Maura Loftus
LCSW

232 West Main Street, Suite 103
Tustin, CA 92780

MENTAL HEALTH DISCLOSURE FORM

I am a Licensed Clinical Social Worker and have been licensed by the California Board of Behavioral Science Examiners since October 31, 1989. I received my Bachelor's Degree in Social Work from Long Beach State University in 1983 and my Master's Degree in Social Work from San Diego State University in 1987. I was employed by and received my post-graduate training at the University of California-Irvine Medical Center, Department of Psychiatry from 1987-1990. I was employed by the County of Orange, Children and Youth Services/Mental health from 1991-1999, and have maintained a private practice since 1991.

I have psychotherapy expertise in working with children, youth and families, as well as individuals and couples. I work with clients from a biological-psychological-social perspective and utilize a cognitive-behavioral treatment modality. I work with clients to resolve conflicts or manage symptoms which impair their current level of optimal functioning. If I am unable to adequately diagnose or treat you, I will work to refer you to appropriate resource(s).

Treatment Philosophy-Explanation of Brief Therapy

Brief therapy is **goal-directed, problem-focused treatment**, approximately ranging from 10-30 sessions. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal(s) in mind and progress is made toward accomplishment of that goal in a time efficient manner. You will take an active role in setting and achieving your treatment goals. This is a **voluntary process** and your commitment to this treatment approach is necessary for you to experience a successful outcome. If you ever have any questions about the nature of the treatment or your care, please do not hesitate to ask.

Initial here: _____

Limits of Confidentiality Statement

All information between practitioner and patient is held strictly confidential. There are legal exceptions to this; refer to the Notice of Privacy Practices, Use and Disclosure of Health Information Section.

All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency.

Initial here: _____

Release of Information

Please refer to the Notice of Privacy Practices, use and Disclosure of Health Information Section.

Emergency Access
If you are having a life threatening emergency or suicidal thought/intentions, please call 911 or go to your nearest hospital/emergency room.
Initial here: _____

Financial Terms: Insurance Coverage and Co-Payments
You are responsible for obtaining prior mental/behavioral health authorization for treatment from your insurance carrier. I will bill your insurance, however, you, not your carrier, are responsible for total payment of your account. Missed appointments are not covered by your insurance and the full charge for the session will be your responsibility. I have a strict 24-hour cancellation policy. If notice to cancel or reschedule is not received a full 24 hours prior to your appointment, you will be charged for the session. The fees for psychotherapy services are $_____, your co-payments is $_____, and your deductible is $_____.

I am responsible for informing you of costs when you are beyond or outside your benefits, to the best of my knowledge. For special modalities of treatment not covered by your benefit plan, a written agreement needs to be signed between you and this office/practitioner. The fee agreed upon should never contain fees that exceed the benefit plan's fee for services/contracted rates.

At any time during treatment should you become ineligible for insurance coverage, you will notify the practitioner and understand that you will be responsible for 100% of the bill.
Initial here: _____

Assignment of Insurance Benefits
Please refer to the Notice of Privacy Practices, Use and Disclosure of Health Information Section.

Appeals and Grievances
I acknowledge my right to request reconsideration (an Appeal) in the case that outpatient care is not certified. I understand that I would request an Appeal directly through _____ Behavioral Health Appeals Department and that I risk nothing in exercising this right.

Please refer to the Notice of Privacy Practices, Questions and Complaints Section. In addition to the sources listed to file a complaint, the California Department of Managed Health Care (DMHC) is responsible for regulating health care services. The California DMHC's toll-free number is (800) 400-0185.
Initial here: _____

Consent for Treatment
I authorize and request my practitioner to carry out psychological and/or psychiatric examinations, treatment and/or diagnostic procedures which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me and they are subject to my agreement. I

also understand that while the course of my treatment is designed to understand and reduce the symptoms/behaviors/feelings which impair my functioning and quality of life, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions, such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.
Initial here: _____

I understand that my participation in the psychotherapeutic process is completely voluntary and if I choose to terminate treatment, I will discuss this with the practitioner prior to doing so. The risk to premature termination and/or non-compliance with psychotherapy recommendations could result in deterioration of my mental status and/or impaired functioning.
Initial here: _____

The above informed consent rules have been discussed with the patient/guardian; there were no areas of disagreement or misunderstanding.

Patient Name_____

Patient Signature_____

Date_____/_____/_____

Practitioner Signature_____