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This statement contains information regarding my office policies. Please read them and if you have any questions, discuss them with me.

Appointments Appointments are typically 45 minutes long. Depending on availability, couples therapy can be arranged for longer sessions. Your appointment time is held exclusively for you. If you are unable to keep an appointment, I require at least 48 hours notice or you will be charged for the time as though you attended (except for illness or true emergency). However, if we are able to reschedule within one week of your previously scheduled session you will not be charged. Insurance companies will not cover this charge and so the full session fee will be an out-of-pocket expense.

Emergencies In case of emergency, you may try to reach me between appointments by leaving a message on my voicemail stating your emergency, and I will try to respond as soon as possible. However, if you need immediate help, you should call 911, or go to your nearest hospital emergency room.

Fees My hourly rate is consistent with that of other clinical psychologists in the Bay Area. Please contact me for current fee. Payment in full is expected at the time of the visit unless I am able to verify applicable insurance benefits prior to the appointment. In this case, at the time of service, clients need only pay what is owed toward the deductible or for the copayment and I will bill your insurance company for the remainder.

Insurance If you would like to use insurance benefits to pay for my services or would like to inquire about whether I would be an eligible provider under your plan, please call your insurance to verify your benefits and check to see whether I am an eligible provider for your plan. However, please know that quotes by insurance companies about benefits are not guarantees of payment. Ultimately, you are responsible for the entire bill whether your insurance pays as expected or not. Please be advised that you are responsible for tracking your coverage over time. Some insurance plans have limits based on number of sessions or dollar amounts within a specific benefit period.

Billing Payments are due at the time of services unless other agreements have been made. I can provide you a monthly statement upon your request. I accept cash, check, or credit card (VISA/MasterCard). Ultimately, if your account becomes delinquent and you do not pay as agreed, your account may be turned over to a collection agency for collection and you will be held responsible for any collection costs incurred. If you receive a statement that you think is incorrect, please contact me. At times, mistakes do happen and I am always happy to clarify misunderstandings and correct errors when they occur.

Confidentiality and the Release of Information Your participation in treatment and all information about you is confidential and will not be disclosed to anyone without your written consent. Exceptions are: 1) Cases of suspected abuse or neglect of a child or elder, 2) Cases where I believe the client presents a clear and imminent danger to him/herself or to another person, 3) Cases where a court subpoenas me to testify or subpoenas my records, 4) Cases where an insurance company is helping to pay the fee and requires information about diagnosis and/or treatment.

HIPAA Notice of Policies and Practices I am committed to preserving the privacy of your personal health information. I am required by Federal law (Health Insurance Portability and Accountability Act, known as HIPAA) and by State law to protect the privacy of your personal information and to give you a Notice that describes (a) how clinical information about you may be used and disclosed and (b) how you can get access to this information.

Your signature below indicates that you have read this agreement and agree to all its terms. It also serves as an acknowledgment that you have received the HIPAA Notice of Policies and Practices described above.

Printed Name	**Signature**	**Date**

INFORMED CONSENT FOR TREATMENT AGREEMENT

BENEFITS AND RISKS OF TREATMENT

There are many potential benefits of therapy. Through therapy, you may learn new and important things about yourself, as well as new ways of handling feelings and problems. However, it is important to be aware that there are some risks involved in treatment. As problems are faced, clients sometimes experience emotional discomfort along the way. Also, therapy may result in changes in relationships, as when a client changes in ways in which family members, partners, or friends cannot easily accept. I will try to limit these risks and to help you be aware of them. But, ultimately, you must be the judge of whether the potential benefits of therapy outweigh the risks.

CLIENT RIGHTS AND RESPONSIBILITIES

Therapy is a shared responsibility between client and therapist, and involves a collaborative process that evolves from shared efforts to better understand thoughts, feelings, and behaviors. You are always welcome to ask questions about my qualifications, my therapeutic approach, or any other aspects of treatment, including treatment alternatives and the possible time frame your treatment may require. In therapy, as in any relationship, sometimes misunderstandings or difficulties arise. If you have any concerns about the therapy or therapy relationship, please feel free to discuss them with me whenever they arise so that we can attempt to resolve them. However, you have a right to terminate therapy at any time. Upon request, I would be happy to assist you in locating an alternative referral.

