The Center for Men's Excellence
Psychological Science with Proven Results

MINOR CLIENT INFORMATION

Name:_____ (Last) (First) (Middle Initial)	**Birth Date:**_____/_____/_____
Age:_____ **Gender:**_____ **Caregiver completing this form:**_____	
Ethnicity: _____	
Local Address:_____ (Street and Number) (City) (State) (Zip)	
Parent/Caregiver Phone: (____) _____ -_____	**May we leave a msg?** ☐Yes ☐No
Alternative contact: _____ **Phone: (___) ___ -_____**	**May we leave a msg?** ☐Yes ☐No
E-mail:_____ *Please be aware that email might not be confidential.	**May we email you?** ☐Yes ☐No
Emergency Contact Name:_____ **Address:**_____ (Street and Number) (City) (State) (Zip)	**Relationship:**_____ **Phone:** (_____)_____-_____
Education:_____ (Please indicate highest degree earned and area of study)	**School:**_____ (Please indicate current job title)
Disability Status:_____ (Indicate documented mental/physical disability)	**Insurance:**_____ (Name of carrier) _____/_____/_____ (Policy Number) (Group Number) (Expiration Date)
Any Special Contact Notes? _____ _____	
Referred by: ☐Self ☐ Other_____	
Is your child currently receiving psychiatric services or psychotherapy elsewhere? ☐Yes ☐No	
Has your child had previous psychological counseling? ☐Yes ☐No **Is your child currently taking prescribed psychiatric medication (antidepressants or others)?** ☐Yes ☐No **If no, have they ever, at any time been previously prescribed psychiatric medication?** ☐Yes ☐No **Have they or any member of their family been hospitalized for psychiatric reasons?** ☐Yes ☐No	
I understand that I am responsible for all fees owed to my therapist at the Center for Men's Excellence, for professional services rendered to the above patient. I also understand that any appointment not cancelled within 48 hours will be charged for, and that charges are expected to be paid at the time services are rendered. I also understand and waive my right to confidentiality if a collection service or court action becomes necessary to collect my delinquent account. **SIGNATURE OF RESPONSIBLE PARTY:**_____ **Date:**_____	

INFORMED CONSENT (ASSENT, IF MINOR) FOR PSYCHOTHERAPY
PRIVATE PRACTICE SERVICES CONTRACT

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. An agreement between us regarding your admission into my practice will be established upon the completion of the entire Intake Process and your signature is obtained on all necessary paperwork in the intake packet you receive. Please provide initials on the bottom right of each page indicating you have read and understood the policies described and sign where indicated on signature pages.

ABOUT DR. RETTGER (License: PSY27863)
I completed the doctorate in clinical psychology from the Institute of Transpersonal Psychology in 2011. My training background is diverse in working with children, adolescents, and adults with numerous psychological concerns including anxiety, depression, trauma, and life transition challenges. In my practice, I utilize evidence-based treatment methods (e.g. Cognitive- Behavioral Therapy or Trauma-Focused Cognitive Behavioral Therapy) and other therapeutic modalities such as mindfulness practices and psychodynamic interpretation while holding an Existential-Humanistic and Transpersonal-Spiritual perspective. This means that I apply state of the art treatments while also addressing your concerns from a Holistic (Mind-Body-Spirit) perspective.

PSYCHOTHERAPY PROCESS
Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. It is important that you understand that psychotherapy is not like a medical doctor's visit. Instead, it calls for a very active effort and engagement on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and outside of our sessions. It is very likely you will have assignments to complete between sessions.

RISKS & BENEFITS
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, frustration, loneliness, and helplessness. I encourage you to discuss these feelings with me as they arise. On the other hand, psychotherapy has also been shown to have benefits for many people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

THERAPY PROCESS
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 opinions of whether you feel comfortable working with me. Therapy involves a commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS & CANCELLATION POLICIES
I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will

usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week (more sessions per week may be more beneficial in certain cases) at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours

[2 FULL DAYS] advance notice of cancellation. If you miss your appointment without 48-hour notice due to circumstances beyond your control, and I have session times available during the remainder of the week (M-F) I will try to schedule a make-up time for you. If we are not able to schedule the make-up session within the same week, then the missed session fee WILL be charged. If there are extenuating circumstances, I MAY extend the make-up period until the end of the calendar month.

