Kelly Haven

Registered Associate Marriage and Family Therapist 111759 Supervised by: Sherie Mahlberg Licensed Marriage & Family Therapist, MFT92236
313 Kendal St Suite B (707) 330-7904

AGREEMENT FOR SERVICE / INFORMED CONSENT MINOR

• Clinical Intake Assessment $110

• Individual and/or Family Session (50 Minutes) $105
• Missed Appointment Fee $60

AGREEMENT FOR SERVICE / INFORMED CONSENT FOR MINORS

Introduction
This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by Kelly Haven, for the minor child _____ (herein "Patient") and is intended to provide_____ (herein "Representative(s)") with important information regarding the practices, polices and procedures of Kelly Haven, Registered Associate Marriage and Family Therapist (111759), (herein "Associate") supervised by Sherie Mahlberg, Licensed Marriage and Family Therapist (MFT92236), (herein"Therapist"), and to clarify the terms of the professional therapeutic relationship between Associate and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Associate prior to signing it.

Policy Regarding Consent for the Treatment of a Minor Child
Associate generally requires the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for psychotherapy, representative must submit supporting legal documentation, such as a custody order, prior to the commencement of services.

Associate Background and Qualifications
Kelly Haven completed a dual master's program at Brandman University in Irvine, CA. She has had experience with the Vacaville Youth Services section offering counseling services to youth ranging from Kindergarten to 12th grade in a school setting. She has also worked as an Emergency medical technician in a variety of roles in the emergency medical services.

Risks and Benefits of Therapy
A minor patient will benefit most from psychotherapy when his/her parents, guardians or other caregivers, are supportive of the therapeutic process. Psychotherapy is a process in which Associate and Patient, and sometimes other family members, discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Patient may be experiencing. Psychotherapy is a joint effort between Patient and Associate. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to Patient, 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 the part of Patient, as well as his/her caregivers and/or family members, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. 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, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Associate will challenge the perceptions and assumptions of the Patient or other family members, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships.

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Patient should address any concerns he/she has regarding his/her progress in therapy with Associate.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice. As such, Associate regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Associate will not reveal any personally identifying information regarding Patient or Patient's family members or caregivers.

Records and Record Keeping

Associate may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute Associate's clinical and business records, which by law, Associate is required to maintain. Such records are the sole property of Associate. Associate will not alter his/her normal record keeping process at the request of any patient or representative. Should Patient or Representative request a copy of Associate's records, such a request must be made in writing. Associate reserves the right, under California law, to provide Patient, or Representative, with a treatment summary in lieu of actual records. Associate also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Representative will generally have the right to access the records regarding Patient. However, this right is subject to certain exceptions set forth in California law. Should Representative request access to Associate's records, such a request will be responded to in accordance with California law. Associate will maintain Patient's records for ten years following termination of therapy, or when Patient is 21 years of age, whichever is longer. However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

Audio Recording

In an effort for Associate to have the opportunity to look back on sessions as a learning tool in their licensing process and career, we are asking your permission to record the audio portion of the session. Patient information will remain confidential.

I consent to audio recording. **Initials** ____ I do not consent to audio recording. **Initials** ____

Confidentiality

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

Representative should be aware that Associate is not a conduit of information from Patient. Psychotherapy can only be effective if there is a trusting a confidential relationship between Associate and Patient. Although Representative can expect to be kept up to date as to Patient's progress in therapy, he/she will typically not be privy to detailed discussions between Associate and Patient. However, Representative can expect to be informed in the event of any serious concerns Associate might have regarding the safety or well-being of Patient, including suicidality.

Patient Litigation

Associate will not voluntarily participate in any litigation, or custody dispute in which Patient, or Representative, and another individual, or entity, are parties. Associate has a policy of not communicating with Representative's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's, or Representative's, legal matter. Associate will generally not provide records or testimony unless compelled to do so. Should Associate be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Representative agrees to reimburse Associate for any time spent for preparation, travel, or other time and/or costs in which Associate has made him/herself available for such an appearance at Associate's usual and customary hourly rate of $105.00. In addition, Associate will not make any recommendation as to custody or visitation regarding Patient. Associate will make efforts to be uninvolved in any custody dispute between Patient's parents.

