PEREZ MOON PEREZ
PSYCHOTHERAPY & FAMILY COURT SERVICES

6700 Indiana Avenue Suite 110 Riverside, CA 92506
E-mail office@perezmoonperez.com • Ph: 951-369-9990 • Fax: 951-369-9090 •
Website: Psychotherapyandfamilycourtservices.com

CLIENT'S INFORMATION SHEET

PLEASE PRINT

PLEASE USE BLUE OR BLACK INK

CLIENT'S NAME * _____
FIRST LAST MI

PREFERRED NAME* _____

HOME PHONE# *(___)_____ WORK PHONE # ( ) _____

CELL PHONE # ( )_____MARITAL STATUS: M S D / W

STREET ADDRESS * _____

CITY*_____ZIP*_____EMAIL* _____

SOCIAL SECURITY_____-_____-_____D.O.B. _____

SEX * M ☐ F ☐ RACE*_____HISPANIC ORIGIN? YES ☐ OR NO ☐

HOW WERE YOU REFERRED:

(Choose one): ☐ Former client ☐ Friend ☐ Attorney ☐ EAP ☐ Internet ☐Court.

RESPONSIBLE PARTY INFORMATION: (Choose One) ☐ SELF ☐ SPOUSE ☐ PARENT/GUARDIAN.

NAME: _____
FIRST LAST MI

ADDRESS: _____

SOCIAL SECURITY ---------- _____ D.O.B_____DRIVERS LICENSE: _____

CELL PHONE ( )_____HOME PHONE NUMBER ( ) _____

EMPLOYER: _____

CITY: _____ **STATE:** _____ **ZIP :** _____

SIGNATURE:_____ **DATE :**_____

--EMERGENCY CONTACT--

INFORMATION ON NEAREST RELATIVE OR FRIEND

NAME:_____**PHONE #:** _____

_____ _____
DATE **SIGNATURE OF PATIENT / LEGAL GUARDIAN**

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CLIENT DATA RECORD

(The following information is required to bill insurance company- Please complete thoroughly)
If you are NOT using insurance, please mark N/A on each highlighted line.

PRIMARY INSURANCE COMPANY: _____

PHONE NUMBER : ( )_____**MEMBER ID :** _____

GROUP NUMBER:_____**POLICY NUMBER:** _____

CLAIMS ADDRESS : _____

INSURED NAME:_____**INSURED D.O.B** _____

SUBSCRIBER NAME:_____**SUBSCRIBERS D.O.B** _____

SUBSCRIBERS SOCIAL SECURITY: ----------_____ **EMPLOYER:** _____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE COMPANY: _____

PHONE NUMBER : ( )_____**MEMBER ID :** _____

GROUP NUMBER:_____**POLICY NUMBER:** _____

CLAIMS ADDRESS : _____

INSURED NAME:_____**INSURED D.O.B** _____

SUBSCRIBER NAME:_____**SUBSCRIBERS D.O.B** _____

SUBSCRIBERS SOCIAL SECURITY: ----------_____ **EMPLOYER:** _____

RELATIONSHIP TO PATIENT: _____

EMPLOYEE ASSISTANCE COMPANY: _____
PHONE NUMBER: ( )_____**EAP REFERRAL NUMBER:** _____

VICTIM SERVICES: ☐ YES ☐ No
☐ Pending
Application Submitted: _____

PHONE NUMBER: ( )_____**REFERRAL NUMBER:** _____

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OPT OUT OF INSURANCE

- ***If this does not apply to you, please mark N/A then sign on signature line.***

Client name:_____ Date of Birth:_____

Please initial next to each statement below:

_____ I prefer to opt out of using my insurance to cover the cost of counseling sessions.

_____ I understand that I could choose to seek services from an in-network provider, but at this time I am choosing to self-pay my provider.

_____ I understand that opting out of using my insurance means I must pay out of pocket for the services I receive. I may be eligible for a sliding scale fee as a result of opting out of using my insurance.

_____ I agree to let my provider know if anything changes or I obtain other insurance.

_____ I understand that by opting out I cannot use the payment for my services towards my deductible because the insurance will not be billed.