PROFESSIONAL FEES

My full hourly fee is $170 (or if we established a sliding scale rate of $___). **Fees are subject to change with advance notice.** In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes (billed per minute starting at the 11th minute), attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge my full fee of $225 per hour for preparation and attendance at any legal proceeding.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

I **DO NOT** currently accept insurance for services provided. If and when this policy changes I will notify you.

CONTACTING ME & EMERGENCIES

I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail. I will make every effort to return your call on the same day you make it or within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call and/or in crisis or emergency, contact your family physician, 911 or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review

them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests. We can discuss this should the situation arise. Also, please see the Notice of Privacy Practices for more information concerning professional records.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents (see Child & Adolescent Informed Consent below) that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with the option to schedule a meeting with me to summarize your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss. At the end of your treatment, your parents can contact me and request a summary of treatment of our work together for your parent(s)/caregiver(s), and we will discuss it before I communicate with them.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

LIMITATIONS TO CONFIDENTIALITY

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or dependent/disabled adult person is being abused, I must file a report with the appropriate state agency. Child abuse also includes sexual exploitation such as preparing, selling, or distributing pornographic materials involving children; performances involving obscene sexual conduct; and child prostitution. If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action. In order to provide you with the best possible care, I may consult with other mental or health professionals about your treatment. I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. 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 may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues.

TREATMENT TERMINATION

The completion of our treatment relationship is an important part of the therapy and it can occur in numerous ways. Ideally, the termination process is based on transparency, communication, and mutuality. I encourage you and I to have ongoing conversations about our progress and feelings about the completion of therapy so we can agree upon a completion date. There are certain situations in which treatment transitions may be more abrupt. These

circumstances include noncompliance with treatment recommendations may result in termination of services. If you are not in agreement with my treatment recommendations, it is important that you share them with me so we can determine what the next best steps are in your treatment. You always have the right to terminate treatment at any time. I reserve the right to terminate treatment immediately and unilaterally if you commit physical violence or verbal harassment to me or anyone associated with my practice or services. Lastly, failure or refusal to pay for services after a reasonable amount of time may also result in termination of services.

PROFESSIONAL NATURE OF THERAPY RELATIONSHIP
Professional therapy never involves sexual, business, or other personal or professional relationships that may or could impair our therapeutic work together or could potentially exploitive in nature.

COMPLAINTS
If you have any concerns or complaints regarding your treatment, please communicate them directly to me. I take all concerns very seriously and will work with you to the best of my ability to resolve any concern you may have. If you believe that I am not addressing your concern appropriately or believe that I have behaved unethically, you may contact the California Board of Psychology at the following:

Board of Psychology - 1625 North Market Blvd., Suite N-215 - Sacramento CA, 95834
Phone: 866-503-3221 Email: bopmail@dca.ca.gov

Your signature on the following signature page indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

INFORMED CONSENT (ASSENT, IF MINOR) SIGNATURE(S)
Patient(s) Name(s) & Signature(s):
1. Print Name:_____

Signature of Patient 1:_____ **Date:**_____

2. Print Name: _____

Signature of Patient 2:_____ **Date:** _____

IF PATIENT IS A MINOR, parent/Caregiver(s) Name & Signatures:
1. Print Name: _____

Signature of Parent/Guardian, if participant is minor:_____**Date:** _____

2. Print Name: _____

Signature of Parent/Guardian, if participant is minor:_____**Date:**_____

Office use only:
Intake Therapist Signature:_____**Date:** _____
John P. Rettger, PhD PSY27863

CHILD & ADOLESCENT INFORMED CONSENT

Prior to beginning treatment, it is important for you to understand my approach to child and adolescent therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is **in addition** to the information contained in the Informed Consent-Private Practice Services Contract. Under HIPAA and the APA Ethics Code, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however, I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, you can request a meeting with me to discuss generally what issues were covered, what progress was made, and what areas I believe may require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between you, the parents/caregivers, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain an advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event.

