HOLISTIC-PSYCHOTHERAPY.NET
Batsheva Gruber-Nass LMFT CSAT CMAT

Counseling Services Information
Informed Consent

Date: ___________

Client name: ____

How were you referred to my office?
____

NOTE: If you are seeing a therapist at holistic-psychotherapy.net for couple's therapy, each person must fill out and bring a separate set of forms to your first couple's session.

Welcome

Welcome, it takes courage to reach out for support and Ilook forward to supporting your healing journey. These forms contain information about *holistic-psychotherapy.net*professional counseling services and business policies. There are also several questions included that will help better identify what challenges you are currently facing so that I can best assist you. It is important that you review the following information before beginning your first session. Please feel free to ask any questions you may have about these policies; I will be happy to discuss them with you. There are various places where your signature is required on the following forms; please bring these **completed** forms with you to your first session.

Therapy Services – Risks and Benefits

The role of a Marriage and Family therapist is to assist clients with issues regarding relationships, addictions, and issues such as depression, anxiety, grief, and other challenges that impact you emotionally. Counseling often involves discussing difficult aspects of your life. During our work together you may experience uncomfortable feelings such as sadness, guilt, shame, anger, or frustration. As a result of what comes out of your therapeutic work and the decisions you make, important relationships may be impacted or may end. Your journey in therapy may also lead to healthier relationships. Counseling support often helps an individual find solutions to problems with family and friends, life challenges, as well as a reduction in feelings of distress, anxiety and depression. If you ever have any concerns about your therapy process,

Iencourage you to discuss this during your sessions so that we can collaborate together as you move forward.

Termination of Therapy

You may terminate therapy at any point. When our work comes to a close, I ask that you schedule at least one final session in order to review the work you have done. Occasionally clients return to therapy to process new challenges. If you decide to return in the future, please know that I have an open door policy and welcomes the possibility of working together again. However, it will be at my clinical discretion and also dependent upon my availability.

Length of Therapy

Therapy is a process that is unique to each client and the challenges they are presenting with. Some presenting issues can be worked on very effectively in a fairly short period of time; other challenges may take much longer. It can be difficult to predict exactly how long therapy will last and this is best discussed in your first session. We will put together a treatment plan and goals that you will be working toward. If you have questions regarding the length of treatment, please feel free to discuss this with your therapist at the start and/or at any point during therapy.

Dual Therapy

It is unethical for two different therapists to provide counseling for the same client at the same time. Unless there is a compelling clinical reason, a crisis, or a specialized therapy treatment plan that we will be working on,I do not work with clients who are under the care of another therapist. If you are working with another therapist, please disclose this so that we can discuss next steps.

Confidentiality

Therapy is best experienced in an atmosphere of trust. Thus, all therapy services are strictly confidential and may not be revealed to anyone without your written permission. **There are exceptions to confidentially where disclosure is required by law (see below).** There may be occasions where I may consult with adjunct therapists in order to discuss aspects of your sessions to best support your process. When doing so, please understand that your name will not be used, and that I will change significant identifying details in order to protect your confidentiality. Your confidentiality is very important to me. Should you request that I speak with another professional or person (i.e. doctors, former therapists, teachers, family, friends or anyone else outside the therapy room), you must first provide your signed written consent in order to do so and only after I determine if this is in the best interest of supporting your therapeutic process and progress.

Confidential Electronic Data Storage and Email Transmission

Your confidentiality as a client is of upmost importance. To support and secure your clinical informationI have set up a system as part of our therapeutic services in order to securely store and protect your information in a confidential and protected capacity. I may be utilizing Yahoo Inc. Google Inc. and the following applications: Yahoo Mail, Gmail, Google Calendar, Google Drive and Google Apps Vaults to electronically save and store client information and data and to confidentially communicate with clients in

various capacities via the Internet. Yahoo Mail, Gmail, Google Calendar, Google Drive and Google Apps vaults and all client protected health information are covered under the Health Insurance and Portability Act of 1996 and in particular 45 C.F.R, Part 164, Subpart C under HIPPA.

