Sarah Ludington MA, LPC

812 Grand Ave #202, Glenwood Springs, CO 81601 970-948-4274 SarahLudington.com

CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

Your child's name: _____
Last First Middle Initial

Parent or Legal Guardian's Name: _____
Last First Middle Initial

Child's date of birth: _____ **Gender:** _____

Home street address: _____

City: _____ **State:** _____ **Zip:**_____

Parent or Legal Guardian's Name of Employer: _____

Address of Employer: _____

City: _____ **State:** _____ **Zip:**_____

Home Phone: _____ **Work Phone:** _____
Cell Phone: _____ **Email:** _____
Calls will be discreet, but please indicate any restrictions:_____
_____

Referred by: _____
- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____
Name Phone
We will only contact this person if we believe it is a life or death emergency. Please provide your signature to indicate that we may do so: (Your Signature):_____

Please briefly describe your child's presenting concern(s):_____
_____
_____

What are your/your child's goals for therapy? _____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?_____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses your child has had:_____
_____
_____
_____

Current Medications (if you need more room, please write on the back of this page):

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons): _____
_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____
_____

Has your child ever talked with a psychiatrist, psychologist, or other mental health professional? (If yes, please list approximate dates and reasons): _____
_____
_____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual
__Transgender __ Asexual __In Question __Other

Racial/Ethnic Identity:
__African/African-American/Black
__American Indian/Alaska Native
__Asian/Asian-American/Asian Pacific Islander
__Bi-Racial/Multi-Racial
__ Latino/Latino-American
__ Middle Eastern/Middle Eastern-American
__White/European-American
__Not listed

FAMILY:

How would you describe your child's relationship with his or her mother?_____
_____
_____

How would you describe your child's relationship with his or her father?_____
_____
_____

Are the child's parents still married or did they divorce?_____ If they divorced, how old was the child when the parents separated or divorced and how do you think this impacted him or her? _____
_____

Please describe your child's relationship with his or her grandparents: _____
_____
_____

Were there any other primary care givers who have had a significant relationship with your child? If so, please describe how these people may have impacted your child's life: _____
_____
_____

How many sisters does your child have? _____ Ages? _____

How many brothers does your child have? _____ Ages? _____

How would you describe your child's relationships with his or her siblings?_____
_____
_____
_____

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

Child's current level of satisfaction with friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

How would you describe your child's relationships with his/her peers? _____
_____

Please briefly describe any history of abuse, neglect and/or trauma: _____
_____
_____

Please briefly describe your child's self-care and coping skills: _____
_____
_____

What are your child's diet, weight, and exercise/activity patterns?_____
_____
_____

Please briefly describe your child's school performance and experience:_____
_____
_____

What are your child's hobbies, talents, and strengths?_____
_____
_____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				Tantrums →				Nausea →		
Depression				Parents Divorced				Stomach Aches		
Mood Changes				Seizures				Fainting		
Anger or Temper				Cries Easily				Dizziness		
Panic				Problems with Friend(s)				Diarrhea		
Fears				Problems in School				Shortness of Breath		
Irritability				Fear of Strangers				Chest Pain		
Concentration				Fighting with Siblings				Lump in the Throat		
Headaches				Issues Re: Divorce				Sweating		
Loss of Memory				Sexually Acting Out				Heart Problems		
Excessive Worry				History of Child Abuse				Muscle Tension		
Wetting the Bed				History of Sexual Abuse				Bruises Easily		
Trusting Others				Domestic Violence				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Makes Careless Mistakes		
Separation Anxiety				Hurting Self				Fidgets Frequently		
Alcohol/Drugs				Thoughts of Suicide				Impulsive		
Drinks Caffeine				Sleeping Too Much				Waiting His/Her Turn		
Frequent Vomiting				Sleeping Too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Head Injury				Sleeping Alone				Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems				Physical Abuse				Depression			
Legal Trouble				Sexual Abuse				Anxiety			
Domestic Violence				Hyperactivity				Psychiatric Hospitalization			
Suicide				Learning Disabilities				"Nervous Breakdown"			

Any additional information you would like to include:

Agreement of Financial Responsibility

I, _____, understand and agree to pay my therapist, Sarah Ludington, the amount of $120/hour at the conclusion of my sessions. **I understand that I am responsible for payment for consultation not canceled 24 hours in advance.** Payment for services is rendered at the conclusion of the consultation unless other arrangements have been made.