If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide

information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $225 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Summary

• If you decide to terminate treatment, I have the option of having a few closing sessions with your child to properly end the treatment relationship.

• You are waiving your right to access to your child's treatment records**.**

• I will inform you if your child does not attend the treatment sessions.

• At the end of treatment, you can request a closing meeting with me to summarize the general description of goals, progress made, and potential areas that may require intervention in the future.

• If necessary to protect the life of your child or another person, I have the option of disclosing information to you without your child's consent.

• You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.). You understand I do not provide court-involved or forensic psychology services.

• You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

• If there is a court appointed evaluator, and if appropriate releases are signed and a court order is provided, I will provide general information about the child which will not include recommendations concerning custody or custody arrangements.

• If, for any reason, I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of my **FULL HOURLY FEE** at $225 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Acknowledgment of Informed Consent
In signing below, you are acknowledging that you reviewed all of the information in this document (full document and summary page), you have had ample opportunity to discuss it with me, and you have had your questions answered to your satisfaction. In so doing, you are making an informed decision about engaging me for services. Your signature(s) indicates that you voluntarily consent to participate (or that you consent to your child's participation) in the evaluation and/or psychotherapy. Your signature(s) does not mean that you have waived any rights.

Signature Requirements
Where possible, I would like all parents or caregivers with legal custody rights to sign-off on this document. It is your duty to inform me of any special circumstances concerning your child's custody that I may not be aware of that impacts one parent or caregiver's ability to legally consent for treatment. Please sign on the following page.

initials:_____

Parent/Caregiver Signing for the following

Patient(s):
1. Print Name:_____

2. Print Name:_____

Parent/Caregiver(s) Signatures:
1. Print Name:_____

Signature of Parent/Guardian, if participant is minor :_____**Date:**_____

2. Print Name:_____
Signature of Parent/Guardian, if participant is minor :_____**Date:**_____

CONSENT FOR TELETHERAPY

Definition of Services:

I,_____, hereby consent to engage in teletherapy with _Dr. John P. Rettger_PSY27863____. Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to teletherapy:

Client's Rights, Risks, and Responsibilities:

1. I, the client, need to be a resident of California. (This is a legal requirement for psychologists practicing in this state under a CA license.)
2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment with_ _Dr. Rettger_____.
4. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my psychologist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
5. There is a risk that services could be disrupted or distorted by unforeseen technical problems.
6. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if my psychologist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area.
7. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychologist, my condition may not improve, and in some cases may even get worse.
8. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24-hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in future, my psychologist will recommend more appropriate services.
9. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychological treatment provider to do the same on their end.
10. I understand that dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent, and I agree not to share images, audio, or video of online sessions.

I have read, understand and agree to the information provided above regarding telehealth:

Minor Client's Name and Signature: _____ Date_____

Parent/Guardian's Signature: _____ Date_____

Notice of Privacy Practices

Effective April 14, 2003, this notice describes how personal health information about you may be used and disclosed and how you can get access to this information.

Our Pledge Regarding Your Personal Health Information

We are committed to protecting personal health information about you. We create a record of care for use in your evaluation and treatment. This notice tells you about the ways in which we may use or disclose this information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your medical information. We are required by law to make sure your personal health information is protected, to give you this notice describing our legal duties and privacy practices, and to follow the terms of the notice that is currently in effect.

How We May Use and Disclose Personal Health Information About You

For Treatment and Operations

We may use personal health information about you to provide treatment or services among staff.

For Payment

We may use and disclose personal health information about you so that evaluation and treatment may be billed to an insurance company or third party. We may also need to give information to an insurance company or third party for preauthorization or reauthorization to find out whether your plan will pay for services.

