INFORMED CONSENT (ADULT)

Confidentiality

The material that you disclose is confidential and cannot be released without your written consent. There are certain circumstances, however, under which I may be legally required to disclose information without your consent. These include:

1. If there is a reasonable belief or suspicion that child abuse has occurred
2. If there is a reasonable belief or suspicion that elder or dependent adult abuse has occurred
3. If you make a threat to harm another person
4. If you pose a risk to your self or others
5. If you enter into a legal proceeding in which the issue of your mental status is raised, then the court may order your records

Confidentiality in Family Therapy

Family therapy may include both joint and individual sessions. In such circumstances the family hereby agrees to waive their right to confidentiality so that information shared in individual sessions can be shared in joint sessions at the discretion of therapist. To maintain an atmosphere of openness and honesty, my policy is that I am unwilling to collude with secrets, wherein one family member shares information with me that they wish to keep from other family members. Any phone call or electronic communication made by a family member to the counselor may be discussed in joint session to maintain openness and trust.

Record Keeping

I will keep notes of my impressions of your counseling sessions. The details will be limited, but enough for me to review progress and track developments in our work together. These records will be stored in a locked file inside the office building.

Termination

Termination typically occurs once goals are met and you feel as though you are no longer in need of therapeutic services. However, I do not work with clients that I determine are unwilling to get help or I think would not benefit from my services. In this case, I would discuss the matter with you and I would provide referrals that may be a better fit.

Risks and Benefits of Therapy

Participating in therapy may result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on your part, as well as your caregivers and/or family members. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. This discomfort may also extend to other family members. The issues presented by the client may result in unintended outcomes,

including changes in personal relationships. During therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. If at any time you have any concerns or questions about your progress or the process of therapy, please feel free to address them with me.

Appointments/Cancellations
A standard appointment time is 50 minutes in length. The appointment time is reserved for you specifically. It is your responsibility to notify me at least 24 hours in advance if you are unable to attend. If you do not cancel more than 24 hours in advance, or do not show up for the appointment, you will be expected to pay in full for the missed session within 24 hours.

Contacting the Therapist (non emergency)
I can be reached by confidential voicemail by dialing 707.720.3400. I am not always available to answer the phone, but will check the voicemail periodically. If you leave a voice message, I will return the phone call, but it may take up to 48 hours if it is not an emergency.

Emergency Calls
It is important to seek help immediately by going to a hospital or dialing 911 in any life-threatening emergency. Please follow this plan FIRST, and then call me after, if emergent:

1. Contact Mental Health Crisis Services at 707.253.4711
2. Go to your local hospital emergency room
3. Call 911 and speak to a mental health worker on call

Email/Phone Communications
I am happy to counsel over the phone from time to time as needed by the client, but am not willing to counsel via text. Text message may be utilized to discuss payment or scheduling concerns. One potential risk, however, is that client privacy cannot be guaranteed via email or texting. Please use discretion when sending personal information in an email or over text message.

Professional Consultation
From time to time, to best serve you or your child as a client, it is best practice and standard of care in the MFT profession to consult with colleagues. In these circumstances, name and identifying information is not disclosed.

Social Media
As a general rule I do not allow clients to follow me on social media, and I do not follow clients on social media. This can potentially put client confidentiality at risk, as well as skew objectivity.

Telehealth
Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. You have a right to confidentiality with regard to treatment and related communications via Telehealth under the same laws that protect the confidentiality of treatment information during in-person psychotherapy. There are risks associated with participating in Telehealth including,

but not limited to, the possibility, despite reasonable efforts and safeguards on the part of the therapist, that your psychotherapy sessions and transmission of treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of treatment information could be accessed by unauthorized persons. There is a risk of being overheard by persons near the client and the client is responsible for using a location that is private and free from distractions or intrusions.

COVID-19

At this time, California Association of Marriage and Family Therapists (CAMFT) recommends that therapists see patients via Telehealth unless the patient is not clinically appropriate for Telehealth services. Sessions will remain through Telehealth until it is safe to return to the office, which will be determined by the comfort level of the therapist, as well as CAMFT and other state regulating boards. If, for any reason, sessions resume in person, the expectation would be that both therapist and client wear a facial covering the entire session sanitize hands before and after entering the office, maintain social distance, sanitize surfaces touched, and that the client of therapist would stay at home if any symptoms of sickness were experienced in which case, Telehealth would be offered as an alternative.

STATEMENT OF ACKNOWLEGEMENT

General Consent to Counseling

By signing this form, I consent to counseling with Mary Elizabeth "Emmy" Clausen, LMFT119269. A signature on this form serves as your acknowledgement that you have read and understand the Informed Consent in its entirety and agree to its terms:

Printed First and Last Name of Client

_____

Signature of Client (if over 18 years old)

_____ Date _____

Signature of Counselor

_____ Date _____

FEE AGREEMENT

Payment:

- *Individual counseling*: The fee for this service is $140.00 per 50-minute session.
- *EMDR*: The fee for this service is $150.00 per session, sometimes longer than 50 minutes.
- *Telephone conversations*: Phone conversations are sometimes necessary and do not incur a charge if they are less than 15 minutes. However, for every phone call that goes over 15 minutes, you will be charged the price of a session, or $140.00. If more than a 15-minute phone call is needed, I recommend that you schedule a session for us to talk more effectively.

