FOR ADULT THERAPY PLEASE FILL OUT PAGES (1-8)

FOR CHILD THERAPY PLEAS FILL OUT PAGES (9-21)

PLEASE NOTE

PLEASE EMAIL ME THE FORMS 24 HOURS PRIOR TO OUR FIRST SESSION.

THANK YOU.

Dr. Shirin Tabib, LMFT 101882
11633 San Vicente Blvd. Suit 318 A, Los Angeles, CA 90049
drshirintabib@gmail.com
Phone (310) 903-9181
Shirintabib.com

INFORMED CONSENT

(Information provided here is protected as confidential information)

LAST NAME:______________________FIRST NAME _____________________ MI:___

ADDRESS: ____

(Number and street, suite #)

____

(City, State, Zip)

Date of birth: Month _____Day _______Year_______

Home Phone ( )___________OK to leave a message? □ Yes □ No

Work Phone ( )___________ OK to leave a message? □ Yes □ No

Cell Phone ( )___________OK to leave a message? □ Yes □ No

OK to text message? □ Yes □ No

E-mail address: _______________________________________OK to send email? □ Yes □ No
(E-mail correspondence is not considered a confidential mode of communication. Communication will be limited to making appointments and rescheduling only.)

DATE OF BIRTH/AGE:____________________ GENDER: □ MALE □ FEMALE

EDUCATION:____

REFERRED BY:____

MARITAL STATUS: □ SINGLE □ MARRIED (IF SO, HOW MANY):____□ DIVORCED □ WIDOWED

CURRENT ROMANTIC RELATIONSHIP:____

CHILDREN & AGES: ____

GRANDCHILDREN & AGES: ______________________________

STEPCHILDREN & THEIR AGES: ______________________________

FATHER: □ ALIVE □ STILL TOGETHER? □ DECEASED YEAR ___AND CAUSE: __________
MOTHER: □ ALIVE □ STILL TOGETHER? □ DECEASED YEAR ___ AND CAUSE: __________
STEPFATHER: □ ALIVE □ DECEASED YEAR:______ CAUSE: ______________________
STEPMOTHER: □ ALIVE □ DECEASED _____ YEAR AND CAUSE SIBLINGS/ AGE- IN BIRTH ORDER:
PRESENTING PROBLEM: ______________________________
IMMEDIATE CLINICAL CONCERNS: ______________________________
SUICIDE RISK (circle): NONE, LOW, MEDIUM HIGH
SUICIDE HISTORY (dates, episodes, hospitalization): ______________________________
VIOLENCE RISK (circle): NONE, LOW, MEDIUM, HIGH
VIOLENCE HISTORY (dates, episodes, police involvement- jail): ______________________________
IMPORTANT PEOPLE IN PATIENT'S LIFE (support system): ______________________
STRENGTHS: ______________________________
THERAPY GOALS: ______________________________

DIFFICULTIES WITH APPETITE OR EATING PATTERNS: ______________________________
DIFFICULTY WITH SLEEPING PATTERNS: ______________________________
CURRENT DEPRESSION (sadness, grief, inactivity, sleep, eating): ____________________

PAST DEPRESSION: ______________________________
CURRENT ANXIETY (panic attacks, phobias, OCD) ______________________________
PAST ANXIETY: ______________________________
CURRENT CHRONIC PAIN: FOR HOW LONG ______________________________
PAST CHRONIC PAIN: ______________________________
OTHER HEALTH ISSUES: ______________________________

FAMILY HISTORY OF PSYCHOLOGICAL DISORDERS:______________________________
SIGNIFICANT LIFE CHANGES OR STRESSFUL/TRAUMATIC EVENTS:________________
CURRENT EMPLOYMENT:______________________________

