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 ADULT

- **Clinical Intake Assessment $110**
- **Individual and/or Family Session (50 Minutes) $105**
- **Missed Appointment Fee $60**

Introduction

This Agreement is intended to provide [name of patient] _____ (herein "Patient") with important information regarding the practices, polices andprocedures 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.

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

Psychotherapy is a process in which Associate and Patient 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, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, including 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. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Associate will challenge Patient's perceptions and assumptions, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient.

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.

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. Should Patient 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 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, at requested, provide a copy of the record to another treating health care provider. Associate will maintain Patient's records for ten years following termination of therapy. 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.

Patient Litigation

Associate will not voluntarily participate in any litigation, or custody dispute in which Patient and another individual, or entity, are parties. Associate has a policy of not communicating with Patient's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient'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, Patient agrees to reimburse Associate for any time spent for preparation, travel, or other time and/or costs in which Associate has made herself available for such an appearance at Associate's usual and customary hourly rate of $105.00 an hour.

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 received 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 Patient or Patient's representative. Patient 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 should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

Fee and Fee Arrangements

As of 1/1/17 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 (on a pro rata basis) for any telephone calls longer than five minutes.

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

Insurance

Patient is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. Patient 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 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.

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, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Associate, and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Associate. Moreover, Patient 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 (or authorized representative)

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) Date

_____ _____

Signature of Responsible Party Date

Restoration Family Counseling Services

313 Kendal St Suite B

Vacaville, CA 95688

Phone: (707) 330-7904

RestorationVacaville@gmail.com

Intake Paperwork for Adult

Please take time to fill out this form. This will aid greatly in providing appropriate therapeutic care for you.

Date: _____ Referred By: _____

General

Name: _____ Date of Birth: _____

Social Security Number (last four): _____ Ethnicity: _____

Primary language spoken at home: _____

Religious Affiliation: _____ Marital Status: _____

Home Address: _____

City: _____ Zip code: _____

Phone Number: _____Email Address: _____

Preferred Method of Contact: _____

Areas of Concern

What issues/concerns cause you to seek treatment? Please describe:

_____

_____

_____

What are your specific goals with regard to your treatment?

_____

_____

_____

Do you have any particular concerns/fears with regard to treatment?

_____

_____

_____

Psychological History

Have you ever received mental health treatment before? _____

If yes, when, and for how long? _____

What was the focus of treatment?

_____

What did you find helpful/not helpful about treatment?

_____

_____

Name of treating therapist: _____

Address: _____ Phone number: _____

Office use only: Release of info required: Yes___

Have you ever attempted suicide? _____ When? _____

Please describe the circumstances that led to that attempt.

_____

_____

Are you currently having any suicidal thoughts? Please describe.

_____

_____

Have you ever been subjected to one or more psychological tests? If so, by whom?

_____

_____

Address: _____ Phone number: _____

Office use only: Release of info required: Yes___

Have you ever been hospitalized for mental or emotional problems?

_____

_____

_____

When and for how long? _____

Why were you hospitalized?

_____

_____

Name of hospital: _____

Address: _____ Phone number: _____

Office use only: Release of info required: Yes___

Trauma History

Were you ever subjected to verbal, physical, emotional, or sexual abuse? Please describe.

_____

_____

_____

Have you ever been a victim of a violent crime? Please describe.

_____

_____

_____

Medical Conditions and History

Do you have a family history of mental illness? If yes, how are you related and what was the diagnosis?

_____

_____

Have you ever taken any medications for a mental or emotional condition? When and for how long?

_____

_____

Have you ever been diagnosed with a serious illness? Please describe.

_____

_____

_____

Do you have any medical conditions that may affect your mental health treatment? Please describe your overall health today.

_____

_____

_____

Date of last physical: _____ Name of physician: _____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe.

