Nicole Luk, Ph.D.

600 West Shaw Avenue, Suite 210 ▪ Fresno, CA 93704 ▪ 559-298-2229 ▪ PSY23087

Welcome to my office,

To follow is information regarding me and my practice which I hope will be helpful to you and ensure that we have clear and open communication. I know that the following information is lengthy, some of it is required by law and necessary to ensure proper care is provided. Please ask me for explanations of any of the material.

Whether you have visited with several therapists in the past, or this is your first time in therapy, I encourage you to ask questions so that you have a clear understanding of the therapeutic process. My goal is to provide you with the most helpful assistance that I can.

I obtained my Bachelor's degree from Concordia College in Moorhead Minnesota, my Master's degree in forensic psychology from the University of Denver in Denver Colorado, and my Doctoral degree from Nova Southeastern University in Fort Lauderdale, Florida. I completed an internship at Central California Psychology Internship Consortium at Alliant University's Psychological Services Center in Fresno, California. My approach to and implementation of psychotherapy is a product of my personal experience with the therapeutic process, my formal education, and my on-going study.

I genuinely believe that the fundamental curative factor in psychotherapy is the relationship between the patient and the therapist. It is within the context of a respectful, caring, and honest professional relationship that one is able to discuss and work through difficulties. The match between therapist and patient is essential. There are many psychotherapists available to you. If you do not feel comfortable with me for any reason, I am happy to help you find another therapist who may be a better fit. Thus, whether we meet only once, a few times, or over a long period, I am committed to being of assistance to you.

Please review the attached forms and ask me any questions you may have. Please sign and date where indicated reflecting that you understand the information.

Sincerely,

Nicole Luk, Ph.D.
Licensed Psychologist
PSY23087

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OFFICE POLICIES & GENERAL INFORMATION
AGREEMENT FOR PSYCHOTHERAPY SERVICES
Consent for Psychotherapy Services

This form provides you, the patient, with information that is in addition to that detailed in the Notice of Privacy Practices and it is subject to HIPAA preemptive analysis.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW:
Some of the circumstances where disclosure is required or may be required by law are:

- reasonable suspicion of child, dependent, or elder abuse or neglect;
- viewing of child pornography
- "sexting" involving minors
- a patient presents a danger to self, to others, to property, or is gravely disabled;
- a patient 's family members communicate to me that the patient presents a danger to others.
- pursuant to legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by me.
- in couples and family therapy, or when different family members are seen individually, even over a period of time, there are limits to confidentiality and privilege. It is best that I meet with individual patients to establish guidelines for disclosure prior to a couples or family session. In all cases, I will use my clinical judgment when revealing such information but I will not release records to any outside party unless I am authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client.

EMERGENCY: If there is an emergency during therapy, or in the future after termination, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the intake sheet.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: At your request, my office will submit insurance claims on your behalf. Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct me, only the minimum necessary information will be communicated to the carrier. I have no control over, or knowledge of, what insurance companies do with the information she submits or who has access to this information.

CONSULTATION: I sometimes consult with other professionals regarding patients, however, each patient's identity remains completely anonymous and confidentiality is fully maintained.

E–MAILS, CELL PHONES, COMPUTERS, AND FAXES: Computers and unencrypted e-mail, texts, and e-faxes communication can be vulnerable to access by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Data on my laptop is password protected and encrypted, and my computer has a firewall and virus protection, however, there is still a possibility that data can be compromised. Should your data be compromised, I will tell you. Please be advised that phone messages are transcribed and sent to me via unencrypted but password protected e-mails.

_____ *DO NOT use texts, e-mail, voice mail, or faxes for emergencies*. In order to provide the best clinical care, I will not respond to email messages or text messages from current patients. Please call me and leave a message. I will return your call as soon as I am able. If there is an emergency, go to the nearest emergency room or call 911.

RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards of my profession require that I keep treatment records for at least 7 years. Unless otherwise agreed to be necessary, I will retain clinical records only as long as is mandated by California law. If you have concerns regarding the treatment records, please discuss them with me. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. In such a case, I will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, I will release information to any agency/person you specify unless I assess that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave a message by calling 559-298-2229. I will return your call as soon as possible. I check messages in the morning and late afternoon or early evening on business days unless I am out of town. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call emergency services. Some community resources are as follows:

Exodus Psychiatric Health Facility (inpatient), 4411 E. Kings Canyon Road, Fresno, CA 93702
(559) 453-5124, (559)-453-6304 (or toll free at 1-800-654-3937)

Exodus Crisis Stabilization Center (outpatient), 4411 E. Kings Canyon Road, Fresno, CA 93702
(559) 453-1008 or (559) 453-1014

National Suicide Prevention Hotline: 1-800-273-TALK (8255) or 1-888-506-5991

Local police and emergency services: 911

DO NOT use email, text, or fax for emergencies.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay my standard fee of $175.00 per 50 minutes at the beginning of each therapy session. Telephone conversations, site visits, reading of reports, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify me if any problems arise during the course of therapy regarding your ability to make timely payments. I can provide you with a bill which you can submit to your insurance company, or I can provide that service for you.

Money can be an uncomfortable topic to discuss. I encourage you to bring your concerns to therapy for an open dialogue.

_____ I am not a preferred provider for any insurance company and I am not a MediCal or Medicare provider.

If your account is overdue and there is no written agreement on a payment plan, I may use legal or other means (courts, collection agencies, etc.) to obtain payment.

MEDIATION & ARBITRATION: All disputes arising out of, or in relation to, this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a precondition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Dr. Luk and the patient(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Fresno County, California in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Dr. Luk can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum as and for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

THE PROCESS OF THERAPY AND SCOPE OF PRACTICE: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior.

There may be times when you feel you are not ready to discuss a certain topic, it is perfectly acceptable to simply say, "I'm not ready to talk about that." Your request will be honored.

I will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation.

During therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

During the course of therapy, I am likely to draw on various psychological approaches depending, in part, on the problem that is being treated and my assessment of what will best benefit you. These approaches include, but are not

limited to, behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. I am also fully trained in Eye Movement Desensitization and Reprocessing.

I do not provide custody evaluation recommendations, medication, prescription recommendations nor legal advice, as these activities do not fall within my scope of practice. A different consent is required for psychological evaluations.

TREATMENT PLANS: At any time, you are welcome to ask about my working understanding of your areas of difficulty, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, the possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits.

CONCLUDING THERAPY: Sometimes people come to therapy and then, despite their best intentions, and for a variety of reasons, do not return. You have the right to terminate therapy and communication at any time, but I believe that it is best if we can discuss your thoughts about ending therapy before you decide to not return.

In our first meeting you and I will both decide if I can be of benefit to you. I do not work with clients who, in my opinion, I cannot help. In such a case, I will offer you referrals that you can contact. If at any point during psychotherapy I assess that I am not effective in helping you reach the therapeutic goals, I will discuss this with you and together we can make a decision about what is best for you. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, I will give you a couple of referrals that you may want to contact.

DUAL RELATIONSHIPS: Not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs my objectivity, clinical judgment or can be exploitative in nature. I will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. I will never acknowledge working with you without your written permission. Patients sometimes choose their therapist because of a recommendation from another patient. I will discuss with you the complexities and potential difficulties that may be involved in dual or multiple relationships. Please advise me if the dual or multiple relationship becomes uncomfortable for you in any way. We will determine the best course of action to maximize effectiveness of the therapy and to protect your welfare.

PUBLIC SETTINGS: Out of respect for your privacy, if we pass in public settings I will never approach you or initiate greetings. If you want to say hello that is fine, but if it feels awkward, simply pass by and I will understand. For the same reason I typically refuse invitations to social events. The professional nature of our relationship and your privacy and confidentiality are guiding principles to all aspects of our interaction. In the same vein, your investment in therapy and/or any referrals are the best signs of appreciation.

