

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Mandatory Health Information Privacy Procedures

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. The privacy of your health information is important to this office. Please review it carefully

LEGALLY DEFINED DUTY OF THIS OFFICE

This office is required by legal statute to protect the privacy of your health information. This "personal health information" is defined as that health information that can be used to identify you, has been created by this office, or has been received from another office or entity. It applies to past, present and future health or condition, your treatment, payment for services, and other health practices which will be explained to you.

This office has the duty to provide you with this NOTICE, which contains a description of how your health information will be used and disclosed for purposes of treatment, payment, and other health practices. The "use" of this information applies to the sharing, utilization, examination, or analysis of this information within this treatment facility. Your health information is "disclosed" when it is released or transferred out of this office to another party or entity. These practices will be explained to you in this NOTICE. This office has the legal duty, with some exceptions, to disclose or use only the necessary information to accomplish the task at hand. Additionally, this office is legally required to apply and follow the practices described in this NOTICE.

This office has the right to change the privacy practices as describe in this NOTICE at any time, as permitted by law. The changes will apply to your health information held by this office. You will receive an updated copy of the NOTICE and it will be posted in this office. You can request a copy of this NOTICE at any time by notifying our CONTACT OFFICER at the address and telephone number located at the end of this NOTICE.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

This office is permitted to use and disclose you health information for the purposes of providing treatment, payment for services rendered, and healthcare operations. Some of these require your authorization and others do not. Some examples that do not require your authorization include:

Treatment: This office may use and disclose your health information to a physician, psychiatrist, or other mental health clinicians who provide treatment to you. The purpose of this disclosure is for coordination of your treatment.

Payment: This office may use and disclose your health information to obtain payment for services provided to you. The disclosure may be to your health insurance company or health plan. If this office uses a third party for billing services, we will make sure they comply with the safe management of your health information.

Healthcare Operations: This office may disclose and use your health information for the purpose of maintaining and running this office. This includes quality assessment protocols reviewing the competence of clinicians providing treatment, or conducting training, certification or licensing activities.

Emergency Situations: This office may use and disclose your health information to emergency personnel in case a situation warrants such treatment.

Federal, State, Local, or Administrative Law: This office may use or disclose your health information when mandated by law. This includes reporting child and/or elder/ dependent abuse, harm to self or others, when required by judicial or administrative actions, or when required by government agencies such as a county

coroner or workers' compensation laws. National Security: This office may disclose your health information to military authorities of the Armed Forces under specific situations. For example, we may disclose to intelligence, counterintelligence, and other national security agencies information required by them.

Authorization: This office may obtain your written authorization for use or disclosure of your health information for situations not listed above. You may give this office your written authorization for use of your health information or to disclose it to anyone for any purpose as defined by the written AUTHORIZATION DOCUMENT. You may revoke your authorization in writing at any time.

Family, Friends, or Others Involved in Your Healthcare: This office may provide your health information to a family member, friend, or other individual designated by you as being involved in your healthcare or for the payment of your healthcare, unless you object.

Appointment Reminders and Other Communications: This office, at times, may use or disclose your health information to provide you with appointment reminders, appointment changes, or other office communications. These may include voicemail messages, letters, or e-mails.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Access To Your Health Information: You have the right to examine or obtain copies of your health information, with some limited exceptions. This office will attempt to comply with the requested format, unless we are unable to do so. The request must be made in writing and we will comply within 30 days of receiving your written request. You will be charged \$0.10 per page. We may choose to provide you with a summary or synopsis of your health information if you agree. Should this office deny your request, you will be provided a reason in writing and an explanation of your rights to initiate a review of the denial.

Requesting Limits on Uses and Disclosures of Your Health Information: You have the right to request limitation on the use and disclosure of your health information. This office will review your request and may choose not to accept it. If your request is accepted, a written format will be included in your records and this office will abide by the request. The request may not interfere with the legally defined uses and disclosures of your health information.

Receiving Health Information: You may request that health information be sent to you to a specific location and by specific means such as E-mail. This office will attempt to comply as long as it is feasible.

Accounting for Disclosures: You have the right to request and receive a list of disclosures made on your behalf by this office for reasons other than treatment, payment, or healthcare operations. The request is valid for the last six years to begin on April 14, 2003. You may make one such request every year. There will be a reasonable charge for additional request made in one 12-month period.

