# SAN FRANCISCO FORENSIC INSTITUTE

Oakland, San Francisco, and Santa Rosa
415 391 7171 phone 844 506 3322 fax
WWW.SFFI.US

**Client Information Sheet**

TODAY'S DATE_____

Client's Full Name_____ SS#_____

Birth Date: _____

Street Address_____

City/State_____ Zip_____

Telephone: _____ _____ _____
Home Mobile Email

If you become a regular client, would you like reminders via text YES NO, email YES NO, or none at all?
Please circle your preferred mode of communication.

Emergency Contacts*:

Name_____ Relationship_____ Telephone_____

Name_____ Relationship_____ Telephone_____

*Please note that by giving us this information you allow us to contact your emergency contacts and request information about you if we lose touch with you or if there is an emergency situation. (medical condition, harm to self, harm to others)

Referred By_____

**Please describe below why you were referred to SFFI**

Primary Clinician: _____ Date: _____

S A N F R A N C I S C O
F O R E N S I C I N S T I T U T E
*At the Interface of Psychology & Law*

***San Francisco, Oakland, Santa Rosa***
***415-391-7171 phone/844-506-3322 fax***
***WWW.SFFI.US***

**Authorization to Release Confidential Information**

_____
Holder of Privilege and/or Client (Please Print)

I, the above-named, request and hereby authorize_____ (Name and/or Organization) to DISCLOSE and RECEIVE personal information regarding my case ***to*** *and* ***from***, respectively, the *San Francisco Forensic Institute, including Charles A. Flinton, PhD, Cynthia V. Rinker, MFT, staff clinicians, and office staff.*

I understand that the information to be released will include data related to my mental and physical health, as well as any court-related and offense-related information. The disclosure is for the purpose of consultation, evaluation, and/or psychotherapy, and includes but is not limited to the following:

- Medical/psychiatric information, results, diagnosis, evaluation, treatment and discharge.
- Summary /copy of psychosocial/ behavioral history and treatment.
- Summary /copy of psychological/vocational/psychosexual/personality testing.
- Pertinent legal information (e.g., police reports, probation, pretrial services, court papers, rap sheet, etc.).
- Case Conferences/Case Management information.
- Physical examination results.
- Oral consultation with the authorized person/organization named above.

In addition, *if I am required to register as a California PC 290,* I understand that I will be scored on various risk assessment tools including the Static 99-R, LS/CMI, and the Stable-2007. These scores will be sent to the State of California, Department of Justice, and the assigned probation officer. (See Penal Code §§ 290.09, 1203.067, 3008, and 9003).

I understand that the person/organization receiving the above specified information, under federal regulations, may not disclose this information further unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

This authorization is effective immediately. This consent may be revoked by me in writing at any time unless the information has been released or transmitted prior to the revocation. If not revoked in writing, this authorization to exchange information is valid for one year from the date indicated below.

_____ _____
Client Signature/Other Person Authorized to Sign Date

_____ _____
Name and Title of Witness Date

Contact Information for

_____ _____
Name and/or Organization Telephone Fax EMAIL

_____ _____
Address City/State Zip Code

PRINTED NAME OF CLIENT: _____

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## TREATMENT DISCLOSURE AND INFORMED CONSENT

The San Francisco Forensic Institute (SFFI) is comprised of psychologist Dr. Charles Flinton PhD, Cynthia Rinker, MFT, and various clinical and administrative team members. In order to provide you with the highest quality services possible, the team may consult with each other regarding your case. In other words the SFFI team will share psychosocial/ behavioral history, legal information, test results, diagnosis, evaluation, treatment progress and discharge information in regard to your treatment and evaluation. Your privacy is important to us. All information shared with the SFFI team is confidential and will not be released to individuals or agencies outside the SFFI team without your written authorization to do so. If you are asking us to bill a third party payer, you are expressly consenting for us to contact the third party payers for the purposes of billing.

By signing here, I agree that I read, understood, and agree to the above disclosures, **sign here:**

_____

Before proceeding, it is important that you are fully aware of the reason for and purpose of your participation in psychotherapy. If you do not understand the objectives for your treatment/therapy, please discuss this with your therapist before proceeding.

Participation in psychotherapy requires that you answer personal questions and possibly take psychological tests. Some of the tests may be administered directly to you in the form of paper-and pencil-tests and/or computer/instrument interaction. Other tests and measures may be scored/ completed based on the clinical interview and, in most cases, a review of your relevant documented history. In some cases, information will be gathered from other sources (e.g., people in your life, agencies, etc.). You must understand that you will be informed, in advance, of all sources of information that your therapist will use for evaluation and treatment planning.

