

JANE BERESFORD, PSY.D.
LICENSED PSYCHOLOGIST – PSY 16618

15300 VENTURA BOULEVARD, SUITE 301
SHERMAN OAKS, CALIFORNIA 91403

PHONE (310) 551-8535
FACSIMILE (818) 508-8594

Patient Information
(PLEASE PRINT)

Patient Name: _____ Today's Date: _____
Patient's SSN: _____ - _____ - _____ DOB: ____/____/____ Age: ____
Sex: ____ Marital Status (circle): Single Married Separated Divorced Other ____
Home Address: _____
City: _____ State: _____ Zip: _____
Email: _____ OK to leave message here? ____Yes ____No
Home Phone: (____)_____ OK to leave message here? ____Yes ____No
Cell: (____)_____ OK to leave message here? ____Yes ____No
Work: (____)_____ OK to leave message here? ____Yes ____No
Occupation (if minor, guardian's occupation): _____
Employer's Name: _____
Work Address: _____
City: _____ State: _____ Zip: _____

Name of Guardian or Responsible Party: _____
Guardian's SSN: _____ - _____ - _____ Guardian's DOB: ____/____/____
Relationship to Patient: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (____)_____ Cell: (____)_____ Work: (____)_____
Employer's Name: _____
Work Address: _____
City: _____ State: _____ Zip: _____

Emergency Contact: _____
Relationship: _____ Phone: (____)_____

Physician: _____ Phone: (____)_____

Referred by: _____

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Office Billing and Missed Appointments Policy

1. I understand that I am responsible for the full amount of my bill for services provided.
2. It is my responsibility to pay the amount due on the date and time service is provided.
3. I understand that I may pay with cash or check.
4. Checks are to be paid to the order of: **Jane Beresford, Psy.D.**
5. There will be a \$35.00 service charge on all returned checks.
6. In the event that my account goes to collections, there will be a 50% collection fee added to my balance.
7. There is a **24-hour Cancellation Policy**, which requires that scheduled appointments must be cancelled 24 hours in advance of the appointment, between the hours of 9:00 AM and 5:00 PM, Monday through Saturday, to avoid being charged.
8. I understand that late cancellations and missed appointments will be charged at the full-fee rate of \$175 per 45-minute appointment.

I understand and agree to the above.

Printed Name: _____

Signature: _____ Date: _____

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LIMITS ON PATIENT CONFIDENTIALITY

We are required to disclose confidential information if any of the following conditions exist:

1. You are a danger to yourself or others.
2. You seek treatment to avoid detection or apprehension, or you enable anyone to commit a crime.
3. You report distribution, possession, or viewing of child pornography.
4. Your psychologist was appointed by the courts to evaluate you.
5. Your contact with your psychologist is for the purpose of determining sanity in a criminal proceeding.
6. Your contact is for the purpose of establishing your competence.
7. Your contact is for the purpose of filing a report to a public employer or to provide information required to be recorded in a public office, if such report or record is open to public inspection.
8. You are under the age of 16 years and are the victim of a crime.
9. You are a minor and your psychologist/therapist reasonably suspects that you are the victim of child abuse.
10. You are a person over the age of 65 and your psychologist/therapist believes that you are the victim of physical abuse. Your psychologist/therapist may disclose information if you are the victim of emotional abuse.
11. You file suit against your therapist for breach of duty or your therapist files suit against you.
12. You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.
13. You waive your rights to privilege or give consent to limited disclosure by your therapist.
14. Your insurance company paying for services has the right to review all records.
15. You die and the communication is important to decide an issue concerning a deed or conveyance, will, or other writing executed by you affecting an interest in property.

If you have any questions about these limitations, please discuss them with your therapist.

I agree to these limits of confidentiality, and I consent to my (or my dependent)

(CHECK ONE) receiving outpatient treatment **OR** participating in an evaluation.

Printed Name: _____

Signature: _____ Date: ____/____/____

Informed Consent, Disclosure Statement and Agreement for Services

Introduction

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your psychologist any questions that you may have regarding its contents.

Information about Your Psychologist

Your psychologist, Jane Beresford, Psy.D., is a Licensed Psychologist (PSY 16618). At an appropriate time, Dr. Beresford will discuss her professional background with you and provide you with information regarding her experience, education, special interests, and professional orientation. You are free to ask questions at any time about her professional background and orientation.

Psychologists are the only mental health professionals required to hold a doctoral degree. For licensure, the state of California requires that a doctoral program in psychology include an internship of one year (a minimum of 1500 hours) of supervised work experience with clients. After earning a doctorate, psychologists must complete another 1500 hours of supervised work experience; submit evidence of completing coursework in human sexuality, child abuse, substance abuse, spousal abuse, and aging and long-term care; and must pass a licensure exam. For license renewal, the state of California requires psychologists to complete 38 units of continuing education every two years.

Fees

The fee for services is \$175 per 45-minute therapy session. At the time services are rendered, fees are payable via cash or check. If you choose to pay by check, it is helpful to have your check filled out in advance, made payable to “Dr. Jane Beresford.”

Confidentiality

All communications between you and Dr. Beresford will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your psychologist will not disclose confidential information about your treatment unless all persons who participated in the treatment with you provide their written authorization to release information. In addition, she will not disclose information communicated privately to her by one family member to any other family member, without permission.

There are exceptions to confidentiality. For example, psychologists are required to report instances of suspected abuse of a child or vulnerable adult. Your psychologist may be required or permitted to break confidentiality when she has determined that a patient presents a serious danger of physical harm to himself/herself or to another person. In addition, a federal law known as The Patriot Act of 2001 requires psychologists (and others) in certain circumstances, to provide FBI agents with books, records, papers, documents, and other items, and prohibits the psychologist from disclosing to the patient that the FBI sought or obtained the items under the Act.

Minors and Confidentiality

Communications between psychologists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child’s treatment are often involved in their treatment. Consequently, your psychologist, in the exercise of her professional judgment, may discuss the treatment progress of a minor patient with the parent or guardian. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their psychologist.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Dr. Beresford may suggest a different schedule of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your psychologist at least 24 hours in advance of your appointment. If you do not provide your psychologist with at least 24 hours notice in advance, you are responsible for payment for the missed session.

Psychologist Availability/Emergencies

Telephone consultations between office visits are welcome, and if longer than 10 minutes, will be billed at a prorated amount. You may leave a message for Dr. Beresford at any time on her confidential voicemail. If you wish for her to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday through Saturday) within 24 hours. If you have an urgent need to speak with your psychologist, please indicate that fact in your message. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Psychologist Communications

Dr. Beresford may need to communicate with you by telephone, mail, or other means. Please indicate your preferences below by circling either YES or NO.

- YES / NO My psychologist may call me at my home.
YES / NO My psychologist may call me on my cell phone. YES / NO May text to my cell phone.
YES / NO My psychologist may communicate with me by email.
YES / NO My psychologist may send mail to my home address.

About the Therapy Process

It is Dr. Beresford’s intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to her, and the specifics of your situation, she will provide recommendations to you regarding your treatment. The psychologist and the patient are partners in the therapeutic process. You have the right to agree or disagree with Dr. Beresford’s recommendations. She will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion. Due to the varying nature and severity of problems and the individuality of each patient, your psychologist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your psychologist. She will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or your psychologist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, initiating a psychological evaluation, or terminating therapy. Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask your Dr. Beresford to address any questions or concerns that you have about this information before you sign below.

Name of Patient (Please print)

Name of Parent /Guardian (Please print)

Signature of Patient

Signature of Parent /Guardian

Date: ____/____/____

Date: ____/____/____