Mark Barnes, Ph.D.
5080 North Fruit Avenue Suite 103 Fresno, CA 93711 (559) 978-3339

Adult Intake Packet

Thank you for coming in today. In order to provide the best care possible the following information is needed. It is absolutely necessary to complete each item thoroughly and accurately. Please take your time and give thoughtful consideration to each question, and ***do not leave any items blank***. When done, return this packet to Dr. Barnes.

Today's Date _____/_____/_____				***If person filling out this form is not the patient:*** What is your name and relationship to the patient?	
Patient's Last Name	First	Middle	Birth Date		Sex
			/ /		❑ M ❑ F
Home Street Address	City	State	ZIP Code	Email Address	Home Phone No.
					( )
					Cell Phone No.
Work Street Address	City	State	ZIP Code	Email Address	( )
					Work Phone No.
Occupation:		Employer:			( )

Do you require any special accommodations? ❑ Yes ❑ No If Yes, Please describe:	Best Number to Call	Can a Message Be Left?

Chose Dr. Barnes Because or Referred by (Please check one box)	❑ Dr.	❑ Therapist	❑ School

❑ Family/Friend	❑Website	❑ Location	❑ Dr. Barnes' Reputation	❑ Other	

Highest Grade or Degree Completed:	Marital Status: ❑ Unmarried ❑ Married ❑ Divorced ❑ Widowed ❑ Engaged ❑ Separated

Ethnicity: Caucasian ❑ African-American ❑ Asian ❑ Hispanic ❑Other_____

Your Children's Names & Ages (If applicable, give further detail if adopted, by previous marriage, etc.):

What is the highest grade or degree you've completed? ☐ Grade:_____ ☐ High School ☐ Technical School ☐ Some College ☐ Associates ☐ Masters ☐ Doctoral degree ☐ Other: _____

If a translator is present today: **Name of translator:** **Company Name:**

If the listed "Primary Contact" is not the *same person filling out this form* or is not a legal custodian: then you must read and sign the following statement, or notify Dr. Barnes of your inability to do so. "I am completing this form on behalf of the person listed above as the primary contact responsible for this client's treatment with Mark Barnes, Ph.D. I accept responsibility for the accuracy of this information and any translation or recitation services I am providing here. I realize that this is confidential and privileged information and I will not disclose anything I have communicated today for any reason. If translating, I agree to translate accurately, *word for word*, including all off-topic communications. I agree that I will be held liable for deliberate/negligent distribution of misinformation and/or translation. I will notify staff that I completed this form on behalf of the listed Primary Contact."

_____

Print Your Name Sign Date

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Nearest Relative Not Living with You _____ Address _____

Phone#:_____ Cell#_____

Emergency Contact _____ Address _____

Phone# _____ Cell# _____

I realize that it is **solely** my responsibility to pay for services as well as to determine what my insurance coverage, benefits and limits are. I request that Mark Barnes, Ph.D. provide clinical services and I agree to be financially responsible for these costs. Dr. Barnes, or his staff will bill my insurance, but regardless of any insurance billing assistance provided to me by Dr. Barnes or his staff, I will be responsible for my account. I authorize insurance payments be paid directly to Dr. Barnes. By signing this Financial Agreement I consent to the release of information to my insurance company as required for validation, billing, reimbursement, and related services. I understand that this account may be subject to finance charges of 1.5% per month (18% per annum) of the unpaid balance after 90 days. If the account becomes delinquent and referred to an attorney or collection agency, I will be held responsible for actual attorney fees and collection expenses. If you have health insurance it may cover a part of the cost of your treatment here, and to determine whether it will, we need the above information.