Patient's Signature_____Date_____

Spouse's Signature_____Date_____

Parent/Guardian's Signature_____ Date_____

I will be happy to discuss my fees, schedule of payments or any other questions relating to billing or insurance. Please do not hesitate to ask.

Sarah Ludington, MA, LPC
812 Grand Avenue, Suite 202
Glenwood Springs, CO 81601
(970) 948-4274
sludington@rof.net

NOTICE OF PRIVACY POLICIES AND PRACTICES AND COMPLIANCE WITH HIPAA REGARDING CONFIDENTIALITY OF CLIENT RECORDS AND DISSEMINATION OF INFORMATION

Given the nature of my work, it is imperative that I maintain the confidence of client information that I receive in the course of my work. Sarah Ludington, LLC (herein "SL") is a private mental health counseling practice that provides therapy to individuals, couples, and families. The practice works solely to provide the best counseling treatment options to its clients. Discussions or disclosure of protected health information (PHI) within the organization is limited to the minimum necessary for the recipient of the information to perform their job. Please review this Notice of Privacy Policies and Practices and Compliance with HIPAA Regarding Confidentiality of Client Records and Dissemination of information. It is the policy of SL to:

1. Fully comply with the requirements of the HIPAA General Administrative Requirements, the Privacy and Security Rules;
2. Provide every client who receives services with a copy of this Notice of Privacy Policies and Practices;
3. Ask the client to acknowledge receipt when given a copy of this Notice of Privacy Policies and Practices;
4. Ensure the confidentiality of all client records and transmitted by facsimile;
5. Provide each client with my informed Authorization for use or disclosure of PHI forms.

SL is required to follow all state statutes and regulations including Federal Regulation 42 C.F.R Part 2 and Title 25, Article 4, Part 14 and Title 25, Article 4, Part 14 and Title 25, Article 1, Part 1, CRS and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R Parts 142, 160, 162 and 164, governing testing for and reporting of TB, HIV AIDS, Hepatitis, and other infectious diseases, and maintaining the confidentiality of PHI.

PHI refers to any information that is created or received by SL and relates to an individual's past, present or future physical or mental health or conditions and related care services or the past, present, or future payment for the provision of health care to an individual; and

1. That identifies the individual;
2. With respect to which there is a reasonable basis to believe the information can be used to identify the individual; or
3. PHI includes any such information described above that SL transmits or maintains in any form, this includes Psychotherapy Notes. HIPAA and federal law regulate the use and disclosure of PHI when transmitted electronically.

YOUR RIGHTS AS A CLIENT:

When it comes to your health information, you have certain rights. This section explains your rights and some of my responsibilities to help you.

Get an electronic or paper copy of your mental health record.

- You can ask to see or get an electronic or paper copy of your mental health record and other health information I have about you. Ask me how to do this.
- I will provide a copy or a summary of your health information, usually within 30 days of your request. I may charge a reasonable, cost-based fee.

Ask me to correct your mental health record

- You can ask me to correct health information about you that you think is incorrect or incomplete. Ask me how to do this.
- I may say "no" to your request, but I will tell you why in writing within 60 days.

Request confidential communications

- You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- I will say "yes" to all reasonable requests
- Please review the Consent for Communication of Protected Health Information by Non-Secure Transmissions
- You are required to "opt-in" to receive communications electronically as set-forth in the Consult for Communication of Protected Health Information by Non-Secure Transmissions. If you choose not to "opt-in" to receive electronic communication, I will not communicate with you via electronic means.

Ask me to limit what I use of share

- You can ask me not to use of share certain health information for treatment, payment, or our operations. I am not required to agree to your request, and I may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask me not to share that information for the purpose of payment or my operations with your health insurer. I will say "yes" unless a law requires me to share that information.

