



[www.recoveryhappens.com](http://www.recoveryhappens.com)

**PLEASE PRINT, COMPLETE AND BRING IN AT THE TIME OF YOUR FIRST APPOINTMENT**

## **Information on Services, Fees and Payments**

Parent involvement is crucial to the successful treatment of your child's issues. It is less likely counseling will be successful in helping your child achieve lasting recovery without your help. **For this reason, participation in the Parent Education Classes, family conferences and parent support groups are a required part of the process.** The Parent Education Classes will provide you with the information and tools needed to support your child's recovery. The more parents are committed to their own personal growth and their role in their child's recovery the more likely we will achieve favorable outcomes. This process requires not only an investment of money, but time, energy and emotion as well. We have compassion for where you are in your journey at this time.

Clients are seen once or twice weekly on an appointment-only basis, at a mutually convenient time. All counseling sessions are 45 minutes in length. Payment Fees is \$175 unless otherwise stated by your assigned clinician.

**Please note:** All missed or canceled appointments will be billed at the usual rate without 48 hours confirmed notice. Due to this, we recommend that if your child cannot attend a session, then you come in their place to continue to work on and process your part in helping your child.

Confidential messages can be left on your counselor's voice mail 24 hours a day, seven days a week. They will make every effort to return your call at their earliest convenience. If your call has not been returned within a reasonable time, please call again. No call is deliberately ignored, but the occasional error may occur.

When additional services are required, such as conferences with your physician or other treatment providers, meetings with school personnel, or court attendance, there will be a charge. The fee for returned checks is \$25.00.

Payments can be made by check or card in our office.

**Payment is expected at the time of or before each counseling session.** For future appointments, please bring a check or send it in with your child at the beginning of the session so that time for our next client is not used waiting for a check to be written.

Please make your check payable to: **Recovery Happens Counseling Services**

## Payment Agreement

I understand that payment for services is due at the time of each session. If I or my child cannot make it to a scheduled appointment, we must provide a **48-hour notice of cancellation** otherwise I will still have to pay for the missed session. I understand that it is not acceptable for me to have an outstanding balance.

I take all financial responsibility for counseling sessions scheduled between any of my family members and our/my child's counselor at Recovery Happens Counseling Services, regardless of whether my child is under or over 18 years of age. I also agree to pay any portion of treatment that my insurance company fails to pay.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Client Information

Today's Date: \_\_\_\_\_

Your Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Your Child's Cell# \_\_\_\_\_

Father/Stepfather's Name \_\_\_\_\_ Home Phone # \_\_\_\_\_

Address \_\_\_\_\_ City/Zip \_\_\_\_\_ Occupation \_\_\_\_\_

Business Phone # \_\_\_\_\_ Cell# \_\_\_\_\_, Email: \_\_\_\_\_

Mother/Stepfather's Name \_\_\_\_\_ Home Phone # \_\_\_\_\_

Address \_\_\_\_\_ City/Zip \_\_\_\_\_ Occupation \_\_\_\_\_

Business Phone # \_\_\_\_\_ Cell# \_\_\_\_\_, Email: \_\_\_\_\_

Your Child's School and School Counselor: \_\_\_\_\_

Your Child's Physician: \_\_\_\_\_

Your Child's Psychiatrist: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

Please provide us with the name and contact information of the person who referred you to our program.

Name of the person who referred you: \_\_\_\_\_

Who in your family was the info about our program given to? \_\_\_\_\_

Do we have your permission to thank them? \_\_\_\_\_

What is their contact info, ph#, address, email, : \_\_\_\_\_

Thank you for the information.

**Monthly Newsletter**

We recognize the need to be educated and kept up to date with current information related to individual, couples and family mental health and wellness. Please provide us with your email address and we will keep you updated. You can be removed from the newsletter at anytime with a click.

**(PLEASE PRINT CLEARLY)**

Email Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Also, if you goto our homepage and sign up for the newsletter you will get a free copy of the book: **“How to Help Your Child Become Drug Free”**

## Consent to Treatment

Most people who participate in treatment benefit from it. Like most kinds of health care, this kind of treatment requires a very active effort on your part if you are going to get something out of it. In addition, there may be certain kinds of risks involved. For example, the therapy process can be challenging and sometimes may involve experiencing some uncomfortable feelings, or engaging in difficult interactions, or facing difficult aspects of your life. Nevertheless, most people find that the benefits outweigh any such risks. In fact, sometimes there can be more risks associated with not participating in therapy.