_____ _____

Signature of Patient or Financial Guarantor **Date**

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES

I HEREBY ACKNOWLEDGE RECEIPT OF THE ABOVE Notice of Privacy Practices Date: _____

Patient Signature: _____ or Signature of Legal Guardian: _____

Printed Name of Legal Guardian: _____Parent _____ Other: Specify Legal Relationship _____

Consent for Treatment

I authorize Mark Barnes, Ph.D., Psychological Services ☐ Yes ☐ No

_____ _____

Signature **Date**

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Barnes will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

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Office Policies / Consent to Treatment / Financial Agreement

Thank you for choosing my practice for you mental health care. This document outlines my office policies and procedures; authorizes me to begin evaluation and treatment; and establishes the financial/clinical agreement between you, and Dr. Barnes. This document also provides information regarding how your medical and/or mental health information may be used and how you may access those records. Please read this information carefully. If you have any questions, please discuss them with your therapist.

MEDICAL/MENTAL HEALTH RECORD KEEPING: The privacy of your medical and mental health information is extremely important to us and we are committed to protecting your privacy. We create a record of care which includes dates of service and type of treatment provided. Dr. Barnes maintains paper records and also makes use of electronic record keeping and electronic billing. All records, whether paper or digital, are maintained by Dr. Barnes in full compliance with state, federal, and professional regulations.

LEGAL CONSENT TO TREATMENT: Any individual over the age of eighteen, who is not legally prohibited from doing so, consents to their own treatment. For minors under the age of eighteen, it is Dr. Barnes' policy that legal guardians provide written consent. In situations of joint legal custody, it is Dr. Barnes' policy that both legal guardians must consent to treatment. A parent having sole legal custody may consent to treatment. It is my policy to request proof of legal custody or guardianship. There are no exceptions to the above policy.

CONFIDENTIALITY: To maximize the benefit of evaluation and treatment trust must be developed between patient and therapist; you must be open and honest. Information disclosed within therapy is confidential and may not be revealed to anyone without your written consent except where disclosure is required by law. Dr. Barnes will discuss issues of confidentiality and will ask for your consent to communicate with anyone considered essential for appropriate evaluation and treatment. Children and adolescents also have the right to confidentiality with their therapist. Sharing helpful information between parents and children is necessary in the treatment of adolescents and children. Your therapist will discuss what is needed and appropriate with you and your child and request your consent.

LIMITS OF CONFIDENTIALITY: Dr. Barnes is a mandated reporter in accordance with California State Law. Disclosure may be made or is mandated in the following circumstances: 1) Where there is a reasonable suspicion of a child neglect/abuse, abuse of disabled persons, or elder adult physical abuse/severe neglect. 2) Where the patient is likely to inflict serious self-harm. 3) Where there is a reasonable suspicion that the patient presents a danger of violence to others. Dr. Barnes has a duty to warn persons in a life-threatening situations and must make a report to authorities and the intended victim(s) to prevent serious imminent harm to another or the public. 4) Dr. Barnes is a mandated reporter to the Food and Drug Administration regarding the adverse effects of prescribed medications. 5) Disclosure may also be required pursuant to some legal proceedings, such as custody disputes. The Dr. Barnes will release confidential information in the course of judicial/administrative proceedings as required by law, law enforcement purposes as required by law, a valid court order, or as provided by your specific written consent. 6) In the event of an emergency, confidential information may be disclosed to notify a person responsible for the care of a minor regarding your location, general condition, or medical information. 7) If you are seeking Worker's Compensation, or you are receiving services through Victims of Crime, or any other third-party which is covering payment, it is necessary for Dr. Barnes to disclose confidential information to those agencies either as required by law or contract. Since agencies vary, if your services are financially supported by a third-party agency, or mandated by court order, you and your clinician will discuss specific limits of confidentiality.