SPIRITUAL/RELIGIOUS AFFILIATION:______________________________
PHYSICALEXERCISE HABITS (DO YOU EXERCISE REGULARLY):________________________
COGNITIVE (MENTAL) EXERCISE HABITS:______________________________
HEIGHT: ____________________CURRENT WEIGHT: ______________________________
Do you sleep well? Y N Easy to get to sleep? Y N
What recreation do you enjoy? ______________________________

CURRENT MEDICATIONS (amount taking/mgs):
Antidepressant:____
Anti-anxiety: ____
Antipsychotic: ____
Benzodiazepine:____
Mood stabilizer (Lithium, Depakote): ______________________________
Pain reliever (aspirin, Tylenol): ______________________________
Sleeping pill: ____
Others: ____

PREVIOUS MEDICATIONS/DATES:
Antidepressant:____
Anti-anxiety:____
Antipsychotic:____
Benzodiazepine:____
Mood stabilizer (Lithium, Depakote):______________________________
Pain reliever (aspirin, Tylenol):______________________________
Sleeping pill:____
Others:____

Drugs (not medications):
Smoking:____
Packs per week:____
Alcohol Intake: ____
Frequency (per week):____
How Much?____
What do you drink? ____________________
Marijuana- ____________________Medical ________________Recreational
Frequency (per week)____
Other:____
What?____
Frequency:____
What?____
Frequency:____
What?____
Frequency:____
What?____
Frequency: ____

SYMPTOMS	NEVER	SELDOM	SOMETIMES	OFTEN
Insomnia				
Loss of Appetite				
Back Pain				
Asthma/ lung issues				
Headaches				
Phobias (Fears)				
Nausea				
Allergies				
Nervousness				
Loss of temper				
Fatigue				
Depression				
High blood pressure				
Constipation				
Diarrhea				
Over-eating				
Mood swings				
Self-harm Behaviors				
Abdominal				

SYMPTOMS	NEVER	SELDOM	SOMETIMES	OFTEN
Arthritis				
Auditory/ tinnitus				
Cancer				
Cataract /glaucoma				
Chronic pain				
Concussion				
Epilepsy				
Heart issues				
Hyper/hypo-tension				
Kidney				
Liver disease/ hepatitis				
Pelvic/genital pain				
PMS				
Prostate/vaginal				
STD				
Thyroid				
TMJ				
Ulcer				

I, the undersigned, hereby acknowledge that I (we) have read the foregoing engagement letter, that the information I (we) provided is true and correct, and that I (we) consent to therapy upon the terms and conditions outlined herein.

Signed: ______________________________ Date: ______________________________

Child Therapy Contract

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Patient-Therapist Agreement. Under HIPAA and the NASW Code of Ethics, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the Psychotherapist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem (GAL), or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $500 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

If you decide to terminate treatment, I have the option of having a few closing sessions with your child to properly end the treatment relationship. You are waiving your right to access to your child's treatment records. I will inform you if your child does not attend the treatment sessions. At the end of treatment, I will provide you with a summary that includes a general description of goals, progress made, and potential areas that may require intervention in the future. If necessary, to protect the life of your child or another person, I have the option of disclosing information to you without your child's consent. You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.) You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. If there is a court appointed evaluator, and if appropriate releases are signed and a court order is provided, I will provide general information about the child which will not include recommendations concerning custody or custody arrangements.

If, for any reason, I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $500 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Fees, Payment and Cancellation

Individual sessions are $300 for 1 hour and $110 for each group/workshop based on the recommendations of the Psychotherapist's Association of Alberta. Clients will be charged an appropriate fee for any preparation time that is required to comply with informal or formal requests, case conferences and extended phone calls or e-mail responses. Clients needing to cancel or change an appointment are required to provide twenty-four hour notice. The client will be charged a $300.00 for individual session and $110 for group workshop cancellation fee if 24 hours' notice was not provided.

