JULIA LUCAS, Ph.D.
Clinical Psychologist
PSY 5514

2412 Professional Drive, Roseville, CA 95661
(916) 813-8844, FAX (916) 772-2442
jlucasphd@gmail.com
website: jlucasphd.com

Patient Information:

Today's Date: _____

Patient Name: (First)_____ (Middle Initial)_____ (Last)_____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Email: _____ *Permission to contact* () Yes () No

Address: _____ City: _____

State: _____ Zip: _____ D.O.B.:_____ Age:_____ () Male () Female

Work Status: () FT Employed () PT Employed () FT Student () PT Student () Homemaker () Retired () Other

Employer's Name / Address: _____

Occupation/Job Title: _____ Work/Shift Hours: _____

Referred By: _____ Phone: _____

Address: _____

May I contact them to thank them for your referral? : () Yes () No

Emergency Contact:

***In case of an emergency you have my permission to contact:*_____**

***Address/Phone #:*_____ *Your Initials:* _____:**

Health History:

Please list any current or recurring health problems: _____

_____

Are you presently taking *any* medications? () Yes () No If yes, please list *name*, *use*, and *dosage:* _____

_____

Have you had previous mental health treatment? () Yes () No Are you in current mental health treatment? () Yes () No

Have you had any psychiatric hospitalizations? () Yes () No If yes, please indicate with whom, dates you attended and /or hospitals:_____

_____

Reasons for seeking counseling:

Please state briefly why you are seeking assistance now and what you would like to achieve: _____

_____

_____

_____

Symptom Checklist

These symptoms may or may not be related to the problem(s) that bring you in to see us. However, they may help in planning your treatment. Please check the *"C"* for current symptoms or *"P"* past symptoms.

C	P		C	P	
___	___	trouble going to sleep	___	___	allergy problem? specify _____
___	___	restless sleep	___	___	high blood pressure
___	___	waking up very early and being unable to go back to sleep	___	___	seizures
			___	___	menstrual irregularity or distress
___	___	sleeping too much	___	___	asthma attack
___	___	feeling guilty	___	___	irritable bowels, constipation, diarrhea
___	___	depressive feelings that are regularly worse in the morning	___	___	tics
			___	___	heart disease
___	___	thoughts about suicide	___	___	eating disturbance
___	___	have made suicide attempts	___	___	frequent flu or colds
___	___	fatigue or loss of energy	___	___	sinus problems
___	___	poor concentration and memory	___	___	grinding teeth, jaw tension/pain
___	___	decreased sex drive	___	___	endocrine dysfunction, e.g. thyroid problems, hypoglycemia, diabetes
___	___	significant feelings of restlessness, agitation			
___	___	loss of pleasure in usual activities; have lost your zest for life	___	___	kidney problems
			___	___	head injury
___	___	appetite loss	___	___	smoking
___	___	feeling worthless	___	___	over eating
___	___	weight loss/how much in how long? _____	___	___	over spending
___	___	weight gain/how much in how long? _____	___	___	gambling problem
___	___	feelings of sadness, depression, hopelessness	___	___	use alcohol/drugs. If you do, how frequently_____ how much_____
___	___	withdrawing from others			
			___	___	other health issue_____ _____ _____
___	___	palpitations, rapid heart beat			
___	___	light headedness			
___	___	sweating			
___	___	trembling	___	___	feeling lonely even when with others
___	___	sense of dread	___	___	feeling shy or uneasy
___	___	muscle tension	___	___	wanting to be alone often
___	___	chest pains	___	___	feeling bored with others
___	___	frequent urination	___	___	arguing with others
___	___	dizziness	___	___	feeling critical of others
___	___	panic attacks	___	___	feeling people dislike you
___	___	shortness of breath	___	___	feel that people are out to harm you
___	___	cold, clammy hands	___	___	other relationship problems
___	___	afraid of losing control	___	___	feel others do not understand you
___	___	avoiding certain situations	___	___	difficulty communicating what you really think or feel
___	___	fainting			
___	___	tense or anxious all day	___	___	feel others do not meeting your needs
___	___	very anxious in social situations	___	___	feel others are inferior to you
___	___	recurring troubling thoughts, images, impulses you can't get out of your mind	___	___	feeling inadequate, less than others
			___	___	have phobias (fears); of what? _____ _____
___	___	repetitive behaviors such as excessive hand washing, etc			
			___	___	feel that you can read people's minds
			___	___	have homicidal thoughts
___	___	decreased need for sleep	___	___	see visions/hear voices
___	___	increased sex drive	___	___	have special powers
___	___	greatly increased energy	___	___	feel that people can read your mind
___	___	described by friends as hyper or excitable	___	___	feel that people control your actions
___	___	headaches	Anything else you would like me to know? _____		
___	___	itching			
___	___	lower back pain			
___	___	nausea, upset stomach, indigestion, ulcers, vomiting			
___	___	hot or cold spells			
___	___	numbness or tingling in parts of your body			

