy yourself to avoid the problems described above [unless prohibited by the insurance contract].

CONTACTING YOUR THERAPIST

Therapists are often not immediately available by telephone and will probably will not answer the phone when with a client. The telephone is answered by a voicemail that is monitored frequently. The voicemail is not confidential and is checked by administrative staff, so please keep private information to a minimum. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach us and feel that you cannot wait for your therapist to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [or psychiatrist] on call. If your therapist will be unavailable for an extended time, he or she will provide you with the name of a colleague to contact, if necessary.

Electronic Communication Policy

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, we have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to

assure that it is consistent with ethics and the law. If you have any questions about this policy, please feel free to discuss this with us.

Email Communications: Roots & Wings' staff and therapists use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with the office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email about clinical matters because email is not a secure way to contact us. If you need to discuss a clinical matter, please feel free to call so we can discuss it on the phone or wait so we can discuss it during your therapy session. Face-to-face context is simply much more secure as a mode of communication.

Text Messaging: Because text messaging is a very unsecure and impersonal mode of communication, our therapists do not text message to nor respond to text messages except in cases of scheduling appointments.

Social Media: Roots and Wings therapists do not communicate with, or contact, any clients through social media platforms like Twitter, Instagram or Facebook. In addition, if we discover that we have accidentally established an online relationship with you, we will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you. Roots & Wings therapists may participate in various social networks. If you have an online presence, there is a possibility that you may encounter your therapists online. Since we believe that communications with clients online have a high potential to compromise the professional relationship, please do not try to contact your therapists in this way. Your therapists will not respond and will terminate any online contact no matter how accidental because it is not confidential for you.

Websites: Roots and Wings and Roots and Wings' therapists have websites that you are free to access. It is used for professional reasons to provide information. You are welcome to access and review the information on the websites and, if you have questions about it, it should be discussed during your therapy sessions.

Web Searches: We will not use web searches to gather information about you without your permission. We believe that this violates your privacy rights; however, we understand that you might choose to gather information about your therapist in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about your therapist through web searches, or in any other fashion for that matter, please discuss this with your therapist during your time together so that we can deal with it and its potential impact on your treatment.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychologist is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent your therapist from providing any information about your treatment. In some legal proceedings, a judge may order testimony if he/she determines that the issues demand it, and we must comply with that court order.

INTAKE FORM for WOOLSEY FIRE EMOTIONAL HEALING PROGRAM

There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a client's treatment. For example, if we believe that a child, elderly person or disabled person is being abused or has been abused, we must make a report to the appropriate state agency.

If we believe that a client is threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, we will attempt to fully discuss it with you before taking any action.

We may occasionally find it helpful to consult other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. Ordinarily, we will not tell you about these consultations unless we believe that it is important to our work together.

Roots & Wings Institute for Personal Growth and Family Excellence is a teaching institution. There are case conferences with other staff at Roots & Wings and with consultants during which the client's situation might be discussed, partly for the benefit of the trainees and interns, but also to ensure the client the highest quality of service. Identifying information will be left out or changed to protect client confidentiality. In support of quality service and training, sessions are sometimes audio - or video - taped. If a therapist wishes to tape a session, the client will be notified in advance, and has the right to refuse without penalty. The client's written permission will be obtained *before* any taping is done.

The assigned therapist will be either a licensed therapist or a therapist in training. Each trainee or intern is supervised by an appropriate licensed professional. When interns or trainees are assigned as the therapist, his/her supervisor's name, license number and contact number will be provided. Any questions about the therapist's training and experience will be answered by the assigned therapist. Clients have the right to meet and question the therapist's supervisor upon request. Trainees and interns discuss all their cases with their supervisors. Clients who have questions may feel free to ask their assigned therapist, the therapist's supervisor, or one of the Roots & Wings directors. It is possible that a client's therapist may leave Roots & Wings. In this event, the client will be given notice and every effort will be made to assist him/or her in finding another therapist.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at

our next meeting. We will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice we are unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and we are not attorneys.

Your signature below indicates that you have read the information in this document, received a copy of this document or have access to it online, and agree to abide by its terms during our professional relationship.

CLIENT SIGNATURE _____ DATE _____

NOTICE OF PRIVACY PRACTICES

I. 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.

II. Roots & Wings Institute for Personal Growth and Family Excellence (Roots & Wings) HAS A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
Roots & Wings is legally required to protect the privacy of your PHI, which includes information that can be used to identify you that we've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this Notice about our privacy practices, and such Notice must explain how, when, and why we will "use" and "disclose" your PHI. A "use" of PHI occurs when we share, examine, utilize, apply, or analyze such information within our agency; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of Roots & Wings. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, we are legally required to follow the privacy practices described in this Notice.

However, we reserve the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to PHI on file with Roots & Wings already. Before Roots & Wings makes any important changes to its policies, we will promptly change this Notice and post a new copy of it in the

waiting room. You can also request a copy of this Notice from us, or read the poster in the waiting room.