All sessions/ Groups/ Workshop is offered at my private practice in Brentwood, at 11633 San Vicente Blvd Suite 318A Los Angeles, Ca 90049. However, for clients who like to have sessions, groups, and workshops at California Kids Pediatrics please read the disclaimer bellow:

Disclaimer: Please note that my services at California Kids Pediatrics, Dr. Leila Bozorgnia and Dr. Marna Geisler is not a part of or affiliated with California Kids Pediatrics. I, Dr. Shirin Tabib am an independent entity with my own practice.

Acknowledgment and Consent

By your signature below, you are indicating that you read and understood this consent form or that any questions you had about this consent form were answered to your satisfaction. Consent for Treatment of Minors: I/we consent that my adolescent/child under the age of 18,_________________(name of child) may be treated as a client by Dr. Shirin Tabib. This form is in effect until ________________________ (date) or until 24 months after the consent was given. Consent can be revoked at any time. I affirm that I am the legal guardian of (name of child/adolescent)______________
______________________Date of Birth (child/adolescent)___________________________________

Parent or Guardian's name (please print)____

Parent or Guardian's Signature:__________________________________Date:_________________

Parent or Guardian's name (please print)____

Parent or Guardian's Signature__________________________________ Date:_________________

Child Intake

Name of the child:________________________________Date of Birth:____________________
Name of Mother/Guardian:_____________________Name of Father/Guardian:________________
Occupation of Mother/Guardian:________________Occupation of Father/Guardian:____________
Child is:____Biological___Adopted____Foster Child
Parents are:______Married ____Defacto ____Separated _____Divorced _________Same Sex
Address:____
____
Home Phone Number:__________________Mother/guardian's mobile:____________________
Father/guardian mobile:__________________Referral? Where did you hear about us?___________
Name and age of siblings:____
____

Medical History
(Please check all that apply):
______Head injury _Loss of consciousness ___Epilepsy ____Headaches or migraines __Frequent ear infections ___Tics/ twitching _____Repetitive / stereotypical motor movements ___Echolalia i.e., repeat what others says for no reason __Sensory issues with sensitivity to sound, light, touch, fabrics etc. __Temper tantrums __Self-Injurious behavior ___Hydrocephalus ____Asthma _____Allergies ______Intellectual delay __Developmental delay _____None ______Other___________

Please describe the above or other medical issues in more depth:____________________________
____
____
(please list any illnesses, hospitalization, or medical conditions)

List all medications: Names & dosages (note whether current or previous)_____________________
____

List any supplementation taken regularly:____
____
____

Developmental History:

List any language spoken at home other than English:_________________________________
____

Please identify any issues with sleep or energy. (Check all that apply):
______Problems falling asleep __Issues waking at night ___Not enough sleep __Excessive sleep for age __Very tired upon walking and hard to get moving _____Low energy during the day _____High energy during the day ____No issues with either sleep or energy

Psychological Background:
Please describe your child's current mental state:____________________________________
____
____
(Please list issues with low mood, depression, anxiety, anger, self-esteem etc.)

Has your child seen a psychologist or other mental health addressed etc. ______________________

____

____

(Note details including names, what year, for how long, issues being addressed etc.)

Previous diagnoses?____

____

List name of practitioner, year of diagnosis, diagnosis given_________________________

____

____

(List all diagnoses including autism spectrum, ADHD, mood disorder, behavioral disorders, learning disorders, intellectual disability, tic disorders, eating disorders, personality disorders etc.)

Does your child have any issues with social skills or socializing?___________________

____

____

(List any issues with socializing e.g., issues making friends, keeping friends, preferring to isolate themselves, Lacking empathy, doesn't seek out peers, poor social skills, poor eye contact, can't see things from others point of view, considers themselves dominant over adults and other children, controlling etc.)