Childhood and Family History

Current Living Situation:

Spouse/Significant Other's Name: _____

Age: _____ Spouse/Significant Other's Occupation: _____

Children's Names and Ages:

Name Age Name Age Name Age

_____

_____

_____

Who currently lives in your household? _____

Background Information:

What is your ethnic, cultural and religious background? _____

List your brothers and sisters from oldest to youngest and their ages. Indicate (B) biological, (S) step or (H) half sibling please:

Name Age Name Age Name Age

_____

_____

_____

Did your parents live together throughout your childhood? () Yes () No If not, what happened and how old were you? _____

_____

Number of times moved and at what age: _____ Grew up in _____

Special problems in the family: () Disabled child () Parents fought () Death in the family () Hospitalizations () Alcohol/drugs
() Serious medical illness () Parent unemployment () Parent changed jobs a lot () Legal problems () Other _____

_____

What were you like as a child? () Had problems learning in school () Got into trouble in school () Had problems with the law

Other (please explain): _____

Did you have any of these problems with your family? () Physically abused () Sexually abused () Fought with parents
() Felt like you did not belong () Had too much responsibility () Isolated yourself from the family () Emotionally abused
() Other _____

Take these few lines to describe your childhood and your relationship with your parents:

_____

_____

_____

_____

_____

_____

_____

CONSENT TO TREATMENT AND CONFIDENTIALITY

CONSENT TO TREATMENT

Psychotherapy may involve change, or the possibility of change, which may feel threatening and cause anxiety not only to you but also to those people close to you. The prospect of giving up old habits, no matter how destructive or painful, can often make you feel quite vulnerable. At the same time, discovering tools and techniques that are used to improve the quality of your life and your relationships can be very helpful. Most people find the benefits of therapy outweigh any risks. In fact, sometimes there can be more risks associated with *not* participating in therapy.

- **My Credentials:** I am a **licensed clinical psychologist** and an **independent private practitioner.** I provide individual, couples and family therapy to adults and adolescents.

- **Session Duration:** Unless otherwise agreed, the session is **45-50 minutes** in length. Weekly appointments are the usual pattern when beginning psychotherapy. Other arrangements may be made depending on your individual circumstances and clinical needs.

- **Fees:** My fee is $150 per session for individual psychotherapy, couples or family therapy. The fee for forensic services (depositions, court appearances, etc.) is $350/hour, including travel time, with a half-day minimum. ***Fees are paid at the time of the appointment.***

- **Insurance Reimbursement:** Your health insurance may provide some reimbursement for mental health treatment. I can provide you with a statement for you to submit directly to your insurance company.

- **Missed or Canceled Appointments:** ***No-show or canceled appointments may incur the full charge of the session unless a twenty-four hour notice is given*****,** except for unforeseen emergencies or crises which require your immediate attention. Please call and let me know as soon as possible if you will not be able to come to your appointment. You may leave a voicemail message at **(916) 813-8844**, which is available **24 hours a day**, 7 days a week.

