LESLIE ELLEN RAY, MS, LMFT
8950 Villa La Jolla Drive, Suite B-208
La Jolla, California 92037
Tel.: 619.850.8759
email: leslie13100@gmail.com

NAME: (first and last)

ADDRESS:

PARTY RESPONSIBLE FOR PAYMENT: (Name and address)

HOME TEL:

EMAIL ADDRESS:

ACADEMIC PROGRAM OR CURRENT OCCUPATION:

DATE OF BIRTH:

EMERGENCY CONTACT: RELATIONSHIP:

ADDRESS: TEL:

REFERRED BY:
May we thank them?

I understand that there will be a full charge for appointments cancelled in less than 24 hours.

I understand that my sessions are held in confidence with the exception of disclosures of child abuse or safety issues involving harm to myself or others.

I understand that fees will be paid at the end of each session unless otherwise determined.

Signature: _____ Date: _____

(Continued on next page)

LESLIE ELLEN RAY, MS, LMFT, CALicense#: MFT27444

Names of Children: Age(s):

Previous Mental Health Treatment (Please include prior treatment for mental health, alcohol, or other substance problems.)

Provider: Approximate Dates: Inpt/Outpt

Please give details of any medical conditions of which I should be aware:

Reason for seeking psychotherapy and goals:

Primary Care Physician:
Name:

Address:

Tel:

Medications: Medication Name Dosage Prescribing professional:
Past:

Present:

Reviewed by: Leslie Ellen Ray, LMFT_____

LESLIE ELLEN RAY, MS, LMFT, CALicense#: MFT27444

OFFICE GUIDELINES

Welcome to my office:
To ensure that your experience in therapy with me is meaningful in terms of your time, energy, and expense, the following guidelines have been prepared to acquaint you with my policies regarding scheduling appointments, billing, insurance, and other relevant issues. Please read these office guidelines carefully and feel free to discuss any questions or reactions you might have with me. When you sign this document, it will represent an agreement between us. You may relax in the reception area until I greet you at your scheduled appointment time.

Counseling Services:
Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you bring forward. There are many different methods that I use to deal with issues that you hope to explore and address. I am a licensed Marriage, Family and Child Therapist. Our work together is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy process to be successful, you will have to work on things we talk about during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, loneliness, and a host of other affects and complexes. On the other hand, psychotherapy has been shown to have benefits for people who go through the process. Therapy often leads to a better relationship with others as well as an integration of new information and skills that enables a reduction in feelings of distress. There are no guarantees of what you will experience.

Our first few sessions will evolve an evaluation of where you are and what you'd like out of our work together. 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. At times, I might ask you to keep track of your dreams or keep a journal as an adjunct to our work. You can evaluate this information along with your opinions of whether you feel comfortable with working this way. Therapy involves a commitment of time, money, and energy. If you have any questions about my procedures, please do not hesitate to discuss them with me whenever they arise. If you have any doubts about our work or don't feel a sense of connection, I will be happy to refer you to other mental health professionals.

My practice is dedicated to maintaining the privacy of your personal health information. According to law, professional ethics, and common sense, whatever you say or do during a psychotherapy session will not be shared with anyone without your written permission. I will use any information about your health that I get from you or others mainly to provide you with therapy services, to arrange payment for my services, and at times for some other business activities that are called, in the law, health care operations. This is described in detail in my **Notice of Privacy Policy.** If you or I want to use or disclose (send, share, release) your information for other purposes, only a **Consent to Use and Disclose Your Health Information Form**, signed by you, may otherwise release me, or my legal supervisor, to discuss any information with certain individuals or agencies. You may revoke this permission at any time. There are, however, some important exceptions in which disclosure is legally mandated to reveal information obtained during therapy to other persons or agencies **without** your permission. These situations are as follows:

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1. In most cases, I keep brief records of each therapy session. In a court of law, these records may be subpoenaed under certain conditions and I may be obligated by law to surrender part or all of the records I keep.
2. If there is sufficient evidence presented in therapy to suspect that a child or dependent adult is being abused, either by neglect, assault, battery, or sexual molestation, I am required to report the 'reasonable suspicion' of such abuse. I have no authority or responsibility to investigate the case.
3. If you threaten that you intend to commit grave bodily harm or death to another person, I am required by law to inform the intended victim, relevant authorities, and the appropriate law enforcement agencies.
4. If you indicate that you intend to harm or kill yourself, as in the event of a potential suicide, I am required by law to break confidentiality and protective measures will be taken to keep you safe. I am required by law to notify the necessary individuals (appropriate law enforcement agencies) to prevent harm.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you have in your session today, and throughout the course of our work together so please feel free to ask me any questions you may have about the procedures mentioned above. I will be available to answer any questions you have to the best of my ability.

Supervision and Consultation:
From time to time, I may need to consult with fellow colleagues and/or qualified professionals to seek information or input that may be helpful to my clients. In such a professional supervision or consultation, I make every effort to avoid revealing identifying information of my patient by changing identifying information so as to preserve and protect confidentiality. Unless you specifically direct me, I will not disclose to you about these consultations regarding your case.

Telephone Conversations and Emergency Procedures:
My office is accessed by way of a confidential voicemail system at 619.850.8759. I check my messages regularly during the day: Tuesday, Wednesday, Thursday, and Saturday, and I return calls as soon as possible. Calls received Sunday are returned the following week. If your call is urgent, you may send a text to the same number. I will return your call as soon as I am able. If I have not returned your call within 24 hours, please assume I did not get your message and leave another message. If your call is a true emergency, you may call the San Diego Crisis Hotline at 1. 800.479.3339. If I will be unavailable for an extended length of time, I will provide you with options for working with me remotely or, if you prefer, I will provide you with the name and contact information of a colleague to contact if necessary.

Payment for Services:
My customary fee is $195.00 for a scheduled 45-50-minute session, $390 for a 90-minute double session. If therapy has begun, I will usually schedule one session per week at a time we agree upon but additional sessions can be scheduled as needed and agreed upon. Payment is due at the time the service is provided unless prior arrangements have been made. If you will be paying by check, please have the check prepared prior to our session. **A minimum of 24 hours notice is required for rescheduling or cancelling of an appointment.** The full fee will be charged for cancellations in less than 24 hours notice or no-shows, except in the case of an extreme emergency. (If possible, I will try to find another time to reschedule the appointment in the same week.) In addition to weekly appointments, a fee of $50 will be charged in 15-minute increments (charges begin after the first 10 minutes) for telephone or crisis sessions lasting up to 30 minutes.

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Termination of Therapeutic Services:

Our therapeutic relationship continues as long as I am providing you with professional services or until you inform me, in person or in writing, that you wish to terminate therapy, or I notify you that therapy is terminated. Before ending therapy, we will meet at least once for termination purposes to review our work together, our goals, and accomplishments, any further work to be done, and our options. The final session is to obtain appropriate closure for our therapeutic relationship. If you choose to continue therapy with another professional and do not have referrals, I will provide you with the names of other qualified professionals whose services you might prefer. Your only obligation at the point of termination is that of a financial nature, for services already incurred and not yet paid in full. Arrangements can be made upon request.

Finally, please let me know if you would like a copy of this policy statement for future reference. Should you have any questions at any time, please ask.

Signature:_____ Date:_____

Therapist's signature:_____

LESLIE ELLEN RAY, MS, LMFT, CALicense#: MFT27444

Consent for Treatment

I, _____, authorize and request that Leslie Ray, LMFT, CALicense#MFT27444, provide assessment, diagnosis, treatment, and/or treatment procedures that are now, or during the course of my care as a client, advisable. The collection of such date is what the law calls **Protected Healthcare Information (PHI)**. The frequency and type of treatment will be decided between my therapist and me.

I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur.