III. HOW WE MAY USE AND DISCLOSE YOUR PHI.
Roots & Wings will use and disclose your PHI for many different reasons. For some of these uses or disclosures, we will need your prior authorization; for others, however, we do not. Listed below are the different categories of Roots & Wings's uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. We can use and disclose your PHI without your consent for the following reasons:

1. For treatment. We can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you are being treated by a psychiatrist, we can disclose your PHI to your psychiatrist in order to coordinate your care.
2. To obtain payment for treatment. We can use and disclose your PHI to bill and collect payment for the treatment and services provided by us to you. For example, we might send your PHI to your insurance company or health plan to get paid for the health care services that we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies, and others that process our health care claims.
3. For health care operations. We can disclose your PHI to operate Roots & Wings. For example, we might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others to make sure we are complying with applicable laws.
4. Patient Incapacitation or Emergency. We may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as we try to get your consent after treatment is rendered, or if we try to get your consent but you are unable to communicate with us (for example, if you are unconscious or in severe pain) and we think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. We can use and disclose your PHI without your consent or authorization for the following reasons:

INTAKE FORM for WOOLSEY FIRE EMOTIONAL HEALING PROGRAM

1. When federal, state, or local laws require disclosure. For example, we may have to make a disclosure to applicable governmental officials when a law requires us to report information to government agencies and law enforcement personnel about victims of abuse or neglect.
2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, we may have to use or disclose your PHI in response to a court or administrative order. We may also have to use or disclose your PHI in response to a subpoena.
3. When law enforcement requires disclosure. For example, we may have to use or disclose your PHI in response to a search warrant.
4. When public health activities require disclosure. For example, we may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.
5. When health oversight activities require disclosure. For example, we may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.
6. To avert a serious threat to health or safety. For example, we may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.
7. For specialized government functions. If you are in the military, we may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.
8. To remind you about appointments and to inform you of health-related benefits or services. For example, we may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that we offer that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. Roots & Wings may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent we haven't taken any action in reliance on such authorization) of your PHI by Roots & Wings.

INTAKE FORM for WOOLSEY FIRE EMOTIONAL HEALING PROGRAM

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI
You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request, but we are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.
B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide the PHI to you in the format you requested.
C. The Right to Inspect and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days of receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, reasons for the denial and explain your right to have our denial reviewed.
D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 14, 2003 receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost based fee for each additional request.
E. The Right to Amend Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request to correct or

update your PHI. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES
If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact Jennifer Johnston-Jones, Ph.D. Executive Director, Roots & Wings, at hello@rootsnwings.org

VII. EFFECTIVE DATE OF THIS NOTICE This notice went into effect on April 14, 2003.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES By signing this form, you acknowledge receipt of the Roots & Wings Institute for Personal Growth and Family Excellence *Notice of Privacy Practices* that we have given to you. This *Notice of Privacy Practices* provides information about how we use and disclose your protected health information. We encourage you to read it in full.

I acknowledge receipt of *Notice of Privacy Practices* of Roots & Wings Institute for Personal Growth and Family Excellence.

Name:_____ Signature:_____ Date:_____
(client/parent/conservator/guardian #1)

INTAKE FORM for WOOLSEY FIRE EMOTIONAL HEALING PROGRAM

Name:_____ Signature:_____ Date:_____
(client/parent/conservator/guardian #2)

CONSENT FORM FOR MINORS

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify us immediately. We will ask you to provide a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is our policy to notify the other parent that we are meeting with your child. We believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, we will strive to listen carefully so that I can understand your perspectives and fully explain our perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, we will honor that decision, unless there are extraordinary circumstances. However, in most cases, we will ask that you allow us the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with your Therapist

In the course of treatment of your child, we may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, our client is your child – not the parents/guardians nor any siblings or other family members of the child. If we meet with you or other family members in the course of your child's treatment, we will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

INTAKE FORM for WOOLSEY FIRE EMOTIONAL HEALING PROGRAM

Mandatory Disclosures of Treatment Information

In some situations,we are required by law or by the guidelines of our profession to disclose information, whether or not we have your or your child's permission. We have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child clients share that they plan to cause serious harm or death to themselves, and we believe they have the intent and ability to carry out this threat in the very near future. We must take steps to inform a parent or guardian or others of what the child has told said and how serious we believe this threat to be and to try to prevent the occurrence of such harm.
- Child clients share that they plan to cause serious harm or death to someone else, and we believe they have the intent and ability to carry out this threat in the very near future. In this situation, we must inform a parent or guardian or others, and may be required to inform the person who is the target of the threatened harm [and the police].
- Child clients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, we will need to use our professional judgment to decide whether a parent or guardian should be informed.
- Child clients share, or we otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, we are required by law to report the alleged abuse to the appropriate state child-protective agency.
- We are ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the client. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is our policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then we will need to use professional judgment to decide whether your child is in serious and

immediate danger of harm. If we feel that your child is in such danger, we will communicate this information to you.

Disclosure of Minor's Treatment Records to Parents

Although the laws of California may give parents the right to see any written records kept about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings, and you agree not to request access to your child's written treatment records.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although our responsibility to your child may require helping to address conflicts between the child's parents, our role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena our records or ask us to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing our opinion about parental fitness or custody/visitation arrangements. Please note that your agreement may not prevent a judge from requiring our testimony, even though we will not do so unless legally compelled. If we are required to testify, we are ethically bound not to give our opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, we will provide information as needed, if appropriate releases are signed or a court order is provided, but we will not make any recommendation about the final decision(s). Furthermore, if required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for our participation agrees to reimburse us at the rate of $150 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Child/Adolescent client:

By signing below, you show that you have read and understood the policies described above. If you have any questions as you progress with therapy, you can ask your therapist at any time.

Minor's Signature* _____ Date_____

INTAKE FORM for WOOLSEY FIRE EMOTIONAL HEALING PROGRAM

Parent/Guardian of Minor client:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. _____ _____

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment. _____ _____

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above. _____ _____

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

* For very young children, the child's signature is not necessary