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Luisa Contreras Family Therapy

Disclosure Statement, Informed Consent & Agreement of Services

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

Welcome!

Here at *Luisa Contreras Family Therapy, Inc. (LCFTI)* a Marriage and Family Therapist Corporation, we are a dedicated team of professionals working to ensure your quality service. Treatment will be provided by **Luisa Contreras, Licensed Marriage and Family Therapist 82977, Licensed Professional Clinical Counselor 651**; registered with the Board of Behavioral Sciences.

Confidentiality.

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. 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. (In addition, your therapist will not disclose information communicated privately to him or her by one family member, to any other family member without written permission.)
With the following exceptions:

(1) Physical and/or sexual abuse of minor (s)
(2) Elder abuse (physical, abduction, isolation, neglect, fiduciary)
(3) Abuse of a dependent adult due to his physical/intellectual condition
(4) Situation where a minor could be in danger
(5) Attempt or plan to commit suicide/homicide
(6) When there is a legal case where the mental/emotional status of the client is an issue

▲ If you have an emergency, call 911 or go to the nearest emergency location. If you need to speak to your therapist urgently, you can call (714) 883-9156 during office hours. To communicate after office hours, you can leave a message.

Minors and Confidentiality

Communications between therapists and clients who are minors (under the age of 18) is confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor client with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur once per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order **to cancel or reschedule** an appointment, you are expected to notify your therapist **at least 24 hours in advance** of your appointment. If you do not provide your therapist with at least 24 hours' notice in advance, you are responsible for payment for the missed session.

Client Initials _____

Therapist Availability/Emergencies

You are welcome to phone your therapist in between sessions. However, as a general rule, it is our belief that important issues are better addressed within regularly scheduled sessions. You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non urgent phone calls are returned during the therapist's normal workdays within 24 hours. Your therapist is not able to return phone calls after 6pm on weekdays, nor on weekends. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Communications, Social Media And Confidentiality

Please note that due to client confidentiality, your therapist will not contact you other than in the scope of your treatment and the ways indicated below. Your therapist will not "friend you" or contact you via any social media; with the exception if you follow or interact with their professional profiles or pages. If you encounter your therapist outside of the office, do not be offended, as your therapist will not make any indication or attempt to interact with you; you are free to address your therapist. At times, your therapist or the office may need to communicate with you by telephone or other means for arranging appointments or other non-clinical communications. Please note that some of these forms of communication are not secure or HIPPA protected, so do not send sensitive or clinical information via these forms of communication; simply notify your therapist to contact you as soon as they are able.

> **Disclosure:** Sensitive, clinical information is to be discussed over the phone or in-person as deemed appropriate by the therapist. For appropriate e-mail or text communication therapist will respond to your e-mail or text within 24 hours. Potential risks of using electronic communication may include, but are not limited to; inadvertent sending of an e-mail or text containing confidential information to the wrong recipient, theft or loss of the computer, laptop or mobile device storing confidential information, and interception by an unauthorized third party through an unsecured network. E-mail messages may contain viruses or other defects and it is your responsibility to ensure that it is virus-free. In addition, e-mail or text communication may become part of the clinical record. You may be charged for time the therapist spends reading and responding e-mail or text messages.

Please indicate your preference by checking and filling out the information for the way in which you wish to be contacted. Please be sure to inform your therapist and make a note of it on this form if you do not wish to be contacted at a particular time or place, or by a particular means.

My therapist or the office may contact me via:

[☐] Home phone. My home phone number is: _____

[☐] Mobile phone. My mobile phone number is: _____

[☐] YES, text message to the mobile phone listed above. [☐] NO, do not text.

[☐] Work phone. My work phone number is: _____

[☐] E-mail. My e-mail address is: _____

[☐] My preferred address to receive mail is: _____

Financial Policy - Standard Fees And Insurance

Below are the terms of agreement regarding payment for services and sessions at Luisa Contreras Family Therapy, Inc. / LCFTI .

Standard Rate Fees – Due upon service

The fee for service is 200.00 per individual therapy session.

Client Initials _____

The fee for service is _200.00 per conjoint (marital /family) therapy session.
The fee for service is _____ per group therapy session.

