LORNA G. CHRISTENSEN, M.A., M.S.W., L.C.S.W.
California License LCS9367
(858) 453-8111

DEL MAR, CA 92014

Dear New Client(s),

Please pardon the paperwork for our first meeting. I request that you complete, read, and sign the attached forms as appropriate and bring them to our first meeting. Filling them out before our meeting will insure that the time we spend will get to the heart of your needs more directly.

I will be happy to discuss any questions you have about the forms at our meeting.

The forms needing your attention are as follows:

- The *Office Policies & Informed Consent* is required by law when we begin our professional relationship.
- The *Client Information* form provides me with basic information about you and will assist me in attending to your needs. I need each person who will be participating in treatment to fill out this form.
- The *Treatment, Payment, and Health Care Operations (TPO) Consent* form is standard for any health care provider and is required by HIPPA law. It also has a place for you to acknowledge receiving the HIPPA Leaflet (below).
- The *HIPPA Leaflet* (separate download document) is yours to have as a future reference of your privacy rights.

All information is strictly confidential and is filed in a locked file cabinet.

Thank you and welcome,

Lorna Christensen, LCSW

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OFFICE POLICIES & INFORMED CONSENT AGREEMENT FOR PSYCHOTHERAPY SERVICES

This form provides you with information that is in addition to that detailed in the Notice of Privacy Practices.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the *Notice of Privacy Practices* leaflet that you received with this form.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; and where a client presents a danger to others (See also *Notice of Privacy Practice*s).

When Disclosure May Be Required: Disclosure may be allowed when a client presents a danger to self, to property, or is gravely disabled. Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony from me. In couple/family therapy, or when different family members are seen individually, confidentiality may not apply. I will use my clinical judgment to support the disclosure of such information. I will not release records to any outside party unless I am authorized to do so by **all** adult family members who were part of the treatment.

Emergencies: If there is an emergency where I become concerned about your personal safety, I will do whatever I can within the limits of the law, to prevent you from injuring yourself and to ensure that you receive the proper medical care. For this purpose, I may contact the emergency person whose name you have provided on the *Client Information Sheet*, or other such documentation.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier/HMO/EAP in order to process the claims. Only the minimum necessary information will be communicated to the carrier. You must be aware that submitting an invoice for reimbursement can entail some risk to confidentiality, privacy, or future eligibility to obtain health or life insurance. Mental health information is entered into insurance companies' computers and soon will be reported to the congress-approved National Medical Data Bank. Computers are vulnerable to break-ins and unauthorized access; therefore, you could be in a vulnerable position.

Confidentiality of E-mail, Cell Phone and Faxes Communication: It is very important to be aware that e-mail and cell phone communication can be accessed by unauthorized people; hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to unauthorized access. Faxes can easily be sent erroneously to the wrong address. Please notify me at the beginning of treatment if you decide to avoid or limit the use of the above-mentioned communication devices. Please DO NOT use e-mail or faxes for emergencies.

Consultation: I consult regularly with other professionals regarding my clients; however, names or other identifying information are never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

* **Considering all of the above exclusions, if it is still appropriate, upon your request I will release information to any agency/person you specify unless I conclude that releasing such information might be harmful in any way.**

TELEPHONE POLICY & EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave a message on my voice mail and your call will be returned as soon as possible. I check my messages a few times a day, unless I'm out of town. At times, phone support between sessions may be honored. However, those calls will be billed accordingly: at one half the client's rate after 15 minutes and at the full rate after 30 minutes. If an emergency arises, please indicate it clearly in your message. If you need to talk to someone right away, please call the Police (911).

PAYMENTS: Fees are agreed upon by therapist and client by the first session. Clients are expected to pay at the end of the first session and at the beginning of subsequent sessions unless agreed otherwise. Individual sessions are 45-50 minutes long; double-sessions are 1½ hours in length. Telephone conversations, report writing, consultation with other professionals, releases, longer sessions, travel time, etc. will be charged at the same rate, unless other arrangements are made. All bounced checks will incur an extra charge of $15.00**.** Please notify me if any problem arises regarding your ability to make timely payments.