Legal Exceptions to Confidentiality

I take confidentiality very seriously. Your information is confidential, with the exception of information relating to child abuse, or suspected child abuse, child pornography, elder abuse, dependent adult abuse, or intent to harm self or others, or **unless mandated by a court of law**. Legally, therapists are mandated reporters of abuse or intent to harm another. If you are suicidal or homicidal, I will take all reasonable steps to prevent harm to you or another.

Legal exceptions to confidentiality are in place to protect your safety and the safety of others. This includes: when there is a reasonable **suspicion** of child abuse (physical, sexual, emotional, neglect), or adult dependent care abuse, elder abuse/neglect; and where a client threatens to harm or kill other(s) (homicide), or threatens to damage another person's property.

If you are homicidal and make a serious threat to hurt another person(s), I will contact 911 and make every attempt to warn the intended victim or victims. Additionally*,* if a court issues an order to release records (for example a divorce hearing or custody hearing), I must abide by the court order and may be compelled by court order to testify under oath and thus must answer all questions honestly.

Mandated Reporting of Incidents Involving Minors

A minor is defined as any person who is legally under the age of 18.

Iam obliged under New York and California law to report to the appropriate authorities any instance where a client discloses that they have accessed, streamed, or downloaded material through any electronic or digital media depictions where a child is engaged in an obscene sexual act.

Should you choose to disclose that you have accessed child pornography of any kind (currently, recently, or in the past) during any of the following:

- during an individual, group, or couples session in the office
- via your client consent forms
- an assessment tool that is administered as part of your treatment, such as the SDI (Sexual Dependency Inventory), or via other assessment tools (such as the SAST or Sex Addiction Assessment Tool)
- via email, text, phone, regular mail
- or by any other means in or out of session

it is important for you to understand that **I am mandated to report this to legal authorities.**

If you are a parent seeking therapy, and discuss with me your concern over your minor teenager sexting OR exchanging nude or sexual pictures of herself/himself to her teenaged minor boyfriend/girlfriend, I am mandated by law to report both minors to authorities under AB1775 for “knowingly accessing, streaming, or downloading material where a child is engaged in an obscene sexual act.”

Additionally, if you share with me that your adult child or any identifiable adult (18 years or older) that you are in relationship with is sexting or texting sexual or nude images to a minor (for example an 18 year old son texting sexual images to his 16 year old girlfriend), or is downloading or accessing child pornography,I am mandated by law to report this to the authorities.

If you are a spouse or partner seeking support with me, or attends a workshop, and you disclose that your spouse or partner has accessed child pornography, or your minor child or minor teen has texted nude photos with other minors **please know that anything disclosed with respect to offending behaviors with minors (a person under the age of 18 years old) is a reportable offense and I am mandated to report you, your spouse or partner, or your minor child to the proper authorities.**

Please sign and date here if you understand the above stated limits of confidentiality and mandated reporting responsibilities of myself as your therapist.

Client’s signature:_________________________________Date:______

Suicide Policy

If you are suicidal, I will take all reasonable steps to prevent harm to yourself. This may include breaking confidentiality if you pose a serious risk of self-harm to yourself. Your signature indicates that you have read and understand confidentiality and limits to confidentiality:

Client’s signature:_________________________________Date:______

Emergency Contact Information

In the event of an emergency, please provide a contact person:

Name____

Relationship______________________________**Phone**_______________________

No Secrets Policy

Please note that with couples and family therapy the couple and/or the family is the client (e.g. the treatment unit), **not the individuals**. As such I practice a **no-secrets policy** when conducting marital/couples/family therapy. This means that confidentiality does not apply between the couple or among family members when one member of the treatment unit requests an individual session or contacts me outside of the therapy session to share a secret. On occasion an individual session may be scheduled to assist in the overall therapy process to the treatment unit (e.g. the couple) and will be scheduled only when mutually agreed upon. Please understand that any information given in the individual sessions **will not** be held in confidence or secret in couples and/or family sessions.

I will encourage the person holding the secret to share the secret in the following session and will support the client in doing so. I also reserve the right to share or disclose information revealed by one partner or family member in an individual session to the other partner or family members as deemed appropriate or necessary to support the treatment units overall treatment progress and goals. If you are seeking couples therapy, or family therapy, please have each member of the treatment unit fill out and sign an intake form.

Conjoint Sessions

On occasion, and only if it benefits the client's therapy goals, I may ask that a family member or significant other join you for a therapy session. It is important to note that this is done only on occasion and at my discretion when it best serves the client.