To Comply with Laws and Regulations

We may disclose personal health information about you to comply with state or federal laws. This may include, but not be limited to, laws regarding child and elderly abuse, anti-terrorism laws, and laws regarding complying with courts and regulatory boards.

To Averts Serious Threat to Health or Safety

We may disclose personal health information about you when necessary to prevent or lessen a serious and immediate threat to your health and safety, or the health and safety of another person. These situations may involve contacting significant others, hospital staff, crisis response personnel, or peace officers to avert threats.

By Requesting Your Authorization

We may disclose personal health information about you if you authorize use to do so. These situations may include, but not be limited to, conferring with other health care providers, legal counselors, or family members.

Your Rights Regarding Personal Health Information About You

Right to Inspect and Copy

With certain exceptions, you have a right to inspect and to receive a copy of your personal health information. If you are denied access to information in your record, you may ask us to prepare a summary of that information or to share that information with another licensed health care provider. We may charge you for summarizing and copying services.

Right to Request and Amendment or Addendum

If you feel that information about you in your record is incorrect or incomplete, you may ask us to amend the information or to make an addendum.

Right to Accounting of Disclosures

You have the right to request a list of disclosures we have made of your personal health information.

Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we may use or disclose. For example, you may request that we not discuss certain aspects of your record with a family member. You also have the right to limit or to revoke authorization that you previously granted. However, we are unable to take back any disclosures made with your permission.

Right to Request Confidential Communications

You have a right to request that we communicate with you in a certain way or location. For example, you may request that we call you at home, but not at work. Or you may request that we email you, but not send letters using paper mail.

Right to Paper Copy of This Notice

You have a right to a paper copy of this notice at any time.

Changes to Our Practices and This Notice

We reserve the right to change privacy practices and notice. We reserve the right to make the revised or changed notice effective for personal health information we already have about you as well as any information we receive in the future.

Questions or Complaints

If you have any questions about your privacy rights, please contact our Clinic Coordinator at 858-216-1686 or contact the Department of Health and Human Services at 866-627-7748

PATIENT BILL OF RIGHTS

You have the right to:

1. Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.

2. Have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies before beginning therapy.

3. Receive respectful treatment that will be helpful to you.

4. A safe environment, free from sexual, physical, and emotional abuse.

5. Ask questions about your therapy.

6. Refuse to answer any question or disclose any information you choose not to reveal.

7. Request that the therapist inform you of your progress.

8. Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.

9. Refuse a particular type of treatment or end treatment without obligation or harassment.

10. Refuse electronic recording (but you may request it if you wish).

11. Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and type of treatment.

12. Report unethical and illegal behavior by a therapist.

13. Receive a second opinion at any time about your therapy or therapist's methods.

14. Request the transfer of a copy of your file to any therapist or agency you choose.

Source: California Department of Consumer Affairs

Dr. John Rettger, PSY27863

Pt. Attestation of Receipt of Documents

Notice of Privacy Practices (NPP)

I have received a copy of, read, and understand the NPP document.

Patient Bill of Rights (PBR)

I have received a copy of, read, and understand the PBR document.

My signature below indicates affirmation of the above statements.

Minor Client Signature	**Signature Date**
Client Printed Name	**Date of Birth**
Parent/Guardian Signature and Name	**Date**

FOR THE PARENT/GUARDIAN TO COMPLETE ABOUT THE MINOR CLIENT

LIFE FUNCTIONING INVENTORY

The information you provide will help in the planning of your child's therapy.

