Mariya Kholodova, Ph.D.
Clinical Psychologist
PSY25103

3636 Fourth Avenue, Suite 210
San Diego, CA 92103
858-805-5302

Client Registration Information

(PLEASE PRINT CLEARLY)

CLIENT NAME_____**DATE**_____

DATE OF BIRTH_____**AGE**_____

*Name of Legal Guardian (if applicable)*_____

CLIENT ADDRESS_____

CITY_____**STATE**_____**ZIP**_____

CLIENT PHONE NUMBER_____

MARITAL STATUS: *(circle) SINGLE ENGAGED MARRIED SEPARATED DIVORCED WIDOWED IN A RELATIONSHIP LIVING WITH A PARTNER*

EMPLOYMENT STATUS: *(circle)* FULL-TIME PART-TIME RETIRED DISABLED UNEMPLOYED FULL-TIME STUDENT PART-TIME STUDENT

In Case of an Emergency notify *(specify relationship to patient):*

NAME_____**RELATIONSHIP**_____

EMERGENCY CONTACT'S PHONE:_____

PLEASE TELL ME HOW YOU HEARD ABOUT ME:_____

_____

CLIENT SIGNATURE (OR LEGAL REPRESENTATIVE) **DATE**

_____

MARIYA KHOLODOVA, Ph.D. **DATE**

CLIENT INITIALS_____

Mariya Kholodova, Ph.D.
Clinical Psychologist
PSY25103

3636 Fourth Avenue, Suite 210
San Diego, CA 92103
858-805-5302

INFORMED CONSENT TO TREATMENT AND NOTICE OF BUSINESS POLICIES AND PRIVACY PRACTICES

This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

ABOUT YOUR PROVIDER:
I have a doctorate degree in clinical psychology from Alliant International University, San Diego, and I am a licensed psychologist in the state of California. I have experience in both individual and group psychotherapy with adults and adolescents; I also have experience in couples counseling. I have worked in various clinical settings throughout my career, and have provided treatment for mood disorders, anxiety disorders, trauma, substance abuse, divorce, domestic violence, grief, and relationship concerns, among other clinical issues. If you have any questions regarding my training and qualifications, I would be happy to discuss them with you. I look forward to working with you.

COMMUNICATION:
I am available between the hours of 9:00 a.m. and 7:00 p.m., Monday through Friday. I am generally able to return voicemail messages within 24 hours. I am not, however, always able to return emergency messages right away. If you are in need of immediate help and I can't reach you soon enough, please call 911 or the San Diego Crisis Line at1-888-724-7240. Please keep in mind that email and texting are not the secure ways to transmit confidential information. To discuss confidential matters, emergency situations, and safety concerns, please call me instead.

If I leave on vacation and if you would like to continue your sessions while I am away, I will designate another therapist to see you for the duration of my absence. Both you and I will discuss this prior to my departure. If you decide not to see another therapist in my absence, please call the Access and Crisis line (888-724-7240) or call 911 if you are in need of immediate assistance or if you are experiencing a psychiatric crisis (i.e. having thoughts of harming yourself or harming another person).

PSYCHOTHERAPY:
In general, psychotherapy is a type of treatment of psychological concerns that uses the strategies of talking, in addition to other techniques. The goal of therapy is to relieve or change emotional, behavioral, or cognitive factors that may stand in the way of living a healthier, happier, and a more meaningful life. Another goal of psychotherapy could be self-exploration – to learn more about yourself.

CLIENT INITIALS_____

Each psychotherapy session will last approximately 45 minutes. Please remember that your session starts and ends at the scheduled time. If you are late, your session will still end at the scheduled time and you will be responsible for the entire fee, regardless of how late you were. Generally, clients attend sessions once a week for 45 minutes.