Get a list of those with whom I've shared information

- You can ask for a list (accounting) of the times I've shared your health information for six years prior to the date you ask, who I shared it with, and why.
- I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make.) I will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. I will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- I will make sure the person has this authority and act for you before I take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1-877-696-6775 or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- I will not retaliate against you for filing a complaint.
- You may also file a complaint with the Colorado Department of Regulatory Agencies, Division of Professions and Occupations, Mental Health Section; 1560 Broadway, Suite 1350, Denver, CO 80202. 303-894-2291. DORA.MentalHeatlboard@state.co.us
- Please note that the Department of Regulatory agencies may direct you to file your complaint with the US Department of Health and Human Services Office for Civil Rights listed above.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A use of PHI occurs within a covered entity (i.e., discussions among staff regarding treatment). A disclosure of PHI occurs when SL reveals PHI to an outside party (i.e., SL provides another treatment provider with PHI, or shares PHI with a third party pursuant to a client's valid written authorization). HIPAA and federal law regulate the disclosure of PHI by electronic transmissions.

SL may use and disclose PHI without an individual's written authorization, for the following purposes:

1. Treatment (including the provision and coordination of care with other professionals, etc.)
2. Payment (to bill and get payment from health plans or other entities, claims management, etc.)

3. Health Care Operations (general administrative activities and operation of SL, resolution of internal grievance, customers service, etc.)

Uses and disclosures for payment and health care operations purposes are subject to the minimum necessary requirement. This means that SL may use only use or disclose the minimum amount of PHI necessary for the purpose of the use of disclosure (i.e., for billing purposes, a therapist would not need to disclose client's entire medical record in order to receive reimbursement. A therapist would likely only need to include a service code, etc.) Uses and disclosures for treatment purposes are not subject to the minimum necessary requirement. SL is required to promptly notify you of any breach that may occur that may have comprised the privacy or security of your information.

Federal law and regulations protect SL's confidentiality of client records and substance abuse client records maintained. It is SL policy that a client must complete an Authorization for use or disclosure of Protected Health information (Attachment 1), provided by SL, prior to disclosing health information for any purpose, except for treatment, payment or health care operations.

Absent the above referenced form, other than for treatment, payment, or health care operations purposes, I am prohibited from disclosing or using any PHI outside of or within the organization, including disclosing that the client is in treatment, unless one of the following exceptions:

SL is permitted and/or required to report or disclose PHI if and when any of the following occur with any SL client:

1. Responding to lawsuit and legal actions (Disclosure by a court order, in response to a complaint against a counselor of SL, etc.)
2. Disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.
3. Help with public health and safety issues (Client commits or threatens to commit a crime either at the program or against any person who works for the program; A minor or elderly client reports having been abused; Client is planning to harm another person, including but not limited to the harm of a child; Client reports suicidal ideation or self harm.
4. Address workers' compensation, law enforcement, and other government requests
5. Respond to organ and tissue donation requests.
6. In compliance with other state and/or federal laws and regulations.

The above exceptions are subject t several requirements under the Privacy Rule, including the minimum necessary requirement (you may only use and disclose the minimum amount of PHI necessary for the intended purpose of the use and/or disclosure) and applicable federal and state laws and regulations. See 45 C.F.R 164.512. Before using or disclosing PHI for one of the above exceptions, consult me to ensure compliance with the Privacy Rule. Violation of these federal and state guidelines is a crime carrying both criminal and monetary penalties. Suspected violations may be reported to appropriate authorities in accordance with federal and state regulations. Know that SL will never market or sell your personal information.

SPECIAL AUTHORIZATIONS

Certain categories of information have extra protections by law, and thus require special written authorizations for disclosures.

Psychotherapy Notes: I will obtain a special authorization before releasing your Psychotherapy Notes and test results. "Psychotherapy Notes" are notes I have made about our conversation during a private group, joint, or family counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

HIV Information: Special legal protections apply to HIV/AIDS related information. I will obtain a special written authorization from you before releasing information related to HIV/AIDS.