1. Individual sessions and conjoint (marital /family) session fees are based on a clinical hour, which is defined by BBS as 45-50 minutes in length.
2. LCFTI is an out of network provider and does not accept insurance payment. Fees are payable to LCFTI at the time that sessions and services are rendered. Cash, Check or Credit Card are accepted.
3. I, the client, understand that if I choose to use a credit card, that all service & session fees will be automatically charged at the end of each session via Ivy Pay, which is HIPPA compliant.
4. If a client's payment is returned or rejected, a $25 fee per incident, on top of the amount owed, will be due and payable immediately. This includes credit card on file being declined.
5. All fees paid are for sessions and services rendered. I, the client, understand and agree that all payments are for sessions and services rendered. All fees are non-refundable, non-creditable, and non-exchangeable at any time.
6. Although LCFTI is happy to assist your efforts to seek insurance reimbursement for Out of Network providers by providing a SuperBill, we are unable to guarantee whether your insurance will reimburse you for services provided. LCFTI is not responsible for any insurance reimbursement or lack thereof; it is solely the responsibility of the client. A SuperBill will be provided to the client upon request, at the end of each month.
7. If I, the client, fail to appear for an appointment without a 24-hour notice of cancellation, appointment fees will be charged and I will be responsible for payment.
8. I understand that if I am late to a session, that session will end at the time originally scheduled. It is my responsibility to arrive on time.
9. Services including phone calls, emails, record reviews, and professional consults at times other than the scheduled therapy session are the patient's responsibility. These services will be billed per quarter of an hour at the standard rate of $__200.00 per hour.
10. Services regarding court cases, including subpoena, reviewing or copying files, or court appearance or testimony will be billed per quarter of an hour at the standard rate of $500.00 per hour. Any court appearance or testimony by therapist will be billed at a minimum of 4 hours.
11. I, the client, understands that if I do not pay for services, or become in arrears, that I will not receive treatment or services.
12. If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist immediately. Your therapist will help you to consider any options that may be available to you at that time.

About The Therapy Process

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion. Your therapist will work with you to develop an effective treatment plan. Over the course of therapy, your therapist will attempt to evaluate whether the therapy provided is beneficial to you. Your feedback and input is an important part of this process. It is the goal of your therapist to assist you in effectively addressing your problems and concerns. However, due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Client Initials _____

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. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist 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 your therapist determines that you are not benefiting from treatment, either of you 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 indicates that you have read this agreement for services and sessions carefully and understand all of its contents. By signing this agreement, you are agreeing to all policy and procedures noted in the agreement, including confidentiality, informed consent, communications policy and financial agreement.

I, _____, authorize and request that **Luisa Contreras, Licensed Marriage and Family Therapist 82977, Licensed Professional Clinical Counselor 651**; to perform assessment, diagnosis and treatment, which now or during the course of my therapy are advisable. I understand the purpose of these procedures will be explained to me and be subject to my verbal agreement. I understand that there is an expectation that I will benefit from Psychotherapy, but there is no guarantee that this will occur. I understand that maximum benefit will occur with consistent attendance and that at times, I may feel conflicted about my therapy, as the process can sometimes be uncomfortable.

I certify that I have read and fully understand this Consent of Treatment, I agree to be treated (or my child) by the therapist mentioned above.

_____ _____

Client, Print Name Date

_____ _____

Signature of Client, Parent/Legal Guardian Witness/Interpreter

Client Initials _____

Emergency Contact Information Form

This information will be extremely important in the event of an accident or medical emergency.

Client Information

Name: _____
Last First MI

Phone Number: (_____) _____ [ ] home [ ] cell [ ] work

Date of Birth: _____/_____/_____ [ ] M [ ] F

Email Address: _____

Address: _____
Street City State Zip Code

Emergency Contacts

Name: _____
Last First MI

Phone Number: (_____) _____ Relationship: _____

Name: _____
Last First MI

Phone Number: (_____) _____ Relationship: _____

In Case of Emergency

Preferred Local Hospital: _____

Insurance Information

Company: _____ Policy #: _____

Comments (include any special medical or personal information you would want an emergency care provider to know – or special contact information:

_____
_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____

Client Initials _____

Client Intake Form

Please answer the following questions to the best of your abilities. These questions are to help the therapist with the therapy process. This information is held to the same standards of confidentiality as out therapy. This questionnaire will take approximately 30 minutes to complete.