I understand and agree. Please Initial Here _____

USE CONFIDENTIAL INFORMATION: The Dr. Barnes will use your mental health records for these purposes. 1.) Treatment: Dr. Barnes will maintain treatment information and records. This information is used to document progress, and record other information relevant to services rendered. 2.) Financial Arrangements/Payment: If you so desire, Dr. Barnes or his staff will submit requests for payment to your insurance company in either electronic or hardcopy format, or both. Dr. Barnes or his staff will provide Insurance companies with the information required in order for you to receive your mental/medical health insurance benefits. Since the policies of insurance companies will vary, please discuss with Dr. Barnes, his staff, and your insurance provider to obtain further specifics. The Dr. Barnes or his staff will attempt to resolve billing concerns including financial difficulties. You must still be aware that in the event that your account is in default, limited and specific information may be released to a Credit Collection Agency in order to settle your account. 3.) Dr. Barnes may also obtain services from our business associates such as accounting/legal service providers or our insurers as necessary. Quality assurance consultants, transcriptionists, billing services,

practice reviewers, auditors, certification/accreditation agencies, and other professionals may use confidential information. These business associates are required to appropriately safeguard your information and any statistical analyses or data exchanges made are conducted without inclusion of identifying information wherever possible. 4.) As a training institution, clinical records are reviewed by supervisors and their trainees.

I understand and agree. Please Initial Here _____

TRAINING AND RESEARCH: Dr. Barnes reserves the right to offer training and research opportunities to others in the field of clinical psychology. He is committed to ongoing training and research in the areas of childhood, adolescent, and family psychopathology, psychological assessment, psychological and psychiatric treatment, treatment outcomes, and mental health service delivery. Dr. Barnes may use case material and mental health records of patients for such purposes. In addition patients may be asked directly to participate in a research study or provide information for research purposes. All personal data is thoroughly disguised for such purposes to assure maintenance of patient confidentiality. The Dr. Barnes adheres to all ethical and legal standards for research and research participants outlined by the American Psychological Association and the California Board of Psychology.

I understand and agree. Please Initial Here _____

PATIENT RIGHTS: Billing and patient care information is maintained in electronic and hardcopy records. If you wish to exercise any of these rights, please contact Dr. Barnes at 5080 North Fruit Avenue Suite 103, Fresno, CA 93711, phone: (559) 978-3339, during normal business hours. You may also contact billing staff at Billing@therapy4kidsfresno.com. Either can assist you in the proper exercising of your rights. The information maintained is available to you in accordance with the following rights.

1. If you would like to limit or restrict the use or disclosure of your health information, you have a right to make such a request in writing. Dr. Barnes may not unconditionally approve the request, but each request is carefully reviewed.
2. You will receive a hardcopy of Dr. Barnes "Notice of Privacy Practices for Protected Health Information." You may also access this information on our website, www.therapy4kidsfresno.com
3. By written request, you may request a copy of your health and billing records, although we are not required to approve all such requests. For copies, pre-payment of two-dollars ($2.00) per page, with a thirty-dollar ($30) minimum fee (in order to cover staff and equipment costs to reproduce your record) is requested. Records are available for in-person pickup within 30-days of receipt of pre-payment (delivery alternatives are available and must be requested in writing). In the event Dr. Barnes determines your access to information may be harmful, additional steps are necessary, and you may wish to discuss this in person with Dr. Barnes to better discuss questions you may have concerning request for records.
4. You may request, in writing, that your health record be amended to address incomplete or incorrect information. Not all requests are accepted although you may appeal a denial by providing an appeal request in writing. If your appeal is denied you may file a statement of disagreement and request that this statement be attached to any required future disclosures.
5. By written request, you may obtain an accounting of disclosures of confidential information made without your permission or request.
6. You may revoke, in writing, any previous authorization to disclose confidential information at any time and the revocation will be effective upon receipt for all future disclosures.

Dr. Barnes reserves the right to refuse services to anyone, including the discontinuation of services as established by legal and professional regulations. The Dr. Barnes also reserves all rights to modify or amend these policies. You may file written complaints with Dr. Barnes. You may also file a complaint with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services. Dr. Barnes does not require you to waive your right to file a complaint in order to receive services here.