_____I understand that if I later choose to use my insurance, my therapist is not liable, and is not obligated to reimburse previous sessions for which I chose to opt out. Opting in to using insurance will not be effective until I notify my provider of the change and cannot be backdated to cover previous services.

I agree to pay the agreed upon fee of $_____per session beginning on_____.

Client Signature:_____Date:_____
Parent/Guardian

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Court Ordered Cases

Please initial next to court ordered case that applies to you and sign on the signature line.
If this does not apply to you, please mark NA on signature line.

- **FC 3111 Child Custody Evaluation: $5,000.00 for retainer.**
  Initial: _____

- **FC 3118 Child Sexual Abuse Evaluation: $7,000.00 for retainer.**
  Initial: _____

- **Reunification Therapy: $200.00/hour**
  Initial: _____

- **EC 730 Child Custody Evaluation: $8,500.00 for retainer.**
  Initial: _____

- **EC 730 Supplemental Child Custody Evaluation: $6,500.00 for retainer.**
  Initial: _____

- **EC 733 Child Custody Evaluation Review: $6,500.00 for retainer.**
  Initial:_____

- **Documentation: $150.00 Deposit per Request- Billable at $150.00 per page thereafter**
  Initial: _____

- **For Sworn Testimony/Deposition: $500.00/hour with 4 hours minimum.**
  Initial: _____

- **Parenting Plan Coordinator/ Special Master (Co- Parenting): $1,500 each party totaling $3,000 for retainer.**
  Initial: _____

- **Professional Visitation Monitor: In house by appointment $50/hour (+$25 per additional child). In field by appointment $75/hour (+$25 per additional child). Initial Interview required via teletherapy or in person. Two hours minimum for all visits. Custodial parent facilitates travel. Documentation additional charge.**
  Initial: _____

- **Court Ordered Substance Abuse Assessment: Includes minimum of 5 sessions at $250.00 + $500 Administrative Fee. Totaling $1,750.00**
  Initial: _____

Sign:_____ **Date:** _____

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- I certify that I am eligible for the insurance indicated upon registration and I understand that payment is my responsibility regardless of insurance coverage**.**

- I authorize Perez Moon Perez, or individual provider and agents thereof, to release my complete health record (including records related to mental healthcare, communicable diseases, HIV or AID, and treatment of alcohol or drug abuse) to my insurance carrier or third party if necessary, to facilitate processing of my insurance claims.
- I authorize payment directly to Perez Moon Perez, or individual provider, for all benefits payable to me under the terms of the insurance policy for treatment of service provided to me or my dependents by this provider.

- I understand that failure to pay outstanding balances within 90 days of notification of the amount due may result in assignment to an outside collection agency. I understand there will be a $35.00 fee for checks returned for insufficient funds.

- Further, I am aware that my insurance may require a prior authorization and it is my responsibility to see to it that prior authorization is in place for the treatment I receive.

SIGNATURE OF CLIENT
Parent/Guardian

PRINTED NAME

RELATIONSHIP TO CLIENT

DATE

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WELCOME TO OUR OFFICE!

We find that communication with our clients regarding financial policies assist us in providing the best service to you. We therefore have answered some of the most asked questions. If you have any additional questions feel free to ask us. We are happy to assist you.

PAYMENT AT THE TIME OF SERVICES RENDERED

Payment is expected at the time services are rendered. We accept Cash, Credit Cards, Debit Cards and Personal Checks. Both Co-Payment and/or the contracted rate from your insurance carrier are due at each session. *On rare occasions and only with case approval are financial arrangements made available.*

INSURANCE AND OTHER THIRD-PARTY PAYORS

Courtesy billing for those with third party payers is available in these offices. We allow 30 – 45 days for third party payer processing. If there is a problem, we will inform you ASAP. It is your responsibility as well to make sure your account is clear. Please inform us if any intake information changes.

EMPLOYEE ASSISTANCE PROGRAMS (EAP)

As a courtesy to our clients, we will bill your employee assistance company for you if you provide us with the appropriate information including the EAP company name and their telephone number. We will need any authorization numbers and any identifying information you can provide. If there are specialized billing forms, you will be responsible for providing those to us at PMPP or you could be responsible for your EAP sessions at our office fee schedule. We will be happy to provide the EAP with the clinical information required.