INSURANCE REIMBURSEMENT: Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, I will provide you with a receipt on a monthly basis, which you can then submit to your insurance company for reimbursement. Not all issues which are the focus of psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. As indicated above in *Health Insurance & Confidentiality of Records,* you must be aware that submitting a mental health invoice for reimbursement carries some risk.

THE PROCESS OF THERAPY/EVALUATION: Participating in therapy can result in numerous benefits, including improving interpersonal relationships and resolving the concerns that led you to seek therapy. Working toward these benefits, however, requires active involvement, honesty, and openness on your part. Moreover, while therapy is effective for many people and often leads to significant and lasting changes, there are some risks involved. Many people report discomfort during therapy, since strong

and sometimes undesirable feelings can emerge as one considers unpleasant or embarrassing subjects. I may challenge some of your assumptions, or, propose different ways of handling situations that may trigger upset for you. Attempting to resolve tensions between yourself and others (such as a partner, child or family member) may lead to changes that were not originally intended. Moreover, a decision that is positive for one person can be viewed quite negatively by another. Change can be easy and swift; but more often it can be slow, and even frustrating. For some people, problems may get worse before they get better. It is also possible that therapy does not work. Even so, many people find that therapy is worth the difficulty it may entail.

Discussion of Treatment: Within a reasonable time after initiating treatment, I will discuss with you (client) my understanding of the therapeutic issues and objectives, and my view of the possible modalities and outcomes of treatment. During the course of therapy, I am likely to draw on various psychological approaches that include, but may not be limited to behavioral, cognitive-behavioral, transpersonal, psychodynamic, existential, system/family, developmental (adult, child, family), EMDR (eye movement desensitization and reprocessing), EFT (Emotional Freedom Technique), other energy-psychology methods, or psycho-educational. If you have any questions about any of the procedures used in the course of your therapy, please ask and you will be answered fully. You also have the right to ask about other treatments and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining that treatment.

Termination: After the first couple of meetings, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals that you can contact. Also, if I assess that I am not effective in helping you reach the therapeutic goals, I am obliged to discuss it with you, and, if appropriate, to terminate treatment. Likewise, I would give you a number of referrals that may be of help to you. If at any time you want another professional's opinion, I will assist you in finding someone qualified; and, with your written consent, I will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, I will provide you with names of other qualified professionals whose services you might prefer.

Dual Relationships: Not all dual relationships are unethical or avoidable. However, therapy never involves sexual or any other dual relationship that impairs the therapist's objectivity, clinical judgment, or therapeutic effectiveness or can be exploitative in nature. I will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. Out in the community I will never acknowledge working therapeutically with anyone without your written permission. Many clients choose me as their therapist because they know me through group situations or a referral. Some clients know each other. Consequently you may bump into someone you know in the waiting room. Also, while dual relationships can enhance therapeutic effectiveness, they can also detract from it; and, often it is impossible to know that ahead of time. It is your, the client's, responsibility to communicate to me if the dual relationship becomes uncomfortable for you. I will always listen carefully and respond accordingly to your feedback. I will discontinue the dual relationship if I find it interfering with the effectiveness of the therapeutic process or your welfare; and, of course, you can do the same at any time.

CANCELLATION: You are responsible for remembering the date, location, and time of appointments. Reminders are not sent out. Since scheduling of an appointment involves the reservation of time specifically for you, **a minimum of 24 hours notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification**. Most insurance companies do not reimburse for missed sessions.

I have read the above Office Policies and Informed Consent Agreement carefully. I understand them and agree to comply with them.