EMERGENCY PROCEDURES: If a need arises to contact Dr. Barnes therapist between sessions, please call him at (559) 978-3339 and your call will be returned as soon as possible. If you have an emergency, be sure to inform Dr. Barnes of the emergent nature of your call so that your call will be handed as quickly as possible. Of course, if an emergency is life-threatening, please dial 911 or proceed to the nearest emergency room.

APPOINTMENTS: Initial evaluations may take anywhere from thirty minutes to three hours depending on the nature of the assessment. Individual therapy sessions are usually 45 to 50 minutes though longer or shorter sessions may be prearranged with Dr. Barnes. You are expected to arrive to each appointment on-time and Dr. Barnes will not extend sessions to make up for lost time when you are late. Dr. Barnes will make every effort to attend each appointment on-time. There are also situations, where therapy sessions must be delayed, such as in emergency session-extensions. In such situations Dr. Barnes will attempt to extend your appointment or provide other arrangements to make up for the lost appointment time.

CANCELLATIONS: Scheduling an appointment involves reservation of time specifically for you. A **minimum of twenty**

four (24) hour notice is required for rescheduling or cancellation of an appointment. The full session fee (typically $150.00) will be charged for missed sessions without such notification. Dr. Barnes may waive this fee in the case of emergencies or acute medical illness. Your insurance company or other third party payer will not pay for late cancelled or failure to cancel a session; you will be solely responsible for this expense. This is a busy practice; your cooperation is essential so that we can provide maximum service to all clients. Even if you fail to provide advanced notice, contact Dr. Barnes as soon as possible and explain the mishap. If you fail to communicate about missed sessions for two consecutive sessions or for three-missed sessions within any six (6) month period of time, Dr. Barnes **may** initiate **termination of your services here** and would then refer you to another agency for continued care.

I understand and agree. Please Initial Here _____

BILLING AND INSURANCE REIMBURSEMENT: Clinical services are rendered and charged to the patient and not to the insurance company. You are expected to keep your account current, not waiting to see what the insurance will pay before making payment. Once you have provided a copy of your insurance card and necessary information, the Dr. Barnes or his staff will bill your insurance company weekly. A statement that reflects all charges and payments will be sent to you each month.

I understand and agree. Please Initial Here _____

PAYMENT FOR SERVICES: Payment is expected at the time of service unless insurance coverage requires another arrangement or there is a prior agreement with Dr. Barnes. **There may also be fees associated with report preparation, letter writing, and extended telephone consults, that will not be covered by your insurance. Please discuss specific fees or other details with Dr. Barnes prior to having these services performed**. Due to the ever-changing insurance environment and wide variety of plans, we cannot be responsible for knowing the filing requirements of each insurance company. In order for us to continue to file some insurance, we must enforce **that *it is your responsibility to know or find out the filing requirements and limitations of your own plan***. Dr. Barnes and his staff are familiar with many insurance plans and managed care companies and are happy to assist in any way we can to help you find that information. *We are required by law to collect all co-pays at the time of service. There will be a $50.00 service charge for any checks returned by your banking institution*. Discuss fees and payment with Dr. Barnes and please notify your him if any problems arise during the course of treatment regarding your ability to make timely payments. A Finance Charge of 1.5% per month (18% per annum) of the unpaid balance may be assessed after 90 days.