I understand the maximum benefit will occur with consistent attendance and depends upon multiple factors including motivation and effort devoted as well as other life circumstances.

I have been informed of the nature of psychotherapy treatment including various methods available, confidentiality and its limits, the treatment plan to be employed and the goals of treatment.

I have read the **Office Guidelines, Consent for Treatment Form**, and **Notice of Privacy Practices** that explain in detail my rights and how my personal health information can be used and shared. In the future, if there is any change in these guidelines or forms, I can ask to receive a revised copy.

If I am concerned about some of my information, I have the right to ask that it not be used or shared for treatment or administrative purposes. I agree to advise Leslie Ray of my concerns in writing. I understand that she will try to respect my wishes but is not required to agree on my limitations.

My signature below indicates that I have read and fully understand this **Consent for Treatment Form**.

_____ _____

Client Signature Date

_____ _____

Therapist's Signature Date

LESLIE ELLEN RAY, MS, LMFT, CALicense#: MFT27444

NOTICE OF PRIVACY PRACTICES

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.

Privacy:
Privacy is a very important concern for all individuals who come to this office for treatment. It is a complicated issue because there is more than one source for offering input into the issue of privacy. Federal law, state law, and the licensing Board Of Behavioral Sciences ethical standards include regulations and rules that involve privacy. The rules indicated in this Notice are detailed and somewhat complicated. If you have any questions, please do not hesitate to discuss them with me.

Safeguarding Your Protected Health Information (PHI):
This notice describes how I handle information about you. It tells how this information is used in this office and how it may be shared with other professionals and organizations as well as how you can have access to it. I am required to inform you about this process because of the privacy regulations of a federal law entitled, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Each time you visit this office or another doctor's office, hospital or clinic, or any other 'healthcare provider', information is collected about you and your physical and mental health. This may be information about your past, present or future health or conditions, or the treatment or other services you received from this office or from others, or about payment for healthcare. The information collected from you is legally called, PHI, which stands for **P**rotected **H**ealth **I**nformation. This information goes into your medical or healthcare record or file at the office.

I am legally required to protect the privacy of your PHI, which includes: information that may be used to identify you that I've created or received about your past, present, or future health or condition, the provision of healthcare to you, or the payment of this healthcare. 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.

The legal term, 'use' of PHI refers to my sharing, examining, utilizing, applying or analyzing this information within my practice. The legal term, 'disclosure' of PHI refers to the release, transfer, or divulgence of information to a third party outside of my practice. Except in some special circumstances, I may not use or disclose any more of your PHI than the minimum necessary to accomplish the purpose for which the use or disclosure is made.

Privacy & the Law:
The HIPAA law requires me to keep your PHI private and to provide you with this Notice of legal duties and privacy practices entitled, 'Notice of Privacy Practices' or NPP. I will obey the rules of this notice as long as it is in effect. I have the right to change the terms of this Notice and my privacy policies at any time. Before enacting any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (when it is available).

Disclosure and Use of your Protected Health Information (PHI):
I will use and disclose your PHI for many different reasons, most of them routine. For some of these uses or disclosures, I will need your prior written authorization for others, I will not.

Protected Health Information is likely to include the following kinds of information:

- Your history (e.g., childhood, education, employment, relationship, and personal)
- Reason for treatment (e.g., problems, complaints, symptoms, goals)
- Diagnosis (e.g., medical term for your symptoms or complaints)
- Treatment plan (e.g., treatments and services used to help you)
- Progress notes (e.g., general information/observations about how you are doing)
- Records from other sources from which you've received treatment or evaluation
- Psychological testing information (e.g., school records, psychological assessments)
- Legal information
- Billing and insurance information

This information is used for a number of reasons:

- To plan your healthcare treatment and determine the effectiveness of this treatment
- To allow for clear communication between referral sources (e.g., your psychiatrist)
- To verify that you've received the treatment billed to you or your insurance company
- For teaching and training purposes and/or medical and psychological research purposes
- To improve the services you receive

It is important to note that although your health record is the physical property of my practice, the information belongs to you. Therefore, you may inspect it, read, or review it. If you want a copy you are entitled to it, but you may be charged for the costs of copies and mailings. In some specific situations, you may not see all of the contents of the records. If you find something in your record that you believe is either incorrect or is missing, you may ask for me to amend it.