The Right to Amend Your Health Information: You have the right to request an amendment or correction to your health information. The request must be made in writing and a reason for your request must also be included. This office must respond to your request within 60 days of the request. The request will be granted or denied.

If your request is granted, the appropriate changes will be made, you will be informed of the changes made and third parties needing to know about the changes will be notified.

This office can deny your request if the information is complete and correct, it was not created by this office, not part of the office records, or cannot be disclosed. You will receive a written statement stating the reason for a denial. You will be provided with the format to file a written disagreement with the denial. You also have the right to request that your original request and my denial be attached to all future disclosures of your health information.

You have the right to receive this notice by e-mail or in written format.

QUESTIONS

Should you require additional information, please contact our CONTACT OFFICER at: (805) 570-3255.

COMPLAINT PROCEDURES

Should you believe that this office has violated your privacy rights, you disagree with a decision made about access to your health information, you disagree with a response to your request to amend or restrict the use or disclosure of you health information, or disagree with our decision to contact you via a specific method or location, you may complain to our CONTACT OFFICER at (805) 570-3255 and/or submit a written complaint to the United States Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C., 20201. This office will not retaliate against you in any way should you choose to file a complaint.

Contact Officer: Yolanda Yturralde
Telephone: (805) 570-3255
Fax: (805) 682-0484
E-mail: yolanda@learnSelfcare.com
Address: 1815 State Street, Suite E, Santa Barbara, CA 93101

The effective date of this NOTICE is April 14, 2003.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(you have the right to refuse to sign this document)

I, _____, have received a copy of this Office's Notice of Privacy Practices on

Date

Client's Signature

Client's Printed Name

Therapist Signature

CONTRACT FOR PSYCHOTHERAPEUTIC SERVICES AND OFFICE POLICIES

PLEASE INITIAL after each section if these procedures are acceptable to you.

CONFIDENTIALITY

I abide by and respect the ethical code of confidentiality in my work. The information and nature of your sessions will not be disclosed to any person or agency without your prior consent to do so. There are four exceptions, which are mandated by California and Federal Law. 1) I must report any life-threatening situation and/or 2) Any suspected physical/sexual abuse. In such cases I will take necessary steps to protect the safety and well being of those concerned. 3) In certain circumstances, under subpoena, I may be required to provide records related to the court. 4) The Patriot Act of 2001 requires therapists, in certain circumstances, to provide FBI agents with records and prohibits the therapist from disclosing this to the client. _____

When working with an individual child I respect his/her right to confidentiality. I will consult with you about your child's progress. Both parents are entitled to know the nature and progress of the child's therapeutic care. If you would like to see me alone, please make a separate appointment. I appreciate your telling me at the beginning of the session whether there have been any unusual happenings since our last session. _____

FEES & CANCELLATION POLICY

Fees are payable at each session unless other arrangements have been previously made. In order to save time, please have your check ready at the beginning of the session. Please make out checks to Yolanda Yturralde, MFT. _____

The fee for an initial assessment/evaluation is \$225. The fee for a 45 minute session is \$150. I am willing to negotiate this fee in cases of financial need. There is a \$25 charge for all checks returned by the bank. Interest will be added to any outstanding bill not paid within one month of the session date. Payment is expected at the time services are rendered unless otherwise agreed upon. Ultimately the client is responsible for payment if insurance fails to cover fees for any reason. _____

Because the time I have for seeing clients is limited and valuable, I must charge you for your appointments missed or cancelled less than 24 hours in advance. _____

Sometimes a session longer than 45 minutes is advisable, particularly for EMDR, couples, or family sessions. These will be arranged individually and the fee adjusted accordingly. For example: a 90 minute session would be \$300. _____

Telephone calls and extensive report writing: I prefer to see and talk with you in person at a scheduled office session. However, there are times when telephone calls are needed. You will be charged for telephone calls over 10 minutes, at the fee rate of your office session. _____

Court Appearances

I am not a forensic psychologist nor a custody evaluator. My role is to provide psychotherapy and consultation to adults, children, and parents who are making changes in their lives or dealing with difficult issues and situations. I will not become involved with lawyers or legal proceedings. If, however, I am subpoenaed or required to do so for other reasons, the fee to the party demanding such services will be \$250 per hour for all related activity, including air travel. A retaining fee of \$1500 is required. _____