Does your child have any issues with attention?_______________________________

____

(E.G., easily distracted, has trouble focusing, forgetful, loses belongings)

Family history of psychological, cognitive, learning or behavioral issues?______________

____

____

Educational Background:

Name of school:____

Grade:____

Does your child ever refuse to go to school?__Never _____Sometimes (1 time or less per week) _ _____Often (2+ times a week)

Does your child have any behavioral issues at school?_________________________

____

____

(E.g., Hitting, tantrums, aggression, defiance, not listening to instructions)

Does your child have any academic/Learning issues?__________________________

____

____

Goals of Therapy:____

____

Depression _______Yes ___No
Anxiety _____Yes ___N0
Anger ______Yes ___N0
Stress ______Yes ___N0
Irritability ____Yes ___N0
Attention ____Yes ___N
Distractibility ______Yes ___N0
Planning ____Yes ___N0
Organization Yes ___N0
Language Skills ___Yes N0
Motor Skills _Yes ___N0
Reading ____Yes ___N0
Writing ___________Yes ___N0
Studying ____Yes ___N0
Behavior at school _Yes ___N0
Social Skills _______Yes ___N0

Please note any additional areas would like to see an improvement in ________________

____

Please note any specific types of treatment you would like at our center ______________

____

(e.g., CBT, ACT, family therapy, neurofeedback etc.)

Behavioral Expectations for Groups

In-Person Groups

1. Confidentiality - what is said in group stays in group
2. Be alert, attentive and engaged
3. Stay awake – sleepy clients should not attend
4. No eating, cell phones or electronics except by permission of Dr. Shirin Tabib
5. Dress appropriately (no skimpy clothing, provocative slogans on T-shirts, no sunglasses, etc.)
6. Private/side conversations with other group members are not permitted
7. Punctual attendance – if you are 1-10 minutes late, you may quietly enter the room
8. Use appropriate language at all times (no threats or insults)

Zoom Groups

1. Confidentiality - what is said in group stays in group
2. Remain in one location (no wandering) during remote groups except with permission from facilitator
3. Be alert, attentive and engaged (no napping)
4. Avoid distractions (no pets, no eating, no vaping, no electronic devices other than what is being used for the remote group)
5. Focus on screen during remote groups
6. Dress appropriately (no pajamas, bathrobes, etc.)
7. Keep camera on during remote groups except with permission of facilitator
8. Please mute during remote groups except when speaking, or if asked to keep mic unmuted by Dr. Tabib
9. Private/side conversations (private chatting during remote groups) with other group members are not permitted. Use appropriate language at all times (no threats or insults)

Behavioral Expectations for our Community

Speaking about your negative reactions to certain clients with other clients in the community is considered gossiping. This behavior contributes to a toxic and hostile environment, does not support the vulnerable work that clients are here to do in groups, distracts from your own work, goes against the group value of safety, and will not be tolerated. These negative reactions are an important part of your healing journey and should be addressed in our individual sessions.

Consequences:

- If group confidentiality is breached, client will be removed from the group if Dr. Tabib determines that repair is not possible with the other group member(s)
- Client(s) will be given a verbal warning for engaging in gossiping
- Client(s) will receive a behavior support plan if they continue to engage in gossiping after they have received a verbal warning
- Clients will be discharged from group, without refund, if they continue to engage in gossiping after receiving a behavior support plan.

Signed (parent and therapist)

__________________________ __________________________

Dr. Shirin Tabib Parent

HIPPA

Notice of Privacy Practices

The Federal Health Insurance Portability and Accountability Act (HIPAA) requires mental health professionals to issue this official Notice of Privacy Practices. This notice describes how information about you is protected, the circumstances under which it may be used or disclosed and how you may gain access to this information. Please review it carefully.

For psychotherapy to be beneficial, it is important that you feel free to speak about personal matters, secure in the knowledge that the information you share will remain confidential. You have the right to the confidentiality of your medical and psychological information, and this practice is required by law to maintain the privacy of that information.

This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices of that information.

This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health and psychological information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice?