Psychotherapist-Patient Privilege

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Associate and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Associate receives a subpoena for records, deposition testimony, or testimony in a court of law, Associate will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by a person with the authority to waive the privilege on Patient's behalf. When a patient is a minor child, the holder of the psychotherapist-patient privilege is either the minor, a court appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law. Representative is encouraged to discuss any concerns regarding the psychotherapist-patient privilege with his/her attorney.

Patient, or Representative, should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient, or Representative, should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

Fee and Fee Arrangements

As of 6/1/17 the usual and customary fee for service is $105.00 per 50 minute session, $110.00 for intake. Sessions longer than 50 minutes are charged for the additional time pro rata. There is a $25.00 fee for returned checks. Associate fees increase at the first of every year. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with Associate.

From time-to-time, Associate may engage in telephone contact with Patient for purposes other than scheduling sessions. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than five minutes. In addition, from time-to-time, Associate may engage in telephone contact with third parties at Patient's request and with Patient's advance written authorization. Patient is responsible for payment of the agreed upon fee at a pro rata basis.

Patients are expected to pay for services at the time services are rendered. Associate accepts cash, checks, and major credit cards.

Insurance

Representative is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. Representative is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles.

Associate is a contracted provider with the following company: MediCal and has agreed to a specified fee. If Patient intends to use benefits of his/her health insurance policy,
Patient agrees to inform Associate in advance.

Cancellation Policy

We are committed to providing all of our patients with exceptional care. When a patient cancels without giving 24-hour notice, they prevent another patient from being seen.

Please call or text us 24 hours prior to your scheduled appointment to notify us of any changes or cancellations. If 24-hour prior notification is not given, you will be charged $60 for the missed appointment. If you call after business hours, voice and text messages may be left.

If 2 appointments are missed (without 24-hour prior notice) within a two-month period, the office will no longer hold your appointment slot as a regular occurring appointment. To be seen, you will need to call the office daily to check availability for a same day appointment. **Initials** _____

Associate Availability

Associate's office is equipped with a voice mail system that allows Patient to leave a message at any time. Office staff will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. Associate is unable to provide 24-hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

Termination of Therapy

Associate reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Associate's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient or Representative has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Associate will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Associate will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient or Representative.

Social Media
Associate will not communicate with, or contact, any patient through social media platforms such as Twitter, LinkedIn or Facebook. Associate will not accept "friend" or contact requests from current or former clients on any social networking site. The concern is that adding clients as "friends" or contacts on these sites can compromise patients confidentiality and Associate's respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up during session.

Office Etiquette
Unlike other waiting rooms, a therapist's office is a particularly important place of solitude. It is important to allow everyone the option for personal and private space as they prepare for their therapy session. In order to maintain this, silence your cell phones and take conversations outside. Ear buds must be worn if listening to music or watching videos. Our waiting room is for clients and guardians only. If it becomes necessary to have other children in the lobby while waiting, please remind them of office etiquette.

Acknowledgment
By signing below, Representative acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Representative has discussed such terms and conditions with Associate, and has had any questions with regard to its terms and conditions answered to Representative's satisfaction. Representative agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Associate. Moreover, Representative agrees to hold Associate free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____
Patient Name (please print)

_____ _____
Signature of Patient (if Patient is 12 or older) Date

_____ _____
Signature of Representative (and relationship to Patient) Date

_____ _____
Signature of Representative (and relationship to Patient) Date

Financial Responsibility

I understand that I am financially responsible to Associate for all charges, including unpaid charges by my insurance company or any other third-party payor.

_____
Name of Responsible Party (Please print)

_____ _____
Signature of Responsible Party (and relationship to Patient) Date

_____
Name of Responsible Party (Please print)

_____ _____
Signature of Responsible Party (and relationship to Patient) Date

Restoration Family Counseling Services

1241 Alamo Drive Suite 3

Vacaville, CA 95687
Phone: (707) 330-7904
RestorationVacaville@gmail.com

Intake Paperwork for Minor

Date: _____ Referred By: _____

Name: _____ Date of Birth: _____

Who has legal custody/guardianship? _____
Please provide documentation upon request.
Note: If parents are divorced, a signed consent from both is required by law.