Payment is accepted in the form of cash, check, or credit card at the time the service is rendered, and most commonly the IVY Pay app is utilized for payment rendering. The fee for bounced checks is $35.00. Insurance is not accepted, however, I am willing to issue you a Superbill for you to submit to insurance after services are rendered and paid for in full. One thing to note about the Superbill, is that it must include a DSM-V Diagnosis, which will be discussed with you if requested. Clients are not permitted to carry a balance. If payment is missed, the responsible party will be expected to pay the balance before the client's next session. By signing this consent, you agree to pay the above amount in full for service at time it is provided. If the fee amount poses an undue hardship, please discuss this with your therapist.

I have read and understand the above statements.

Client Signature: _____ Date: _____

CLIENT RISK ASSESSMENT

Please take a few moments to thoroughly complete this form. Please answer the questions completely and honestly to the best of your abilities.

Name: _____ Date: _____

Suicide

In the last two weeks (including today), have you had **any thoughts** of ending your life?

Yes No

If you answered, "Yes," do you have a **plan** to end your life?

If you have a plan, how likely are you to follow through with this plan if 0 is "absolutely not" and 10 is "I am certain I will follow through?"

0 1 2 3 4 5 6 7 8 9 10

Homicide

Do you currently or have you in the past wanted to end the life of someone else?

Yes No

If you answered, "Yes," do you have a **plan** to end their life?

If you have a plan, how likely are you to follow through with this plan if 0 is "absolutely not" and 10 is "I am certain I will follow through?"

0 1 2 3 4 5 6 7 8 9 10

Child Abuse

Have you ever been abused in the past? (Physically, sexually, psychologically, or neglect?)

Yes No

If yes, who was the abuser?

Does this person still have access to children?

Elder Abuse

Do you know of anyone over the age of 65 that is currently being abused or has been in the past?

Yes No

If yes, who are they and could this person still be at risk of abuse?

Self-Harm

Do you have a history of hurting yourself?

Yes No

If yes, how have you hurt yourself in the past?

When did your self-harm begin?

How motivated are you to stop?

0 1 2 3 4 5 6 7 8 9 10

CONSENT TO RELEASE INFORMATION (optional)

If you would like any information to be obtained from or given to (a parent, medical professional, former therapist, parole officer, etc.), please fill out this form. Please understand that if you are over the age of 18, no information can be obtained from or given to anyone without a signature on this form (with the exception of the limits to confidentiality listed in the Informed Consent).

Client Name: _____ Phone: _____

I AUTHORIZE Mary Elizabeth "Emmy" Clausen

TO OBTAIN INFORMATION FROM OR GIVE INFORMATION TO

Agency/Person's Name: _____
Address: _____
_____Phone: _____

THE FOLLOWING INFORMATION CONTAINED IN MY CLINICAL RECORDS MAY BE OBTAINED OR GIVEN:

Any and all information necessary

This authorization is valid for one year from the date below. I understand that this information may not be released to any other organization without my permission. I release the source of these records from any liability arising from their release. A photocopy of this authorization shall be considered valid.

Client or Parent/Guardian Signature:_____ Date: _____

CLIENT DATA FORM

Date _____ Referred by_____

Name _____ Age _____

Date of Birth_____

Street Address _____ City _____

Zip _____

Email Address _____ ☐ Male ☐ Female

Phone Number(s)

Home ( ) _____ OK to call Y / N

Cell ( ) _____ OK to call Y / N

Work ( ) _____ OK to call Y / N

Emergency Contact:

Name_____ Relationship_____

Contact Phone ( ) _____

YOUR PRESENTING PROBLEM/ISSUES/CONCERNS?

How would you rate how serious this problem feels to you? (circle one)

1 2 3 4 5

Mildly upsetting Extremely Serious

What goals would you like to accomplish through counseling?

SUPPORT NETWORK:

Current church affiliation (if any) _____

What "Small" or "Support" groups do you currently attend? None
Please list here:

EDUCATION: Highest grade completed_____

HEALTH HISTORY:

Are you currently seeing, or have you seen in the past, a therapist, counselor, psychologist, or psychiatrist? Yes No

Type of Counseling/Counselor: _____ *How Long?* _____

*Reason for seeking counseling?*_____

*Was it helpful? Explain:*_____

Name of Physician: _____ *Date(s) of Care:*_____

*Diagnosis?*_____

Are you currently, or in the past, abused over-the-counter, prescription medications or used illegal drugs? Yes No

*List drug/medication & dosage*_____ *How Long?* _____

What medical information about you should we know?

Please list current/chronic conditions here: _____

What current medications do you use? None

*List medication & dosage*_____ *How Long?* _____

How often do you exercise? _____

How well do you sleep? 1 2 3 4 5

Poorly *Very Well*

DEVELOPMENTAL HISTORY:

Who raised you?

Number of brothers and/or sisters:

Your birth order:

Briefly describe Mom:

Briefly describe Dad:

Briefly describe their parenting styles:

Please check the following boxes if applicable:

FAMILY HISTORY	FATHER	MOTHER	SELF	SIBLING	GRANDPARENT
Depression					
Suicide or Attempts					
Drug or Alcohol Problems					
Anxiety					
Anger/Violence					
Mental/Emotional Issues					
Heart Disease					

LIST OF SYMPTOMS:

Please circle any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble
career choices	children	compulsions
compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (high/low)
extreme fatigue	fears	fetishes
finances	friends	guilt

headaches	health problems	inferiority feelings
insomnia	loneliness	making decisions
marriage	memory	my thoughts
nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	sadness
self-esteem	separation	sexual problems
short temper	shyness	sleep
stress	suicidal thoughts	work

Is there anything else you would like me to know about you?

YOU HAVE COMPLETED THE INTAKE PACKET! THANK YOU AND I LOOK FORWARD TO GETTING TO KNOW YOU BETTER.