INSURANCE

You are responsible for the payments of all psychological services. Reimbursement from insurance companies should go directly to you. If you have managed health

insurance coverage and you miss an appointment without 24-hour cancellation notice, you will be charged my full fee out of pocket as insurance will not pay for missed sessions. Insurance is not handled automatically. Individual insurance companies differ as to coverage. You will need to check with your insurance company to determine if these sessions are covered. I am a licensed Marriage, Family, and Child Therapist. However, many insurance companies require a referring physician. Be sure to give me the name, address and phone number of your referring physician for my records. Please have your part of the form filled in before you give it to me and be sure to indicate whether you want it sent back to you or sent directly to the insurance carrier.

For Managed Care clients who will be making only the co-pay: I understand my co-pay is \$_____. If and when my benefit has been exhausted I understand that I am responsible for services rendered. If reimbursement has not been provided by insurance within 60 days of billing I understand I am fully responsible to pay for the entire bill. _____

YOUR RIGHTS

You have the right to ask questions about any of the procedures used in the course of your therapy. Should you choose not to enter therapy with me, I will provide you with the names of other qualified professionals whose services you might prefer.

You have the right to terminate therapy with me, I will provide you with referrals without any financial, legal, or moral obligations other than those you've already incurred. I have the right to terminate therapy with you under the following conditions: a) When I believe that therapy is no longer beneficial to you. b) When I believe that another professional will better serve you. c) When you have not paid for the last two sessions, unless I have made special arrangements. d) When you failed to show up for your last two therapy sessions without a 24 hour cancellation notice. e) If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If I have written consent, I will provide that professional with information they request. If any of these situations apply, I will send a certified letter to your address of record to inform you of my decision, and I will give you the names of several therapists for your future counseling needs. _____

As life can bring unexpected circumstances, should I be unable to continue your therapy, my trusted colleague, Lani Votaw, MFT will contact you to discuss what would be best for you at that time. _____

Termination: A final "good-bye" session is essential to the therapy process. As a part of your contract with Mrs. Yturralde, you agree to a final session, regardless of the reason for the termination. _____

OFFICE HOURS

I am in the office generally Tuesday thru Friday 1 p.m. until 5 p.m. I return messages Monday thru Friday 9 a.m. to 5 p.m. If you need to contact me between sessions please leave me a message and I will call you as soon as feasible. If your matter is urgent or an emergency you may call my cell phone 805.570.3255. AN EMERGENCY IS AN UNEXPECTED EVENT THAT REQUIRES IMMEDIATE ATTENTION AND CAN BE A THREAT TO YOUR LIFE. If an emergency situation arises, please state this when you leave your message and I will return your call as soon as possible. If I have not called you back within 60 minutes and the emergency persists, and the emergency requires it, please call your physician, 911 or admit yourself to a hospital for observation.

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE POLICIES

(You have the right to refuse to sign this document.)

I _____ (full name) authorize and request that Yolanda Yturralde, MFT may carry out psychotherapeutic examinations, diagnostic procedures, and/or treatments which now or during the course of my care as a patient are advisable. I also understand that the purpose of any treatment will be explained to and be subject to my agreement. I have read and fully understand this Consent for Treatment form. I am also receiving a copy of this office's Notice of Privacy Practice. By signing below I agree to abide by the office policies for Yolanda Yturralde, MFT.

Date

Signature of Client

Date

Signature of Parent

Date

Signature of Therapist

Confidential Client Information

First Name _____ Last Name _____

Street Address _____ City _____ State _____ ZIP _____

You may contact me at the following Numbers: (Home) _____ (Cell) _____ (Work) _____

Date of Birth _____ Age _____ E-mail _____ Social Security No _____

Occupation/School _____ Working now? Yes No Monthly Income _____

Family Physician's Name _____ Phone _____ Address, City, State, ZIP _____

Health Insurance _____ Insurance Plan # _____

Marital Status single married separated divorced in relationship in relationship and living apart others living in household _____

Number of Children, living or deceased (include Name, Gender, Date of Birth/Death) _____