Occasionally, I see clients more or less often than once a week. Both you and I will agree on the frequency of sessions, according to your needs.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own impressions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures or become dissatisfied for any reason with your clinical care, please let me know your concerns as soon as possible. This may provide you with a helpful means to work through the issues that concern you about your treatment. If your doubts persist or if you are still unhappy with your care, I will be happy to provide referrals to you to see a different therapist. I also suggest you discuss terminating treatment with me before doing so, as the majority of clients find this to be a beneficial part of their treatment.

MY APPROACH:
My approach to therapy is psychodynamic and cognitive behavioral in orientation. I use a variety of techniques in therapy, trying to find what will work best for you. These techniques are likely to include dialogue, interpretation, and cognitive reframing, among others. If I propose a specific technique that may have special risks attached, I will inform you of that, and discuss with you the risks and benefits of what I am suggesting. I may suggest that you consult with a physical health care provider regarding corollary medical treatment that could help you. You have the right to refuse anything that I suggest.

RISKS INVOLVED:
Therapy has potential emotional risks. Approaching feelings or thoughts that you have tried to distance yourself from may be painful, and may sometimes, temporarily, disrupt relationships or other aspects of your life. Learning new strategies and releasing the old ones can be frightening and energy consuming. It is important that you consider carefully whether these risks are worth the benefits to you. Most people who take these risks find that therapy is helpful. It is important to remember that there are no guarantees of what you will experience or if the treatment will work for you.

Mariya Kholodova, Ph.D.
Clinical Psychologist
PSY25103

3636 Fourth Avenue, Suite 210
San Diego, CA 92103
858-805-5302

CONSULTATION:
To ensure that I am providing you with appropriate care, I may, on occasion, consult (talk) about your treatment with another mental health professional. I will not reveal your full identity, and the other professional is also legally bound to maintain the confidentiality of your information.

CONFIDENTIALITY:
With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may also request anyone you wish to attend a therapy session with you.

If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record. In addition, please note that text messages can, in theory, be retrieved by your cell phone company, and hence, are not confidential either.

The following are the <u>exceptions to your right to confidentiality</u>:

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services and Adult Protective Services.

3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am obligated to protect your

CLIENT INITIALS_____

safety, and would explore all other options with you before I involve other parties. If at that point you were unwilling to take steps to guarantee your safety, I would call the police or the crisis team.

4. In general, if you get involved in court proceedings you can prevent me from testifying about what you have told me. This is called privilege, and it always your choice to invoke it or waive it allowing me to testify. However, I cannot assert privilege on your behalf if I receive a court order instructing me to testify in legal proceedings that you might be involved in, or instructing me to release any/all records.

5. Section 215 of the Patriot Act of 2001 requires mental health providers to disclose parts or all of the client's record (if requested by the FBI) and prohibits the therapist from disclosing to the client that an FBI agent sought or obtained the client's personal information under the Act.

6. If you are using your insurance plan to pay for my fees, I am required to disclose certain information about your treatment to the insurance company. This information may include your diagnosis, my fee, dates of service, treatment plan, or/and a summary of treatment.

REKORDKEEPING:
The laws and standards of my profession require that I keep treatment records. What may be included in your record is the initial assessment, intake paperwork, your diagnosis, notes regarding each session, any communication that occurs outside of session, any information released to third parties, court documents, and other paperwork I receive or send out regarding your treatment. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them, or a treatment summary to a mental health professional of your choice. You will be charged a fee for any time spent in preparing information requests. I do not keep electronic records at this time.

DIAGNOSIS:
Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If you are using your insurance plan to pay for my services, I am normally required to give a diagnosis in order to be paid. If you do not meet the criteria for a mental health diagnosis, I will not be able to bill your insurance. In that case, you will be responsible for payment for my services.

TERMINATION:
You have the right to end your treatment any time for any reason. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures or become dissatisfied

for any reason with your clinical care, *please let me know your concerns as soon as possible*. This may provide you with a helpful means to work through the issues that concern you about your treatment. If your doubts persist or if you are still unhappy with your care, I will be happy to provide referrals to you to see a different therapist. I also suggest you discuss terminating treatment with me before doing so, as the majority of clients find this to be a beneficial part of their treatment.