It is important that you participate in this treatment willingly. If you have any questions or concerns about this document, the services being provided to you, or about other treatment options, please feel free to discuss with your therapist.

## Acknowledgment

By signing your name in the space below, you are acknowledging that you have read and understood this document and that you voluntarily agree to participate in this treatment. *If the person receiving care is a minor, a parent or legal guardian acknowledges having read and understood this document and voluntarily agrees to the minor's participation in the treatment.*

---

Client Signature (If signature other than client, list relationship)

Date

---

Witness' Signature

Date

## Authorization to Consult

I understand and authorize the staff at Recovery Happens Counseling Service to consult with each other for the sole purposes of evaluation, assessment, diagnostic, treatment planning, and continuity of care for myself, child and family. Any case consultation with a clinician required outside of Recovery Happens Counseling Services will first require a separate authorization to release information form separate from this one.

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Parent, Guardian or Conservator: \_\_\_\_\_ Date: \_\_\_\_\_

*(If Guardian or Conservator, please see attached Affidavit)*

Counselor: \_\_\_\_\_ Date: \_\_\_\_\_

**Please keep a signed copy for your records too**

## **COUNSELOR-CLIENT CONFIDENTIALITY, CLIENT SAFETY, AND CLIENT RECORDS**

*The confidentiality of communications between a client and a counselor is important and, in general, is protected by law. Subject to legal exceptions, information given in therapy will not be shared with anyone without the client's written permission. The following outlines some, but not all, of the circumstances when California or Federal law allows, or requires, a counselor to breach a client's confidentiality.*

**Safety:** If a client communicates directly that they are a threat of physical harm to an identifiable person, we are required by law to warn the intended victim and notify the police. If a client is in such mental or emotional condition that he/she poses a danger to him/herself or others, or the property of another person, confidentiality may be breached to contact others to facilitate the client's safety. It may be required to initiate psychiatric hospitalization of a client for up to 72 hours, even without client's voluntary consent. A counselor has both a legal and ethical responsibility to take action to protect endangered individuals from harm when his or her professional judgment indicates that such a danger exists. If such a situation should arise, it is our policy to fully discuss these matters with a client before taking any action, unless, in our professional opinion, there is a good reason not to do so. If there is reasonable suspicion of child abuse or neglect, or abuse of a dependent, or elder adult (age 65 or older), it is required by law to file a report with the designated protective agencies.

**Privilege:** In most legal proceedings, a client may assert the Counselor-Patient privilege to protect information about his or her treatment. However, certain legal activities or court actions, such as a client making his/her mental or emotional state an issue in a court proceeding, may limit a therapist's ability to maintain confidentiality. A court may also order a therapist to disclose confidential client information. If you are involved in a legal proceeding, please speak with your attorney about the limits of confidentiality.

**Group:** In the event that group therapy services are provided, the counselor or practice of professionals involved in conducting or co-conducting the group therapy cannot be held responsible for a breach of confidentiality on the part of group members. However, the therapist will uphold confidentiality and mandated reporting as above listed.

**Secrets Policy:** When a client shares information outside of the presence of other persons participating in the therapy (such as a spouse or other family members), this information may be shared with other therapy participants. This is commonly referred to as a "no secrets policy".

**Minors:** Information shared by minors will generally not be shared with parents or others outside of the therapy unless circumstances meet the mandated or permissible reporting criteria described in this section, or if the minor child discloses information which suggests that they are engaging in serious, at risk behavior. However, family sessions may be used to create the space for the child to share their truth with their family.

**Insurance:** Most insurance agreements require you to authorize your counselor to provide clinical information, for example, a diagnosis, a treatment plan or summary, or even a copy of the entire record. Once the insurance company has this information, the counselor has no control over what the

insurance company does with it. If you request that I provide information to your insurance company, I will ask you to sign an authorization for that purpose. If the use of a collection agency becomes necessary, I will furnish them with the required information to collect the fees due.

**Use of Technology:** Communication platforms such as e-mail, texting, or other electronic methods may be used for scheduling sessions or discussing relevant information to therapeutic work. This will not be a form of therapy, but used for the above mentioned purposes. If mutual agreement for telehealth sessions are determined as a good fit, you will be asked to fill out a separate informed consent for telehealth services. Please know that there are associated risks involved in the use of technology. I cannot guarantee complete confidentiality when using these resources due to unexpected access by unauthorized persons, and technical failures could result in disrupted communication. Please discuss with me any forms of technological communication you would like to decline for any of the above reasons.