_____

_____

Office use only: Release of info required: Yes___

Current Medications

Please list current prescription medications you are taking.
Name of medication: _____ Dose: _____ Start Date: _____
Prescribed by: _____ Phone #: _____
Name of medication: _____ Dose: _____ Start Date: _____
Prescribed by: _____ Phone #: _____
Name of medication: _____ Dose: _____ Start Date: _____
Prescribed by: _____ Phone #: _____
Name of medication: _____ Dose: _____ Start Date: _____
Prescribed by: _____ Phone #: _____
Name of medication: _____ Dose: _____ Start Date: _____
Prescribed by: _____ Phone #: _____

Office use only: Release of info required: Yes___

Substance Use

Have you ever been in a 12-step program? Please describe.

_____

_____

If yes, does it seem helpful?

_____

_____

Do you smoke? _____ How much? _____ For how long? _____

Do you drink alcohol? _____

On average, how much alcohol do you consume in a week? _____

Do you currently use illegal drugs? Please describe your use.

_____

_____

Have you ever used illegal drugs? Please describe your use.

_____

_____

Support System

List the members living in your home at this time.

Name: _____ Age: _____ Relationship to you: _____

Name: _____ Age: _____ Relationship to you: _____

Name: _____ Age: _____ Relationship to you: _____

Name: _____ Age: _____ Relationship to you: _____

Name: _____ Age: _____ Relationship to you: _____

Name: _____ Age: _____ Relationship to you: _____

Family of Origin History

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother:

_____

_____

_____

Father's name, age, living/deceased, patient's age at the time of the father's death, description of relationship with father:

_____

_____

_____

Names and ages of siblings:

_____

_____

Please briefly describe your childhood experience:

_____

_____

Please briefly describe any developmental milestones or delays you would like to share:

_____

_____

Which of the following describes your current living situation?

____ Rent apartment
____ Rent house
____ Own house
____ Foster care
____ Condominium
____ Shelter
____ Homeless
____ Group home
____ Residential Treatment

Other Information

Occupation: _____ Education Level: _____

Are you now, or have you ever been involved in a lawsuit? Please describe.

_____

_____

Do you currently have a parole officer? _____ Name: _____

Do you have any restraining orders against you or someone else. Please describe.

_____

_____

Please check off any areas you may be concerned about – check all that apply

____ depression
____ crying a lot
____ sexual abuse
____ obsessive thoughts
____ anxiety
____ physical abuse
____ obsessive behaviors
____ hot temper
____ gambling too much
____ nightmares
____ worry excessively
____ gender confusion
____ weight loss
____ strange behaviors
____ paranoia
____ destroy things
____ learning difficulties
____ promiscuity
____ hopelessness
____ suicidal thoughts/plans
____ odd beliefs
____ chemical use
____ hyperactivity
____ mood changes
____ fighting
____ lack of friends
____ avoid others
____ don't pay attention
____ stealing
____ perfectionist
____ self-injurious behavior
____ panic attacks
____ vandalism
____ fire setting
____ violence
____ physical problems with no known medical cause

Please identify your strengths – check all that apply

____ stay active
____ employed
____ attend school/work
____ regularly copes with problems well
____ independent
____ positive outlook
____ spiritual
____ humorous
____ helpful
____ easy going
____ intelligent
____ caring
____ share with others
____ maintain friends
____ hardworking
____ playful
____ good looking
____ a leader
____ have a hobby
____ artistic
____ athletic
____ liked by others
____ structure time well
____ responsible
____ good health
____ honest
____ has positive view of the world
____ Others:
_____

Please describe your interests/hobbies:

_____

_____

Emergency Contact Information

Name: _____ Relationship to Client: _____

Phone (cell): _____ Phone (home): _____

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

Responsible Party

Name: _____ Relationship to Client: _____

Date of Birth: _____ Social Security Number (last four): _____

Home Address: _____

City: _____ Zip code: _____

Financial Information

How do you intend to pay for treatment? (cash, check, charge, insurance) _____

If planning to use insurance:

Name of Company: _____ Policy #: _____

Group #: _____ Employer: _____

Customer Service Phone #: _____

Subscriber: _____ Subscriber Date of Birth: _____

Is there any other information that would be helpful in getting to know you?

_____

_____

Thank you for taking the time to fill out this intake form.

Date: _____

Printed Name: _____ Signature: _____

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