Alcohol and Drug Use Information: Special legal protections apply to information related to alcohol and drug use and treatment. I will obtain a special written authorization form you before releasing information related to alcohol and/or drug use/treatment. You may revoke all such authorizations (of PHI, Psychotherapy Notes, HIV information, and/or Alcohol/Drug Use information) at any time, provided each revocation is in writing, signed by you, and signed by a witness. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage law provides the insurer the t=right to contest the claim under the policy.

As a covered entity under the Privacy and Security Rules, SL is required to reasonably safeguard PHI from impermissible uses and disclosures. Safeguards may include, but are not limited to the following:

1. Not leaving lab results unattended where third parties without a need to know can view them.
2. Any PHI received by SL about a client or a potential client, may not be used or disclosed for non-work purposes or with unauthorized individuals. SL may only use and disclose such PHI as described above.

3. When speaking with a client about his or her PHI where third parties could possibly overhear, move the conversation to a private area.
4. Seek legal counsel in uncertain situations and/or incidences.

YOUR CHOICES:

For certain health information, you can tell me your choices about what I share. If you have a clear preference for how I share your information in the situations described below, talk to me. Tell me what you want me to do, and I will follow your instructions. I may request you sign a separate document if you authorize me to share certain PHI. You may revoke that authorization at anytime for future disclosures.

In these cases, you have both the right and choice to tell me to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief, situation
- Include your information in a hospital directory

If you are not able to tell me your preference, for example if you are unconscious, I may go ahead and share your information if I believe it is in your best interest. I may also share your information when needed to lessen a serious imminent threat to health or safety.

In these cases I will never share your information unless you me give me written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- I may contact you for fundraising efforts, but you can tell me not to contact you again.

Changes to the Terms of this Notice

I can change the terms of this notice, and the changes will apply to all information I have about you. The new notice will be available upon request, in my office, and on my website.

This notice is effective _____ 201__.

_____

Sarah Ludington, MA, LPC

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION BY NON-SECURE TRANSMISSION

This consent is for the communication of Private Health Information that the Sarah Ludington LLC, hereafter "SL", may transmit without the written authorization of the client as described in the Uses and Disclosures section of SL's Notice of Privacy Policies and Practices.

I, _____ hereby consent and authorize SL to communicate my personal health information through the following non-secure transmissions (Please initial your choices):

_____Cellular/Mobile Phone this includes text messaging.
(Please insert cell phone number_____).

_____Unsecured email.
(Please provide email address_____)
Please circle one: Work Personal

_____Other media
(Please describe:_____)

_____I do not wish my personal health information transmitted electronically

Should we agree to communicate by the approved communications listed above, i.e. text, email, telephone, or any other electronic method of communication, confidentiality extends to those communications. However, I cannot guarantee that those communications will remain confidential. Even though I may utilize state of the art encryption methods, firewalls and backup systems to help secure our communications, there is a risk that our electronic or telephone communications may be compromised, unsecured, and/or accessed by an unintended third party.

I, _____ understand that SL may use and disclose the following protected health information without written authorization. However, I consent to SL transmitting the following protected health information by the above selected electronic communications (Please initial your choice):

_____Information regarding scheduling
_____ Information related to billing and payments
_____Information related to your mental health treatment (this may contain personal materials, forms, suggested articles, homework, etc.)
_____Information related to SL's operations
_____Other information. Please describe _____
_____
_____

_____
Signature of Client/Parent/ Legal Guardian

_____
Print Name

Mandatory Disclosure Statement

This disclosure statement contains important information about your mental health that I am required to disclose and the policies and procedures of my practice. This disclosure statement is HIPAA compliant. By signing this disclosure statement, you acknowledge you have received a copy of my Notice of Privacy, Policies and Practices and Compliances with HIPAA Regarding Confidentiality of Client Records and Dissemination of Information.

About me:

I completed my Master's Degree in Counseling Psychology at Pacifica Graduate Institute in Santa Barbara, CA in March 2012. I have been working with clients in Community Mental Health since July 2009. My education builds on a Bachelor of Science in Health Care Management and an Associate of Science in Dental Hygiene.

I am trained and certified in EMDR – Eye Movement Desensitization and Reprocessing.

