OMEGA
MENTAL HEALTH
2549 W Shaw Ave
Fresno, CA 93711
Tel 559-290-7142
Fax 559-283-8166

File Checklist

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Court Orders

Letters/Correspondence

ROIs

Standard Chart Audit

Clinical Chart Audit

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Consent for Treatment

Therapeutic Contract

Receipt of PP

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Consent for Treatment

I _____ authorize and request that _____,_____/Omega Mental Health to carry out a clinical assessment and therapeutic treatment which now or during the treatment of Myself / Child are advisable.
(Circle one above)

Office Policies

Litigation / Court:

I / Omega Mental Health will not be involved in litigation unless required by law. If required by law my fee is $300.00 per hour with a 4-hour minimum and payment must be paid by cash, check, or money order. Payment is due before the court date. This charge is not payable from the insurance company. You will be responsible for this charge.
I /Omega Mental Health also will not write any letters or fill out any forms on your behalf as it relates to litigation or court unless required by law.
*fees not applicable to Medi-Cal clients

Insurance Reimbursement:

Any co-payments for insurance reimbursements must be made at the time services are rendered. If billing a PPO insurance, then you must bill your own insurance. I will provide you with the appropriate billing information, which you will send for reimbursement.
** You are responsible for checking your insurance coverage and confirming certain coverage for examples at times family or couples is not covered. If you start treatment and we find out these are not covered, you are responsible for the full fee that we would charge your insurance. If you change insurance carriers you are responsible for letting us know.

No-Shows/ Cancellation:

Since an appointment time is reserved specifically for you, telephone notice is required 24 hours in advance for rescheduling or cancellation of an appointment.
** Even with a phone call to cancel if there are two cancellations within 2-3 months your case will be closed as multiple cancellations are not conducive to your progress in therapy.

Health and Safety:

If anyone in your household has (or you suspect they have) bed bugs, fleas, lice, or any other highly communicable infestation we ask that you leave and not return until the issue is resolved. This is for

the protection of all the many clients and clinicians who are in and out on a regular basis. Please be sure to let your clinician or an office staff member know of any condition regarding this policy.

Contact information:

If you need to contact me between sessions, please call me at the above number and leave a message and contact number where you can be reached. I will return your call as soon as possible. Office hours are Monday – Friday 9am-6pm. You may also e-mail me at the e-mail address listed on my card.

Emergency Procedure:

An emergency is an unexpected event that requires immediate attention and can be a threat to your health. If an emergency arises, and the emergency requires it, please call 911 or admit yourself to a hospital for observation as I may not always be available. You may then call the office and we can arrange an earlier session.

I have read and understand these policies:

_____	_____	_____
Name Printed (self if 12 or older)	*Signature*	*Date*
_____	_____	_____
Name Printed (Parent or Guardian)	*Signature*	*Date*

_____ _____

Therapist Signature & Title with Omega Mental Health *Date*

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Consent for Telehealth

I, _____ understand that “telehealth” allows my therapist to diagnose, consult, treat, transfer medical data, and educate using interactive audio, video, or data communication regarding my treatment. I understand that telehealth may also involve the communication of my medical/mental information to health care practitioners located in California to further my diagnosis and treatment or to insure payment of treatment.

I understand that I have the following rights under this agreement:

I have a right to confidentiality with telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the telehealth interaction to any other entities shall not occur without my written consent.

I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal, and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to telehealth, including, but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I understand that I have a right to access my medical information and copies of medical records in accordance with applicable California law.

I understand that I have a right to withhold or withdraw consent at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

I have read and understand the information provided above. I have the right to discuss any and all of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I _____ hereby CONSENT to participating in psychotherapy via video internet (hereinafter referred to as “telehealth”) with my therapist,_____.

I _____ hereby DECLINE to participating in psychotherapy via video internet (hereinafter referred to as “telehealth”) with my therapist,_____

_____

Email

_____

or Cell Phone Number

_____ _____

Client Signature *Date*

_____ _____

Parent/Guardian Signature *Date*

_____ _____

Therapist Signature & Title with Alpha Behavioral Counseling Center *Date*

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Therapeutic Contract

The therapy process: Participating in therapy can result in several benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working towards these benefits however, requires effort on your part and may result in you experiencing some discomfort. Change will sometimes be easy and swift, but more often it will be slow and frustrating. Remembering and resolving significant life events in therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended. As part of my therapeutic process I use several techniques pulled from various theoretical approaches to help improve the quality of life for my clients.

