

# ERENE SOLIMAN, PSY.D.

Licensed Psychologist, PSY 23162

## New Patient Intake Form

Please provide the following information and answer the questions below. Information you provide here is protected as confidential information.

Today's Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Your Name: \_\_\_\_\_ (First, Middle, & Last)

Home Street Address: \_\_\_\_\_ Apt. \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ (May I leave a message/text?)  Yes  No Please Note: Text correspondence is not considered to be a confidential medium of communication.

Email: \_\_\_\_\_ (May I email you?)  Yes  No Please Note: Email correspondence is not considered to be a confidential medium of communication.

Your Medical Doctor/Clinic: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_

Doctor's Address: \_\_\_\_\_ Suite \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If you enter treatment with me, may I coordinate your care with your medical doctor?  Yes  No

How were you referred  NetworkTherapy.com  PsychologyToday.com  Google Ad to me:  My Professional Website  Insurance Referral  Word of Mouth  Referred by friend  Referred by Physician  EAP: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Religious/Spiritual  Christian  Catholic  Jewish Affiliation:  Islamic  Buddhist  Protestant  Agnostic or Atheist  Other: \_\_\_\_\_

Spiritual Involvement:  None  Some/Irregular  Active

Race/Ethnicity:  White  Hispanic or Latino  Asian American  Native American  Black or African American  Native or Other  Other: \_\_\_\_\_ Pacific Islander

Sexual Orientation:  Heterosexual  Bisexual  Gay  Lesbian

Other: \_\_\_\_\_

With whom do you currently live: \_\_\_\_\_

5151 N. Palm Ave.  
Suite 500  
Fresno, CA, 93704  
Esoliman@att.net  
559 449-2734  
559 449-2733

Relationship status:  Single/Never Married  Domestic Partnership  Married  
 Separated  Divorced \_\_\_ times  Widowed \_\_\_ times  
 Dating/Not Living Together  Dating/Living Together

Do you have children/ages of children? \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Relationship to You : \_\_\_\_\_

Emergency Contact Telephone Number: (\_\_\_\_) \_\_\_\_\_

Educational Level:  Some High School  GED or High School Graduate  
 Some College  Four-Year Degree  
 Currently in College  Graduate or Advanced Education

Military History: Years in Service: \_\_\_\_\_ Branch: \_\_\_\_\_ Discharge Rank: \_\_\_\_\_  
Military Occupation: \_\_\_\_\_

Employment Status:  Part-Time  Full-Time  Unemployed  
 Stay-at-home Parent  Disabled  Retired  
 Student  Other

Occupation/employer: \_\_\_\_\_

Do you have any legal problems/history of arrests? \_\_\_\_\_

Do you have a worker's compensation claim/injury? \_\_\_\_\_

Are you court-ordered or court-recommended for therapy? \_\_\_\_\_

What medical problems/illnesses do you have? \_\_\_\_\_

How is your current physical health, in general?

Excellent  Good  Satisfactory  Fair  Poor

How would you rate your current nutrition and eating habits, in general?

Excellent  Good  Satisfactory  Fair  Poor

On average, how many days do you exercise per week?

None  1-2 days  3-4 days  5-6 day  7 days

How would you rate your current sleeping habits?

Excellent  Good  Satisfactory  Fair  Poor

On average, how many hours of sleep do you get per night? \_\_\_\_\_

Do you smoke cigarettes or chew and if so, how much? \_\_\_\_\_

Do you drink alcohol and if so, how much? \_\_\_\_\_

Do you use recreational drugs and if so, what and how much? \_\_\_\_\_

Have you ever received (or been encouraged to receive) alcohol/drug treatment? \_\_\_\_\_

What are your current medications & doses? \_\_\_\_\_

What is the main difficulty/presenting issue(s) that motivated you to seek therapy at this time? \_\_\_\_\_

How long have you been coping with this? \_\_\_\_\_

What is the severity level of your current distress (scale of 1-10, 10 being worst): \_\_\_\_\_

Please list any previously received mental health services (therapy, psychiatric services, dates of service): \_\_\_\_\_

Have you ever been prescribed psychiatric medication? If so, when and what medications? \_\_\_\_\_

Have you ever been hospitalized for mental health reasons? If so, when and what was the reason(s) for your hospitalization(s)? \_\_\_\_\_

Have you ever engaged in any self-harming behavior (cutting, scratching, burning, etc.)? If so, when and how? \_\_\_\_\_

Have you ever attempted to take your own life? If so, when and how did you try? \_\_\_\_\_

Have you ever attempted to or succeeded in harming someone else? If so, when and how did you try? \_\_\_\_\_

Are you currently having thoughts of harming yourself or someone else? \_\_\_\_\_

How was your childhood/growing up? \_\_\_\_\_

To your knowledge, did you have any developmental delays, special education, or grade retention? \_\_\_\_\_

Do you have any distress in relationships with your parents/siblings/extended family? \_\_\_\_\_

Please list any mental health and medical problems that run in your family (e.g., mother with depression): \_\_\_\_\_

Do you have any distress in your present day close relationships (romantic, marital, friendship, etc.)? \_\_\_\_\_

How is your current level of accessible social support in your life?

- Excellent       Good       Satisfactory       Fair       Poor

Who is in your support system? \_\_\_\_\_

What is one of your strengths? \_\_\_\_\_

What is one of your limitations/areas for growth? \_\_\_\_\_

What do you hope to accomplish in therapy? \_\_\_\_\_

Please check if you are experiencing any of the following mood symptoms:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Depressed or sad mood        | <input type="checkbox"/> Feeling less joy in life or less interest in life                             | <input type="checkbox"/> Thoughts of death/suicide |
| <input type="checkbox"/> Fatigue/low energy           | <input type="checkbox"/> Weight/appetite change (gain or loss)   | <input type="checkbox"/> Decreased sexual desire   |
| <input type="checkbox"/> Too much or too little sleep | <input type="checkbox"/> Feel worthless or too much guilt  | <input type="checkbox"/> Difficulty concentrating  |
| <input type="checkbox"/> Increased irritability       | <input type="checkbox"/> Feeling rested after 3-4 hours of sleep for many nights and not feeling tired | <input type="checkbox"/> Reckless behavior         |
| <input type="checkbox"/> More talkative than usual    | <input type="checkbox"/> Increased sexual activity or promiscuity                                      | <input type="checkbox"/> None of these             |
| <input type="checkbox"/> Feeling powerful             | <input type="checkbox"/> Thoughts of harming someone else  |  |

Please check if you are experiencing any of the following anxiety symptoms:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Anxiety or panic attack   | <input type="checkbox"/> Worry that is difficult to stop    | <input type="checkbox"/> Trembling or shaking   |
| <input type="checkbox"/> Racing heart beat/pulse   | <input type="checkbox"/> Felt anxiety was making you crazy  | <input type="checkbox"/> Fear of losing control |
| <input type="checkbox"/> Fear of death or dying  | <input type="checkbox"/> Uncomfortable in social situations | <input type="checkbox"/> Checking constantly    |
| <input type="checkbox"/> Worried about anxiety so much that it stopped you from leaving your home or going out |   |   |
| <input type="checkbox"/> Thoughts in your mind that are hard to stop (obsessing)                               |   | <input type="checkbox"/> Counting in your head  |
| <input type="checkbox"/> Repetitive hand washing, tapping, showering or activity you could not stop            |   | <input type="checkbox"/> None of these          |

Please check if you are experiencing or have experienced (in childhood or adulthood) any of the following stress/trauma symptoms or traumatic experiences:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Emotional Abuse           | <input type="checkbox"/> Physical Abuse                               | <input type="checkbox"/> Sexual Abuse                              |
| <input type="checkbox"/> Neglect                   | <input type="checkbox"/> Unwanted Sexual Experience                   | <input type="checkbox"/> Distressing dreams                        |
| <input type="checkbox"/> Feeling out of body       | <input type="checkbox"/> Distressing memories of past events          | <input type="checkbox"/> Feeling things are not real               |
| <input type="checkbox"/> Losing big chunks of time | <input type="checkbox"/> Attempts to block out or forget old memories | <input type="checkbox"/> Have had painful or hard life experiences |
| <input type="checkbox"/> Other: _____              |   |  |
| <input type="checkbox"/> None of these             |   |  |

Please check if you are experiencing or have experienced any of the following thought symptoms:

- |  |   |
|--|---|
| <input type="checkbox"/> Heard voices that others say might not be there     | <input type="checkbox"/> Seen images that others say might not be there       |
| <input type="checkbox"/> Strange smell that others do not smell              | <input type="checkbox"/> Strange tastes that do not make sense                |
| <input type="checkbox"/> Felt sensations on your body that do not make sense | <input type="checkbox"/> Felt people are out to get you, harm you, follow you |
| <input type="checkbox"/> Felt people are talking about you                   | <input type="checkbox"/> Receiving unspoken messages from others              |
| <input type="checkbox"/> None of these                                       |   |

Please check if you are experiencing any of the following eating/body symptoms:

- |  |  |
|--|--|
| <input type="checkbox"/> I am very concerned about my weight                       | <input type="checkbox"/> I restrict my diet                                  |
| <input type="checkbox"/> I make myself vomit or use laxatives to control my weight | <input type="checkbox"/> I sometimes binge on food                           |
| <input type="checkbox"/> I spend hours every day working out to control my weight  | <input type="checkbox"/> I spend a lot of time thinking about my weight/body |
| <input type="checkbox"/> None of these   |  |

Please check if any of the following traits describe you:

- |   |  |
|---|--|
| <input type="checkbox"/> I am very fearful of being alone or being abandoned                          | <input type="checkbox"/> I feel like I am on an emotional roller coaster     |
| <input type="checkbox"/> I tend to build people up and then be disappointed                           | <input type="checkbox"/> I can change my personality to fit the situation    |
| <input type="checkbox"/> Sometimes I am not sure who I am   |  |
| <input type="checkbox"/> I can be impulsive in ways that are harmful (sex, spending, driving, eating) |  |
| <input type="checkbox"/> I tend to feel empty inside  | <input type="checkbox"/> I can get angry and have a temper                   |
| <input type="checkbox"/> People sometimes call me arrogant  | <input type="checkbox"/> I find it difficult to understand what others feel  |
| <input type="checkbox"/> I am very concerned about power  | <input type="checkbox"/> I am special and sometimes people do not realize it |
| <input type="checkbox"/> I find it difficult to follow social norms                                   | <input type="checkbox"/> I find it difficult to plan ahead                   |
| <input type="checkbox"/> I sometimes get into physical fights   | <input type="checkbox"/> It is difficult for me to show remorse              |
| <input type="checkbox"/> I am superstitious   | <input type="checkbox"/> I have a sixth sense                                |
| <input type="checkbox"/> I prefer solitary activities   | <input type="checkbox"/> I neither desire nor enjoy close relationships      |
| <input type="checkbox"/> I have limited but intense interest in only a few activities                 |  |
| <input type="checkbox"/> I have difficulty making every day decisions                                 | <input type="checkbox"/> I have a hard time initiating project on my own     |
| <input type="checkbox"/> I tend to be preoccupied with details and rules                              | <input type="checkbox"/> I tend to be perfectionistic                        |
| <input type="checkbox"/> Right is always right and wrong is always wrong                              | <input type="checkbox"/> None of these                                       |

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here:

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THANK YOU!



**ERENE SOLIMAN, PSY.D.**

Licensed Psychologist, PSY 23162

Credit/Debit Card on File: Billing Authorization Form

Missed Appointments & Cancellations: As indicated in my Informed Consent for Treatment, I ask that you provide a minimum of 24 hours' notice for cancellations. A fee of \$150 will be charged for missed appointments and late cancellations. These charges are not covered by insurance.

Please initial each of the following five items and then complete the credit/debit card information for this authorization form:

- 1) \_\_\_\_ The undersigned agrees and authorizes Erene Soliman, Psy.D. to charge the credit/debit card indicated below for any account balances.
- 2) \_\_\_\_ Account balances include, but are not limited to, co-pays, co-insurance, balances not covered by insurance, fees for cancellations given with less than 24 hours' notice, and no-show appointment fees.
- 3) \_\_\_\_ For late cancellations and no-show appointments, the card will be charged on the same date as the missed appointment.
- 4) \_\_\_\_ The undersigned authorized Erene Soliman, Psy.D. to process the credit/debit card as "Signature on File" for any balance due on your account.
- 5) \_\_\_\_ If you would like a receipt sent to you for billed charges, indicate your email address or cellular phone number that you would like a receipt sent to: \_\_\_\_\_

Name as it appears on the credit card: \_\_\_\_\_

Type of credit card: Visa    American Express    MasterCard    Discover

16-Digit Card Number: \_\_\_\_\_

Card Expiration Month & Year: \_\_\_\_\_

3-Digit Security Code (on back of card): \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_

Your Name (Printed): \_\_\_\_\_

Your Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_



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Fresno, CA, 93704  
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559 449-2733



# ERENE SOLIMAN, PSY.D.

Licensed Psychologist, PSY 23162

## Informed Consent for Treatment

Welcome to my practice! This form contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. If you have any questions about anything within this document, I encourage you to bring them up when we meet. When you sign this form, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me with the following exceptions: I have taken action in reliance on it, if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied any financial obligations incurred.

**Consent to Use and Disclose Your Health Information:** When I assess, test, diagnose, treat, or refer you, I will be collecting "protected health information" (PHI) about you. This information will be used in my office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to help provide other treatment to you. By signing this form, you are agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard my Notice of Policies and Practices to Protect the Privacy of Your Health Information, which explains in more detail what your rights are and how I can use and share your information. In addition, your signature acknowledges that I offered you a copy of the notice and this informed consent form.

**Confidentiality:** I adhere to the provisions of California law, which protects the confidentiality of your treatment. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA and/or California law. However, there are some situations in which I am legally obligated to take actions to protect people from harm. In these situations, I may have to reveal some information about your treatment. If any of these situations arise, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is legally or ethically necessary. These situations include the following:

***Imminent Danger:*** When there is a clear and present danger to someone's life (suicidal threats, homicidal threats, or investigations of homicide).

***Child Abuse:*** If I, in my professional capacity, have reasonable cause to believe a child may be an abused child, a neglected child, or the victim of mental suffering/emotional endangerment.

***Adult and Domestic Abuse:*** If I, in my professional capacity, have reason to believe physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult has occurred.

***Court Orders:*** When information is subpoenaed by a court of law and a court order is issued.

In addition to the above legal obligations, no Authorization is required in the following situations:

***Email Communication:*** If you elect to communicate with me via email, please be aware that email is not considered a confidential medium of communication.

***Text Message Communication:*** If you elect to communicate with me via text message, please be aware that texting is not considered a confidential medium of communication.

***Consultation:*** I regularly find it helpful to consult with other mental health professionals about my work. I do not reveal the identity of my patients, and I use the consultation to gain perspective on my assessment and treatment. The professionals with whom I consult are also legally bound to keep the information confidential.

***Court Orders:*** If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot disclose any information without a court order, but sometimes courts issue such orders. 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.

**Health Oversight Activities:** If a government agency is requesting the information for health oversight activities, I may be required to provide it to them.

**Lawsuits:** If you file a complaint or lawsuit against me, I may disclose relevant information in order to defend myself.

**Worker's Compensation:** If you file a worker's compensation claim, and I am rendering treatment or services in accordance with the provisions of California Workers' Compensation law, I must, upon appropriate request, provide a copy of your Clinical Records to your employer or his/her appropriate designee.

**Office Hours:** Hours are by appointment only Monday – Friday. Usually, once we have agreed upon an appointment time, this will likely remain your regular appointment day/time unless we specify otherwise.

**Emergencies:** If you have an emergency, you should contact emergency resources by **calling 911** or going to the nearest emergency room. In addition, you can also call the **24-hour crisis hotline 888-506-5991**. I monitor my messages frequently, but I do not use a back-up answering service. Therefore, it is not usually possible to reach me quickly outside of normal business hours for an emergency. If you may need extra help during a crisis, please bring that to my attention so we can make specific plans.

**Telephone Calls, Emails, & Text Messages:** I have voicemail, email, and text messaging but I am often not immediately available to be in contact with you outside of your regular appointment time as I am usually in session. I typically return calls, texts, and emails within 24 hours unless specified otherwise. Calls, texts, and emails received on weekends or holidays will normally be responded to the following business day.

**Risks & Considerations of Using Email/Text to Communicate:** I will use reasonable means to protect the security and confidentiality of information sent and received between us. However, I cannot guarantee the security of email and text communication and I am not liable for improper disclosure of confidential information that is not caused by intentional misuse. Transmitting information by email and text message has a number of risks and responsibilities that you should consider before using these methods of communication. These include, but are not limited to, the following:

- Email/text is to be used for general information only. Do not use it for medical emergencies, time sensitive matters, or for sharing non-general medical/psychiatric information.
- Email/text is not a substitute for the care provided during a session; an in-person appointment should be made to discuss any new issues as well as any sensitive information.
- Email/text is not considered a confidential medium of communication:
- Email/text can be forwarded and stored in numerous paper and electronic files.
- Email/text can be accidentally received by unintended recipients.
- Email/text can be used as evidence in court.
- Backup copies of email/text may exist even after the sender/recipient has deleted his or her copy.
- Employers and online services may archive and inspect emails/texts transmitted through their services.

**Social Media Sites:** The Internet and technology are ever evolving and it is important to understand how I conduct myself on the Internet as a licensed psychologist and how you can expect me to respond to various interactions that may occur on the Internet. I do not accept friend or contact requests from current or former patients on any social networking site (Facebook, LinkedIn, Twitter, etc.). Social media sites may compromise your confidentiality, compromise our respective privacy, and/or blur the boundaries of our professional, therapeutic relationship. Please do not use messaging on social networking sites to contact me as these sites are not secure or confidential.

**Business Review Sites:** You may find my psychology practice on sites such as Healthgrades, Google Business, Yelp, YellowPages, or other sites which list businesses. Some of these sites include forums in which users rate their providers and add reviews and some automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is not a request for a testimonial, rating, or endorsement from you as my patient. Of course, you have a right to express yourself on any site you wish but it is not a confidential form of communication and there is a good possibility I may never see the feedback. All of the information available on my website ([www.esolimanpsychservices.com](http://www.esolimanpsychservices.com)) is accessible for public viewing and you may also send me a message via my website.

**Professional Records:** The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Records. I maintain these records in a locked secure location and my electronic files are secured in a fully encrypted database. You may examine and/or receive a copy of your Clinical Records if you request it in writing. 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. In most circumstances, I am charging a copying fee of \$0.25 per page (and for certain other expenses). I may deny your access to your Clinical Records 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.

**Fees, Billing, & Payments:** My fee for services is \$150 regardless of whether it is an individual, couples/marriage, family, or group therapy session. In addition to weekly appointments, I charge this amount for other professional services you may need. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. I ask that you pay for each session/service at the time it is held unless we make other arrangements. Fees for psychological assessments are generally set for the entire examination rather than the specific time involved and will be discussed in the first meeting. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. I charge \$175 per hour for preparation and attendance at any legal proceeding.

**Missed Appointments & Cancellations:** I require a minimum of 24 hours advance notice for cancellations. A fee of \$150 will be charged for missed appointments and late cancellations. These charges are not covered by insurance. If you have 2 or more consecutive missed appointments, we will transfer care to another mental health professional in the community along with a list of providers who maybe be able to assist with your needs.

**Returned Checks & Unpaid Charges:** Should your check be returned for any reason a \$25.00 service fee will be added to your account. Any unpaid balance over 60 days is subject to late charges unless other terms have been negotiated. Should your account become delinquent, overdue charges, collection fees, attorney fees, and court costs may be added to the outstanding balance. I use a collection service for unpaid accounts of more than 60 days unless a repayment plan has been negotiated and followed.

**Insurance:** To determine if you have mental health coverage through your insurance carrier, you should contact your insurance carrier to confirm benefits. Due to the rising costs of health care, insurance benefits have become increasingly more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs sometimes require authorization before they provide reimbursement for mental health services. Check your coverage carefully and make sure you understand their answers. I will provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you, not your insurance company, are financially responsible for any balances not covered by insurance.

**Notice to Consumers:** California Board of Psychology regulates the practice of psychology. If you are ever unhappy with my services or our work together, I hope you will talk about it with me so that I can respond respectfully to your concerns. The Department of Consumer Affairs' Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. If you have questions or complaints you may contact the Board on the internet at [www.psychboard.ca.gov](http://www.psychboard.ca.gov), by emailing [bopmail@dca.ca.gov](mailto:bopmail@dca.ca.gov), calling 866-503-3221, or writing: Board of Psychology; 1625 North Market Blvd. Suite N-215; Sacramento, CA 95834.

## **Minors:**

### **Parent Authorization for Minor's Mental Health Treatment**

In order to authorize mental health treatment for your child, both parents must consent to treatment. I require an affidavit to be signed for all minors. If you are separated or divorced from the other parent, please notify me immediately. I request you to provide me with a copy of the most recent custody order that establishes custodial rights of the child.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.



**Camera Surveillance.** The Corporation may use camera and/or video surveillance equipment in strategically located internal and external areas of the workplace to monitor movements. Cameras may operate continuously, and surveillance may be ongoing. You will not be recorded during your own private session.

**Safety:** The safety of Erene Soliman, Psy.D employees and clients are an important concern to the organization. Threats, threatening behavior or acts of violence against employees, clients, visitors or others while in my practice, conducting business or receiving services from my practice will not be tolerated. Violations of this policy may result in immediate termination. Physical violence may result in being asked to leave the facility or the possibility of law enforcement being involved.

**Substance Use:** Treatment will not be effective if you come under the influence and you will be asked to leave.

**Patient Acknowledgement & Agreement:** Your signature below indicates that you have read and fully understand the information in this document, you have discussed with me and had answered any questions you had, and you agree to abide by the terms of this document during our professional relationship. This form will be kept in your file and you may have a copy if you would like. I, Erene Soliman, Psy.D, supervise trainees to help improve accessibility to services in an underserved community. If you have objections to this treatment, please indicate so below in writing in the additional space below.

\_\_\_\_\_  
Your Printed Name

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Parent/ Guardian Signature (if patient is under 18)

\_\_\_\_\_  
Date Signed

## Notification of Trainee Clinician Status

Erene Soliman, Psy.D.  
Clinical Psychologist PSY23162  
5151 N. Palm Ave., Suite 610  
(559) 449-2734  
erenesoliman@erenesolimanpsyd.hush.com  
esolimanpsychservices.com

This notification advises you that \_\_\_\_\_ is an unlicensed clinician who is supervised by Dr. Erene Soliman, a licensed clinical psychologist. Dr. Soliman is \_\_\_\_\_'s clinical supervisor and oversees the treatment and/or assessment you will receive. Dr. Soliman is a California-licensed Psychologist; license number PSY 23162. Under California laws pertaining to the practice of Psychology, \_\_\_\_\_ is authorized to provide psychological services under Dr. Soliman's direct supervision. If you have questions about either our services or the supervision provided under this training arrangement, you may discuss them with your clinician or their supervisor.

*From the Client:*

"I understand that my privileged and confidential information will be exchanged between Dr. Soliman, as Clinical Supervisor, and \_\_\_\_\_ as unlicensed clinician, solely for the purpose of training and supervision. My information will be kept confidential in all other circumstances, except as required by law, unless I provide a written release."

Please sign below as an indication of your having read and understood this notification.

\_\_\_\_\_  
Client/Legal Guardian of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client/Legal Guardian

\_\_\_\_\_  
Training Clinician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Erene Soliman, Psy.D.  
Clinical Psychologist PSY23162

\_\_\_\_\_  
Date

## Current Medications List

Name: \_\_\_\_\_ Emergency Contact Name/Phone: \_\_\_\_\_

Date Last Updated: \_\_\_\_\_

**Prescription Medications:**

Name of Medication	Strength and Frequency	Condition Medication Taken For	Physician who Prescribed Med	Notes

**Allergies**


**Pharmacy/Prescription Drug Plan**
