Jane Beresford, Psy.D.
Licensed Psychologist – PSY 16618
(310) 551-8535
Info@DrBeresford.com

Sohila Sue Sakuei, Psy.D., LMFT
Registered Psychological Asst. – PSB 94022207
(818) 470-2632
Sue@DrBeresford.com

15300 Ventura Boulevard, Suite 301
Sherman Oaks, California 91403

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: ____

Jane Beresford, Psy.D.
Licensed Psychologist – PSY 16618
(310) 551-8535
Info@DrBeresford.com

Sohila Sue Sakuei, Psy.D., LMFT
Registered Psychological Asst. – PSB 94022207
(818) 470-2632
Sue@DrBeresford.com

15300 Ventura Boulevard, Suite 301
Sherman Oaks, California 91403

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 $150 per 45-minute appointment.

I understand and agree to the above.

Printed Name: ____

Signature: ____ Date: ___________________

Jane Beresford, Psy.D.
Licensed Psychologist – PSY 16618
(310) 551-8535
Info@DrBeresford.com

Sohila Sue Sakuei, Psy.D., LMFT
Registered Psychological Asst. – PSB 94022207
(818) 470-2632
Sue@DrBeresford.com

15300 Ventura Boulevard, Suite 301
Sherman Oaks, California 91403

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. Your psychologist was appointed by the courts to evaluate you.
4. Your contact with your psychologist is for the purpose of determining sanity in a criminal proceeding.
5. Your contact is for the purpose of establishing your competence.
6. 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.
7. You are under the age of 16 years and are the victim of a crime.
8. You are a minor and your psychologist/therapist reasonably suspects that you are the victim of child abuse.
9. 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.
10. You file suit against your therapist for breach of duty or your therapist files suit against you.
11. You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.
12. You waive your rights to privilege or give consent to limited disclosure by your therapist.
13. Your insurance company paying for services has the right to review all records.
14. 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 & 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 therapist any questions that you may have regarding its contents.

Information about Your Therapist
At an appropriate time, your therapist 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 your her background, experience and professional orientation. Your psychologist, Sohila Sue Sakuei, Psy.D., LMFT, is a Registered Psychological Assistant. In addition to being a Licensed Marriage and Family Therapist, she has completed her doctorate in psychology, and is in the process of accruing supervised hours to take the licensing examination in psychology; she is registered by the state of California (PSB 94022207). As a requirement, her practice is conducted under the clinical supervision of a Licensed Psychologist, Jane Beresford, Psy.D., who is licensed by the state of California (PSY 16618).

The benefits of utilizing the services of a Psychological Assistant are significant. Because your therapist is discussing your goals, treatment plan, and progress on a weekly basis with a supervising psychologist, you are able to receive the insights and responses of two professionals. Your therapist has recently completed a course of advanced graduate study in the field of psychology, and is well versed in current research and new treatments. Additionally, the fees are lower than those of a licensed psychologist.

Fees
The fee for services is $150 per 45-minute therapy session. This is due at the time services are provided and payable by cash or check. It is helpful to have your check filled out in advance, made payable to “Dr. Jane Beresford.” Although Psychological Assistants may physically receive payment from you, they are employees, and are not paid directly for services rendered at the training site; your therapist will provide you with a receipt for cash, and forward all funds to Dr. Beresford. Please discuss any questions or concerns about this with your therapist or Dr. Beresford.

Confidentiality
All communications between you and your therapist will be held in strict confidence, with the exception of weekly progress reviews with the supervising psychologist, unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist and the supervising psychologist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release information. In addition, your therapist and the supervising psychologist will not disclose information communicated privately to them by one family member to any other family member, without permission.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected abuse of a child or vulnerable adult. Your therapist 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 therapists (and others) in certain circumstances, to provide FBI agents with documents and other items, and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

Minors and Confidentiality
Communications among therapists, supervising 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 therapist, 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 therapist.

Appointment Scheduling and Cancellation Policies
Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different schedule for therapy depending upon 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 therapist at least 24 hours in advance of your appointment. If you do not provide your therapist with at least 24 hours advance notice, you are responsible for payment for the missed session.

Therapist 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 your therapist 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 therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail. 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.

Therapist Communications
Your therapist may need to communicate with you by telephone, mail, or other means. Please indicate your preferences listed below by circling either YES or NO.

YES / NO My therapist may call me at my home.
YES / NO My therapist may call me on my cell phone. YES / NO Text on my cell phone.
YES / NO My therapist may send mail to my home address.
YES / NO My therapist may communicate with me by email.

About the Therapy Process
It is your therapist'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 therapist and patient are partners in the therapeutic process. You have the right to agree or disagree with your therapist'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 therapist 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 your 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 therapist. 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 therapist determine 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, or terminating therapy. Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask your therapist 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: ____/____/_______