

Pyrysys Psychology Group, Inc.

8950 Villa La Jolla Drive, Suite B214

La Jolla, CA 92037

Initial Clinician: _____

Client Name: _____ Home Phone: _____

Home Address: _____ City: _____ State: _____

Zip: _____ E-mail address: _____ Cell Phone/Pager: _____

Date of Birth: _____ SS#: _____ / _____ / _____ Driver's License #: _____

Employer Name (Client or, if client is a minor, guardian's employer): _____

Employer Phone: _____ Employer Address: _____

Spouse Employer: _____ Spouse Phone: _____

Spouse Address: _____

In Case of Emergency, Notify: _____ Relationship to you: _____

Phone: _____ Address: _____

Who may we thank for referring you? _____ Phone: _____

I, the undersigned, accept full financial responsibility for the cost of all services rendered to the client and attest that the information given is true and correct. I agree to pay a service charge of 0.833% per month (10% per year but not to exceed the maximum rate by law, plus a \$5.00 rebilling charge) to be added to all charges not paid within 30 days from the date of service. I shall pay Pyrysys Psychology Group, Inc. on demand all costs including reasonable attorney fees and collection costs incurred in collecting payment due for services performed under this agreement. I understand that regardless of what any insurance company or other third party may reimburse, I am ultimately responsible for this bill. I agree to pay a \$25 service charge for all checks returned unpaid by my bank. **I UNDERSTAND THAT 24 HOURS NOTICE FOR AN APPOINTMENT CANCELLATION IS REQUIRED OR I WILL BE BILLED AT REGULAR RATE FOR THAT TIME.** If client is a minor, I will be financially responsible for this bill and I give consent for treatment.

Any dispute as to malpractice will be determined by submission to arbitration as provided by California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration. Agreeing to arbitrate all disputes that are connected with this treatment is not necessary in order to be treated. If the client or the undersigned does not want to agree to arbitration, he/she should initial here _____ now or send a written notice within 30 days from today saying that he/she no longer agrees to arbitration.

Person accepting full financial responsibility for client's account per above agreement:

(Print name)

(Signature)

Billing Address: _____

Social Security #: _____ Date: _____

Relationship to client: _____

(Over for privacy information)

Please help us protect your privacy by checking the appropriate boxes:

- | | | |
|-----------------------------|---------------------------------|--|
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages on my HOME answering machine. |
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages with any other person. |
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages on my WORK voice mail. |
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages with co-workers. |
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages on my CELL PHONE voice mail. |
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages with any other person answering cell phone. |

CONFIDENTIAL CLIENT INFORMATION

Name: _____ Date: _____

Briefly describe your reasons for seeking help: _____

List previous psychotherapists, psychiatric hospitalizations, or addiction treatments (include reasons, dates and outcomes): _____

What was helpful or unhelpful about this treatment? _____

List previous suicide attempts: _____

List any significant difficulties or bad experiences from childhood onward: _____

List any major changes in your life in the last two years: _____

How often do you use or do (what is your pattern of involvement with):

Alcohol: _____

Cigarettes/tobacco: _____

Coffee/caffeine: _____

Other addictive substances: _____

Gambling: _____

Television/internet: _____

Other addictive activity: _____

How do you exercise and how often? _____

How do you relax and how often? _____

How much do you sleep? _____

Describe your overall health: _____

My primary physician is (name, address, and phone): _____

My last complete physical was on _____ with Dr. _____

My last doctor's visit (other than a physical) was on _____ with Dr. _____

(over)

List all medications you are now taking, both prescription (including birth control pills) and over-the-counter (such as aspirin, allergy medication, etc.):

<u>Medication</u>	<u>Dosage</u>	<u>Reason</u>	<u>PRESCRIBING PHYSICIAN NAME & PHONE NUMBER</u>
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Note any other health problems: _____

List the persons currently living in your home, including yourself:

<u>Name</u>	<u>Age</u>	<u>Relationship to you</u>	<u>Occupation</u>	<u>Education</u>
(Myself)		(Myself)		

List previous spouses or children not at home, their current ages, and locations: _____

Describe your parents, brothers, and sisters:

	<u>Age</u>	<u>Occupation</u>	<u>Where living</u>	<u>Your relationship with each other</u>
Mother:				
Father:				
Brother:				
Sister:				

What are your major strengths? _____

What do you like best about yourself? _____

Is there any additional information that would be important to know about you? _____

Problem List

Name: _____

Date: _____

In the left hand column check off any issue you are having a problem with. In the right hand column, rank the severity of these problems (1=severe, 2=fairly severe, 3=moderate, 4=mild) You may use each number more than once.