**Therapist/Treatment:** Recovery Happens is committed to serving those impacted by drug and substance abuse, along with their family system, in order to bring sustainable change to those suffering. The clinicians working within Recovery Happens employ modalities such as Family Systems, Attachment Theory, 12-Step, and Cognitive Behavioral Therapy. Each clinician will have their own style and personality within these, and may be receiving attentive supervision while they obtain their licensing hours.

*Your Therapist's Name/Title: \_\_\_\_\_  
Supervised by: Dr. Angela Chanter, PsyD #20014 Licensed Psychologist in California*

**Records:** This office maintains confidential client records for 7 years after the client is 18, or 7 years after termination of therapy if already 18 at initiation. After the 7-year post termination period, the client's records will be destroyed so as to protect client confidentiality.

**Non-Competing Contract:** Should your primary clinician ever move on to another job elsewhere, please understand that that clinician has signed a non- compete contract which prevents them from taking Recovery Happens Counseling Service's clients with them. Recovery Happens Counseling Services will assist you with another clinician within the program as all of the clinicians are trained in the same model of treatment.

**HIPAA:** Please review the following page for the following specifics to your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPPA").

**Acknowledgement:** Your signature below indicates that you have read and understood these policies, you have read and understood HIPAA and you have been offered a copy. Please sign and print your name and write today's date on the line below.

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Parent, Guardian or Conservator: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor: \_\_\_\_\_ Date: \_\_\_\_\_

*Please keep a signed copy for your records too*



## HIPAA

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (“HIPAA”).

1. Tell your mental health professional if you don't understand this authorization, and they will explain it.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and you're your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. Special instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as “Psychotherapy Notes.” All Psychotherapy Notes recorded on any medium (i.e., paper electronic) by a mental health professional (such as a psychologist or psychiatrist\_ must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. “Psychotherapy Notes” are defined under HIPAA as notes recorded by a health care provider who is a mental health professional or a group, joint, or family counseling session and that are separate from the rest of the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. In order for a medical provider to release “Psychotherapy Notes” to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.



Phone: (916) 276-0626, Fax: (916) 241-9836

**Fair Oaks Location:** Old Winding Way, Suite #300, Fair Oaks CA 95628

**Davis Location:** 204 F Street, Suite E, Davis, CA 95616

**Roseville Location:** 3017 Douglas Blvd, Suite #300, Roseville CA 95661

**Walnut Creek Location:** 2121 North California Blvd. #290, Walnut Creek CA 94596

## Authorization to Release/Receive Information

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ PH# \_\_\_\_\_

Address: \_\_\_\_\_

### I authorize the exchange of information between:

My counselor at Recovery Happens Counseling Services:

(Name, Ph#, Fax#) \_\_\_\_\_

and

(Name, Ph#, Fax#) \_\_\_\_\_

**Duration:** The authorization is effective immediately and shall remain in effect for one year from the authorization date unless otherwise specified: \_\_\_\_\_

### Information to Be Exchanged:

Mutual exchange of information relevant to assessment, diagnosis and treatment.

Evaluation or Progress Letter

Treatment Summary

Other: \_\_\_\_\_

*I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above. I acknowledge that I have been offered a copy and may either accept or refuse.*

### Authorizing Signatures:

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Gaurdian/Conservator: \_\_\_\_\_ Date: \_\_\_\_\_

Treatment Provider: \_\_\_\_\_ Date: \_\_\_\_\_



## Informed Consent for Telehealth Services

*This is an optional form of treatment to be used as needed. If you would like this treatment option, please sign.*

Telehealth allows my therapist (Name: \_\_\_\_\_ License Title/# \_\_\_\_\_) to diagnose, consult, treat and educate using interactive audio, video or data communication regarding treatment. I hereby consent to participating in psychotherapy via telephone or the internet.

I understand that my therapist is under supervision by: \_\_\_\_\_ License #: \_\_\_\_\_:

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

I understand I have the following rights under this agreement: I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential. I understand that the fee will be \$175, or the same as your individual, face to face session.