Client Information

Client Name:_____

Last First MI

Date of Birth: _____/_____/_____ Age: _____ Gender: Male ☐ Female ☐

Name of Parent/Guardian (if minor): _____

Marital Status: ☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of Children: _____ Ages: _____

Current Address: _____

Street City State Zip Code

Home Phone Number: (_____) _____ May we leave a message? □ Yes □ No

Cell/Other Phone Number: (_____) _____ May we leave a message? □ Yes □ No

Email: _____ May we email you?* □ Yes □ No

*Note: Emails may no be confidential

General and Mental Health Information

Referred By: _____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? □ Yes □ No

Reason for change:_____

Have you had any mental health services in the past? □ Yes □ No

Reason for change:_____

Are you currently taking any psychiatric prescription medication? □ Yes □ No

If yes, please list:_____

Have you been prescribed psychiatric prescription medication in the past? □ Yes □ No

If yes, please list:_____

How is your physical health at the present time? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.): _____

Client Initials _____

_____

_____

Are you on any medication for physical/medical issues? □ Yes □ No
If yes, please list:_____

Are you having any problems with your sleep habits? □ Yes □ No
If yes, circle those that apply:

Sleep too much☐ Sleep too little☐ Poor quality☐ Disturbing dreams☐ Other:_____

How many times per week do you exercise? _____ days _____ minutes/hours

Are there any changes or difficulties with your eating habits? ☐ Yes ☐ No
If yes, circle one:

Eating less ☐ Eating more ☐ Bingeing ☐ Restricting ☐

Have you experienced a weight change in the last two months? ☐ Yes ☐ No

Do you consume alcohol regularly? ☐ Yes ☐ No

In one month, how many times do you have four or more drinks in a 24-hour period?_____

How often do you engage in recreational drug use? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

Have you felt depressed recently? □ Yes □ No
If yes, for how long?_____

Have you had any suicidal thoughts recently? □ Yes □ No
If yes, how often? ☐Frequently ☐Sometimes ☐Rarely

Have you ever had suicidal thoughts in your past? □ Yes □ No
If yes, how long ago?_____

How often did you have these thoughts? ☐Frequently ☐Sometimes ☐Rarely

Are you currently in a romantic relationship? □ Yes □ No
If yes, how long have you been in this relationship? _____

On a scale from 1 – 10 (10 being great), how would you rate the quality of your relationship? _____

In the last year, have you had any major life changes? (e.g. new job, moving, illness, relationship change, etc.)

_____

_____

_____

_____

_____

Quick Check (Check the issues below that apply to you)

Client Initials _____

☐	Extreme Depressed Mood	☐	Mood Swings	☐	Rapid Speech	☐	Extreme Anxiety
☐	Panic Attacks	☐	Phobias	☐	Sleep Disturbance	☐	Hallucinations
☐	Memory Lapse	☐	Alcohol/Substance Abuse	☐	Body Complaints	☐	Eating Disorder
☐	Repetitive thoughts	☐	Anxiety	☐	Time Loss	☐	Repetitive Behaviors
☐	Homicidal thoughts	☐	Suicide Attempts	☐	Trouble Planning	☐	Difficulty w/ relationships

Occupational Information

Are you currently employed? □ Yes □ No
If yes, who is your empoyer? _____
What is your position? _____
Are you happy in your current position? ☐ Yes ☐ No
Are you fulfilled in your current position? ☐ Yes ☐ No
Does your work make you feel stressed? ☐ Yes ☐ No
If yes, what are your work related stressors? _____
_____
_____
_____
_____

Religious/Spiritual Information

Do you practice a religion? □ Yes □ No
If yes, what is your faith? _____
_____
If no, do you consider yourself to be spiritual? □ Yes □ No

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes indicate the family member affected.

Depression	Yes	☐	No	☐	
Anxiety Disorder	Yes	☐	No	☐	
Bipolar Disorder	Yes	☐	No	☐	
Panic Attacks	Yes	☐	No	☐	
Alcohol/Substance Abuse	Yes	☐	No	☐	
Eating Disorder	Yes	☐	No	☐	
Learning Disability	Yes	☐	No	☐	
Trauma History	Yes	☐	No	☐	
Domestic Violence	Yes	☐	No	☐	
Obesity	Yes	☐	No	☐	
Obsessive Compulsive Behavior	Yes	☐	No	☐	
Schizophrenia	Yes	☐	No	☐	

Client Initials _____

Other Information

List your strengths

_____
_____
_____
_____

List areas you feel you need to develop:

_____
_____
_____
_____

What do you like most about yourself?

_____
_____
_____
_____

What are some ways you cope with life obstacles and stress?

_____
_____
_____
_____

What are your goals for therapy/what would you like to accomplish?

_____
_____
_____
_____

Client Initials _____