Client's Rights: you have the right to a confidential relationship with me. Within certain legal limits (see #3 below), information revealed by you during therapy will be kept completely confidential and will not be revealed to any person without your written permission.

1. You have the right to know the content of your records at any time and I have the right to provide you with the complete records or a summary of their content.
2. If you ask me, I can release any part of your records on file to any person you specify. I will tell you when you make your request whether I think releasing that information to that agency or person might be harmful to you.
3. Under certain legally defined situations, I have the duty to reveal information you tell me during therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:
    - Revealing to me active child or elderly abuse or neglect. If a perpetrator is in contact with the victims and there is reasonable suspicion, he/she may still be engaging in such abuse I am legally mandated to make a report.
    - Revealing active or past abuse of a child that resulted in the child's death, I am legally mandated to make a report.
    - If you seriously threaten harm or death to another person, I am required to warn the intended victim and notify the appropriate law enforcement agencies.
    - If you are in therapy or are being tested by court order, the results of the treatment or tests must be revealed to the court.
    - If a judge issues a legitimate subpoena, I am required to provide the information specifically described in that subpoena.
    - If you are in a lawsuit claiming emotional harm, the opposing side may subpoena your therapy records.
    - If you state or I have reason to believe you will harm or kill yourself, I will take the necessary steps for your protection.
4. You have the right to ask questions about any of the techniques used in the course of your therapy.

5. Should you choose not to enter therapy with me, I will provide you with the names of other qualified professionals whose services you might prefer.
6. You have the right to terminate therapy with me at any time without any financial, legal or moral obligations other than those you have already incurred. I have the right to terminate therapy with you under the following conditions:
    - When I believe that therapy is no longer beneficial to you.
    - When I believe that you will be better served by another professional.
    - When you have not paid for the last two sessions.
    - When you have failed to show up for your last two therapy sessions without a cancellation phone call.
    - If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If I have written consent, I will provide that professional with information they request.

Initial here:

_____ If any of these situations apply, I will send you a letter to your address of record to inform you of my decision and I will give you the names of several therapists for future counseling needs.

As life can bring about unexpected circumstances, should I be unable to continue your therapy, I will have a trusted therapist contact you to discuss what would be best for you at the time.

Fees and Length of Therapy:

I agree to enter therapy with Omega Mental Health. I understand that I can leave therapy at any time and I have no financial, legal, or moral obligation to complete a maximum number of sessions.

_____ _____

Client Signature *Date*

_____ _____

Parent/Guardian Signature (if necessary) *Date*

_____ _____

Therapist Signature & Title with Omega Mental Health *Date*

Local Emergency Services for Suicide Prevention

If you are experiencing a LIFE THREATENING EMRGENCY please call 911.

If you require mental health crisis intervention, which is not a medical or psychiatric emergency, please contact:

Exodus Recovery

Crisis Stabilization Center

(Cedar Ave. and Kings Canyon Rd.)

4411 E. Kings Canyon Road

Fresno, CA 93702

Youth Unit (559) 600-6760

Adult Unit (559) 453-1008

Resources for Adult:

Community Behavioral Health

7171 N Cedar Ave, Fresno, CA 93720

(559) 449-8000

Option #1

Urgent Care Wellness Center

4441 E Kings Canyon Rd, Fresno, CA 93703

(559) 600-9171

Resources for Children and Youth:

Central Star Psychiatric Health Facility (PHF)

4411 E Kings Canyon Rd #319, Fresno, CA 93702

(559) 800-2382

Extension 100

National Resources for Suicide Prevention and Survivors

American Foundation for Suicide Prevention

Web site: http://www.afsp.org

Suicide Prevention Resource Center

Web site: http://www.sprc.org

Suicide Prevention National Hotline:

1-800-273-8255

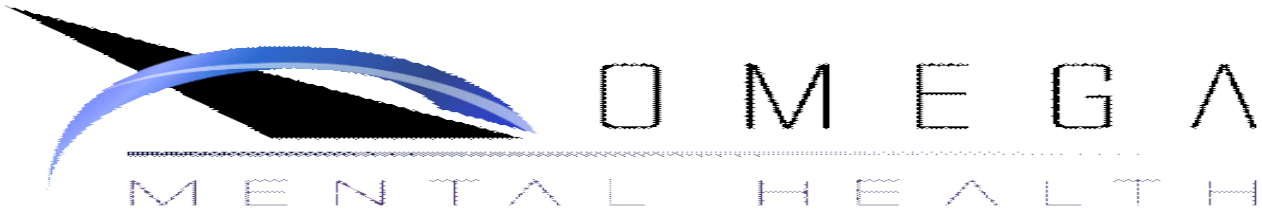
http://suicidepreventionlifeline.org/

At the top right-hand corner, there is a chat option.

Crisis Text Line

Text 741741

A crisis counselor will text you back.



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you (the client or parent/guardian of client) acknowledge that this agency has offered you the Notice of Privacy Practices. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my Notice, you may obtain a copy of the revised Notice by contacting me at (559)290-7142.

If you have questions about my Notice of Privacy Practices, please contact me at:

2549 W Shaw Ave
Fresno, Ca 93711

I acknowledge the offer or receipt of the Notice of Privacy Practices of Omega Mental Health.

_____ _____

Signature of Client or Parent/Guardian *Date*

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

I made good faith attempts to obtain my client's acknowledgement of their receipt of my Notice of Privacy practices including:_____

However, because of the following reason(s) the acknowledgement was not obtained:

_____

I was unable to obtain my client's acknowledgement.

_____ _____

Signature of Provider & Title *Date*

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Session Observation Permission Form

Omega Mental Health is a non-profit organization utilizing Marriage and Family Therapist Trainees, Professional Clinical Counselor Trainees, and Clinical Social Worker Trainees. As such, there will be times when other clinicians associated with Omega Mental Health will be sitting in on sessions, or some sessions may be recorded on audio and/or video, for the intended purpose of educational and clinical growth. However, all confidentiality remains in place.

- ❑ I agree to allow a licensed clinician to observe my session(s) as needed during my treatment at Omega Mental Health.

- ❑ I decline to allow a licensed clinician to observe my session(s) as needed during my treatment at Omega Mental Health.

Print Name: _____ Date: _____

Signature: _____ Date: _____

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CLIENT EMERGENCY CONTACT FORM

Name_____

Primary Therapist_____

Emergency Contact Info:

Name_____

Relationship _____

Address _____

City, State, ZIP _____

Home Telephone Number _____

Cell Phone Number _____

Work Telephone Number _____

Employer _____

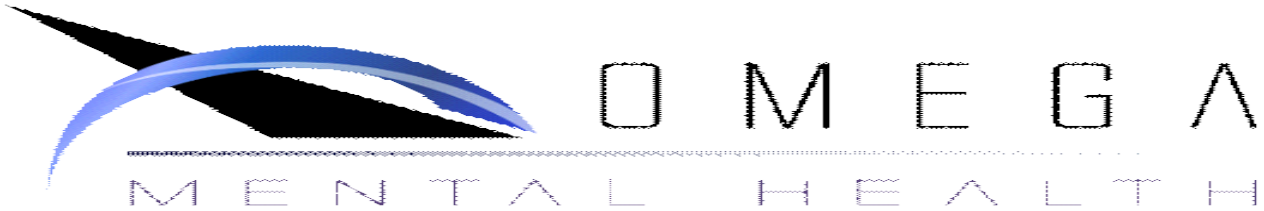
Medical Contact Info:

Doctor Name. _____

Phone Number _____

▪ I have voluntarily provided the above contact information and authorize Omega Mental Health and its representatives to contact any of the above on my behalf in the event of an emergency.

Signature: _____ **Date:** _____



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Counseling Intake Form

This information will be kept confidential.