1. Uses & disclosures of your PHI in healthcare with your consent:

After you have read this Notice you will be asked to sign a separate Consent form to allow me to use and share your PHI. In almost all cases I intend to use your PHI here or share your PHI with other people or organizations to provide **treatment** to you, arrange for **payment** for my services, or some other business functions called healthcare **operations**. Together these routine purposes are termed 'TPO' and the Consent form allows me to use and disclose your PHI for TPO.

I require information about you and your condition to provide care to you. In order for me to care for you properly, I must be granted your consent to collect, use, and disclose information about you as is necessary. Therefore, you must sign the Consent form before treatment may begin. If you do not agree and consent, then I cannot treat you.

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For treatment purposes:
In my office, I use your PHI to provide you with treatment or services. Treatment might include: individual, family, group, or couple therapy, treatment planning, consultation, or measurement of the effects of my services.

I may share or disclose your PHI to others who also provide treatment to you (e.g., your personal physician, or psychiatrist, or other licensed healthcare providers.) If a team is treating you, I may share some of your PHI with the team members so that the services you receive will be carefully coordinated. They will also enter their findings, the actions they took, and their plans into your record. This will allow coordinated decisions about which treatments work best for you and enable a coordinated treatment plan. I may refer you to other professionals or consultants for services I do not or cannot offer (e.g., special testing or assessment or adjunctive treatments), and may need, as a result of this referral, to share with them information about you and your condition. Their findings and opinions will be sent here and placed in your records in my office. If you receive treatment in the future from other professionals, I may share your PHI with them.

For payment purposes:
I may use and disclose 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 reimbursed for the health care services that I have provided to you. I may also provide your PHI to my billing service to determine your insurance coverage for my services or process insurance claims on your behalf for reimbursement. As a result of these disclosures, I may have to disclose information about your diagnosis, treatments you have received, as well as expectations and prognoses on your behalf.

For healthcare operations:
I may disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of healthcare services that you received or to evaluate the performance of healthcare professionals who provided such services to you. I may also have to provide your PHI to government healthcare agencies in order for them to study disorders and treatments. If this information is provided, your name and identity will remain anonymous.

Other uses and disclosures:

Appointment reminders:
I may use and disclose your PHI to reschedule or remind you of appointments for treatment or other care. I value discretion, therefore if you prefer that I contact you at a specific place (e.g., only at home, only at work), which can be arranged as needed.

Treatment alternatives:
I may use and disclose your PHI to recommend or discuss possible treatments, health related services, or alternatives that may be of interest to you.

Business associates:
Periodically there are some jobs I have other business provide at my office. Legally, these are termed, 'business associates'. One example includes my billing service, which keeps an accounting of my billing, sends out claims to insurance companies and prints and mails the billing. These business associates need access to some of your PHI in order to provide these services. To protect your privacy they have agreed in their contract with me to safeguard your information.

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2. Uses and disclosure requiring your Authorization:
In order to use your information for any purpose other than TPO or those aforementioned, I must have your permission on an Authorization form. If you do authorize me to use or disclose your PHI, you may revoke that permission, in writing, at any time. After that time, I will not use or disclose your information for the purposes we agreed to initially. I cannot take back any information already disclosed or used with your permission prior to your cancellation of permission.

3. Uses & disclosure of PHI from mental health records NOT requiring consent or authorization:
As indicated by law, I may disclose your PHI to others without your consent or authorization in certain situations.

