# Jane Beresford, Psy.D.

*Licensed Psychologist – PSY 16618*

**(310) 551-8535**

**Info@DrBeresford.com**

**15300 Ventura Boulevard, Suite 301**
**Sherman Oaks, California 91403**

**14724 Ventura Boulevard, Suite 1100**
**Sherman Oaks, California 91403**


## Patient Information

**(PLEASE PRINT)**

**Patient Name**: ________________________________________ Today's Date: _____________

Patient's SSN: ________ - _______ - ________ DOB: _____ /_____ /________ Age: _______

Sex: ____ Marital Status (circle): Single Married Separated Divorced Other: _______

Home Address: ________________________________________________________________

City: ____________________________________ State: ____________ Zip: _________________

Email: _____________________________________ OK to leave message here? ___Yes ___No

Home Phone: (______)_________________________ OK to leave message here? ___Yes ___No

Cell: (______)______________________________ OK to leave message here? ___Yes ___No

Work: (______)_____________________________ OK to leave message here? ___Yes ___No

Occupation (if minor, guardian's occupation): _________________________________________

Employer's Name: ____________________________________________________________

Work Address: _______________________________________________________________

City: ____________________________________ State: ____________ Zip: _________________

**Name of Insured Party/Responsible Party**: ____________________________________________

Insured's SSN: ________ - _______ - ________ Insured's DOB: ______/______/__________

Relationship to Patient: ______________________________________________________

Home Address: ________________________________________________________________

City: ____________________________________ State: ____________ Zip: _________________

Home Phone: (_____)_____________ Cell: (_____)_____________Work: (_____)____________

Occupation: ____________________ Employer's Name: __________________________________

Work Address: _______________________________________________________________

City: ____________________________________ State: ____________ Zip: _________________

Insurance Company: ___________________________________ Phone: (_____)_____________

Insurance Company Address: ____________________________________________________

City: ___________________________ State: _________ Ins. Co. ID#: ______________________

Group#: ________________________________ Cert.#: __________________________________

Secondary Insurance: ___ No ___ Yes; Company: ___________________________________

Policy #: ______________________________ Phone: ____________________________________

Job-Related Injury/Workmen's Comp. Co.: ___ No ___ Yes; Company: __________________

**Emergency Contact**: __________________________________ Relationship: ________________

City: ___________________________ State: _________ Phone: (_____)_____________________

**Physician**: ___________________________________ Phone: (_____)______________________

**Referred by:** _________________________________________________________________

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## Office Billing and Missed Appointments Policy

1. I authorize use of this form for all of my insurance submissions.
2. I authorize the release of information to my insurance company(ies).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I understand that it is my responsibility to pay the amount due on the date and time service is provided.
5. I authorize direct payment to my service provider.
6. I hereby permit a copy of this to be used in place of an original document.
7. I understand that I may pay my bill with cash or check.
8. I understand there will be a $35.00 service charge on all returned checks.
9. In the event that my account goes to collections, I understand that there will be a 50% collection fee added to my balance.
10. I understand there is a 24-hour Cancellation Policy, which states that scheduled appointments must be cancelled 24 hours in advance of the appointment, between the hours of 9:00 AM and 5:00 PM, Monday through Saturday, to avoid being charged.
11. I understand that late cancellations and missed appointments will be charged at the full-fee rate of $175 per 45-minute appointment.

I understand and agree to the above.

Printed Name: ____________________________________________________________

Signature: ___________________________________________ Date: ___________________

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# LIMITS ON PATIENT CONFIDENTIALITY

As a licensed psychologist, I am required to disclose confidential information if any of the following conditions exist:

1. You are a danger to yourself or others.
2. You seek treatment to avoid detection or apprehension, or you enable anyone to commit a crime.
3. Your psychologist was appointed by the court to evaluate you.
4. Your contact with your psychologist is for the purpose of determining sanity in a criminal proceeding.
5. Your contact with your psychologist is for the purpose of establishing your competence.
6. Your contact with your psychologist is for the purpose of filing a report to a public employer or to provide information required to be recorded in a public office, if such report or record is open to public inspection.
7. You are under the age of 16 years and are the victim of a crime.
8. You are a minor and your psychologist/therapist reasonably suspects that you are the victim of child abuse.
9. You are a person over the age of 65 and your psychologist/therapist believes that you are the victim of physical or emotional abuse.
10. You file suit against your therapist for breach of duty or your therapist files suit against you for any reason.
11. You have filed suit against someone and have claimed mental/emotional damages as part of the suit.
12. You waive your rights to privilege or give consent to limited disclosure by your therapist.
13. Your insurance company paying for services has the right to review all records.
14. You die and the communication is important to decide an issue concerning a deed or conveyance, will, or other writing executed by you affecting an interest in property.