All information discussed within sessions is confidential, except when required by law or if required by your health insurance if you are asking them to help pay for my services. Disclosure may be legally required when: 1) there is a reasonable suspicion of child or elder abuse, 2) there is reasonable suspicion that a client presents an imminent danger of violence to others, or 3) a client is likely to harm him/herself unless protective measures are taken. If my client is an adolescent, I let the confidentiality rest between the adolescent and myself, except for mandated reporting.

I understand that while psychotherapeutic treatment has been found to be effective in treating a wide range of mental disorders, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured. At the initiation of service, I acknowledge that I will be asked my full name and address of present location in case of emergency.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that therapy sessions could be altered by technical failures or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment or crisis management, I will be locally referred in my geographic area as my therapist may not be local at the time of service.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I understand that I can withdraw my consent to Telehealth communications by providing written notification. My signature below indicates that I have read this Agreement and agree to its terms.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Client History for a Minor

### Substance Use History

What incidents or behaviors first caused you to be concerned about the possibility that your child might be using substances? (missing money, liquor, etc.)

---

---

---

Prior to coming to our program, what actions were undertaken to address the issue of your child's chemical use?

---

---

---

At this time, what problems do you directly attribute to your child's chemical use?

---

---

---

What substances do you believe your child is using?

---

---

---

Which therapists or programs has your child worked with in the past?

---

---

---



## Your Child's Medical History

Doctor's name: \_\_\_\_\_

History of health issues and hospitalizations:

---

---

---

---

---

---

---

List any medications or supplements your child is taking:

---

---

---

What other information would be helpful for our team:

---

---

---

---

---

---

---

---

---

---



## Family History

List who currently or in the past who in your family has had a problem with alcohol, other drugs or process addictions, i.e., eating disorders, sex, gambling, workaholic, etc:

---

---

---

List who in your family are in recovery:

---

---

---

List who in your family has had a history of mental health issues, i.e., depression, anxiety, personality disorders, schizophrenia, bipolar, etc:

---

---

---

---

---

---

Any other information you think might helpful:

---

---

---

---

---

---

Check the box below regarding your observations of your child. “Current” represents in the past 90 days, Past is 90 days ago or longer.

	Current	Past		Current	Past		Current	Past
Restless and unable to sit still			Hurt animals			Slurred speech		
Act without thinking			Sneak out at night			Eat little or fast to lose weight		
Difficulty paying attention			Hurt people			Vomit food intentionally		
Low motivation			Sexual problems			Gorge food		
Short attention span			Problems with the law			Hearing voices or seeing things that aren't there		
Easily frustrated			Fire-setting			Headache		
Easily distracted			Been arrested, in jail or on probation					
Daydream or fantasize a lot						Sadness, crying &/or depression		
Temper outbursts			Nervous/can't relax			Hard to make decisions		
Uncooperative			Worry more than others			Irritable/angry		
Back Talk			Very anxious			Withdrawn from others		
Hard to admit mistakes			Worry a lot about past behavior			Trouble Concentrating		
Argue a lot			Fearful			Trouble going to sleep		
Enjoy “bugging” people			Worry a lot about the future			Memory problems		
Swear of use obscene language			Unusual fears or phobias			Restless sleep, wake up frequently		
Easily annoyed by others			Panic			Nothing fun anymore		
			Overly concerned about germs, safety, and/or health issues,			Wake up very early and can't go back to sleep		
Use alcohol/drugs			Repeat an act over and over that not necessary to do (e.g. washing, checking locks, counting, lining things up.)			Low self-esteem		
Smoke cigarettes						Sleep too much		
Rebellious attitude or behavior			Seem confused a lot			Feeling tired and fatigued		
Damaged property			Can't control body movement			Nightmares, night fears		
Want to run away from home			Not knowing where you are			Weight gain or weight loss		
Stolen things			Feeling odd or different than other people			Have made suicide attempts in the past		
Have run away from home			Blurred or double vision					

## **Facilitated Parent Support Group**

(for parents of drug/alcohol using teens & young adults)

CHECK WITH YOUR COUNSELOR FOR THE MOST UP TO DATE TIME AND  
LOCATION OF THE GROUP

**Our experience has shown that this group provides better outcomes for the  
parents, child and family recovery as a whole.**

(Space is limited so please R.S.V.P) Fee: \$35.00 per parent but **free if you are enrolled  
in our program**

Parents of drug-using teens & young adults have many struggles in the process of their child's use, intervention and recovery. Many find themselves confused about what is helpful support vs. enabling and what is having healthy boundaries vs. being callous just to name two examples. Moreover, many parents are alone, unable to talk about it at work, with friends, and don't really understand what their own healing around this issue looks like and how to get started. This group will be a safe container for this work to occur. It can be a place to explore your own family history of addiction, co-dependency or other issues which can participate in your child's illness, and how you react to it.