If a family member or significant other agrees to meet for a session, it will be for the client's benefit. If the person joining the session is your significant other, this does not constitute as couples therapy, rather it is as a support to your work, and/or a check-in session.

Sobriety Policy

I ask that all clients, couples, families, and group members arrive to therapy sober and not under the influence of drugs and/or alcohol. If I notice that you are intoxicated (such as slurred speech, rapid speech, smelling of alcohol, behavior that indicates intoxication with cocaine, prescription drug abuse, marijuana, or other substances) the therapy session will be immediately terminated. I will also assist you in finding a safe ride home (via friend, family member or taxi) as driving while under the influence constitutes a risk to others and is a reportable offense. Once you are safely home, I will reschedule the therapy session where this occurrence will be processed. **You will be charged your full fee for the session if you arrive intoxicated.**

Therapy Sessions

Therapy sessions are weekly, and are scheduled in advance. Standard sessions are **45-minutes** in length and begin and end on time. Therapy can be conducted in office or via teletherapy (phone). The fee is the same for in-office or teletherapy as the same amount of time must be blocked out for teletherapy sessions. It is understandable that occasionally you may be late. If you are late to your session, please understand that the session will not extend past your 45-minutes, nor will the time be made up at future sessions, as this will impact other clients.

Therapeutic Approach & Style

My goal as a therapist is to help people navigate through difficulties in their life and relationships while providing a safe place to heal, explore, develop insight, practice healthy coping tools, and integrate and take responsibility for their changes. I facilitate a process where the client is able to move toward healing, self-acceptance, and to ultimately grow and thrive in a supportive environment. While I will meet you each step of the way in your therapy process with accountability, compassion and empathy, a therapist is not a cure all, a parent, a friend, or a miracle worker.

My style is collaborative, honest, challenging, and direct with solid boundaries and empathy. I reflect, assist, encourage, and point out incongruent patterns around actions and words. I will not work harder than my clients or accept responsibility for your choices or consequences. I respect my client's decisions, and do not advise or direct my clients, as I believe that you are the expert in your own life and are fully capable of creating the life that you want with support and tools.

I as your therapist will formulate the therapeutic plan collaboratively with clients based on each client's needs, their presenting problems, and the goals they wish to achieve. I believe that each client has the potential for healing and change and is responsible for their choices and changes, and for meeting their therapy goals – I do not make guarantees for healing. I use a combination of cognitive behavioral, existential, and client centered therapy with most clients.

Cognitive Behavioral (CBT) Therapy stresses the role of thinking patterns in how we feel and what we do. It is based on the belief that our thoughts, rather than people or outside events, cause our negative feelings. The therapist assists the client in identifying, testing the reality of, and correcting dysfunctional beliefs underlying his or her thinking – uncovering the 'root to the fruit' so to speak. The therapist then helps the client modify those thoughts and the behaviors that flow from them. CBT is a structured collaboration between therapist and client and often calls for homework assignments.

Existential psychotherapy is based on the philosophical belief that human beings are fully equipped to create one's own meaning, and exercising one's freedom to choose. The existential therapist encourages clients to face life's anxieties and to start making his or her own decisions while reflecting on consequences and moving away from fear based thinking. The therapist will emphasize that along with having the freedom to carve out meaning comes the need to take full responsibility for the consequences of one's decisions.

Non-Discrimination Policy

I respect each person's right to choose his or her own belief system. I work well with thetheist and the atheist client, as well as clients from many religions and beliefs. If a client would like to work from a faith-based approach, I will be happy to discuss this with you and support your process. Additionally, I respect each person's right to their choices in terms of sexual orientation, and provide a safe place for both straight, gay and transgender clients.

I believe in supporting people of all ethnicities, cultures and physical challenges. While our gender, ethnicity, orientation or spirituality may be different, I am open to discussing any concerns or questions you may have in working with a therapist who is either a different race, religion, orientation or gender than you. Having an open discussion on any of these topics can lead to a greater level of trust and rapport. If you have any questions regarding my therapeutic approach and style, or my non-discrimination policies, please feel free to discuss this with me now and/or in the future.