Please advise us immediately if you have insurance coverage or secondary insurance coverage or if there is any change in your insurance coverage or policy while you are involved in treatment. We can bill an insurance carrier immediately after EAP authorizations are used. You are responsible to inform us if there are changes to your EAP benefits. Please note, some EAP's have different billing cycles, i.e. some only allow for billing at end of authorized sessions. While in treatment, you are expected to understand that company's practices and our office practices.

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FEE SCHEDULE

Our office fee schedule is $180 for all initial sessions and $160 for all subsequent sessions for providers:

- Claudia Moon-Perez LMFT
- Robert Perez LMFT
- Jennifer Simmons, LMFT
- Ashley Saldana, LCSW

Fee Schedule for other providers: $50.00 per session

- Katherine Hall, ALMFT

Initial Here: _____

If we are contracted providers for your insurance, our staff will assist you with the applicable contracted rate. Note, when it is necessary to bill for non-covered and/or non-medically necessary clinical time for example for **court work or forensic work that fee schedule is at a $200/ hour rate.** That fee can be billed in incremental 15-minute time periods. If you are a candidate for that billing system, your therapist will orient you to that process.

Initial Here: _____

APPEALS AND GREIVANCES

I acknowledge my right to request reconsideration, an appeal, in the case that outpatient visits are denied by insurance certification. I understand that I would request an appeal through my therapist and know I risk nothing in exercising this right.
I understand that I may submit a complaint or grievance to my provider or the group director at any time about my care. If I am not satisfied with the response I receive, I can send my complaint directly to my insurance carrier.

Initial Here: _____

EMERGENCY ACCESS

Therapists are available after hours to handle emergency or life-threatening situations. By calling the main office number and following the directions for emergency contact, you may speak to a therapist on-call by telephone. It is always recommended to call your PC and/or visit your urgent care or emergency room whenever there are medical complications. Urgent calls can also be required during regular office hours and all therapists in these offices are directed to return urgent calls within a two-hour period. Please note that the office staff are not clinicians and they cannot/will not discuss any clinical issues with you and will refer you back to your therapist.

Initial Here: _____

OFFICE HOURS/ ON-CALL POLICY

I recognize that office hours are formally 9am-5pm weekdays. Appointments are generally offered during these hours. Some therapists have chosen to work outside of these official office hours. Office staff will often not be able to accommodate questions and billing information beyond office hours. It is my responsibility to work with the office staff to update my business account during office hours.

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CANCELLATION - LATE SHOWS- MISSED APPOINTMENTS

Scheduled appointments are reserved especially for you. If an appointment is missed or cancelled with less than 24-hour notification, you will be billed accordingly to the fee schedule and rules of your benefit plan. Repeated "No Show" appointments could result in referring you back to your insurance carrier for reassignment, to another provider, or you may receive a referral list to other local providers. If your insurance or third-party payer does not pay for no shows, you may be responsible and expected to pay this if that missed appointment time cannot be filled.

Initial Here: _____

CONSENT FOR TREATMENT

I authorize and request that my therapist carry out psychological examinations, treatment, and/or diagnostic procedures, which are now and during my care advisable. I understand that while the course of therapy is designed to be helpful, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, anger, etc. Please be aware that this is a normal response to talking about unresolved life experiences and will be worked on between you and your therapist. If at any time these reactions become unbearable; I will notify my therapist as soon as possible.
Initial Here: _____

INTERN FEE FOR SERVICE

When available and for the convenience of our clients we do, at times, offer a sliding scale-based fee schedule with interns who are supervised with licensed clinicians. Income verification with PerezMoonPerez Psychotherapy (PMPP) director's approval is required for those appointments.
Initial Here: _____

CHILDREN
Please decide with your agents if you cannot provide monitoring for unattended children. Children are welcome but should have activities to occupy their time.
Initial Here: _____

ADDITIONAL FEES
If there is an occasion to either review paperwork, former treatment, consult with other relevant professionals or you chose with your therapist's consent to communicate via email, text or by electronic means, note that this is the utilization of the professional time strictly dedicated to you by your clinician and will be or can be billed as professional time. Please feel free to discuss this with your clinician. The time billed can be at a minimum of 15 minutes of our office "court fee" schedule of $200/hour per occurrence.

Initial Here: _____

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CONSENT FOR TREATMENT

As the adult authorizing treatment please indicate the primary clinician you have designated to treat:
If the patient is a child or dependent of the beneficiary, then the legal guardian/representative for the patient should complete the following.

I legally authorize Claudia S. Moon-Perez, LMFT to deliver Mental Health Care services.
Initial Here: _____

I legally authorize Robert R. Perez, LMFT to deliver Mental Health Care services.
Initial Here: _____

I legally authorize Jennifer M. Simmons, LMFT to deliver Mental Health Care services.
Initial Here: _____

I legally authorize Katherine Hall, AMFT to deliver Mental Health Care services.
Initial Here: _____

I legally authorize Ashley Saldana, LCSW to deliver Mental Health Care services.
Initial Here:_____

Please sign below your consent to treatment:

_____

Signature of Patient or Legal Guardian/Representative

_____

Date

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Authorization for Release of Confidential Information

❖ **If this does not apply to you, please mark N/A, then sign on signature line**

NAME:_____ **DOB:**_____
NAME:_____ **DOB:**_____
NAME:_____ **DOB:**_____
NAME:_____ **DOB:**_____

Disclosure of the specific type of information which is considered instrumental in the ongoing evaluation and treatment of the above individual shall be limited to the following professional:
I hereby authorize:

☐ **Claudia S. Moon-Perez, LMFT 31370**
☐ **Robert R. Perez, LMFT 28017**
☐ **Jennifer M. Simmons, LMFT 34926**
☐ **Katherine Hall, AMFT 109169**
☐ **Ashley Saldana, LCSW 101444**
☐ **Catherine Perez, BA 0931500**
Professional Supervised Visit Monitor

Disclose and release information to party indicated below: (please provide name and contact info)
1._____
2._____
3._____
4._____
5._____

I understand that I may revoke this consent at any time, except to the extent that has already been acted upon prior to my revocation. This consent shall remain in effect unless a written request for revocation is received.
I am fully aware that before my records may be released, I must give consent. I may refuse to sign this release and having been made aware of State and Federal statutes, I voluntarily and knowingly sign.

_____
Signature

_____
Date

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Consent to Record, Videotape or Photograph

I give Perez Moon Perez Psychotherapy and Family Court Services permission to record my child and or myself in assessment and sessions while my family is receiving treatment. Video will be used only by the therapist in her/his treatment of clients (for example, to review portions of sessions to enhance treatment outcomes, etc.), and for supervision with a qualified supervisor. Photographs of my child or their creations (for example, drawings, etc.) will likewise be used only to further treatment goals or to document important therapeutic goals. I understand that these videos and content of these sessions are confidential material. I understand that I may withdrawal my permission to record at any time by supplying the office with a written request. A copy faxed/emailed/scanned/photograph of this release shall be considered as an original.

SIGNATURE OF LEGAL GUARDIAN/PARENT

PRINTED NAME OF LEGAL GUARDIAN/PARENT

SIGNATURE OF LEGAL GUARDIAN/PARENT

PRINTED NAME OF LEGAL PARENT

SIGNATURE OF CHILD OVER 12 YEARS OLD

PRINTED NAME OF CHILD OVER 12 YEARS OLD

DATE

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Credit / Debit Card Payment Consent Form

- If this does not apply to you, please mark N/A on line 3
- If you wish to pay cash only, please fill out client name and write cash pay on line 3

1. CLIENT NAME
2. NAME ON CARD IF DIFFERENT THAN CLIENT
3. CREDIT CARD #
4. EXPIRATION DATE
5. CVV CODE; ON BACK OF CARD
6. ZIP CODE AFFILIATED WITH BILLING ADDRESS

I authorize Perez Moon Perez Psychotherapy, or third party as assigned, to charge my credit/debit/health account card for professional services rendered. It is my understanding that if I have provided valid contracted insurance information, this office will first bill the insurance(s) for assignment of benefits, with the exception of office co-pay which may be paid on or about the date of service, and charges incurred as a result of no-shows, late cancellations, or checks returned due to insufficient funds – in accordance with office policies.
I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied.