You are not alone and don't have to be alone. You deserve recovery just as much as your child. Your child has the love, guidance, support and healthy challenge from their own counselor and possibly group, yet many parents need the same container for their own education and healing around these issues. This group is about creating that space for parents to come together, learn, and work on a path of recovery.

**To create group cohesion, clients must make the commitment to attend group every week. A 48 hour notice of cancellation must be given or you will still be billed the \$35.00 per person fee.**

**As the party responsible for payment, I agree to the cancellation policy outlined in this document:**

---

PRINTED NAME

SIGNATURE

DATE



## **GETTING STARTED: The Parents Role In Our Treatment Program**

***Parents: please keep this page for your reference and pass it on to co-parents***

As stated at the top of the first page on the clipboard, your role is crucial in the successful treatment of your child's issues! We want you to get started right away. Listed below are the necessary parts of your role. For your child to get well it will require an investment of time, energy, money, and emotions.

1. Drug test your child **weekly** and call your counselor with the results. Drug testing protocol is extremely important, so please watch the "Drug Testing Protocol", a nine minute video on our website at [www.recoveryhappens.com](http://www.recoveryhappens.com).
2. All parents please read the book "How to Help Your Child Become Drug Free" online. You will find a link to the book at the end of the Phase One Parent Education Class (see below). Hard copies of the book can be purchased if preferred for \$20.
3. All parents watch the Phase One Parent Education Class online at [www.recoveryhappens.com](http://www.recoveryhappens.com). Choose the link that says "Parent Education Class." Your child's counselor will provide you with the password to gain access: **parentclass**
4. After you have read the book and watched Phase One please work on the home contract as described in Chapter 5 of the book and discussed on the online parent class.
5. Develop the "Chemical Use Assessment" (CUA) as described in the online parent education class.
6. When you have read the book, viewed the Phase One class and developed a rough draft of the Home Contract, contact your therapist so you can schedule an appointment to process the material and receive feedback for home contract.
7. Attend some of the parent Al-Anon Meetings and determine which one feels the most comfortable to attend on a regular basis while your child is in the counseling process.
8. After the above is completed view the Phase Two Online Parent Class.
9. After viewing the Phase Two class set up an appointment with your child's counselor so that they can help apply the information to your specific situation.
10. After the Phase One Family session, begin working on Chemical Use Assessment as outlined in the online videos. You and your therapist will coordinate the best fit for processing CUA with your teen. Following this, your therapist may begin working with your family on a "Developmental History".

**Have compassion for yourself and your child as this journey requires a lot of work. We certainly acknowledge your commitment. ☺ We thank you; your child thanks you.**

**PLEASE FILL OUT AND BRING THIS INTAKE PACKET TO FIRST SESSION AND MAKE COPIES FOR YOURSELF**

## CAREGIVER'S AUTHORIZATION AFFIDAVIT

**(Please fill out *only* if you are a caregiver *without* legal rights to child)**

Use of this affidavit is authorized by Part 1.5 (commencing with Section 6550) of Division 11 of the California Family Code.

The minor named below lives in my home and I am 18 years of age or older.

1. Name of Minor: \_\_\_\_\_

2. Minor's birth date: \_\_\_\_\_

3. My Name (adult claiming authorization): \_\_\_\_\_

4. My home address: \_\_\_\_\_

Please check one or more of the following:

5.  I am a grandparent, aunt, uncle, or other qualified relative of the minor (spouse, parent, stepparent, brother/sister, stepbrother/sister, half-brother/sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or great".

6.  I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care, and have received no objection.

7.  I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time, to notify them of my intended authorization.

8.  I am this child's current, licensed foster parent

9.  I am this child's attorney for a ward of the state

7. My date of birth: \_\_\_\_\_

8. My California driver's license or identification card number: \_\_\_\_\_

***Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.***

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: \_\_\_\_\_ Signed: \_\_\_\_\_

**This affidavit shall remain in effect for one year after the date on which it is executed.**