Court Reports or Letters

I do not write legal letters or court reports on behalf of clients involving divorce, custody or other legal matters or lawsuits. I do not write letters pertaining to legal matters to any outside person (i.e. doctor, school, attorney, etc.) or agency regarding your treatment. If a special circumstance arrives where a letter is **required by court order,** it will require your written consent and will be billed to you at $25.00 per page and **in addition to my hourly fee**. I reserve the right to refuse to write letters on your behalf (unless court mandated) if I do not feel this would be in your best interest, if it places us in a dual relationship, or will compromise our therapeutic relationship. I will not write letters on your behalf if you are involved in a lawsuit for any aspect of your personal or professional life, as this places us in a dual relationship as both your therapist and court advocate, thus crossing therapeutic boundaries. **If you are involved in a lawsuit, please understand that entering your mental health into a court hearing may not always be in your best interest as it may compromise your confidentiality and your clinical files may be requested and your therapist must speak honestly if under oath.**I will not be your advocate in a court hearing or speak on your behalf as that is not the nature of the therapist/client relationship.

Court Fees

If you become involved in legal proceedings that require your therapist's mandated participation, you will be expected to pay for all of your therapist's professional time, including preparation and transportation time and costs, even if called to testify by another party. Because of the time involved and the interruption to my clinical work, you will be charged $250 per hour for time out of practice, time for preparation, travel time, and attendance at any legal proceeding on your behalf that you will be responsible for.
Additionally, if other client sessions must be cancelled, these must be covered at the rate of those sessions and will be billed to you. Court fees can be very expensive so please sign and date below to indicate that you understand your financial responsibility in covering these expenses should I be mandated to go to court for a legal issue you are involved in. A therapist is not a court advocate or friend. A therapist must legally speak truthfully under oath.

Client's signature:________________________________Date:______

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Health Care/Managed Care Insurance Policy

I am glad to provide a "superbill' receipt that you may submit to your insurance company if you wish for a **possible** out of network reimbursement, however, I will not fill out forms or work directly with or on your behalf with your health care insurance company.

Additionally, it is important that you also understand that there is **no guarantee** that your insurance carrier will cover your therapy sessions. I ask that clients carefully consider this before we begin our work together. If you choose to work with me as your therapist, my policy is a fee-for-service policy as described in the following section. Your signature indicates that you understand and agree to respect this policy around health insurance, and will honor this agreement now and in the future.

Client's signature:________________________________Date:______

Fees

My fee is $175 per **45-minute** session. This fee is the same for in office, teletherapy (phone sessions), walk/talk, or couples therapy. On occasion clients will ask for an extended session for 90 minutes. The fee is doubled for a 90 min session. Therapy is an investment in self-care, and is a process that takes time.

Session Payments

Therapy sessions are paid via check, Visa, MasterCard or debit card. Please fill out the credit card form included in this packet and bring with you to your first session.I charge clients in the morning on the day of their session.

Some clients prefer to pay by cash for confidential reasons. *Please bring the exact cash amount for your session fee. Charges for unpaid services may be turned over to a collection agency which compromises confidentiality*. We do not "carry over" session payments from week to week, or extend credit as this could constitute as an unethical "debtor/creditor" dual relationship and ultimately impact the therapeutic relationship.

Fee Increases

Fees are reviewed each year, and may increase periodically. Every consideration to a client's current finances will be made. The increase will be discussed with the client, and a 30-day notice will be given prior to the increase. I will be happy to answer any questions you may have about this fee agreement. Please understand that you have the right to terminate therapy at any point. If you have any questions regarding the fee policy, please do not sign until discussing with me. Your signature indicates that you understand and agree to these conditions:

Client's signature:________________________________Date:______

Appointments/Cancellations

If you are trying to reach me on the same day of your session, please contact me via the phone number you have been given vs. an email. I make every effort to return calls and emails within 24 hours. I understand that occasionally circumstances beyond your control may arise which would prevent you from keeping your appointment. If I am unable to attend your therapy session (outside of scheduled vacations) due to an

unexpected emergency or illness, every attempt will be made to contact you 24 hours in advance on the phone numbers and/or email you have provided.

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Client Cancellation Procedures and Fees

Short-Notice Cancellation: Appointment cancellations made less than **48 hours** before the scheduled appointment will be charged the full agreed upon fee for the session.