(X)	Problem:	(#)	(X)	Problem:	(#)
_____	Alcohol	_____	_____	Loss	_____
_____	Anger	_____	_____	Making Decisions	_____
_____	Appearance	_____	_____	Marriage	_____
_____	Assertiveness	_____	_____	Memory	_____
_____	Boredom	_____	_____	Money	_____
_____	Bowel Trouble	_____	_____	Mood Changes	_____
_____	Career Choices	_____	_____	My Thoughts	_____
_____	Children	_____	_____	Nervousness	_____
_____	Chronic Pain	_____	_____	Nightmares	_____
_____	Compulsiveness	_____	_____	Pain	_____
_____	Concentration	_____	_____	Parenting	_____
_____	Dating	_____	_____	Perfectionism	_____
_____	Depression	_____	_____	Relationships	_____
_____	Disgust	_____	_____	Relaxation	_____
_____	Divorce	_____	_____	Religion	_____
_____	Drugs	_____	_____	School	_____
_____	Eating	_____	_____	Self-Control	_____
_____	Energy	_____	_____	Self-Esteem	_____
_____	Family	_____	_____	Sexual Problems	_____
_____	Fears/Worries	_____	_____	Shyness	_____
_____	Guilt	_____	_____	Sleep	_____
_____	Headaches	_____	_____	Spiritual Concerns	_____
_____	Health Problems	_____	_____	Stress	_____
_____	Irritability	_____	_____	Suicidal Thoughts	_____
_____	Isolation	_____	_____	Unhappiness	_____
_____	Legal Matters	_____	_____	Work	_____
_____	Loneliness	_____	_____	_____	_____

UNDERSTANDING PSYCHOTHERAPY AND CONSENT TO TREATMENT

Consent to Treatment

The success of psychotherapy depends upon a high degree of trust between us. We therefore want you to be fully informed about what to expect from us and from your sessions here.

Our Staff

All staff work under the supervision of Dr. Horvath (PSY7732). In addition to other psychologists and postdoctoral psychology fellows, the staff at Pyrysys Psychology Group, Inc. includes counselors and specialists in alternative health (yoga, bodywork, meditation, etc.).

Understanding Psychotherapy

During initial visits the emphasis will be on understanding the nature of your personal problems and on creating a plan of treatment. Psychotherapy will consist largely of an ongoing dialogue between you and your therapist(s) about 1) problematic behavior, feelings or attitudes, which may be deeply entrenched, 2) what new behaviors, feelings or attitudes you might adopt; and 3) how you might adopt them. Our training, resources, and experience will be used to help you identify, select, and accomplish these desired changes.

You may be given homework assignments, which help carry on our work between sessions. These assignments may include reading, keeping records of behaviors, feelings or attitudes, or experiencing new activities. Any difficulties in accomplishing these assignments should be reported promptly, so that we may develop assignments that you will be able to accomplish.

We encourage you to ask questions at any time. The more deeply you understand what we are doing, the more effectively you will be able to cooperate with it and accomplish the changes you desire. We will evaluate the effectiveness of our work on an on-going basis. By mutual agreement with your specific psychotherapist, if you bring a blank audiocassette, a recording of your session can be made for you.

Psychotherapy is not magic. Your persistence in carrying out homework assignments will have a determining role in how much you accomplish. In particular, the extent to which you are open and honest about yourself will determine how accurately we can assess your situation and recommend appropriate methods and goals.

There can be discomfort involved in participating in psychotherapy. You may remember unpleasant events, or have aroused intense feelings of anger, fear, anxiety, depression, frustration, loneliness, helplessness, or other unpleasant feelings. Homework assignments can at times be uncomfortable. Your family and friends may need time to adjust to changes you make.

In addition to accomplishing your stated goals, there may be additional benefits to participating in psychotherapy, including greater maturity as a person, better understanding of personal goals and values, improved ability to relate to others, and greater self-confidence, self-respect, and self-acceptance.

If you arrive a few minutes ahead of your appointment time, you will have the opportunity to set aside the irrelevant concerns of the day, and prepare for your session.

Confidentiality

In accordance with professional ethics and California law, the information revealed in psychotherapy is confidential, and will not be revealed to anyone without your written permission, except as required by law. California law requires that we make appropriate reports if you are suicidal, homicidal, or gravely disabled, or if any child or elder adult has been abused or neglected.