When required by law:
Some federal, state, or local laws require me to disclose PHI. Below is a listing of mandated reporting issues:

- In cases of suspected child abuse
- In the case of legal proceedings, which include a subpoena, or a discovery request, or other lawful process, some of your PHI may have to be released. This will only be done after trying to contact you about this request, consulting your attorney, or trying to get a court order to protect the information requested.
- In the event that government agencies require information from my office to verify that I am obeying privacy laws, I must release or disclose specific information requested.

For Law Enforcement purposes:
I may release medical information if asked to do so by law enforcement official to investigate a crime or criminal.

For public health activities:
I may disclose some of your PHI to agencies that investigate certain diseases or injuries.

For specific government functions:
I may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment, to Worker's Compensation programs, to correctional facilities if you are an inmate, and for national security reasons.

To prevent a serious threat to health or safety:
If I have reason to believe that there is a serious threat to your health or safety or that of another person or the public at large, I may disclose some of your PHI. I may only disclose this to persons who can prevent the danger or harm.

4. Uses & disclosures requiring you to have an opportunity to object:
Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person you indicate is involved in your care or the payment of your healthcare unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations. I will ask you about whom you want me to tell what information to about your condition or treatment. I will honor your requests as long as they are not against the law.

Disclosures in emergency situations. Your consent is not required if you need emergency treatment, as long as I try to get your consent after treatment is provided, or if I try to get your consent but you are unable to communicate with me (e.g., if you are unconscious or in severe

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pain) and I think that you would consent to such treatment if you were able to do so. If I must share information in an emergency situation, I will tell you as soon as possible. If you do not approve, I will stop, as long as it is not against the law.

5. An accounting of disclosures:
When I disclose your PHI, I keep records regarding the recipient of the disclosure, the date of the disclosure, and contents of the disclosure. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, to whom PHI was disclosed, 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 will charge you a reasonable cost-based fee for each additional request.

Questions, additional information or problems:
If you have questions about these privacy practices, if you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, please contact me, Leslie Ray, LMFT, to discuss this matter, as I am the 'Privacy Officer' in charge of this information. You have the right to file a complaint with me and with the Secretary of the Federal Department of Health and Human Services; your filing will not limit your care. I may be reached by phone at 619.850.8759 or via email at leslie13100@gmail.com

Effective date of this notice:
This notice went into effect on 1 January 2024.

LESLIE ELLEN RAY, MS, LMFT
8950 Villa La Jolla Drive, Suite B-208
La Jolla, California 92037
Tel.: 619.850.8759
email: leslie13100@gmail.com

CONSENT FORM
For Use and Disclosure of Personal Health Information

This form indicates that you agree to the 'use and disclosure' of your Personal Health Information (PHI) as indicated in the Notice of Privacy Practices Form, provided to you prior to signing this Consent Form.

As you may remember from the Notice of Privacy Practices Form, when I examine, diagnose, treat, or refer you, I will be collecting your Protected Health Information in order to determine and provide the best course of treatment for you. I may, at times, need to share this PHI with others who provide treatment to you, arrange payment for your treatment, or for other business or government functions.

In the future there may be a change in how 'use and disclosure' is shared, and therefore, my Notice of Privacy Practices will be updated to reflect these changes. I will provide you with current copy, if changes occur.

Please be aware that you have the right to make a written request not to use of share some of your information for treatment, payment or administrative purposes. While I am not required to grant your request for these limitations, I will comply if at all possible.

After you have signed this Consent Form, you have the right to revoke it and, at that time, I will abide by your request regarding using or disclosing your PHI from the time I receive your written revocation request. Please know that prior to your written revocation, information about you may have already been shared which cannot be changed.

This form is an agreement between you, _____ and me, Leslie Ray, LMFT, indicating your consent for my use and disclosure of PHI on your behalf for treatment purposes. If you choose not to sign this consent form agreeing to the contents of the Notice of Privacy Practices, I will not be able to provide you with treatment.

_____ _____
Client signature or personal representative Date

_____ _____
Printed name of client or personal representative Relationship to client

_____
Description of personal representative's authority

Date of Notice of Privacy Practices _____ ☐ Copy given to client/parent/representative