If you have any questions about these limitations, please discuss them with your therapist.

I agree to these limits of confidentiality, and I consent to my (or my dependent)

**(CHECK ONE)** _____ receiving outpatient treatment **OR** _____ participating in an evaluation.

Printed Name: ______________________________________________________________

Signature: ________________________________________ Date: ____________________

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## Informed Consent, Disclosure Statement and Agreement for Services

**Introduction**

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your psychologist any questions that you may have regarding its contents.

**Information about Your Psychologist**

Your psychologist, Jane Beresford, Psy.D., is a Licensed Psychologist (PSY 16618). At an appropriate time, Dr. Beresford will discuss her professional background with you and provide you with information regarding her experience, education, special interests, and professional orientation. You are free to ask questions at any time about her professional background and orientation.

Psychologists are the only mental health professionals required to hold a doctoral degree. For licensure, the state of California requires that a doctoral program in psychology include an internship of one year (a minimum of 1500 hours) of supervised work experience with clients. After earning a doctorate, psychologists must complete another 1500 hours of supervised work experience; submit evidence of completing coursework in human sexuality, child abuse, substance abuse, spousal abuse, and aging and long-term care; and must pass a licensure exam. For license renewal, the state of California requires psychologists to complete 38 units of continuing education every two years.

**Fees**

The fee for services is $175 per 45-minute therapy session. At the time services are rendered, fees are payable via cash or check. If you choose to pay by check, it is helpful to have your check filled out in advance, made payable to “Dr. Jane Beresford.”

**Confidentiality**

All communications between you and Dr. Beresford will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your psychologist will not disclose confidential information about your treatment unless all persons who participated in the treatment with you provide their written authorization to release information. In addition, she will not disclose information communicated privately to her by one family member to any other family member, without permission.

There are exceptions to confidentiality. For example, psychologists are required to report instances of suspected abuse of a child or vulnerable adult. Your psychologist may be required or permitted to break confidentiality when she has determined that a patient presents a serious danger of physical harm to himself/herself or to another person. In addition, a federal law known as The Patriot Act of 2001 requires psychologists (and others) in certain circumstances, to provide FBI agents with books, records, papers, documents, and other items, and prohibits the psychologist from disclosing to the patient that the FBI sought or obtained the items under the Act.

**Minors and Confidentiality**

Communications between psychologists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child’s treatment are often involved in their treatment. Consequently, your psychologist, in the exercise of her professional judgment, may discuss the treatment progress of a minor patient with the parent or guardian. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their psychologist.

**Appointment Scheduling and Cancellation Policies**

Sessions are typically scheduled to occur once weekly, but Dr. Beresford may suggest a different schedule of therapy depending on the nature and severity of your concerns. If you do not provide your psychologist with at least 24 hours notice in advance, you are responsible for the full-fee payment, or $175, per missed session.

**Psychologist Availability/Emergencies**

Telephone consultations between office visits are welcome, and if longer than 10 minutes, will be billed at a prorated amount. You may leave a message for Dr. Beresford at any time on her confidential voicemail. If you wish for her to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday through Saturday) within 24 hours. If you have an urgent need to speak with your psychologist, please indicate that fact in your message. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

**Psychologist Communications**

Dr. Beresford may need to communicate with you by telephone, mail, or other means. Please indicate your preferences below by circling either YES or NO.

YES / NO My psychologist may call me at my home.
YES / NO My psychologist may call me on my cell phone. YES / NO May text to my cell phone.
YES / NO My psychologist may communicate with me by email.
YES / NO My psychologist may send mail to my home address.

**About the Therapy Process**

It is Dr. Beresford's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to her, and the specifics of your situation, she will provide recommendations to you regarding your treatment. The psychologist and the patient are partners in the therapeutic process. You have the right to agree or disagree with Dr. Beresford's recommendations. She will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion. Due to the varying nature and severity of problems and the individuality of each patient, your psychologist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

**Termination of Therapy**

The length of your treatment and the timing of the eventual termination of treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your psychologist. She will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or your psychologist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, initiating a psychological evaluation, or terminating therapy. Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask your Dr. Beresford to address any questions or concerns that you have about this information before you sign below.

___________________________________
Name of Patient (Please print)

___________________________________
Name of Parent /Guardian (Please print)

___________________________________
Signature of Patient

___________________________________
Signature of Parent /Guardian

Date: _____/_____/________

Date: _____/_____/________