

**Lori L. Riddle-Walker, MA**  
Licensed Marriage and Family Therapist  
MFC40306

**Mailing address: P.O. Box 2907, Escondido, CA 92033-2907**

**Phone: 760-715-7273**

**Email: llrwalker@sbcglobal.net**

**CLIENT INFORMATION**

DATE: \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ CA, Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Other phone \_\_\_\_\_

Email address \_\_\_\_\_

Employer or school attending \_\_\_\_\_

How long at this job \_\_\_\_\_

Social Security # \_\_\_\_\_

Marital Status: S M D Widow Separated

Spouse/Partner's name if applicable \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance \_\_\_\_\_

***Name of insured*** \_\_\_\_\_ ***DOB*** \_\_\_\_\_

***Social Security number of insured*** \_\_\_\_\_

Employer \_\_\_\_\_

ID and Group number \_\_\_\_\_

Medi-Cal number if applicable \_\_\_\_\_

Medi-Cal card issue date \_\_\_\_\_



Who may I contact in case of an emergency?

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Where did you hear about my practice?

\_\_\_\_\_

*If you were referred, may I thank that person?* \_\_\_\_\_ YES \_\_\_\_\_ NO

\_\_\_\_\_  
Signature of Client or Representative

date

\_\_\_\_\_  
Signature of Client or Representative

date

## ASSIGNMENT OF BENEFITS

Please sign this section if insurance benefits are to be paid to the provider rather than to the client.

I hereby authorize payment, directly to Lori L. Riddle-Walker, MFT, of the benefits otherwise payable to me under the terms and conditions of my health insurance. I understand I am financially responsible to the above provider for the charges not covered by my insurance.

SIGNATURE \_\_\_\_\_

Date \_\_\_\_\_

## RELEASE OF INFORMATION

I authorize the release of any medical or other information necessary to process insurance claims or obtain additional/continued authorization for services. I understand that this release includes billing and clerical personnel who are also under legal obligation to maintain confidentiality.

SIGNATURE \_\_\_\_\_

Date \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have provided for you in paper or electronic form. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice by contacting me at 502 W. El Norte Parkway, Escondido, CA 92026 or view and download a copy on my website at [www.lrwalker.net](http://www.lrwalker.net). If you have any questions about my *Notice of Privacy Practices*, please contact me at: 760-715-7273.

SIGNATURE \_\_\_\_\_

Date \_\_\_\_\_

## AGREEMENT FOR SERVICE / INFORMED CONSENT

### **Introduction**

This Agreement is intended to provide [name of patient]

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(herein "Patient") with important information regarding the practices, policies and procedures of Lori L. Riddle-Walker, MFT (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

### **Therapist Background and Qualifications**

Therapist has a Master of Arts degree in Counseling Psychology from Trinity College of Graduate Studies, and has been working as a therapist for 12 years, with both children and adults. Therapist has been practicing as a licensed marriage and family therapist (LMFT) for approximately 6 years, working with individuals, families, children and adolescents.

Therapist's theoretical orientation can be described as *Cognitive Behavioral*. Cognitive Behavioral Therapy explores the relationship between thoughts, behaviors and feelings and the impact they have on our lives. Cognitive Behavioral Therapy can help one change negative thinking and behavior patterns so greater happiness, productivity and intimacy can be experienced.

### **Risks and benefits of Therapy**

Psychotherapy is a process in which Therapist and Patient, and sometimes other family members, discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his/her life more fully. It provides and opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge the perceptions and assumptions of the Patient or other family members, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient.

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Length of treatment can be affected by many variables. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

### **Professional Consultation**

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical and legal consultation with appropriate professionals. During such consultation, Therapist will not reveal any personally identifying information regarding Patient or Patient's family members or caregivers.

### **Records and Record Keeping**

Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute Therapist's clinical and business record, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient. Should Patient request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Patient's records for ten years following termination of therapy. However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

### **Confidentiality**

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

Additionally, in couple or family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members.

Patient should also be aware that e-mail and cell phone communication can be easily accessed by unauthorized persons and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong number. Please notify Therapist at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail or faxes for emergencies.

### **Patient Litigation**

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient, and another individual, or entity, are parties. Therapist has a policy of not communicating with Patient's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such and appearance at Therapist's usual and customary hourly rate.

### **Psychotherapist-Patient Privilege**

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by Patient or Patient's representative. Patient should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

### **Fee and Fee Arrangements**

The usual and customary non-contracted fee for service is \$100.00 per 45-minute session. The usual and customary non-contracted intake fee is \$125.00. Sessions longer than 45-minutes are charged for the additional time pro rata. The usual and customary non-contracted fee for groups is \$35.00 for a 60 minute session. The agreed upon fee between Therapist and Patient is \$100.00 individual therapy / \$35 group therapy. Therapist reserves the right to periodically adjust this fee. Patient will be notified of any fee adjustment in advance.

From time-to-time, Therapist may engage in telephone contact with Patient for purposes other than scheduling sessions. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at the request of Patient and with the advance written authorization of Patient. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. Patient is expected to pay for services at the time services are rendered. Therapist accepts cash or checks.

**Insurance**

Therapist is a contracted Medi-Cal provider for San Diego and Riverside counties. Currently therapist is not a contracted provider with any other insurance company or managed care organization. Should Patient choose to use his/her insurance, Therapist will bill insurance or provide Patient with a statement, which Patient can submit to the third-party of his/her choice to seek reimbursement of fees already paid.

**Cancellation Policy**

Patient is responsible for payment of the agreed upon fee of \$50.00 for any missed individual sessions(s) and \$10 for any missed group sessions. Patient is also responsible for payment of the agreed upon fee for any sessions(s) for which Patient failed to give Therapist at least 24 hours notice of cancellation. Cancellation notice should be left on Therapist's voice mail at 760-715-7273.

**Therapist Availability**

Therapist's office is equipped with a confidential voice mail system that allows Patient to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee that calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, Patient should call 911, or go to the nearest emergency room. The number for the 24 hour, San Diego County Department of Mental Health, access and crisis line is 800-479-3339.

**Termination of Therapy**

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in a least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient.

**Acknowledgement**

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient agrees to hold Therapist free and harmless for any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Patient also acknowledges that although Therapist shares office space with other independent mental health professionals, Therapist is completely independent in providing Patient with clinical services and is responsible for Patient's services alone. Therapist's records are maintained separately and those sharing office space have no access to Patient's records.

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Patient Name (please print)

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Signature of Patient (or authorized representative) date

I understand that I am financially responsible to Therapist for all charges including unpaid charges by my insurance company or any third party payor.

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Name of Responsible Party (Please print)

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Signature of Responsible Party (and relationship to Patient) date