Demographic Information

Name:	Date of Birth:
Gender:	Marital Status:
Age:	SSN:
Race:	Ethnicity:
Home/Mobile Phone:	Ok to leave message? Yes No
Work Phone:	Ok to leave message? Yes No
Email:	Ok to email? Yes No
Mailing Address:	
City:	Zip Code:
# of Dependents:	Occupation Status?
Current Employer:	Position/Title:
How were you referred:	If online, which website?

Counseling Intake Form Page 2

This information will be kept confidential.

Current Concerns

What concern brings you to us?

When did this begin to be a problem for you (dates)?

Please describe significant events occurring at that time, or since that time, that may be related to the development or maintenance of this concern.

Are you having difficulty or increased stress in your current job? If so please briefly describe those difficulties.

What goals do you hope to accomplish in counseling?

What obstacle might get in your way?

Have you been in therapy before or received any prior professional assistance for your concerns? If so, please provide approximate dates of treatment(s) and describe results:

Counseling Intake Form Page 3

This information will be kept confidential

Behavior – please circle any of the following that apply to you.

Overeating	Attempted suicide	Can't keep a job	Use alcohol or illegal drugs to cope
Compulsive behavior	Insomnia/can't sleep	Smoking (and want to stop)	Find myself doing risky things
Odd behavior	Withdrawn socially	No motivation	Nervous tics
Obsessing about my weight	Crying for no reason	Very impulsive	Overwork myself
Procrastinating too much	Sleep too much	Lose control easily	Temper outbursts
Racing thoughts	Tapping, fidgeting constantly	Pull hair or skin	Physical violence

Feelings – please circle any that apply to you.

Angry	Bored	Guilty	Sad	Unhappy	Annoyed	Happy
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Helpless	Hopeful	Excited	Optimistic	Panicky
Energetic	Relaxed	Tense	Envious	Jealous	Others	

Physical – please circle any that apply to you.

Headaches	Stomach trouble	Skin problems	Dizziness	Tics	Dry Mouth	
Fatigue	Burning/itchy skin	Muscle Spasms	Twitches	Chest pains	Tension	
Rapid heartbeat	Sexual issues	Tremors	Can't relax	Fainting spells	Bowel disturbances	
Hear things	Excessive sweating	Tingling	Watery eyes	Visual difficulties	Blushing/flushed	
Hearing problems	Don't like to be touched	Palpitations	Neck pain	Blackouts	Numbness	

Overly active	Can't sit still	Easily distracted	Poor communication	Impulsive	Restless

Does not do as asked	Argues with others	Back talks	Trouble	Bossy	Hits kids
Teases or is teased	Irritable	Temper outbursts	Destructive	Threatens others	Hits adults
Steals	Mean to animals	Lies	Gang involved	Alcohol/drug use	Ran away from home
Fire starting	Juvenile Hall/Prison involvement	History of physical abuse	History of Foster Care	Grades dropped	Doesn't complete homework
Difficulty with school/work	Truant	Late often	Has been suspended	Sad	Clingy
Suicidal thoughts	Sexual activity/problems	Low self-esteem	Hopeless	No friends	Stays to self
Overly tired	Reduced activity	Reduced interest	Cuts on self	Too little or too much sleep	Strange Behavior or Thinking
Wakes up at night	Wets the bed	Sees/hears things	Too little eating	Too much eating	Concerned with diet
Forces self to vomit	Often worries and afraid	Shy	Headaches or stomach aches	History of molestation	Afraid due to family problems

Biological Factors

Do you have any medical conditions or physical issues? (please list):

Medications you are taking or have taken in the past six months (Include over the counter medications):

Do any of your maternal or paternal relatives have mental health diagnoses or substance abuse issues (please specify):

Do you exercise regularly, and if so, how often/what kind of exercise?

	Never	Rarely	Often	Very Often		Never	Rarely	Often	Very often
Marijuana use					Heart problems				
Tranquilizer use					Nausea				
Sedatives					Vomiting (voluntary)				
Aspirin					Vomiting (involuntary)				
Cocaine					Insomnia				
Coffee					Headaches				
Alcohol					Backaches				
Cigarettes					Wake too early				
Narcotics					Can’t get to sleep				
Stimulants					Junk food				
Hallucinogens					Lack of interest in activities				
Diarrhea					Constipation				
Compulsive exercise					High blood pressure				
Use of laxatives to lose weight					Allergies				