- **General Availability and Telephone Calls:** I am available in the office for appointments and telephone calls on **Monday, Tuesday, Wednesday, and Thursday during normal business hours and on Friday mornings.** During evenings and other days of the week, (Friday, Saturday, Sunday), a message can be left on my voicemail at any time. **If it is urgent you reach me during these hours, leave your message and indicate that it is urgent that you speak to me.** I will return your call as soon as I am able. Please remember to leave your telephone number(s), including cell #s. ***If your call is not returned within two days, please call again. Errors can occur in telephone numbers or voicemail clarity*****.**

- **Email:** I prefer using email only to schedule appointments or for other administrative matters. Please do not email me content related to your therapy sessions, as **email is not completely secure or confidential**. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send you become part of your psychotherapy record.

- **Emergencies:** ***If you are dealing with an imminent or life-threatening emergency please phone 911 immediately*. If you are experiencing a psychiatric emergency, please call Sutter Center for Psychiatry at (800) 801-3077.**

- ***Professional Records:*** *The laws and standards of my profession require that I keep information about you in your Clinical Record. Except in unusual circumstances where I believe that access is reasonably likely to cause substantial harm, you may request a copy of your Clinical Record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents.*

- **Treatment of Minors**: In most cases, when the patient is a minor, the law allows parents to examine their child's treatment records. However, because privacy is crucial to successful progress for many children and adolescents, it is usually my policy to request an agreement between patient and their parents about access to information. This agreement provides that during treatment, I will give only general information about progress and the patient's attendance at scheduled sessions. If a patient discloses something which affects their safety, I will either assist the patient in discussing this with their parents or notify their parents of my concerns. In the rare case where disclosure of this information to the parent would put the patient at risk, I will notify the appropriate agencies to ensure the patient's safety.

- ***Termination:*** *As the patient, you have the right to terminate treatment at any time. As the therapist, I can terminate treatment at anytime and facilitate a referral. If I determine you are not sufficiently benefiting from treatment, it is my ethical duty to refer you to alternative care.*

CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you provide written Authorization. But, there are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- I may find it helpful to consult other health and mental health professionals about a case without revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential.

- You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis and sometimes additional clinical information. I will make every

effort to release only the minimum information about you that is necessary for the purpose requested. Though all insurance companies claim to keep such information confidential, I 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. I will provide you with a copy of any report I submit, if you request it.

- If you are involved in a court proceeding and a request is made for records, I cannot provide any information without your written authorization, a court order, or other legal action compelling me to release the information. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities pursuant to their legal authority, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files a worker's compensation claim, I must, upon appropriate request, disclose information relevant to the claimant's condition, to the worker's compensation insurer.

- If a patient's account is seriously past due, I may disclose necessary information to a collection agency.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I reasonably suspect that a child under 18 has been the victim of child abuse or neglect, the law requires that I file a report with the appropriate governmental agency. I also may make a report if I reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way. Once such a report is filed, I may be required to provide additional information.

- If I observe or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, the law requires that I report to the appropriate government agency. Once such a report is filed, I may be required to provide additional information.

- If a patient communicates a serious threat of physical violence against an identifiable victim, I must take protective actions, including notifying the potential victim and contacting the police. I may also seek hospitalization of the patient, or contact others who can assist in protecting the victim.

- If I have reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to him or herself, I may be obligated to take protective action, including seeking hospitalization or contacting family members or others who can help provide protection.

If such a situation arises, I will make every effort to fully discuss it with you and I will limit my disclosure to what is necessary.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTOOD THIS AGREEMENT AND THAT YOU VOLUNTARILY AGREE TO PARTICIPATE IN TREATMENT. If the person receiving care is a minor, a parent or legal guardian acknowledges having read and understood this document and voluntarily agrees to the minor's participation in treatment.