Medications and Medical Procedures

Psychologists are not physicians, and do not prescribe medication or perform medical procedures. If evaluation by a physician is indicated, we can recommend one, or you may consult your personal physician.

Emergencies

Your psychotherapist or the colleague providing coverage for your therapist can be reached at any time by calling our answering service (858-569-2796) and paging. However, you will likely be charged for this call. Routine business, including the making of appointments, can often be handled during normal working hours by the administrative staff, by calling 858-546-1100.

Fees

Except in cases of emergency, you will be expected to pay for appointments not canceled at least 24 hours in advance. Your appointment time is set aside specifically for you, and cannot usually be given to someone else with less than 24 hours notice.

We charge by the hour for our services. In addition to the time spent directly with you in the office, we charge for any other time spent on your behalf, including telephone calls with you or others, reading or writing documents, doing research, meetings with others, or other activities. Please see the administrative staff for current hourly rates for each provider.

Surcharges for special services may apply. Whenever feasible you will be informed if surcharges apply. The most common surcharges are for deposition, testimony, or after hours services.

Please sign below to indicate that you understand and agree to the above, and consent to treatment. We recommend that you keep a copy of this form, and refer to it from time to time during our work together.

Name

Date

Signature

Pyrysys Psychology Group, Inc.

8950 Villa La Jolla Drive, Suite B214
La Jolla, CA 92037
Tel: (858) 546-1100
Fax: (858) 455-0141

A. Thomas Horvath, Ph.D., ABPP, President
California Psychology License PSY7732
www.pyrysys.com

Required HIPAA Notice of Privacy Practices

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IT WILL GENERALLY PROTECT YOUR PRIVACY TO A MUCH GREATER DEGREE THAN REQUIRED BY THE LANGUAGE OF THE DOCUMENT.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you which I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of the health care. I must provide you with this Notice about my privacy practices and such Notice must explain how, when, and why I will “use” and “disclose” your PHI. A “use” of PHI occurs when I share, examine, give, or otherwise divulge to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this Notice; however, I reserve the right to change the terms of the Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office.

III. HOW I MAY USE AND DISCLOSE YOUR PHI

I will use and disclose your PHI for many different reasons. I will need your prior written authorization for some of these uses or disclosures; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

For Treatment. I can use your PHI within my practice to provide you with mental health treatment including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your case. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

To Obtain Payment for Treatment. I can use your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

For Health Care Operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who have provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

For Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent is not required if you need emergency treatment as long as I try to get your consent after treatment is rendered; or, if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

- When federal, state, or local laws require disclosure.** For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to governmental agencies and law enforcement personnel about victims of abuse or neglect.
- When judicial or administrative proceedings require disclosure.** For example, I may have to use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or claim for workers’ compensation benefits. I may also have to use or disclose your PHI in response to a subpoena.
- When law enforcement requires disclosure.** For example, I may have to use or disclose your PHI in response to a search warrant.
- When public health activities require disclosure.** For example, I may have to use or disclose your PHI to report to a governmental official an adverse reaction that you may have to a medication.
- When health oversight activities require disclosure.** For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.
- To avert a serious threat to health or safety.** For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. Any such disclosures will only be made to someone able to prevent the threatening harm from occurring.
- For specialized government functions.** For example, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations, if you are in the military.

8. **To remind you about appointments and to inform you of health-related benefits or services.** For example, I may have to use or disclose your PHI to remind you about your appointments or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

Disclosures to family, friends, or others: I may provide your PHI to a family member, friend, or other person that you indicate that is involved in your care or the payment for your health care unless you object in whole or in part. The opportunity to consent may be obtained retroactively in an emergency situation.

- D. Other Uses and Disclosures Require Your Prior Written Authorization.** In any situation not described in sections III A, B, and C, above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

- A. The Right to Request Restrictions on My Uses and Disclosures.** You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members, friends, or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests but am not legally required to accept them. If I do accept your requests I will put them in writing and will abide by them except in emergency situations. Be advised that you may not limit the uses and disclosures that I am legally required to make.
- B. The Right to Choose How I Send PHI to You.** You have the right to request that I send confidential information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.
- C. The Right to Inspect and Receive a Copy of Your PHI.** In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I do not have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.
- D. The Right to Receive a List of the Disclosures I Have Made.** You have the right to receive an Accounting of Disclosure listing the instances in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use; disclosures permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; and, disclosures made before April 14, 2003. I will respond to your request for an Accounting of Disclosure within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year I may charge you a reasonable, cost-based fee for each additional request.
- E. The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide, in writing, the request and your reason for the request. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request to amend your PHI, I will make the changes, tell you that I have done it, and tell others that need to know about the change to your PHI.
- F. The Right to Receive a Paper Copy of This Notice.** You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I have made about access to your PHI, you may file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S. W., Washington D. C. 20201. I will not take retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES: Vance Barse, Business Administrator: (858) 546-1100, ext. 223.