Any health care professional authorized to enter information into your medical record, all employees, staff, and other personnel at this practice who may need access to your information must abide by this notice. All subsidiaries, business associates (e.g., a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your Protected Health Information (PHI), for treatment, payment, and health care operations purposes. The following should help clarify these terms:

- PHI refers to information in your health record that could identify you. For example, it may include your name, the fact you are receiving treatment here, and other basic information pertaining to your treatment.
- Use applies only to activities within my office and practice group, such as sharing, employing, applying, utilizing, and analyzing information that identifies you.

- Disclosure applies to activities outside of my office or practice group, such as releasing, transferring, or providing access to information about you to other parties.
- Authorization is your written permission to disclose confidential health information. All authorizations to disclose must be made on a specific and required form.

Notice of Privacy Practices

- Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. For example, with your written authorization I may provide your information to your physician to ensure the physician has the necessary information to diagnose or treat you.
- Payment Your PHI may be used, as needed, in activities related to obtaining payment for your health care services. This may include the use of a billing service or providing you documentation of your care so that you may obtain reimbursement from your insurer.
- Health Care Operations are activities that relate to the performance and operation of my practice. I may use or disclose, as needed, your protected health information in support of business activities. For example, when I review an administrative assistant's performance, I may need to review what that employee has documented in your record.

Written Authorizations to Release PHI

- Any other uses and disclosures of your PHI beyond those listed above will be made only with your written authorization, unless otherwise permitted or required by law as described below. **You may revoke your authorization at any time, in writing.**

Uses and Disclosures without Authorization

- The ethics code of the American Psychological Association, California State law, and the federal HIPAA regulations all protect the privacy of all communications between a client and a mental health professional. In most situations, I can only release information about your treatment to others if you sign a written authorization. This Authorization will remain in effect for a length of time you and I determine. You may revoke the authorization at any time, unless I have taken action in reliance on it. However, there are some disclosures that do not require your Authorization. I may use or disclose PHI without your consent in the following circumstances:
- Child Abuse – If I have reasonable cause to believe a child may be abused or neglected, I must report this belief to the appropriate authorities.
- Adult and Domestic Abuse – If I have reason to believe that an individual such as an elderly or disabled person protected by state law has been abused, neglected, or financially exploited, I must report this to the appropriate authorities.
- Health Oversight Activities – I may disclose your PHI to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information by any party about your treatment and the records thereof, such information is privileged under state law, and is not to be released without a court order. Information about all other psychological services (e.g., psychological evaluation) is also privileged and cannot be released without your authorization or a court order. The privilege

does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.

- Serious Threat to Health or Safety – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.
- Worker's Compensation – I may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to **fault.**

Special Authorizations

Certain categories of information have extra protections by law, and thus require special written authorizations for disclosures.

- Psychotherapy Notes – I will obtain a special authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.
- HIV Information – Special legal protections apply to HIV/AIDS related information. I will obtain a special written authorization from you before releasing information related to HIV/AIDS.
- Alcohol and Drug Use Information – Special legal protections apply to information related to alcohol and drug use and treatment. I will obtain a special written authorization from you before releasing information related to alcohol and/or drug use/treatment. You may revoke all such authorizations (of PHI, Psychotherapy Notes, HIV information, and/or Alcohol and Drug Use Information) at any time, provided each revocation is in writing, signed by you, and signed by a witness. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

Patient's Rights and Psychotherapist 's Duties

- Right to Request Restrictions – You have the right to request restrictions on certain uses/disclosures of PHI. However, I am not required to agree to the request.
- Right to Receive Confidential Communications by Alternative Means – You have the right to request and receive confidential communications by alternative means and locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy of PHI in my records as these records are maintained. In such cases I will discuss with you the process involved.

- Right to Amend – You have the right to request an amendment of PHI for as long as it is maintained in the record. I may deny your request. If so, I will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of all disclosures of PHI. I can discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the Notice of Privacy Practices from me upon request.

Psychotherapist 's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you at our next session, or by mail at the address you provided me.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

If you have any questions about this notice or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me: Dr. Shirin Tabib (310) 903-9181. Email address: drshirintabib@gmail.com