SIGN HERE

_____

Patient's/Guardian's Signature Date

_____

Printed Name

NOTICE OF PRIVACY PRACTICES
Notice of Julia Lucas, Ph.D.
Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Disclosures for Treatment, Payment, and Health Care Operations
As your psychologist, I may *use* or *disclose* your *protected health information* (*PHI*), for certain *treatment, payment, and health care operations* purposes without your *authorization*. In certain circumstances I can only do so when the person or business requesting your PHI gives a written request that includes certain promises regarding protecting the confidentiality of your PHI. To help clarify these terms, here are some definitions:

- "*Use*" applies only to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.
- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment"* is when I provide diagnosis or therapy for you. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist, regarding your treatment.
- "*Payment"* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *"Health Care Operations"* is when I disclose your PHI to your health care service plan (for example your health insurer), or to your other health care providers contracting with your plan, for administering the plan, such as case management and care coordination.
- *"Authorization"* means written permission for specific uses or disclosures.

II. Uses and Disclosures Requiring Authorization
Under certain circumstances, I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances, I will obtain an authorization from you before releasing this information. You may revoke or modify this authorization at any time; however, the revocation or modification is not effective until received. I will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this Notice.

III. Uses and Disclosures with Neither Consent nor Authorization
I may also use or disclose PHI *without your consent* or authorization in the following circumstances:

Child Abuse: Whenever I, in my professional capacity, have knowledge of or observe a child I know or reasonably suspect, has been the victim of child abuse or neglect, I must immediately report such to a police department or sheriff's department, county probation department, or county welfare department. Also, if I have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, I may report such to the above agencies.

Adult and Domestic Abuse: If I, in my professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these or if I reasonably suspect such, I must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency.

I do not have to report such an incident if:

- I have been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect;
- I am not aware of any independent evidence that corroborates the statement that the abuse has occurred;
- The elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and
- In the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

Health Oversight: If a complaint is filed against me with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is protected by psychologist-patient privilege law. I cannot provide any information without your (or your legally-appointed representative's) written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where that party has given you proper notice (when required) has stated valid legal grounds for obtaining PHI, and I do not have grounds for objecting under state law (or you have instructed me not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

Serious Threat to Health or Safety: If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.

Worker's Compensation: If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of the your initial examination, and at subsequent intervals as may be required by the administrative director of the Worker's Compensation Commission in order to determine your eligibility for worker's compensation.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:
Right to Request Restrictions –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket – You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

Right to Be Notified if There is a Breach of Your Unsecured PHI – You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Dr. Lucas' Duties:
I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures and you are a current patient, I will attempt to notify you of the revisions on or after the effective date and you may request a written copy of the Revised Notice from this office.

Breach Notification:
When I become aware of, or suspect a breach in security of your PHI, I will conduct a Risk Assessment. I will keep a written record of this assessment and notify you if there is a reasonable probability that your PHI has been compromised. I will also make changes in my privacy practices to prevent the re-occurrence of such breaches**.**

V. Complaints
If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me and if you believe your concerns are not addressed, you may contact the Board of Psychology at the California Department of Consumer Affairs.
You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Effective Date, Restrictions, and Changes to Privacy Policy
This notice will go into effect on April 15, 2003. Updated September 1, 2013.
I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. You may request a copy of the revised notice on or after the effective date.

JULIA LUCAS, PH.D.
Licensed Psychologist, PSY 5514
2412 Professional Drive, Roseville CA 95661

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

This form serves to acknowledge that I have received the Notice of Privacy Practices of Julia Lucas, Ph.D. The Notice of Privacy Practices describes my rights and the obligations of Julia Lucas, Ph.D. to protect my health information including how my psychological and medical information may be used and disclosed as well as how I may access this information.

Patient Name: _____

Relationship to patient: Self _____ Other: _____

Date Notice Received: _____

By signing this form, I acknowledge that I have received the Notice of Privacy Practices of Julia Lucas, Ph.D.

_____ _____
Patient/Guardian's Signature Date