CONFIDENTIALITY

Under most circumstances, the information shared by you during the course of our professional relationship will not be disclosed to any other agency or person without your permission. There are, however, some situations where I am permitted or required by law or by ethical standards of my profession to disclose otherwise confidential information. These situations include threat of imminent harm to self or others, child or elder abuse, court order or subpoena of records, and billing and collection purposes.

CONSENT FOR TREATMENT AND TO THE TERMS OF THE AGREEMENT

I have read this statement of policy and understand its contents. I have asked any questions I have had about these policies. My signature below indicates that I voluntarily consent to therapy from Dr. Qin Fan under the terms described above and that I understand that I have the right to terminate therapy at any time I desire.

Name of Client/s (Print): ___________________________________ D.O.B.:__________________

Signature of Clients/Guardian: _________________________________ Date: ___________________

CLINICAL INFORMATION

I. Client's Name: ________________________________ Date of Birth:__________________
(Last) (First)
Address: ____
(Street) (City) (State) (Zip)
Phone Number(s):____
(Please note "Y" or "N" to indicate whether or not I can leave a message)

II. DEMOGRAPHICS
Age: ______Ethnicity:________________ Marital/Relationship Status: ______________
Occupation:_____________________________Company/Organization: _____________
Highest Grade Completed/Degree Earned and Date Completed: ____________________
If you attended college, provide name(s) of school(s) and field(s) of study:
____
____

III. CURRENT RELATIONSHIPS/FAMILY INFORMATION
Marital Status (Circle all that apply):
Married Committed Relationship Single Divorced Widowed

If married or domestic partner status, how long? _________________________________

If you have been married previously, note date(s) and duration below:

If you have children, list ages and gender below:

Who currently lives in your house with you?
Name Age Relationship (i.e. husband, partner, son, stepdaughter)

Is there any alcohol or drug abuse in your current home that concerns you? Yes No Unsure
Is there any violence or other abuse in your current home that concerns you? Yes No Unsure

IV. FAMILY OF ORIGIN INFORMATION
Is your mother still living? _____yes _____no Is your father still living? _____yes _____no
Are your parents (Circle all that apply): Married To Each Other Divorced/Separated Remarried
If your parents are deceased or divorced, note your age(s) when these events occurred:

If you have siblings, list ages and gender below:

Was there any alcohol or drug abuse in your home growing up? Yes No Unsure
Was there any violence or other abuse in your home growing up? Yes No Unsure
Does anyone in your family (including extended family) have a history of mental or emotional difficulties, substance abuse, or eating disorder? If yes, please list who and indicate what condition below:

V. TRAUMA/LOSS

Please briefly describe and provide approximate dates or ages related to any personal history of trauma, abuse, or significant loss you have experienced:

VI. MEDICAL/MENTAL HEALTH INFORMATION

Name of your primary care provider: ____

Address/Medical Group:_________________________ Telephone Number:___________________

Do you have any ongoing medical conditions? ________If yes, please explain:

____

____

Are there any prescribed medications that you are currently taking? _________If yes:

Medication:	Dose:	Frequency:	Prescriber:
__________________	___________	__________	_______________________

Have you ever received counseling or psychotherapy before? _______ If yes, please list:

Therapist Name:	Location (City/State):	Approximate Dates:
____________________	___________________	_________________
____________________	___________________	_________________

Have you ever been hospitalized for a psychiatric condition? _______. If yes, briefly describe why and approximate dates/ages:

Have you ever seriously considered ending your life or intentionally inflicting harm on yourself?_______ If yes, please briefly describe and provide approximate dates/ages:

Have you ever experienced any formal negative consequences because of behavior related to alcohol or drug use? _______ If yes, please briefly describe and provide approximate dates/ages:

Have you ever been charged with a crime (except traffic violations)? _______ If yes, please list crime(s) and provide approximate dates/ages:

Please indicate frequency and amount of any use of tobacco, recreational drugs, or alcohol below:

	Currently	At Greatest Frequency (Indicate approximate dates/ages)
Tobacco		
Recreational Drugs		
Alcohol		

VII. REASON FOR SEEKING SERVICES

Please briefly describe your reason(s) for seeking services from me at this time: