Erene Soliman Psychologist, Inc.
Licensed Psychologist, PSY23162

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 Ste 500
Fresno, CA 93704
(559) 449-2734
(559) 449-2733
esolimanpsychservices.com

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 or 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 days ❑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 & does? ______________________________

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:

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

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

❑Anxiety or panic attack ❑Worry that is difficult to stop ❑Trembling or shaking
❑Racing heartbeat/pulse ❑Felt anxiety was making you crazy ❑Fear of losing control
❑Fear of death of dying ❑Uncomfortable in social situations ❑Checking constantly
❑Worried about anxiety so much that it stopped you from leaving your home or going out
❑Thoughts in your mind that are hard to stop (obsessing) ❑Counting in your head
❑Repetitive hand washing, tapping, showering or activity you could not stop ❑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:

❑Emotional Abuse ❑Physical Abuse ❑Sexual Abuse
❑Neglect ❑Unwanted Sexual Experience ❑Distressing dreams
❑Feeling out of body ❑Distressing memories of past event ❑Feeling things are not real
❑Losing big chunks of time ❑Attempts to block out or forget old memories ❑Have had painful or hard life experiences
❑Other: ______________________
❑None of these

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

❑Heard voices that others say might not be there ❑Seen images that others say might not be there
❑Strange smell that others do not smell ❑Strange tastes that do not make sense
❑Felt sensations on your body that do not make sense ❑Felt people are out to get you, harm you, follow you
❑Felt people are talking about you ❑Receiving unspoken messages from others
❑None of these

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

❑I am very concerned about my weight ❑I restrict my diet
❑I make myself vomit or use laxatives to control my weight ❑I sometimes binge on food
❑I spend hours every day working out to control my weight ❑I spend a lot of time thinking about my weight/body
❑None of these

Please check if any of the following traits describe you:

❑I am very fearful of being alone or abandoned ❑I feel like I am on an emotional roller coaster
❑I tend to build people up and then be disappointed ❑I can change my personality to fit the situation
❑Sometimes I am not sure who I am
❑I can be impulsive in ways that are harmful (sex, spending, driving, eating)
❑I tend to feel empty inside ❑I can get angry and have a temper
❑People sometimes call me arrogant ❑I find it difficult to understand what others feel
❑I am very concerned about power ❑I am special and sometimes people do not realize it
❑I find it difficult to follow social norms ❑I find it difficult to plan ahead
❑I sometimes get into physical fights ❑It is difficult for me to show remorse
❑I am superstitious ❑I have a sixth sense
❑I prefer solitary activities ❑I have neither desire nor enjoy close relationships
❑I have limited but intense interest in only a few activities
❑I have difficulty making everyday decisions ❑I have a hard time initiating project on my own
❑I tend to be preoccupied with details and rules ❑I tend to be perfectionistic
❑Right is always right and wrong is always wrong ❑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:

____

____

THANK YOU!

Erene Soliman Psychologist, Inc.
Licensed Psychologist, PSY23162

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 $175 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: ______________________________

6) _____Session starts at the scheduled time. There is a 15-minute grace period. Any time after 15 minutes, the session will be considered a late cancellation and you will be charged $175.00.

7) _____If you are not in a secured, confidential location for your telepsychology apt, you will be charged $175.00 for your late cancellation charge and session will not be held due to not following the rules of the telepsychology consent form that was signed.

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: ______________

5151 N Palm Ste 500
Fresno, CA 93704
(559) 449-2734
(559) 449-2733
esolimanpsychservices.com

Erene Soliman Psychologist, Inc.
Licensed Psychologist, PSY23162

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.

5151 N Palm Ste 500
Fresno, CA 93704
(559) 449-2734
(559) 449-2733
esolimanpsychservices.com

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 Rules: This office is not responsible for watching unattended children in the waiting room and will not be held liable.

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.

Resources: At times I may provide helpful handouts, tools, accessories, and etc. to assist with therapeutic goals and treatment. I will not be liable for any injurious actions as a result of being given these resources and tools.

Emergencies: If you have an emergency, you should contact emergency resources by calling 911 or going to the nearest emergency room. 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) is accessible for public viewing and you may also send me a message via my website.

Technology Based Treatment: I do not provide treatment services via technology including, but not limited to, telephone sessions, video sessions (e.g., Skype), email, or text message.

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 $175 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 $200.00 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 $175 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 may 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: 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, by emailing 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 custody order that establishes custodial rights of 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. In order to protect clients and clinicians, cameras may operate continuously, and surveillance may be ongoing. Erene Soliman, Psy.D. will be the only person who has access to the recordings.

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 other while in my practice, conducting business or receiving services from my practice will not be tolerated. Violations of the 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.

____
Your Printed Name

____________________________________ ____________________
Your Signature Date Signed

____________________________________ ____________________
Parent/ Guardian Signature (if patient is under 18) Date Signed

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

Adopted from: Aging in Stride – Plan Ahead, Stay Connected, Keep Moving · www.AgingInStride.org

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 clincian, 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. Date
Clinical Psychologist PSY23162

Erene Soliman Psychologist, Inc.
Licensed Psychologist, PSY23162

"Supporting Children, Individuals, Couples, & Families."

Assent for Treatment of Minor

I, ______________________________ (insert name), give my consent to Dr. Erene Soliman to provide me psychotherapy services. _________ (initial here)

I understand that my parent/legal guardian is my holder of the privilege, which means material discussed during psychotherapy sessions are confidential and can be released only with the permission of my holder of privilege. I have been informed of the limitation to confidentiality in the Office Policies Form, which I have read and signed. _________ (initial here)

Because I am a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept Dr. Soliman's judgement in regard to releasing or sharing information obtained during the course of psychotherapy with me and I understand that information that may endanger or jeopardize my well-being will be disclosed. _________ (initial here)

______________________________ Client's Name

______________________________ Grade

______________________________ Signature of Patient

______________________________ Date

5151 N Palm Ste 500
Fresno, CA 93704
(559) 449-2734
(559) 449-2733
esolimanpsychservices.com