No-Show: If you do not show up for a scheduled appointment (that you have not called to cancel) you will be charged the full fee for the session. You are responsible for keeping track and attending your sessions.

Group Therapy: Group therapy runs in 12-week modules. Group is closed at 6 members per module. Each client is responsible for their commitment to the group for the full module (12 weeks). Payment is due at the start of each month for the number of groups within that month. All 12 groups are to be paid whether or not the client attends as the spot in group is saved for that particular client. A client may be asked to leave group if more than 2 sessions are missed per module, as it will impact the group flow and bonding.

NOTE: While group therapy can be very helpful, it is not for everyone. Group therapy is available as space becomes open in group and at the discretion of your therapist.

Ongoing Cancellations or Multiple No-Shows: It is understandable that occasionally an appointment will be cancelled or missed due to illness or emergency. However, your regular session day/time has been reserved for you. My current client schedule and wait list does not allow for a great deal of flexibility with respect to continual cancellations, rescheduled appointments, or no shows. If you find that your schedule is no longer able to accommodate the session time reserved for you, please discuss this with me. I will do my very best to find an alternative solution, such as phone sessions, so that we can continue our work together. However, please note that should ongoing cancellations, frequent reschedules (even those within the same week), missed appointments, late payments/nonpayment become an issue, I will discuss this with you. If after discussing other options with you your attendance has not changed, I will need to open up your reserved time to the waitlist and add you to the waitlist. If you prefer not to be placed on the waitlist, then I will provide you with three therapy referrals and/or terminate with you.

Client's signature:________________________________Date:______

Therapist Availability between Sessions

I am available to take a brief 5-minute phone call or to answer a short 1 paragraph email regarding your **therapy appointment times or therapy homework one time** between sessions and **no more than 1 time per month** without the client incurring a fee. I will not process therapy issues via email unless you have been specifically asked by me to check in as part of your treatment. If the client feels that more contact is needed between sessions due to crisis, I will be willing to discuss the possibility of increasing the weekly sessions or scheduling a phone appointment temporarily if I feel that it supports the client's therapy. If frequent non-crisis contact continues between sessions,

it will be important to talk about charging for that support time, and/or referring out for a higher level of care than a once a week therapy session can offer.

Client's signature:________________________________Date:______

Therapist Time off Policy

During my out of office time, I will not be available for individual session, group, family or couple's therapy both in person, via email, text or phone unless it is a serious crisis, or life threatening emergency where there is imminent danger to self or others. If you are a threat to yourself or another when I am away, please call 911 immediately. On occasion I may provide the phone number and contact information of a therapist colleague who may fill in during my time away for emergency situations. I ask that clients respect my time away and unless there is a critical emergency, they wait until the next session to discuss.

For **emergency** situations, I will respond to the client within 24 hours of receipt of the email, call or text. For **non-emergency** clients, I will respond the first business day upon returning back to my office. Please respect this boundary regarding emailing, texting and calling during my week away.

Your signature indicates your agreement to Batsheva's boundaries around client contact during Batsheva's time away:

Client's signature:________________________________Date:______

Holiday, Weekend and Evening Contact

I will make every effort to return a call, email or text message of a **non-emergency** client message within 24 hours during a scheduled work week. If this call, text or email arrives during a holiday, weekend or evening, I will return **the non-emergency** client contact during the first working day following the holiday, weekend or evening. For **emergency only** clients (*emergency constitutes imminent danger to self or others*) I will make every effort to return the call, text or email within 24 hours and ask that if the client is facing a life threatening emergency that they call **911 immediately**. There will be a regular session fee or partial session fee for emergency phone calls and sessions that are in excess of 5 minutes, or more than 1 time per month.

Explanation of Dual Relationships

While a therapeutic relationship can feel psychologically close, it is one that is professional in nature with important boundaries. It is unethical for a therapist to invite you into a business venture, ask you for personal favors, start a social relationship with you, etc. These examples are called, "dual relationships" and can negatively impact clinical boundaries. Although our sessions may be intimate psychologically, it is important to acknowledge that we have a strictly professional relationship. On the rare occasion that I see a client outside of the office (when we may accidentally run into each other in public), I will be highly discreet and will maintain your confidentiality. I will do my best to follow your lead, and thus it is your choice to acknowledge the encounter and your therapist. If you do not choose to acknowledge the encounter, I will respect this and will follow your lead.