I understand and agree. Please Initial Here _____

ABOUT MY PRACTICE: I provide a variety of services including individual, couples, group, psychotherapy, psycho-education, consultation, school counseling, psychological assessment, forensic assessment, and treatment. Dr. Barnes is actively engaged in ongoing continuing education and follow the highest professional and ethical standards. Psychologists like Dr. Barnes have a doctorate degree in psychology, have completed both pre- and post-doctoral internships, and have completed strict state competency standards for licensure. Psychologist may conduct personality or neurocognitive assessments, forensic assessment, provide psychotherapy, or supervise psychological trainees and interns. Psychiatrists have a medical doctorate and have completed medical school with additional training including residency in Psychiatry. At times Dr. Barnes may employ other mental health clinicians such as Licensed Professional Counselors (LPC), Licensed Clinical Social Workers(LCSW), and Licensed Marriage and Family Therapists (LMFT). All have completed a Bachelors and/or Master's Degree in social work or a related field and can provide psychotherapy, and case management/care coordination. Also, Dr. Barnes may employ Psychology Post-Docs or Psychological Assistants who have completed their doctoral degree and are practicing under the supervision of Dr. Barnes. Psychology Interns are in their final year of doctoral training, and Practicum Students are Master's level trainees. They are registered by the Board of Psychology as Psychological Assistants or by the Board of Behavioral Science as Associates, and are supervised by a Licensed Psychologist, Dr. Barnes.

Psychotherapy and counseling have earned a reputation for enhancing the quality of life of others. Although the vast majority benefit from these services, there are no certainties and each person will experience these services differently. All psychotherapy involves a substantial commitment, and as with most endeavors, the amount of effort you put forth into your treatment will effect the outcome greatly. Psychotherapy often involves an unsteady rate of progress and many people experience periods of depression, anger, resentment, guilt, fear, tension, anxiety, and other feelings during treatment. Services are provided without warranty or guarantee, but it is important to notify Dr. Barnes if you feel you or your child are experiencing any negative effects as a result of treatment.

You can expect Dr. Barnes to share with you:

a. his understanding of the problems you have brought to his attention
b. his approaches to those problems
c. other approaches he may be aware of
d. what research says about the advantages and disadvantages of various approaches
e. his assessment of progress or lack thereof and resultant options he may be aware of
f. his best opinion about what may happen without treatment

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Dr. Barnes will make every effort to inform patients of all options for treatment. If you feel that your treatment is not progressing in the way that it should, please discuss this with Dr. Barnes. Sometimes treatment advances most rapidly during moments where you and your therapist directly address such obstacles.

I have read and understand each of the above policies. I agree to follow and abide by them. I understand that I may revoke my consent, by submitting revocation in writing to Dr. Barnes, which will be made effective upon receipt. Your signature below also acknowledges that you have received a copy of these policies and the HIPAA Notice of Privacy Practices.

_____

Signature of Patient or Responsible Party Today's Date

Health and Background Questionnaire

Check if you have any symptoms in the following areas, and briefly explain.

☐ Seizures _____	☐ Chest/Heart _____	**Any Recent Changes In:**
☐ Head/Neck Injury _____	☐ Back_____	☐ Weight ☐ Energy Level
☐ Ear/Nose/Throat _____	☐ Intestinal _____	☐ Ability to Sleep ☐ Mood
☐ Headaches _____	☐ Bladder _____	☐ Appetite ☐ Sexual Energy
☐ Skin_____	☐ Bowel_____	☐ Other Pain/Discomfort, Describe:
☐ Lungs _____	☐ Circulation _____	

Childhood Illnesses: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations : ☐ Tetanus ☐ Pneumonia ☐ Hepatitis ☐ Chickenpox ☐ Influenza ☐ MMR

List Any Medical Problems, Allergies or Conditions (Include Diagnosis & Diagnosing Doctors Name if Known):

List Any Medications you are using (Include Prescribing Doctor and Dosages if known):

Describe any family history of Mental Illness or Physical Illness:

Surgeries/Hospitalizations or Serious Accidents/Injuries

Year	Reason	Hospital

Exercise ☐ Sedentary ☐ Mild Exercise ☐ Occasional Vigorous Exercise ☐ Regular Vigorous Exercise

Diet:
Are you dieting? ☐ Yes ☐ No If yes, is this a physician prescribed diet? ☐ Yes ☐ No
Estimate Salt Intake: ☐ Hi ☐ Med ☐ Low Estimate Fat Intake: ☐ Hi ☐ Med ☐ Low
Estimate Sugar Intake ☐ Hi ☐ Med ☐ Low Estimate Caffeine Intake ☐ Hi ☐ Med ☐ Low