Responsible Party: _____ Relationship to Client: _____
Email Address: _____ Cell Phone #: _____
Home Phone #: _____ Alt. Phone #: _____
Occupation: _____ Employer's Name: _____

Client Information

Home Address: _____

City: _____ Zip Code: _____

Ethnicity: _____ Religious Affiliation: _____

Primary language spoken at home: _____

Current school: _____

Insurance provider: _____ ID #: _____

Group #: _____ Provider Services #: _____

Last four digits of SSN: _____

Emergency Contact: _____ Relationship to Client: _____

Phone #: _____ Work #: _____

Address: _____

I give permission for this person to be contacted in case of a physical or mental health emergency. Initials _____

Office use only: Release of info required: Yes____

What is the reason for seeking help now?

What problem is the child having?

When did the problems start?

What have you done to try to solve the problems?

What has been effective/ineffective?

Is there a history of mental illness in the family? If yes, what was the diagnosis and how are they related to the client?

Prior counseling? Yes _____ No _____ If yes, with whom? _____
Address: _____

Office use only: Release of info required: Yes____

If child was adopted or in the adoption process, what information do you have regarding the biological parents?

Was the child told of the adoption? If yes, when? _____

Was the adoption process traumatic? If yes, how was the child/family affected?

Medical History

Has your child suffered any of the following:
Sexual trauma? _____ Physical trauma? _____ Emotional trauma? _____

Has your child been hospitalized? If yes, why were they hospitalized?

_____

Has there been any previous counseling or psychiatric care for your child or other family members?

Office use only: Release of info required: Yes___

Any head injuries? _____

Problems with vision/eyesight? _____

Hearing/ear infections/tubes?_____

Does your child wear glasses? _____ Does your child wear hearing aids? _____

Any problems with speech or language? _____

Taking any medications? _____

Any major surgeries in the immediate family?

Please indicate if the following illnesses accompany the child or genetic side:

Illness	Child	Mother's Side	Father's Side
Diabetes			
Allergies			
Asthma			
Heart disease			
Seizures			
Depression			
Extreme nervousness			
Psychiatric illnesses			
Suicide or attempt			
Cancer			
Other major illness			
Legal problems			
Alcohol/drug problems			

Early Development (0-5 years)

Birth history:
Planned? _____ Wanted by both parents? _____ Birth weight? _____

Please describe the mother's health during pregnancy: _____

Were there complications? _____

Accidents? _____ Drugs? _____

Difficulties in living situation or marriage during pregnancy?
_____

Full term? If not, what week were they delivered?_____

Problems during labor/birth? If yes, please describe the problems.

_____

_____

Were there complications to the mother or baby after birth? If yes, what kind, and did that change after birth?

_____

_____

Did the baby like to be cuddled?_____ Have problems feeding? _____

Sleeping problems?_____ Bed wetting?_____

Did they have any fears, phobias, or nervous habits?
_____

Please check the descriptor of your child:

_____ Cautious _____ Curious _____ Over-active _____ Under-active

_____ Accident prone _____ Destructive _____ Tantrums

If they had/have tantrums, how were/are they handled?

_____

_____

How did/does your child approach the following:
New people? _____
New situations? _____
New demands? _____

Did/does your child become frustrated easily? _____

Under/over react to situations? _____

What is his/his usual mood? _____

Please describe his/her attention span: _____

Good or poor coordination? _____

Has your child ever or does your child currently:
Bang their head? _____ Rock? _____ Grind teeth? _____
Have difficulty making eye contact? _____
Go limp or still when held? _____
Flap hand/arms or twirl fingers? _____
Have a fascination regarding spinning objects? _____
Seem to be in their own world? _____
Have difficulty using the pronoun "I" appropriately? _____

Was or is your child in preschool/nursery school or any other peer social activity? If yes, for how long? _____

Were/are there any problems? _____

If your child has a younger sibling, how did he/she react to him/her being born?
_____

Which parent usually disciplines? _____

How? And is this effective? _____

Were there times that discipline got out of control? _____

Is there a history of child abuse (physical, emotional, or neglect)? _____

Any deaths of close family or friends age 0-5 years old? _____

Did the parents divorce or separate in the first five years of the child's life? _____

Please use this space to describe any other information you think would be important for me to know about this developmental phase of your child's life.