SIGNATURE

PRINTED NAME

DATE

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Text Messaging and E-Mail

I hereby consent and state my preference to have the office of Perez Moon Perez and representatives thereof, communicate with me by email and/or standard SMS/Text messaging, in addition to or instead of leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to appointment scheduling, appointment reminders, and billing statements. I understand that email and standard SMS/text messages are not considered confidential methods of communication and may not be secure, I further understand that because of this there is a risk that email, and standard SMS/text messaging might be intercepted by and read by a third party.

Please indicate appointment reminder preference (Choose only one):_____Text_____Voice

SIGNATURE

PRINTED NAME

DATE

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Copies of Valid Photo ID and Insurance Card

Our office asks that you provide us with a copy of a valid photo identification and a copy of your insurance card, if applicable. We have provided a list of acceptable forms of ID and a space to indicate if you will be forwarding an insurance card. Please take a photo or scan the **front and back** of these cards. You can attach these files when forwarding your filled out new client packet. We thank you for your cooperation.

Please check which form of ID you will be forwarding:

- ☐ Government/ State Issued ID
- ☐ Drivers License
- ☐ US Military ID
- ☐ Military dependent's ID
- ☐ US Passport or Passport card
- ☐ Permanent Resident Card
- ☐ Student ID

Will you be forwarding copies/photos of your Insurance Card?

- ☐ Yes
- ☐ N/A

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CONFIDENTIALLY OF PERSONAL AND HEALTH INFORMATION (PHI)

NOTICE OF PRIVACY PRACTICES

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.
Our office is committed to protecting the personal and health information (PHI) of our patients in each of the settings in which such information is received or disclosed.
When you complete an application for health coverage, your signature authorizes your health plan to collect personal information that included both your medical information and individually identifiable information about you such as your social security number, date of birth, address, telephone number, etc.
As a patient of our office his general consent allows your counselor to communicate with your authorized
providers and health plan about treatment and payment decisions.
Our office also participates in qualify measurement activities that may require us to access your PHI, and
we have policies to protect this information from inappropriate disclosure. We release this information only if aggregated or encoded.
We will not disclose, sell, or otherwise use your PHI unless permitted by law for protection of personal safety and to the extent necessary to administer your benefit.
We will obtain written authorization from you to use your PHI for any other purpose than indicated above.
For any of our patients unable to give consent, we have a policy in place to protect your rights and which permits your legally authorized representative to give consent on your behalf.
Our office will also not release you PHI to your employer without specific authorization, unless law permits such release.
Your healthcare plan has policies in place to allow you to inspect your medical records maintained after April 4, 2003 and, when needed, to include a written statement from you. You also have the right to request an accounting of disclosures of PHI made for purposes other than stated above. To exercise any of these
rights, you may contact your health plan. If at any time, you have a complaint regarding how your PHI was used and/or disclosed, you may file a grievance, which will be investigated, and outcome reported in
writing to member.

This policy is in effect as of April 4, 2003.

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SYMPTOMS IDENTIFICATION LIST

PATIENT'S NAME _____

Please state your present problem(s) and the length of time you have experienced it/them:

_____

_____

_____

Please take a few minutes to complete this survey. Circle the number that applies to you.
The numbers range from 0-5 depending upon the severity of the symptom.

	0	1	2	3	4	5
	No problem					**Severe problem**
Nervousness	0	1	2	3	4	5
Nightmares	0	1	2	3	4	5
Poor memory	0	1	2	3	4	5
Poor concentration	0	1	2	3	4	5
Worry all the time	0	1	2	3	4	5
Panic attacks	0	1	2	3	4	5
Feelings of dread	0	1	2	3	4	5
Loss of appetite	0	1	2	3	4	5
Sadness	0	1	2	3	4	5
Crying spells	0	1	2	3	4	5
Loss of interest in activities	0	1	2	3	4	5
Weight loss	0	1	2	3	4	5
Extreme tiredness	0	1	2	3	4	5
Headaches	0	1	2	3	4	5
Suicidal thoughts & plans	0	1	2	3	4	5
Suspiciousness	0	1	2	3	4	5
Hearing voices	0	1	2	3	4	5
Feelings of hopeless/helplessness	0	1	2	3	4	5
Loss of interest in sex	0	1	2	3	4	5
Impulse control problems	0	1	2	3	4	5
Sleep Problems	0	1	2	3	4	5