“Friending”

It is my policy to not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when you meet with your therapist to discuss further.

Google Reader and Other Related Forums

I do not follow current or former clients on Google Reader and do not use Google Reader to share articles. If there are things you want to share with me that you feel are relevant to your treatment, whether they are news items or things you have created, I encourage you to bring these items of interest into our sessions.

Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

Your initials indicate that you understand and agree to these boundaries regarding the social media and online policy: ______________ (Initial here)

Physical Contact

Sexual contact is never acceptable in the therapeutic relationship. Romantic or sexual talk, flirting, or sexual innuendos and sexual jokes are also unacceptable in the therapeutic relationship. If you should express a sexual comment or joke while in session directed to your therapist, we will explore this comment professionally and in a non-shaming way within a therapeutic non-sexual relationship.

Hugging is an expression of affection, a greeting or a goodbye within many cultures. However, in some cases hugging can be misconstrued as sexual, and can be triggering for some clients, or may interfere with the therapeutic relationship. Occasionally a client may spontaneously hug his or her therapist while they exit the office, may ask for a hug after a particularly difficult or emotional session, or may feel quite comfortable with a hug at the end of sessions or when ending therapy. Some clients are huggers, some are not, and so it is important for your therapist to understand your stance and to maintain appropriate professional boundaries.

If your therapist believes after discussing the request that a non-sexual brief hug is appropriate and supports your therapy, hugs will be allowed on occasion. Please understand, if your therapist chooses not to hug you, <u>it is not an expression of judgment, dislike or dismissal</u>, rather it would be denied in the best interest of your clinical care based on a therapeutic decision.

Illness Policy

When a private practice therapist is consistently exposed to cold and flu viruses in the office and becomes ill as a result, the office closes down, sessions and groups are cancelled, and everyone suffers. In order to maintain good health and create a safe and relatively germ free environment so that I can support all of our clients, I ask that clients

who are experiencing any stage of illness to respect boundaries and to conduct their sessions via phone until they have recovered completely and are no longer experiencing any signs of illness..

Please review the following illness agreement and initial:

If I am ill with any potentially contagious illness at any stage no matter how mild that would potentially expose my therapist or others in the therapy office, I agree to alert my therapist, and either reschedule my session by the **48-hour cancellation time period**, or agree to conduct my individual therapy session via phone. ___________ (Initial here)

I understand that my therapist may, on the rare occasion, ask that my session be conducted via phone if she is ill or recovering from a contagious flu virus. _____________ (Initial here)

If I am seeing a therapist for couple's therapy, I agree to cancel the session by 48 hours if my spouse or I am ill. _____________ (Initial here)
I agree not to bring in sick family members or children to the office setting if they are experiencing any stage of illness or flu. I understand I will be asked to leave the office if I choose to do this. _____________ (Initial here)

I understand that my fee will apply to all sessions that are not cancelled by 48 hours prior to my scheduled session. On the rare occasion that an emergency or grave illness occurs that does not allow me to give 48 hours notice, special consideration may be extended. Otherwise the session will be conducted via phone and the fee will stand. _____________ (Initial here)

Referrals of Friends, Family, Co-workers

The greatest compliment a therapist can receive are referrals from current or former clients. There are times when clients wish to introduce their therapist so they can make a recommendation as a referral, which is ethical and acceptable. Please understand that your confidentiality is extremely important to me. If another client that I see referred you to me, or if you refer a friend, co-worker or family member to me, legally and ethically your therapist is not able to acknowledge that other person's attendance to you if they should begin seeing me in therapy or if they are currently in therapy with me.

On occasion a client may say, "My friend Jane/John Doe mentioned that she/he started seeing you and is enjoying the work you are doing with him/her." This is an example of our standard response which is stated in a kind tone: "I appreciate any referrals clients make, however, I cannot reveal who I see in therapy, and thus I cannot remark on who I see clinically at this time." Because this may sound rather official to clients, and because I will not acknowledge who is seen in therapy, including you, we thank our clients here on this page one time in advance for any referrals they may make:

Thank you for the referral; I am honored by your trust and confidence.

(Please proceed to the next section and fill out the following information in full.)