I have been training with the Couples Institute on the Developmental Model (Bader/Pearson) since 2013 to facilitate my work with couples. I am currently in the Masters Mentorship Program with Drs. Ellyn Bader and Pete Pearson.

I have completed the training for DBT – Dialectic Behavioral Therapy.

My primary goal is to meet the client where they are. My focus is on depth psychology, which calls to attention the importance of what lies below the surface of conscious awareness. This type of intervention has its foundation in Analytical Psychotherapy. This approach attempts to create, using a symbolic approach, a dialectical relationship between consciousness and the unconscious. The therapist encourages and guides communication between the two systems via an imaginable process using "symbolic language", as in dreams, fantasies, etc. Increased awareness, and thus symptomatic relief, is brought about by the translation and interpretation of this "symbolic language."

The Mental Health Licensing Section of the Division of Registrations regulates the practice of licensed or registered persons in the field of psychotherapy. The Board of Registered Psychotherapist Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. As to the regulatory requirements applicable to mental health professionals:

- A Registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.
- Certified Addiction Counselor I (CAC) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.
- Certified Addiction Counselor II (CAC II) must compete additional required training hours and 2,000 hours of supervised experience.
- Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, completed additional required training hours and 2,000 hours of supervised experience.
- Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements.
- Licensed Social Worker must hold a master's degree in social work.
- Psychologist Candidate, a Marriage and Family Therapist, and a **Licensed Professional Counselor** must hold a master's degree in their profession and have two years of post-masters supervision.
- A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.

In a professional relationship:

- Sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.
- It may be inappropriate for therapists and clients to have a "dual relationship". Specifically it is unethical for the therapist and client to have other business or personal relationships is addition to the therapeutic relationship/ If you or a member of your family has a person or business relationship with your therapist or her family, please discuss this immediately with your therapist.

You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.

I have read the preceding information, it has also been provided verbally, and I understand my rights as a client or as the client's responsible party.

Everyone fifteen years of age and older must sign this disclosure statement. A parent or legal guardian must sign on behalf of any minor child under the age of fifteen.

_____

Print Client's name

_____ _____

Client's or Responsible Party's Signature Date

If signed by Responsible Party, please state relationship to client and authority to consent:

_____

Confidentiality

All communication between you and I, your therapist, will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. However, it is important that you know that I utilize a "no-secrets" policy when conducting family or marital/couples therapy. This means that if you participate in family, and/or marital/couples therapy, I am permitted to use information obtained in an individual session that you may have had with me, when working with other members of your family. Please feel free to ask about this policy and how it may apply to you.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. A court order signed by a judge requires release of information. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, paper, and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

Minors and Confidentiality

Communication between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, I may discuss the treatment progress of a minor with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with me.

Appointments Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify me at least 24 hrs. in advance of your appointment. **If you do not provide at least 24 hours notice in advance, you are responsible for payment for the missed sessions.**

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, I will attempt to keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for me at any time on my confidential voicemail. If you want me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Nonurgent phone calls are returned during normal workday (Monday through Friday) within 24 hours. If you have an urgent need to speak with me, please indicate that fact in your message and follow any instructions that are provided by my voicemail. **In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.**

I am not able to return phone calls after 9 P.M. or on Saturdays or Sundays.

About the Therapy Process/Informed Consent Information

It is my intention to provide services that will assist you in reaching your goals. Based upon the information you give me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

If you are entering psychotherapy for the first time you may not be aware that often the emotional pain that causes a person to seek therapy can be increased temporarily in the therapy process. The other side of this truth is that the psychic container of he therapeutic relationship can provide the safety and support that makes such pain bearable. You will be paying me for my time, attentive and informed listening, important guiding questions and some well-established therapeutic techniques and tools. I will not give you direct advice unless you are in a crisis or some kid of danger.

I may recommend that you utilize outside support such as an M.D. referral, evaluation by a psychiatrist for medications, a therapy or support group in the community that may enhance the therapeutic process or your chosen spiritual support or church.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in

collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing treatment plan, or terminating therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask me to address any questions or concerns that you have about this information before you sign!

_____

Name of Client

Date: ___/___/____