Nearest relative's name _____ Tel. _____ Best Friend's name _____ Tel. _____

Number of Siblings, living or deceased (include Name, Gender, Date of Birth/Death) _____

Check and briefly describe your present problem and reason for seeking therapy:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Obsessions/Compulsions | <input type="checkbox"/> Sexual Issues/Abuse |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Health Issues | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Substance/Alcohol Abuse |
| <input type="checkbox"/> Eating Problems | <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Relationship Issues | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Family Issues | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Separation/Divorce | <input type="checkbox"/> Work Problems |
| <input type="checkbox"/> Other: _____ | | | |

Brief Description: _____

Have you had previous psychotherapy or are you currently in therapy with another psychotherapist? (date of last visit with most recent former therapist/Psychiatrist, issues/type of problem?) _____

Will you sign an Authorization to Disclose Health Info? Yes No If yes, please provide Tel/Fax where Health Info can be acquired: Tel. _____ Fax _____
Please note any information restrictions on Authorization to Disclose Health Info form.

Please describe your spiritual identity/orientation at birth and at present _____

Describe any current medical or health problems, medications and/or past medications and dosage if known _____

Please indicate what (if any) medications, vitamins or over the counter drugs you are taking/prescribing MD/to address what?/results? _____

Have you or has anyone in your family ever been hospitalized? Yes No If yes, whom? _____ What date? _____ Any family history of mental illness? Yes No Hospitalization or reason for medication: _____

Please indicate your current use of cigarettes, alcohol, and/or other drugs (frequency per week/month) _____

Substance use: Have you felt the need to cut down, annoyed by criticism, guilty about using, morning use, legal issues due to use)? _____

Do you have any of the following? *Please circle Y (yes) or N (no) and explain*
Y N Thoughts of Suicide _____ Y N Troubles Sleeping _____
Y N Trouble Exercising _____ Y N Attempts of Suicide in the past _____
Y N Troubles Eating _____ Y N Other _____

Education history (school/adjustment issues/graduation) _____

Abuse history (not abused/abused physically/sexually/emotionally/neglected) _____

Are there any other pertinent issues or concerns you would like to share, including legal or custody issues, symptoms, etc.? _____

What do you hope to gain from therapy? _____

Today's Date _____

Signature _____

Print Name _____

Authorization to Use and Disclose Health Information

By signing this document, I, _____, hereby authorize Yolanda Yturalde, Marriage & Family Therapist (License # MFC 36018) to exchange my health records and information obtained during the course of my treatment with _____.

(name, title, phone and fax number of person receiving information)

This disclosure of information and records authorized herein is required for purpose of carrying out treatment, payment activities, and/or health care operations.

Such disclosure shall be limited to the following specific information:

- obtain treatment information obtain psychiatric information
 obtain school information other: _____

Such disclosure shall be limited to the following specific information:

- to enhance treatment records to create a relapse prevention program
 to create treatment plan to create a discharge summary
 to create a diagnosis previous hospitalization
 to obtain previous treatment history other: _____

I also understand that any cancellation or modification of this authorization must be in writing to the clinician named above. I have the right to refuse to sign this form. I understand that information that is used or disclosed according to this authorization may be subject to re-disclosure by the recipient. The Provider will not make providing treatment a condition of signing this Authorization. I am entitled to receive a copy of this form. California law may provide additional protection regarding the possible re-disclosure stated above.

This release will remain valid until one day after completion of psychotherapy treatment unless other date state here _____.

Today's Date

Signature

Print Name

Date of Birth

Social Security No.

Health Care Providers may reach Yolanda in person on her cell phone 805.570.3255.

OPTIONAL PSYCHOTHERAPEUTIC SERVICES

Optional EMDR Treatment Authorization Form

Should you elect this treatment now or in the future please read and sign below.

Before I engage in Eye Movement Desensitization and Reprocessing (EMDR) Treatment and therapy with Yolanda Yturralde, MFT, I have been advised and understand that EMDR is a treatment approach that has been widely validated by research only with civilian Post traumatic Stress Disorder. Research on other applications of EMDR is now in progress.

I have also been specifically advised of the following:

A) Distressing, unsolved memories/emotions may surface through the use of EMDR.

