

Disclosure Statement & Agreement For Services
(completed by client or client's parent/legal guardian)

Welcome! This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask any questions that you may have regarding its contents.

Confidentiality

It is understood that all information between client and therapist is held strictly confidential, and the therapist will not release any information about therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State laws;
2. The client presents an imminent danger to self,
3. The client presents an imminent danger to others;
4. Child/elder abuse/neglect is suspected;
5. If a judge determines that our discussions are not confidential, a judge may request specific information,
6. As requested by a court-appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3, and #4, the therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family.

Financial Terms and Insurance

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you and I will be paid directly by the carrier. You will be responsible for any applicable deductibles and co payment at the time of service. By signing below, you agree to make these payments at each appointment; and you understand that if in case you are not eligible at the time services are rendered, you are responsible for payment, even if the determination is made after services are rendered. **Returned checks are subject to a \$20 fee.** Please note that the amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage with your carrier. If you wish to discuss a written agreement that specifies an alternative payment procedure, please let me know.

\$50 CHARGE FOR LATE CANCELLED/MISSED APPOINTMENTS/ REQUEST OF RECORDS.

BY INITIALING AT THE END OF THIS LINE, I ACKNOWLEDGE THAT IN THE EVENT OF A "NO SHOW" OR FAILURE TO GIVE 24-HOUR NOTICE PRIOR TO A CANCELLATION, A \$50 CHARGE WILL BE ASSESSED TO MY ACCOUNT. THIS CHARGE IS SOLELY MY RESPONSIBILITY AND WILL NOT BE PAID BY MY INSURANCE. _____ **initial**

I ACKNOWLEDGE THAT IN THE EVENT I SIGN TO REQUEST MY RECORDS TO BE RELEASED, I AGREE TO PAY A \$30 FEE FOR RELEASE OF RECORDS. _____ **initial**

Please sign the following, if using your insurance plan or Employee Assistance Program

"I authorize the release of any information (including treatment summaries and diagnosis) necessary to process insurance or Employee Assistance claims, or to request additional sessions. I authorize payment of benefits to be made to Rosanna Reyes Feet, MFT for services provided."

Client's signature: _____

General consent for treatment (if a client is a minor)

"On the client's behalf, I (legal guardian, legal representative) authorize Rosanna Reyes Feet, MFT to deliver mental health services to the client. I accept that the child's records are confidential and that by law, I cannot have access to the child's records if such access would be detrimental to the child."

Client (legal guardian) initials

INFORMED CONSENT

Minors and Confidentiality

Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child’s treatment are often involved in their treatment. Consequently, I may discuss the treatment progress of a minor Client with the parent or caretaker. Please ask or discuss with me any questions or concerns with regards to this topic.

Therapist Availability/Emergencies

You may leave me a voicemail message at any time. Non urgent phone calls are returned during normal workdays (Monday through Friday) within 48 hours. I am not available to return calls on Saturdays or Sundays or after 8 pm. If you have an urgent need to speak with me, please indicate that fact in your message and follow any instructions that are provided on my voicemail. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance. You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis:

San Diego Crisis Hotline: 1-800-479-3339 or 911

Y N	My therapist may send mail to me at my home address.	Y N	My therapist may send mail to me at my work address.
Y N	My therapist may communicate with me by email (including appointment reminders). My email is: _____ (I understand that email is not a completely private form of communication.)	Y N	My therapist may send a fax to me. My fax no. is _____
Y N	My therapist may call me at: Home _____ . Message ok? Y or N Cell phone _____ . Message ok? Y or N		Work: _____ . Message ok? Y or N

About the Therapy Process

It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapist and client(s) are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. We will also periodically exchange feedback regarding your progress. Due to the varying nature and severity of problems and the individuality of each client, I am unable to predict the length of your therapy or to guarantee a specific outcome or result. Please be aware that although therapy is designed to be helpful, it may at times be difficult and uncomfortable. Also for your information, **I do not perform custody evaluations and do not make recommendations regarding custody.**

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature below indicates that you have read this agreement for services carefully and understand its contents, and that you consent to receive counseling services under these conditions. Your signature also states that you have read the notice of privacy practices and that you have received a copy for your records.

Please don’t hesitate to ask any questions or concerns that you have about this information before you sign.

Name of Client(s)

Signature of Client(s) Date

Signature of Client(s) Guardian(s) Date

Client Information				
Client's Name:				
Male:	Female:	Date of Birth	Age:	Marital Status
Single:	Married:	Separated:	Divorced:	Widowed:
Home Address:				
Home Phone: (_____)		Cellular Phone: (_____)		
Occupation/Student:				
Employer (School, if student):				
Work/School Phone: (_____)				
E-mail Address:				
Fax Phone: (_____)				
RESPONSIBLE PARTY and/or SPOUSE'S INFORMATION				
Responsible Party:				
Date of Birth:		Age:		Marital Status:
Single	Married	Separated	Widowed	Divorced
Home Address:				
Home Phone: (_____)		Cellular Phone: (_____)		
Occupation/Student:				
Employer (School, if student):				
Work/School Phone: (_____)				
E-mail Address:				
Fax Phone: (_____)				
Spouse's Name:				
Date of Birth:				
<p>In order for me to be able to fully evaluate you, please fill out the following intake form and questionnaires to the best of your ability.</p>				

SUBSTANCE USE

Coffee (# ___ cups/daily) Cigarette (# ___ per day) Alcohol (# ___ drinks weekly) Date last drank:	Prescription drugs: Type: Amount: Frequency: Date last used:
Street Drugs: Type: Amount: Frequency: Date last used:	Describe impact of substance abuse use on your life
Family History of substance use	Past treatment for substance use
OTHER INFORMATION:	
What do you see as strengths:	
What do you see as weaknesses:	
Goals for treatment:	
Goals and expectations of significant others	
Motivation for treatment:	

Psychosocial History/Functioning

Rate how the problems are impacting areas of Functioning:
1) Mild 2) Moderate 3) Severe

Marriage/Relationship	Club/group membership
Work/School	Legal
Family	Housing
Financial situation	Spirituality
Physical health	Current stressors
Social interests	Other
Leisure activities	

TO BE COMPLETED BY PROVIDER

Psychiatric or psychological treatment of any kind before: Yes _____ No _____ If Yes what type of care was received: Inpatient: ___ Outpatient: ___ Both _____ When was the treatment:	How long was the treatment _____ Name of the therapist or doctor: Were medications prescribed at that time? If yes, what was prescribed _____
Where was the treatment: How long was the treatment Name of therapist or doctor:	Family history of psychiatric treatment. Family members currently in psychiatric treatment:

Signature of Client _____

Date _____