SOCIAL NETWORKING AND INTERNET SEARCHES: I do not accept friend requests from current or former patients on social networking sites such as Facebook. I believe that adding patients as friends on these sites and/or communicating via such sites is likely to compromise your privacy and confidentiality.

_____ CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hour notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

A FINAL NOTE: Psychotherapy is unlike visiting other healthcare providers, it is a unique experience. It requires a great deal of time and energy on your part and there are not specific guarantees. Nevertheless, it is my heartfelt belief that psychotherapy, particularly the therapeutic relationship, plays an integral role in one's intellectual, emotional, and spiritual development. My experience with the therapeutic process is that the more one is able to invest, the more one will profit.

Once again, welcome. I look forward to being of assistance to you and/or your family.

I have read the above Office Policies and General Information, Agreement for Psychotherapy Services or Informed Consent for Psychotherapy carefully and reviewed them with Dr. Luk. I understand them and agree to comply with them, and I acknowledge receipt of a copy of this information and Notice.

Patient's Name (print) _____ Date _____

Signature _____

Nicole Luk, Ph.D. _____ Date _____

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Intake Form

Date: _____

First Name: _____ Last Name: _____ Middle Initial:_____

CA Driver's License: _____ Occupation:_____ Ethnicity:_____

Date of Birth: _____ Age: _____ Sex:_____ Marital Status:_____

Street Address/City/State/Zip: _____

Home phone: _____ Mobile: _____

Work phone: _____ Other: _____

Preferred number for confidential messages: HOME/MOBILE/OTHER Referral Source: _____

Primary Physician (name/phone):_____

Emergency Contact Person:_____ Relationship:_____

Address: _____ Phone Number: _____

I understand that Dr. Luk does not accept assignment (direct payment) from any insurance company including MediCal and MediCare. I understand that she is not a MediCal or MediCare provider. I understand that full payment is due at time of service. At my request, Dr. Luk will provide me with information which I can submit to my insurance company or she will utilize a billing service to do so on my behalf. I understand that she is not a preferred provider for any insurance company and any reimbursement from my insurance will be at an out-of-network rate. Fee for returned check is $35 plus the amount of the check due immediately.

Signature:_____ Date/Time:_____

I authorize Dr. Luk to submit claims on my behalf to using the insurance information listed above.

Signature:_____ Date/Time:_____

Insurance Company:_____

Please have insurance card ready, Dr. Luk will make a photocopy of it.

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Acknowledgement of Receipt of Notice of Privacy Practice

It is your right to refuse to sign this document.

I have received a copy of this Office's Notice of Privacy Practices.

Patient name: _____

Signature:_____ Date: _____

For Office Use Only:

The reason that a standard acknowledgment (such as the above) of the receipt of the Notice of Privacy Practices was not obtained:

_____ Patient refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented this office from obtaining it.

_____ Other: _____

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AUTHORIZATION TO RELEASE INFORMATION

I, (name of patient) _____, hereby authorize Dr. Luk to **disclose and receive** mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, therapist's diagnosis of me, **to**, and to receive information **from**:

Name:_____Relationship:_____

Address:_____Phone number:_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Dr. Luk has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Dr. Luk at 600 W Shaw Ave, STE 210, Fresno, CA 93704, in order to be effective.

I am authorizing disclosure for the following purpose:

_____

Limitations of what can be disclosed (be as specific as you choose to):

_____

Such disclosure shall be limited to the following specific types of information (written or verbal or both):

_____

Dr. Luk shall not condition treatment upon me signing this authorization and I have the right to refuse to sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid until: _____

Patient's signature: _____ Date: _____Time:_____

Witness: _____

_____

REVOCATION OF AUTHORIZATION

Patient's signature: _____ Date: _____Time:_____