CLIENT INFORMATION		
Full Name: Name that you like to be called (nickname):		Relationship Status: □ S □ M □ D □ Sep □ W
Date of Birth:	Sex: □M □ F	Driver's License Number:
Occupation:		Monthly Income: Other Income:
Employer/Company Name: Work Address:		
Home Address w/zip code: Ok to mail to this address? □ Yes □ No	Email: Ok to email? □ Yes □ No (Please note that email correspondence is not guaranteed to be confidential)	
Home Phone#:	Cell Phone#:	Work Phone#:
Ok to leave messages? □ Yes □ No	Ok to leave messages? □ Yes □ No	Ok to leave messages? □ Yes □ No
Have you previously attended therapy? □ Yes □ No What kind of therapy? Inpatient /Outpatient/ Other: ___________________	If yes, what was the length of treatment, and when were the dates attended? Length: Date(s):	If yes, why did you stop attending therapy?

BIOPSYCHOSOCIAL HISTORY			
Symptoms and Behaviors (Please be as specific as possible to any 'yes' responses)			
Mania/manic symptoms	□Yes	□No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Depressed Mood	□Yes	□No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Appetite Disturbances	□Yes	□No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Sleep Disturbances	□Yes	□No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Change in Energy Level	□Yes	□No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Decreased Concentration	□Yes	□No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Worthless/Helpless Feelings	□Yes	□No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Anxiety Symptoms/ Panic Attacks	□Yes	□No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Bingeing/Purging	□Yes	□No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High

Feelings of Guilt	□Yes	□No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Obsessions/ Compulsions	□Yes	□No	If "Yes", please describe:
Phobias	□Yes	□No	If "Yes", please describe:
Medical Conditions	□Yes	□No	If "Yes", please describe:
Hyperactivity	□Yes	□No	If "Yes", please describe:
Are you having suicidal thoughts?	□Yes	□No	If "Yes", do you have a plan about how you would commit suicide:
Do you have the means to carry out your plan?	□Yes	□No	If "Yes", how would you do this?
Have you ever made a suicide attempt or been hospitalized for suicide?	□Yes	□No	Describe: Date(s) of attempt(s):
Is there a history of suicide in your family of origin?	□Yes	□No	If "Yes", please list who and what year:
Have you had a previous diagnosis by a therapist or psychiatrist?	□Yes	□No	If yes, please list the diagnosis's and the years:

Prescription Medications (please list all currently taking or have taken, the length of time and what they are prescribed for: pain, illness, depression, etc.)

1.
2.
3.
4.

List anything other medications or comments that your therapist should be aware of regarding your physical or mental health:

Substance Use

Are you currently using alcohol, nicotine or other prescription or non-prescription drugs? Please list how much and how often you drink and/or take prescription or non-prescription drugs:	□Yes	□No
Have you ever felt you would like to cut down on your substance use?	□Yes	□No
Have you ever felt you would like to cut down on your substance use?	□Yes	□No

Have you ever been arrested for a DUI, or drug use? Or do you have a past that involves using drugs or alcohol. Please briefly describe circumstances below:	□Yes	□No

Family & Relationship History (Use reverse side of this page if you need additional space)

	Age	Name	Living With You (Y/N)	Deceased (Y/N)
Spouse/Partner	______	________________________	_____	_____
Parent	______	________________________	_____	_____

	Age	Name	Living With You (Y/N)	Deceased (Y/N)
Parent	______	________________________	_____	_____
Stepparent	______	________________________	_____	_____
Stepparent	______	________________________	_____	_____
Sibling	______	________________________	_____	_____
	______	________________________	_____	_____
	______	________________________	_____	_____
	______	________________________	_____	_____
Children/Step	______	________________________	_____	_____
	______	________________________	_____	_____
	______	________________________	_____	_____
	______	________________________	_____	_____

Are your parents divorced? □ Yes □ No Remarried? □ Yes □ No

Religion (if any) ______________________________

Sexual orientation ____________________________

Gender orientation____________________________ (female, male, transgender, transsexual)

Ethnic Group (select all that apply):

American Indian Alaskan Native Caucasian Middle Eastern
Asian Phillipino Native Hawaiian Pacific Islander Hispanic/Latino
Black/African American Multi-Ethnic/Other_____________________________

Family of Origin(Circle Your Answer)

Have you experienced any abuse in your family or relationships?