Name of Client:_____ Date: _____

Person completing this form:_____ Date: _____

CULTURAL BACKGROUND

1. What is your child's **ethnicidentity**? _____

2. How much does your child identify with their **ethnic heritage**? (Circle one):
   Not Sure Not at all A little Somewhat Moderately Strongly

3. **Religious preference**:_____
   Is your child currently active in this religion? ☐ Yes ☐ Somewhat ☐ No

4. Does your family **speak a language** other than English at home? (Circle one):
   Not at all Very little Sometimes Frequently Always
   If "Sometimes" to "Always", what language is spoken?_____

5. Was your child and both your child's biological parents **born in the USA**? ☐ Yes ☐ No ☐ Unsure
   If no, who was foreign-born, where and what was the approximate age of immigration to the USA? (e.g. bio-dad, Korea, 12; father Korea, 40; etc.) International clients check here ☐
   _____
   _____

PROBLEM ANALYSIS

1. PROBLEM DESCRIPTION: Briefly **describe the problem** your child most wishes help with right now:
   _____
   _____
   _____

2. PROBLEM INTENSITY: How would you **rate the intensity** of the problem or concern that brought you in?

1	2	3	4	5	6
Not Intense			Moderately Intense		Extremely Intense

3. PROBLEM DURATION: Approximately **how long** has your child had the current problem? _____

4. COPING ATTEMPTS: In what ways has your child attempted to cope with this problem?

_____

_____

FAMILY BACKGROUND

1. Please list the **members** of your child's current family, including ages and occupations (e.g. father, 42, Lawyer; stepmother, 40, teacher; brother 16, student; etc.)

_____

2. Please circle any past, present, or impending special problems in your child's family:

deaths divorce
frequent relocations debilitating injuries/disabilities
alcohol/drug abuse
serious illness psychiatric disorder
physical/sexual abuse
financial crisis/unemployment
legal problems
attempted/completed suicide
eating disorders
other _____

Please specify family member(s), which special problem, and approximate year of occurrence (e.g. mother-serious illness,1998,etc.)

3. Has your child personally experienced significant **abuse**?

None Unsure Emotional Physical Sexual

How was this abuse handled and reported if applicable? _____

4. Has your child personally experienced **legal problems**? ☐ No ☐ Yes

5. Did your child experience **learning problems** in elementary or high school, or college? (Circle one):
None Little Some Substantial Lots, constant struggle

6. In general, how **happy or adjusted** was your child growing up? (Circle one):
Poor Unsatisfactory About average Substantial Completely

7. How much is your child's immediate family a source of **emotional support** for them? (Circle one):
None Little Somewhat Substantial Very Strong

8. How much **conflict** does your child currently experience within the family? (Circle one):
Very little or none Some Moderate Strong Extreme

9. Who in your child's family do they usually go to for support? _____

Who are they in most **conflict** with? _____

HEALTH & SOCIAL ISSUES

1. Rate your child's current **physical health:** ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good
2. When was your child's most recent **physical** or visit with a physician? _____
3. Please list any **persistent physical symptoms** or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____
4. Is your child presently on **prescribed medication**? No Yes If yes, please describe: _____
5. Problems with your child's sleep habits? No Yes If yes, please describe: _____
6. Please describe your child's exercise routine: Needs Attention Appropriate I don't know
7. Please describe any concerns you have with your child's eating habits or appetite if any: _____
8. Any concerns over weight changes, if yes please describe: No Yes _____
9. Has your child had problems related to drinking? Yes No Unsure

   Does your child use **alcohol**? Yes No

   If yes, how often: _____
10. Does your child engage in **recreational drug use**? Yes No Unsure

    If yes, how often and do you consider this drug use a problem? _____
11. Do you have any problems or worries about **your child's sexual activity?** No Yes
12. Has your child ever experienced **sexual assault, unwanted sex or uncomfortable touching**? No Yes
13. Has your child had **suicidal thoughts recently**? No Yes Not sure
    How about **in the past and if so when?** No Yes Not sure If yes, please state when: _____
14. Has your child ever intentionally **inflicted any harm upon themselves?** No Yes Not Sure
    How about someone else? No Yes Not Sure
    Are there any current concerns of them causing harm to themselves or someone else? Yes No Not Sure
    If yes to any of the above, please describe: _____
15. In the past, how would you rate the quality of your child's **peer relationships**?

    Very Poor Unsatisfactory About Average Good Excellent

    Do you have any concerns about your child's developing **romantic relationships**? Yes No
16. Besides family members or significant other, approximately how many people can your child really count on right now for **friendship or emotional support**? _____