School Age (6-12)

How old was your child when they started school? _____
Any problems separating from parents? _____
Any difficulties in kindergarten? _____
Average grades in elementary school? _____
Any period when grades were better or worse? _____

Has your child been involved in organized sports or clubs? If yes, for how long?

_____

_____

If they stopped participating, why did they stop? _____

Any behavioral problems in school? _____

Please use this space to describe any other information you think would be important for me to know about this developmental phase of your child's life.

_____

_____

_____

Junior High/High School (13-18)

Do they earn average grades? _____
Any period where they got better/worse? _____
Current problems in school? _____
How have you dealt with them? _____
Have the neighbors complained about your child's behavior? _____
Has your child ever been cited for his/her behavior? _____
Has your child ever been on, or are they currently on probation? _____

Adolescent Development

Has your child entered puberty? _____
Have you discussed reproduction/sexuality with your child? _____
Does your child have friends of the opposite sex? _____
Does your child belong to special peer groups or gangs? _____
Does your child use drugs? _____ Alcohol? _____ Cigarettes? _____

Please use this space to describe any other information you think would be important for me to know about this developmental phase of your child's life.

_____

_____

_____

Please describe your child's strengths:

Please describe their hobbies or special interests:

Please describe your goals/expectations of treatment or what you would like to have accomplished:

Is there any other information you think would be important for me to know in treating your child?

Thank you for taking the time to complete the above information. It will be helpful in the treatment of your child.

RESTORATION FAMILY COUNSELING CENTER

PRIVACY PRACTICES

We are required by law to protect the privacy of your medical information and to provide you with a detailed written notice describing how this clinic may use or disclose medical information about you and how you can obtain or correct this information. Here is a brief summary. Please review carefully.

- The law permits us to disclose information to those involved in your treatment.
- We may disclose your information for billing purposes, gaining insurance or benefits information, insurance authorization and payment for services.
- Your healthcare information may be used during normal healthcare operations.
- We may use your information to contact you, to call to remind you of your appointments, for scheduling purposes, or to inform you of insurance benefits. This may involve leaving messages on an answering machine or with the person who answers the phone.
- We may release some or all of your information when required by law.

Your authorization is required to disclose your health information to other healthcare providers, individuals, or third parties requesting information about you. We will provide a detailed NOTICE OF PRIVACY PRACTICES to you, which fully explain your right and our obligation under the law. We may revise our NOTICE from time to time. If you have not yet reviewed a copy of our current notice, a copy will be made available upon request.

- You have the right to request restrictions on uses and disclosures of your health information.
- You have the right to receive confidential communications.
- You have the right to inspect and copy your health information. This right does not apply to psychotherapy notes, information gathered for court actions. There are some other additional circumstances that your request may be denied.
- You have the right to amend your health information.
- You have the right to receive an accounting of disclosures.
- You have the right to obtain a copy of this notice.

Acknowledgment

I have the received a copy of Restoration Family Counseling Services, S-Corp Notice of Privacy Practices. I authorize Restoration Family Counseling Services to release any medical information required by my insurance company or worker compensation carrier for the processing of any medical claims filed on my behalf.

_____

Patient signature Printed Name Date

Crisis Contacts

In the event that you are ever feeling unsafe or you require immediate medical or psychiatric assistance, please call 911, or go to the nearest emergency room. Additional numbers for help include:

- National Suicide Prevention Hot line (800) 273-TALK
- Sexual Assault Hot Line: (800) 656-HOPE
- Safe Quest (DV & Sexual Assault) (866) 487-7233
- Solano County Crisis (707) 428-1131
- Emergency 911