VII. Effective Date of This Notice

This notice went into effect on April 14, 2003.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES**

I, _____, have received a copy of Pyrsys Psychology Group, Inc.'s
Notice of Privacy Practices.

Name _____

Signature _____

Date _____

You may refuse to sign this acknowledgement

For Pyrsys Psychology Group, Inc. Use Only

We made every attempt to obtain written acknowledgment of receipt of our Notice of
Privacy Practices, but acknowledgement could not be obtained because:

_____ Above named individual refused to sign

_____ Emergency situation prevented obtaining signature

_____ Other (Please Specify)

Nutrition and Recovery

While in recovery, you may feel unwell or experience fatigue. However, when you understand that your fatigue may be related to early-stage malnutrition, you can recognize that feeling unwell is not something to “tough out.” Nutrition counseling provides support and encouragement to change erratic patterns of eating. With sensible patterns of eating, you establish a foundation for both emotional and physical well-being.

Is Your Diet Energy Boosting or Energy Depleting?

Indicate how often you practice the following dietary habits. Then total your score for a quick check of how your diet stacks up.

Score as follows: <i>3-always; 2-often; 1-seldom; 0-never.</i>	SCORE
1. Do you eat four or more times per day (include meals and snacks)?	_____
2. Do you eat breakfast?	_____
3. Do you limit sugar intake?	_____
4. Do you avoid eating sugary foods on their own (i.e. without other foods)?	_____
5. Do you limit caffeinated beverages to one 8-ounce serving or fewer each day?	_____
6. Do you consume at least 2 fresh fruits and 4 vegetables each day?	_____
7. Do you regularly include nuts, legumes, soy and/or fish as protein sources in your diet?	_____
8. Do you avoid white flours, refined cereals (Rice Krispies, Chex, etc.), sweetened cereal, bagels and baked sweets (muffins, cookies, etc.)?	_____
9. Do you avoid severe calorie-restricted diets?	_____
10. Do you avoid eating large meals that leave you uncomfortably full?	_____
11. Do you drink at least six glasses of water each day?	_____
12. Do you avoid tobacco?	_____
13. Do you limit alcohol intake to five drinks or fewer each week?	_____
14. Do you get at least seven hours of restful sleep each night?	_____
15. Do you exercise 3 or more times per week?	_____
TOTAL SCORE:	_____

SCORING:

40 or More:

Your diet and lifestyle support high energy. If you still suffer chronic fatigue, consult your physician.

30-39:

Your diet and lifestyle might be contributing to fatigue. Consult with the nutrition counselor to determine at least two areas for improvement.

Less than 30:

Your diet and lifestyle are major contributors to waning energy levels. Consult with the nutrition counselor to determine at least four or more areas for improvement.

Please answer the following questions:

1. Would you be interested in receiving a complete nutrition assessment?
2. Would it be helpful to receive a meal plan that is specific to your lifestyle and nutritional needs?
3. Would you be interested in improving your meal planning and basic cooking skills?

Pyrysys Psychology Group, Inc.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the client's original signature and date sign, or if it has expired as described below. A copy of this signed form will be provided to the patient, if requested.

I authorize Pyrysys Psychology Group, Inc. to release to

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

Fax _____

I authorize the above entity to release to Pyrysys Psychology Group, Inc.

The following information from the health records of:

Name: _____ Birth date: _____ SSN: _____

Telephone: (H) _____ (W) _____

Address: _____
Street City State Zip

Covering the periods of healthcare (dates of service):

From (date) _____ to (date) _____

For the purpose of:

(Not required if the disclosure is requested by the patient)

I understand that this will include information relating to (initial, if applicable):

Billing information, including number and type(s) of sessions (including late cancellations and no-shows charged to my account), balance due, payments received, discounts applied, etc., unless otherwise specified below.