_____

Client name (print) **Date** **Signature**

_____

Client name (print) **Date** **Signature**

Lorna Christensen, MA,MSW, LCSW

_____

Date **Signature**

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CLIENT INFORMATION FORM

Name: _____ Date of Birth _____ Today's Date _____

Address: _____ Marital Status _____

_____

Home Phone #: _____ Safe to call? Y N Cell Phone #:_____

Employer: _____Occupation:_____

Work Phone #: _____ OK to call? Y N

E-Mail: _____

Emergency Contact:

Name: _____ Relationship to you _____

Address: _____

_____

Phone #: _____ Other Phone #: _____

Please state in your own words your reason for seeking counseling:

_____

_____

_____

_____

Please check any areas where you are experiencing challenges:

Grief, death, illness	____	Financial stressors	____	Legal issues	____
Work, profession	____	Family stressors	____	Health, sleep, physical challenges	____
School	____	Change in residence	____	Other loss: _____	____
Relationships	____	Loss / promotion of a job	____	Other big change: _____	____
Marriage, separation, divorce	____	Pregnancy, miscarriage birth, abortion	____	Other _____	____

Have you experienced any of the following in the past year?

Fatigue	____	Mood swings	____	Isolation / loneliness	____
Intrusive thoughts	____	Decreased concentration	____	Loss of interest in daily activities	____
Panic / anxiety	____	Memory loss	____	Feelings of guilt, worthlessness	____
Depression	____	Weight gain / loss	____	Other: _____	____
Physical violence	____	Sleep disturbances	____	Other _____	____

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What role (if any) does spirituality or religion play in your life?
_____-
_____

How will you know when you overcome your challenges? What will be different?
_____
_____

How did you find out about my services?
_____

Relationships:

Relationship / Marital History (Give names, Ages & Duration):_____

_____

_____

_____

Children (Give names & DOB):
_____

_____

_____

Family of Origin (Give names & DOB):
_____

_____

_____

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CLIENT INFORMATION FORM (continued)

Support Systems:

Coping Skills / Self Care:

_____

_____

_____

Education / Degrees:

_____

_____

Friendships: _____

_____

Work / Hobbies / Interests:

_____

_____

_____

Medical & Mental Health History:

Medical History:

_____

_____

_____

Current MD: _____Date of Last Visit:_____
For:_____

Current Psychiatrist: _____ Date of Last Visit:
_____ For:_____

Current Medications & Dosages: (include herbal substances and vitamins taken regularly and over the counter medications)

_____

_____

_____

Previous Counselor: _____Date of Last Visit:_____

Previous counseling for:

_____

_____

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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Client Name(s) (print): _____ _____

Federal regulations (HIPAA) allow me as your service-provider to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The *Notice of Privacy Practices* leaflet describes these disclosures in more detail. You have the right to review the *Notice of Privacy Practices* before signing this consent.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, I do not have to agree to these restrictions.
If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken regarding the PHI prior to the date of revocation.

This consent is voluntary; you may refuse to sign it. However, I reserve the right to deny treatment if this consent is not granted, or if the consent is later revoked.

I (client) hereby consent to the use or disclosure of my Protected Health Information as specified above.

Signature of Client/Parent/Guardian: _____ **Date:** _____

Signature of Client/Parent/Guardian: _____ **Date:** _____

ACKNOWLEDGMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES*

By signing this section, you (the client) acknowledge receipt of the *Notice of Privacy Practices* leaflet that I have given to you. The *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information (PHI). I encourage you to read it in full. If you have any questions about the *Notice*, please contact me.

A current copy of *Notice* may be obtained by contacting me at:

P O Box 2136, Del Mar, CA 92014 or (858) 453-8111

I (client) acknowledge receipt of the *Notice of Privacy Practices* of Lorna G. Christensen, LCSW

Signature of Client/Parent/Guardian: _____ **Date:** _____

Signature of Client/Parent/Guardian: _____ **Date:** _____

Office use only

Good faith effort to obtain consent (describe)