Please be aware that your participation in therapy is confidential. In other words, everything that is discussed, the results of psychological tests, and conclusions will be kept private and will not be given to anyone except you. However, there are exceptions, or limits, to your confidentiality. In other words, under some circumstances your therapist may be required to disclose the results, conclusions, and data related to you. The limits are described below:

PRINTED NAME OF CLIENT: _____

*Limits of Confidentiality*

1. You authorize a release of information with a signature. (e.g., attorney, probation officers/parole agents, community agencies, health insurance companies, and/or other third party payers).
2. You assert that a mental condition is an issue in a lawsuit.
3. You present as a physical danger to yourself (Johnson v County of Los Angeles, 1983).
4. You present as a danger to others (Tarasoff v Regents of the University of California, 1967).
5. *Your evaluator* suspects that you are engaging in or have engaged in child or elder abuse and/or neglect that have not been previously reported to authorities (Welfare & Institution Code 11165.1).
6. If you disclose that you have knowingly developed, duplicated, printed, *downloaded, streamed, accessed through any electronic or digital media*, or exchanged, a film, photograph, videotape, *video recording*, negative, or slide in which a child is engaged in an act of obscene sexual conduct. (Welfare & Institutions Code 11165.1)

In some cases, your therapist will be required by law to inform potential victims and legal authorities so that protective measures can be taken. Please review the limits of confidentiality that may be specific to your case/situation with your therapist or a legal representative.

If you understand the above disclosures, **initial here: _____**

**Consent for Treatment/Evaluation**

I authorize and request the San Francisco Forensic Institute to carry out therapy sessions, clinical interviews, psychological exams, and/or diagnostic procedures. I understand that the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I am also aware that the therapy process may cause uncomfortable feelings and reactions such as anxiety, sadness, anger, and other strong emotions. I understand that these can be normal responses to participating in psychological therapy. If I experience these reactions, I may contact my therapist to discuss these issues.

**Emergency Contact Procedures**

The **San Francisco Forensic Institute** is not open 24 hours hours/seven days per week. In the event of an emergency, please call 911. You may also call one of the emergency numbers provided below.

**San Francisco:**

| | |
|---|---|
| 24 hours Crisis Line S. F. General Hospital Psychiatric Emergency Services | 415-206-8125 |
| 24 hours Crisis Line San Francisco Suicide Prevention | 415-781-0500 |
| 24 hours Crisis Line Friendship Line for the Elderly | 415-752-3778 |
| 24 hours Crisis Line Child Crisis Services | 415-970-3800 |
| Westside Crisis (245 11th Street) | 415-355-8300 |

**Alameda:**

| | |
|---|---|
| 24 Hour Crisis Hotline Alameda County | 800-309-2131 |
| 24 hours Crisis Line Nationwide Hotline | 800-SUICIDE |
| 24 hours Crisis Line | 800-273-TALK |
| 24 hours Crisis Line Child Abuse Hot Line | 510-259-1800 |
| 24 hours Crisis Line Crisis Support Service | 800-260-0094 |

PRINTED NAME OF CLIENT: _____

**Sonoma County:**

| | |
|---|---|
| 24-hour Emergency Mental Health Hotline | (800) 746-8181 |
| North Bay Suicide Prevention Hotline, confidential 24/7, | (1-855-587-6373) |
| 24-hour access line to mental health information, screening, and referrals: | (707) 565-6900 |
| | or (800) 870-8786 |

**Attendance and Payment**

I understand that I am required to pay for services at the time services are rendered or before unless my services are being paid for by a third party.

**Third party payers** include but are not limited to San Francisco Adult Probation, San Francisco Behavioral Health Care, MHM Services (ConRep), Liberty Healthy Care, Salesian Society, Kaiser. I understand that I may be required to pay a co-payment or for services in full if I let my coverage or authorization lapse. Copays will be billed monthly. Checks should be made out to San Francisco Forensic Institute (or SFFI). Other: _____ please circle who will be paying for your services if not you directly. If the third party payer is not listed, please discuss with the administrator to make sure we have a contract prior to writing in "other."

**Private Pay**

Individual therapy is $_____ and group therapy is $_____. I understand that I am required to pay for services at the time services are rendered or before. Cash, Checks, and Credit Cards are accepted. We do not bill third party payers unless listed above. However, you may ask for a "superbill" to be sent to you monthly so that you can submit to your insurance company for out-of-network reimbursement. This is your responsibility but we will assist you in getting the information you need to do it yourself.

I understand that there is a **48 hour cancellation policy**. Cancellations and "no shows" will be charged at the full agreed upon rate. If your services are being paid by a third party and they do not cover missed sessions, you will be billed for the missed sessions.

In addition, repeated cancellations and/or missed appointments may result in termination from the program. If you are on probation or mandated to be in treatment, your

By signing below, I agree that I have read, understood, and agree to all of the above disclosures.

_____ _____

Client/Guardian Signature Date

_____ _____

Clinician Signature Date

I have a right to a copy of this document. If I would like one, I will ask my clinician or the admin. If I do NOT want a copy, sign here:

_____

Client