You alone or both of us together will decide when therapy will end *except under the following circumstances:*

1. If we have contracted for a specific short-term work, we will finish therapy at the end of that contract.
2. If I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs.
3. If you or a person close to you does violence to, threatens verbally or physically, or harasses myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but I cannot guarantee that they will accept you for therapy.

Psychotherapy is not the only option for dealing with emotional concerns. Depending on the reasons that led you to seek therapy, alternative options that may be helpful for you may include meditation, yoga, diet and exercise, psychiatric medications, pastoral counseling, and others.

OTHER RIGHTS:
You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I have decided to do what I am doing, and to look at alternatives that might work better. Please feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

If you feel I have done something harmful or unethical and you do not feel comfortable discussing you concerns with me, you can always contact California Board of Psychology, and they will review your complaint.

Board of Psychology
1625 North Market Blvd., Ste. N-125
Sacramento, CA 95834
866-503-3221

Mariya Kholodova, Ph.D.
Clinical Psychologist
PSY25103

3636 Fourth Avenue, Suite 210
San Diego, CA 92103
858-805-5302

PAYMENT INFORMATION:

Please Read This Information Carefully Regarding Your Financial Responsibility.

1. My fee is $200 per session with each session lasting approximately 45 minutes. Payment is made in the beginning of the session on the day of service, unless prior arrangements have been made. I accept cash or check.

2. Payment of any unpaid balance on an account must be received in full before close of the month. You will be charged a $30 fee for all returned checks. Unpaid balances older than 90 days will be subject to collections proceedings for which you agree to pay all associated costs.

3. If you have health insurance, it will usually provide some coverage for mental health treatment. I am an in-network provider with Anthem Blue Cross, Blue Shield, Magellan, and Aetna. Please note that *you* are financially responsible for my fees if your insurance plan does not cover my services for any reason (unless I made a billing error and in that case I will resubmit the claim).

4. I also accept other PPO plans as an out-of network provider. If I am an out-of-network provider with your insurance plan and if you plan to seek reimbursement for a part of my fee, I will provide a signed receipt with the necessary information for you to submit to your insurance company.

Please note that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes, I have to provide additional clinical information such as treatment plans or treatment summaries. This information will become a part of the insurance company files and will probably be stored in the computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. I will provide your insurance company with only the information required in order to meet their administrative needs. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above. *By signing this consent, you authorize me to provide information to your insurance company as needed for payment for my services.*

5. <u>You are financially responsible for sessions missed without a 24-hour advance cancellation</u>. Please keep in mind that you will be charged a full fee for the missed appointment.

CLIENT INITIALS_____

Mariya Kholodova, Ph.D.
Clinical Psychologist
PSY25103

3636 Fourth Avenue, Suite 210
San Diego, CA 92103
858-805-5302

6. Insurance plans do not reimburse for late notice cancellations or missed appointments. Phone calls are charged at the usual session rate and charges are made if they last longer than *five* minutes. Your insurance company may not provide reimbursement for phone calls.

Please provide the following information for your insurance plan:

INSURANCE COMPANY:_____

NAME OF INSURED SPONSOR:_____

SPONSOR DATE OF BIRTH:_____

SPONSOR ADDRESS:_____

SPONSOR PHON NUMBER:_____

GROUP NUMBER:_____

POLICY NUMBER:_____

Client Consent to Psychotherapy

I have read this statement (Informed Consent to Treatment and the Notice of Business Policies and Privacy Practices), had sufficient time to be sure that I considered it carefully, and asked any questions that I needed to understand it fully. I agree to pay the agreed upon fee per session. I understand my rights and responsibilities as a client, and I understand my therapist's responsibilities to me. I agree to undertake therapy with Mariya Kholodova, Ph.D., and I know I can end therapy at any time. I know I can refuse any requests or suggestions made by Mariya Kholodova, Ph.D.