Military: If you have previously served in the military, please list division and highest rank achieved:

Legal History:
If you check yes to the following questions please provide details on the reverse side of this paper
Are you currently involved in any current litigation such as criminal, civil or divorce proceedings? ☐ Yes ☐ No
Have you ever been convicted of a felony? ☐ Yes ☐ No
Have you ever been arrested/convicted of inappropriate sexual or criminal behavior involving a minor? ☐ Yes ☐ No

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Current Psychotherapist or Psychiatrist:	Address:	Dates Seen
Previous Therapists:	Address:	Dates Seen
Previous Psychiatrists:	Address:	Dates Seen
Primary Care Physician:	Address:	Dates Seen
Previous Psychological Testing/Educational Testing:	Address:	Dates Seen
Previous Mental Health Agencies Involved:	Facility:	Therapist
Any other medical care		

Mental Health Symptom Checklist

☐ Yes Any history of a seizure or epileptic attack?
☐ Yes Any history of drug or alcohol abuse?
☐ Yes Any misuse of over-the-counter or prescription drugs?
☐ Yes Any history of head injury or black-outs?
☐ Yes Decreased academic or work performance?
☐ Yes Difficulty eating, excessive eating, or forced vomiting?
☐ Yes Difficulty sleeping, falling asleep, or difficulty waking up in morning?
☐ Yes Do you have access to guns, rifles, weapons or explosives?
☐ Yes Do you wears glasses, contact lenses, hearing aid or a prosthesis?
☐ Yes Ever been in the car during a serious car accident?
☐ Yes Ever made a serious threat or attempt to cause serious injury to another person?
☐ Yes Excessive shakiness, arm or leg tremors?
☐ Yes Experiencing frequent panic, terror or nervousness?
☐ Yes Feeling depressed, unusually lethargic, tired, bored, or apathetic?
☐ Yes Frequent or disturbing nightmares? Night sweats/terror?
☐ Yes Hallucinations: visual, auditory or olfactory (smell)
☐ Yes Have you ever attempted or threatened to attempt suicide?
☐ Yes Have you previously been to a counselor or therapist?
☐ Yes Increased difficulties with eye and hand coordination?
☐ Yes Increased difficulty in concentration or attention?
☐ Yes Increased moodiness or irritability?
☐ Yes Loss of simple movement of various body parts, such as paralysis or numbness?
☐ Yes Preoccupied with death, dying or morbid thoughts?
☐ Yes Problems with over-eating or poor appetite?
☐ Yes Recent changes in vision, balance, hearing or coordination?
☐ Yes Recent dizziness spells?
☐ Yes Recent surgery or hospitalizations?
☐ Yes Threatened, attempted or engaged in serious destruction of property, including fire setting?

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Please circle if any of the following apply to you…

Distractible	Phobic	Listless/Fatigued	Impulsive	Hostile	Stomach Aches
Domestic Violence	Strange thoughts	Sexual Difficulty	Tired	Self-mutilation	Anorexic
Fearful	Clumsy	Overactive	Difficulty Concentrating	Easily Distracted	Nightmares
Legal Problems	Family Problems	Poor Social Life	Drug or Alcohol Abuse	Difficulty at work	Academic Problems
Over-eating	Poor Appetite	Excessive Worry	Pessimistic	Agitated	Forgetful
Socially Isolated	Hyperactive	Frequently Ill	Headaches	Body Pains	Nervousness
Suicidal Thoughts	Marital Problems	Parenting Worries	Financial Problems	Crying Episodes	Recent Death/Loss
Very unhappy	Irritable	Frequently Angry	Withdrawn	Difficulty Sleeping	Hallucinating

What services you are seeking and what are your expectations for treatment?

Revised: 05/29/2020