B) Some clients have experienced reactions during the treatment sessions that neither they nor the administering clinician anticipated, including a high level of emotion or physical sensations. Some clients forget memories and lose access to details from their distressing situations. Because EMDR can trigger addictions, it is important for clients to have a structured recovery / 12-step program in place. I understand this and have support _____ (initial here)

C) Subsequent to the treatment session, the processing of incidents/material may continue, and dreams, memories, flashbacks, feelings, etc. may surface.

Before commencing EMDR treatment, I have thoroughly considered all of the above, I have obtained whatever additional input and/or professional advice I deemed necessary or appropriate to having EMDR treatment, and by my signature below, I hereby consent to receiving EMDR treatment. My signature on this Acknowledgment and Consent is free from pressure or influence from any person or entity.

Today's Date

Signature

Print Name

Consentimiento Optional Para el Tratamiento Con MODR/EMDR

Si quiere este tratamiento ahora o en el futuro, por favor firmalo esta pagina.

Antes de comenzar con en el procedimiento llamado Movimiento de Ojos con Desensitización y Reproceso/MODR, (Eye Movement Desensitization and Reprocessing /EMDR), y antes de comenzar la sicoterapia con la Lcda. Yolanda Yturralde, MFT, certifico lo siguiente: Yo he sido debidamente aconsejado/a sobre los usos, propósito, riesgos y consecuencias de este tratamiento. También yo entiendo que el MODR es un tratamiento que ha sido ampliamente estudiado a través de investigaciones científicas por profesionales, inicialmente en los casos de un desorden emocional llamado "Ansiedad Post Traumática" y después en otros usos específicos. También entiendo que otras investigaciones sobre usos diferentes del MODR están en progreso en el presente.

Además yo he sido específicamente aconsejado/a sobre lo siguiente:

A) Memorias / emociones que no han sido resueltas pueden salir a la superficie de nuevo a través del uso del MODR.

B) Algunos clientes han tenido experiencias durante las sesiones de tratamiento que ni ellos ni el sicoterapeuta han anticipado. Estas incluyen un alto nivel de emoción o sensaciones físicas. Algunos clientes pierden memorias y pierden el recuerdo de los detalles sobre situaciones pasadas de alta ansiedad. Debido a que MODR puede reactivar adicciones pasadas, es importante que los clientes tengan un programa organizado profesionalmente, tal como los "12 pasos" (por ejemplo los de AA/NA). Este programa debe estar activado y con controles. Yo comprendo esto y certifico que estoy de acuerdo y que tengo respaldo profesional y legal adecuado. Favor de poner sus iniciales aquí: _____ .

C) Subsecuente a las sesiones de terapia el reproceso de incidentes y memorias pasadas pueden continuar y otros sueños nuevos, memorias y recuerdos subitos pueden reaparecer. Al final de las sesiones, inicialmente sus emociones pueden estar mas agitadas y confusas. Esto usualmente dura pocos dias, y contribuye a la ayuda final del programa. Antes de yo comenzar la terapia MODR yo certifico que he considerado toda la informacion explicada arriba. Tambien yo he obtenido todos los consejos y la ayuda profesional y ayuda legal que yo determiné que era apropiada o necesaria antes de obtener este tratamiento. Por mi firma aqui yo doy mi consentimiento para obtener la terapia de MODR. Mi firma la doy voluntariamente, libre de presión o de influencia de otras personas o entidades.

Fecha

Firma del Cliente

Escriba el Nombre del Cliente

PLEASE
DO NOT
STAPLE
IN THIS
AREA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM												
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)					
CITY		STATE			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE			
ZIP CODE		TELEPHONE (Include Area Code)			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (INCLUDE AREA CODE)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____		b. EMPLOYER'S NAME OR SCHOOL NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____							
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (I, MP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.							
23. PRIOR AUTHORIZATION NUMBER												
24. A DATE(S) OF SERVICE To		B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												
25. FEDERAL TAX I.D. NUMBER SSN EIN 75-3004236 <input type="checkbox"/> <input checked="" type="checkbox"/>			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)			33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (805) 570-3255 Yolanda M. Yturralde, M.S. Marriage & Family Therapist 1815 State Street, Suite E Santa Barbara, CA 93101				