Mental health services/psychiatric care.

- ___Assessment and treatment of alcohol and/or drug abuse.
- ___Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) Infection.

Please indicate specific information that can/cannot be released to party indicated above. If all information may be released, please indicate "all."

If compensation will be received: I understand that Pyrysys Psychology Group, Inc. may receive compensation for its use/disclosure of the information release pursuant to this authorization.

Client's initials: _____

Affirmation of Release:

I give Pyrysys Psychology Group, Inc. or the named agency above permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have indicated. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization at any time/ any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a client I have the right to access my treatment records during treatment and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearing house covered by the federal privacy regulation or a business associate of these entities, the information described above may be re-disclosed and no longer protected by the regulations.

Signature of the Client/Guardian/Legal Representative

Date Signed

Signature of Spouse/Partner

Date Signed

Signature of Witness/Relationship to Patient

Date Signed

Expiration date: _____
(or one year from date signed)

Authorization to release confidential information to the Pyrsys Psychology Group, Inc. professional staff

Pyrsys Psychology Group, Inc. (PPG) consists of a team of treatment specialists. I desire to benefit from the expertise of this entire treatment team, either by my direct contact with team members, or by consultation about me provided to team members by one another.

Therefore, I, _____, hereby authorize any member of the PPG professional staff (or, I limit this authorization to the following members)

to release to any member of the PPG professional staff (or, I limit this authorization to the following members)

any information that has been gathered about me for the purpose of coordinating and enhancing the effectiveness of my treatment at PPG.

I understand that at any time I may revoke this consent to release information. I also understand that any release that has been made prior to revocation, and which was based on the authorization I am now signing, shall not constitute a breach of my right to confidentiality.

Unless I revoke this authorization prior to such time, it shall remain valid until the termination of my services with PPG.

I have a right to receive a copy of this authorization and do/do not (circle) want one.

(Signature of client)

(Date of Birth)

(Authorization Date)

(Parent, Guardian, or Legal Representative)

(Authorization Date)

(Signature of staff witnessing consent)

(Date)

Pyrysys Psychology Group, Inc.

A Human Services Company
www.pyrysys.com

8950 Villa La Jolla Drive, Suite B214
La Jolla, CA 92037
Tel (858) 546-1100
Fax (858) 455-0141

Deposit Agreement and Credit Card Authorization

I, the undersigned, authorize Pyrysys Psychology Group, Inc. (PPG) to charge my credit card \$3,000 to hold a place in the Visitor Program at Practical Recovery Services, My Therapy Team, Supporting ME, Second Family, or another PPG service for me or the person(s) listed below for whom I accept full financial responsibility. \$300 of this deposit is for a non-refundable Program Fee. \$100 of this deposit is for a non-refundable Basic Psychological Testing Fee; additional psychological testing and interpretation, if necessary, will be charged to my account. Services may include, but are not limited to: psychological assessment, testing, and treatment, and other ancillary services. If the start-date changes there is a \$150 non-refundable re-scheduling fee. I understand my credit card will be charged at the end of each week for any balance due plus a deposit for all services scheduled for the following week. If there is a credit on my account at the end of the week, this credit will be applied to the following week. If I have a credit on my account at the end of treatment services, PPG will issue me a refund check within one week. I or the person(s) listed below may withdraw from treatment at any time but my credit card will be charged in full for any appointments not cancelled at least 24 hours in advance. I have the right to terminate this deposit agreement and credit card authorization at any time but must do so in writing via mail or hand-delivery to 8950 Villa La Jolla Dr., B214, La Jolla, CA, 92037 or fax to 858-455-0141. The termination is effective 24 hours after PPG receives my termination letter. If I fax my termination letter to PPG, I will mail the signed original to the above address on the same day.

I authorize PPG to keep my signature on file and to charge my credit card listed below per the terms of the above agreement for a \$3,000 deposit and:

- recurring charges for my ongoing treatment
- recurring charges for the ongoing treatment for the following persons:

(authorized person)

(authorized person)

(authorized person)

(authorized person)

Check one: VISA® American Express® MasterCard®
 Discover® Card PulseCard® (the healthcare credit card)

Cardholder Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Expiration Date: _____

V-Code (See below): _____ Billing Zip Code: _____

(V-Code: the last 3 digits in signature block on MasterCard & Visa or the 4 digit code above the account number on American Express)

Cardholder Signature: _____ Date: _____

❖ Charge will appear on credit card statement as “PPG INC”