I have read, understand, and agree to comply fully with the above policies (pages one through eight). I accept full financial responsibility for all professional services rendered.

CLIENT SIGNATURE (OR LEGAL REPRESENTATIVE) **DATE**

MARIYA KHOLODOVA, Ph.D. **DATE**

CLIENT INITIALS_____

Mariya Kholodova, Ph.D.
Clinical Psychologist
PSY25103

3636 Fourth Avenue, Suite 210
San Diego, CA 92103
858-805-5302

NOTICE OF PRIVACY PRACTICES (HIPAA)

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. As required by "HIPAA" I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information. I may use and disclose your medical records only for the following purposes:

- Treatment - providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- Payment - such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running my practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer services. I may also create and distribute de-identified health information by removing all references to individually identifiable information. I may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing - I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other persons identified by you. I, however, am not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from me by alternative means or at alternative locations.

CLIENT INITIALS_____

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from me upon request.

I am required by law to maintain the privacy of your protected health information and to provide you with notice of my legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003 and I am required to abide by the terms of the Notice of Privacy Practices currently in effect. I reserve the right to change the terms of my Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. I will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with my office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of my office. I will not retaliate against you for filing a complaint. Please contact me for more information at the address listed at the top of this page.

For more information about HIPPA or to file a complaint:
The U.S. Dept. of Health & Human Services Office of Civil Right
200 Independence Avenue, S.W.
Washington, D.C. 20201

CLIENT SIGNATURE (OR LEGAL REPRESENTATIVE) **DATE**

MARIYA KHOLODOVA, Ph.D. **DATE**

Mariya Kholodova, Ph.D.
Clinical Psychologist
PSY25103

3636 Fourth Avenue, Suite 210
San Diego, CA 92103
858-805-5302

Intake Questionnaire

Name Date of Birth Date

Education_____

Occupation_____

Employer_____

Who lives with you at home? List names, ages, and relation to you.

Do you have children? Please list the names, ages, and whom they live with.

Are you in contact with your parents? How would you describe your relationship with them?

What brought you to see me today? Why *now?*

Have you ever been involved with litigation? If yes, please explain.

CLIENT INITIALS_____

Mariya Kholodova, Ph.D.
Clinical Psychologist
PSY25103

3636 Fourth Avenue, Suite 210
San Diego, CA 92103
858-805-5302

Have you seen a therapist before? If yes, please provide the following: the name of the therapist, when you saw him/her, and the reason for seeking treatment. Was it helpful? Why/why not?

Have you seen a psychiatrist (a doctor who prescribes psychiatric medication) before? If yes, please provide the doctor's name, when you saw this doctor, and what medications you were prescribed.

Do you have a doctor you usually see for medical reasons? If yes, please provide your doctor's name and phone number.

When was the last time you had a general medical checkup?

Are you currently being treated for any health problem or recovering from any injury, surgery, etc.? If yes, please briefly describe below.

Are you currently taking any prescription medication? If yes, please list the medication and the dosage below.

CLIENT INITIALS_____

Please list any major illnesses or surgeries you have experienced.

Have you ever used the following substances and how often do/did you use:

-Coffee:

-Tobacco (smoking or chewing):

-Alcohol:

-Marijuana (if yes, do you have a medical marijuana card?):

-Any form of cocaine, crystal, speed, or ecstasy:

-Pain-killing or sedative drugs, such as Valium, Quaaludes, heroin, morphine, opium, etc. (not prescribed by a doctor):

-Hallucinogenic drugs, such as LSD, Psilocybin mushrooms (‘shrooms), etc.:

Please put a checkmark if any of your biological relatives (parents, grandparents, siblings, aunts, or uncles) have experienced the following:

_____Have been treated in a psychiatric hospital
_____Threatened to commit suicide
_____Committed suicide
_____Had problems with alcohol
_____Abused drugs
_____Had an eating disorder
_____Have been in trouble with the law/arrested
_____Have been severely depressed
_____Have been diagnosed with bipolar disorder or depression
_____Have been diagnosed with schizophrenia
_____Seemed excessively anxious or prone to worry

Mariya Kholodova, Ph.D. **3636 Fourth Avenue, Suite 210**
Clinical Psychologist **San Diego, CA 92103**
PSY25103 **858-805-5302**

Please circle the number that is the most true for you:

1. Getting my schoolwork done has often been a problem
(Not at all true for me) - 0 1 2 3 4 5 - (Very true for me)

2. I had a lot of good times at school
(Not at all true for me) - 0 1 2 3 4 5 - (Very true for me)

3. I've been in trouble a lot at school
(Not at all true for me) - 0 1 2 3 4 5 - (Very true for me)

4. When I was younger, I was unhappy a lot of the time
(Not at all true for me) - 0 1 2 3 4 5 - (Very true for me)

5. If this applies to you: How satisfied are you now with your relationship with your mother?
(Not at all satisfied) - 0 1 2 3 4 5 - (Very satisfied)

6. If this applies to you: How satisfied are you now with your relationship with your father?
(Not at all satisfied) - 0 1 2 3 4 5 - (Very satisfied)

7. If this applies to you: How satisfied are you now with your relationship with your stepmother or stepfather?
(Not at all satisfied) - 0 1 2 3 4 5 - (Very satisfied)

8. How satisfied are you with your love life, partnership, or marriage?
(Not at all satisfied) - 0 1 2 3 4 5 - (Very satisfied)

9. How satisfied are you with your friendships and social contacts?
(Not at all satisfied) - 0 1 2 3 4 5 - (Very satisfied)

CLIENT INITIALS_____

Mariya Kholodova, Ph.D.
Clinical Psychologist
PSY25103

3636 Fourth Avenue, Suite 210
San Diego, CA 92103
858-805-5302

In the last six months, how often have you experienced each of the following?

	Never	Occasionally	Fairly Often	Very Often
Trouble sleeping	0	1	2	3
Restless sleep	0	1	2	3
Nightmares	0	1	2	3
Waking up in the middle of the night	0	1	2	3
Waking up early in the morning and can't go back to sleep	0	1	2	3
Not feeling rested in the morning	0	1	2	3
Weight loss (without dieting)	0	1	2	3
Weight gain	0	1	2	3
Binge eating	0	1	2	3
Purging	0	1	2	3
Isolating from others	0	1	2	3
Feeling alone	0	1	2	3
Low sex drive	0	1	2	3
Sadness	0	1	2	3
Flashbacks (sudden, vivid, distracting memories)	0	1	2	3
Headaches	0	1	2	3
Stomachaches	0	1	2	3
Anxiety	0	1	2	3

CLIENT INITIALS_____

Mariya Kholodova, Ph.D.
Clinical Psychologist
PSY25103

3636 Fourth Avenue, Suite 210
San Diego, CA 92103
858-805-5302

	Never	Occasionally	Fairly Often	Very Often
Uncontrollable crying	0	1	2	3
Panic attacks	0	1	2	3
Trouble controlling your temper	0	1	2	3
Trouble getting along with others	0	1	2	3
Dizziness	0	1	2	3
Desire to physically hurt yourself	0	1	2	3
Desire to hurt others	0	1	2	3
Not feeling satisfied with your sex life	0	1	2	3
Being confused about your sexual feelings	0	1	2	3
Sexual feelings when you shouldn't have them	0	1	2	3
Unnecessary or over-frequent washing	0	1	2	3
Feelings of inferiority	0	1	2	3
Feelings of guilt	0	1	2	3
Feeling that things are "unreal"	0	1	2	3
Memory problems	0	1	2	3
Feeling that you are not always in your body	0	1	2	3
Feeling tense	0	1	2	3
Trouble breathing	0	1	2	3

CLIENT INITIALS_____