None Emotional Physical Sexual Uncertain

In general, how happy were you growing up?

None Somewhat Mostly Extremely

How much is your family of origin a source of support for you?

None Somewhat Very Extremely

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How much conflict in values do you experience with your parents?
None Somewhat Substantial

Legal Issues
Have you personally experienced legal problems? □ No □ Yes (describe)

Are you currently involved in a lawsuit? If so please describe:

Briefly describe concerns in your life and/or in your relationships that would be relevant for your therapist to know. You may use the back of the form for more space if needed:

On a scale of one to ten, how motivated are you to resolve this issue? _____

Please list your therapy goals (list as many that apply & use the back if need be):
1.

2.

3.

Thank you for taking time to read and complete these questions. This information will be helpful in your therapy process. Your signature is required on the last page before we can begin our work together. Please discuss any questions you may have with me prior to signing.

Client Signature Page for Informed Consent For Therapy

- **I have thoroughly read and fully understand the Informed Consent and the therapy policy pages of this document.**
- **I understand that I am financially responsible for charges and fees incurred. And I agree to honor the 48 hour cancellation policy.**
- **I understand limits of confidentiality and all mandated reporting by my therapist.**
- **I understand that any disclosures of sex with a minor, viewing underage**

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pornography,or sexual behavior with minors (a person under the age of 18) is reportable under law.**

- **I agree to respect the boundaries of contact between sessions and understand email and text is not an appropriate form of processing what is best discussed in session.**
- **I understand that emailing, texting and cell phone are not guaranteed as confidential.**
- **I understand and agree to the illness policy and will conduct sessions via phone if I am ill and agree that if my therapist is ill, she/he will conduct via phone.**
- **I understand and agree to the social media boundaries and policy.**
- **I have answered all questions in full, truthfully and to the best of my knowledge.**
- **I have had all questions about this document answered and sign willingly.**
- **I authorize my Batsheva Gruber-Nass LMFT CSAT CMAT to provide psychotherapeutic treatment for me, the client, signing below:**

Client's name (printed): ___________________________________

Client's signature: __________________________________ Date: _______________

Therapist's name (printed): _____________________________________

Therapist's signature: ____________________________________ Date: _______________

Acknowledgement of Receipt of Privacy Practice Notice

By signing below, I hereby acknowledge receiving and reviewing Batsheva Gruber-Nass LMFT Notice of Privacy Practices and Limits of Confidentiality.

____
Client's Name (print)

____ _______________
Signature of Client Date

Client Credit Card Authorization Form

I authorize Batsheva Gruber-Nass LMFT CSAT CMAT to keep my signature and card information on a virtual terminal file that is password protected and HIPAA compliant in order to charge therapy session fees (individual, group, workshops, couples, family or other), and any fees related to therapy related materials (workbooks, DVD's, CD's, and other materials, and/or fees), or for any appointments with my therapist that are not cancelled 48 hours before the scheduled appointment time to be charged to my credit, charge, or debit card as filled out below for therapy services provided to:

____
(Therapy Client's Name: Please Print)

I understand that this authorization is valid until canceled in writing. I understand that charges for ongoing services or materials will normally be posted to my credit/debit/flex card account within 48 hours of each session date and **my session fee will be charged at the start of the day on the day of my session.**

Additionally, I agree that the card listed below may be charged by my therapist in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials (i.e. books, CD's, DVD's) that I have not returned within one week of completion of my therapy services. I understand that if a charge back fee is incurred or a retrieval fee of is incurred I am responsible for these fees. ___________ (Initial here)

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Batsheva-Gruber-Nass LMFT for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with my therapist and those attempts have failed. ___________ (Initial here)

Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions.___________ (Initial here)

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Cardholder Name (print):____

Signature____

Relationship to client:____

Billing Address:____

Zip Code: ____________________________

Card Type (**circle one):** 1.Visa 2.Mastercard 3. Amex

Acct. Number: ____________-____________-____________-____________

Exp. Date: ___________

I understand that my therapy sessions will be charged via this form and not by swiping my card on the morning of my session unless cancelled 48 hours in advance:

Cardholder Signature: ___________________________________ Date: __________

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