Mindful Therapy Practice.
Melissa Barsotti, LCSW # 64017
TEL 626-893-0480

CLIENT INFORMATION FORM

Date: _____________

Client's Name (or Responsible Adult) **Home Phone**

Address (including ZIP code)

Occupation **Work Phone** **Cellular Phone**

Partner's Occupation **P's Work Phone** **P's Cell Phone**

Minor or Dependent Adult as patient **Patient's work phone** **Patient's Cell Phone**

FOR MINOR CLIENTS OR FAMILY AS CLIENT

Name (minor client) **Age** **Date of birth** **Current School**

SIBLINGS

Name (minor client) **Age** **Date of birth** **Current School**

Name (minor client) **Age** **Date of birth** **Current School**

Name (minor client) **Age** **Date of birth** **Current School**

REFERRAL INFORMATION

Name of person referring you **Agency/School** **Phone number**

INSURANCE INFORMATION

(PLEASE COMPLETE IF YOU PLAN TO SEEK REIMBURSEMENT FROM YOUR INSURANCE PLAN.)

______________________	___________________	____________	__________________
Name of insured	**Insurance Co.**	**Plan/Group #**	**Insured SS #**

Therapy Information and Treatment Consent

The Process of Psychotherapy

Psychotherapy is often helpful to people who are experiencing some degree of emotional, mental, or psychological distress. The process of therapy can help you to better clarify your goals and values, improve interpersonal relationships, increase your productivity and creativity, and assist you in solving various other personal challenges or problems. In fact, various research studies have shown that most people who enter therapy report that it has helped them in some way. Of course, there are no guarantees. But, effort on your part, a desire to be open-minded and honest with your therapist, and a genuine desire to improve some aspect of your life will increase the likelihood that therapy will help you.

In the beginning, we will meet for a certain number of evaluation sessions, usually between 3 and 5 sessions. These evaluation sessions will: **(1)** Give you an opportunity to introduce, describe and detail the exact nature of the problem(s) or challenge(s) which have brought you to therapy; **(2)** Allow me an opportunity to assess if and how therapy will be helpful in addressing your issues; **(3)** Determine if your concerns are within the scope of my practice, and what approaches might prove most beneficial; and **(4)** Give us both a chance to get to know each the other. This will give you the opportunity to determine if I will be a good "match" for you as a therapist. This is particularly important given that the therapeutic relationship requires considerable trust and quite often involves a significant investment of time, energy, and money. If for any reason you decide that you would prefer another therapist, I will be happy to help you find one.

Following the evaluation sessions we will discuss my preliminary assessment of your issues. We will then discuss and develop specific goals that you would like to work on in therapy. We will explore and discuss the treatment options available to us, given the scope and nature of your issues, and my experience and expertise. If I determine that I cannot treat your specific concern I will do my best to find a therapist who you can work with. Throughout the therapy we will periodically re-visit your progress toward your treatment goals, thereby giving us specific and measurable data as to when the therapy is nearing completion.

It is important for you to know that the process of therapy entails some risks. At times you may feel considerable discomfort in therapy. Remembering and resolving unpleasant events and experiences may bring on strong feelings like anger, frustration, anxiety, sadness, or fear. Also, attempts to resolve issues between you and other important people in your life can lead to unexpected changes (such as divorce, or remaining in a relationship you thought you might leave). Finally, the process of therapy, like any professional service, may not lead to the outcomes you anticipated or desired. There are no guarantees. Even so, many people feel

that the outcome of psychotherapy is worth the discomfort and challenges they may have to face.

Touch in Psychotherapy

My approach to therapy often actively integrates the body with the mind and emotions. Attention to body experiences is used to develop awareness and build tolerance for experiencing sensations and emotions. For some people, depending upon many factors, I may suggest bodywork that involves physical touch. Touch in psychotherapy is never sexual or about sex.

Your Rights as a Client

Your safety and comfort are my foremost concern. It is therefore important that boundaries are clear and honored in both bodywork and psychotherapy. To these ends, I unhesitantly support the ethical sanctions of my profession prohibiting any kind of sexual contact or activity between therapists and clients during the course of therapy. I am also legally bound by these sanctions. The methods of touch in which I have been trained are done consciously, non-sexually, and always with your consent. However, if you ever feel uncomfortable in any way, it is important that you communicate that to me. You always have the right to stop or change any procedure at any time for any reason. You always have the right to know, beforehand, what methods will be employed. You always have the right to ask, at any time, any questions that arise for you.

Termination

As set forth above, after the first couple of meetings I will assess if I can be of benefit to you. I will not accept a client who, in my opinion, I cannot help. If at any point during psychotherapy I assess that I am not effective in helping you reach our therapeutic goals, I am obligated to discuss it with you and, if appropriate, to terminate treatment. In either case, I would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, 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. However, in some circumstances people feel that they want to stop coming to therapy when they are about to face something that is uncomfortable, yet potentially could be very fruitful. For this reason, I request that we have at least one session to discuss termination.

Dual Relationships

Despite a popular perception, not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs objectivity, clinical judgment or can be exploitative in nature. I will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. It is important to realize that in some communities, particularly small towns, small communities, military bases, university campuses, spiritual and rehabilitation communities, etc., multiple relationships are either unavoidable or expected. I will never acknowledge working with anyone without his/her written permission.

Social Networking

I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites can compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites.

Confidentiality

Your therapy will likely include discussions of very private things. To some extent, my ability to help you will depend on how open you can be about yourself – your ideas, feelings, experiences, and actions. So that you can feel safe to talk openly with me, and to protect your right to privacy, the law makes it my duty to keep information about you confidential. This means that, with very few exceptions, I **cannot** discuss your case with anyone or disclose any information about you without your **written** permission.

You should also be aware that I keep records of our sessions which are very specific. These notes are commonly referred to as "Protected Health Information" or **PHI**. Your PHI consists of a very brief listing of important and circumscribed aspects of our sessions together (e.g., the date the session, session modality, length of session, fees paid, diagnosis, treatment goals focused on in the session, treatment progress, and any special issues which may arise). I also keep a record of our phone conversations, insurance forms you submit, and information required for such forms. These notes and records are just as confidential as the issues we discuss in therapy.

Exceptions to Confidentiality

There are certain exceptions to confidentiality that you should know about. Please note that these exceptions are usually rare and may not happen – but in case they do, they are important for you to understand.

1. If I have received information from either you or a family member that leads me to believe you pose a risk of grave bodily injury to another person, I am required by law to take steps to protect people who are in danger. These steps include contacting the person(s) who are being threatened, arranging appropriate hospitalization, and notifying the police.

2. If you threaten to cause severe harm to yourself, and I feel the threat is serious, I am ethically required to protect you to the best of my ability. This may include talking to you about voluntarily going to a hospital, talking with friends or family members who may provide protection, or having you placed in a hospital even without your permission.

3. If I suspect that any child, elderly individual, dependent adult, or incompetent person is being abused or neglected, I am mandated by law to report this suspected abuse to the appropriate county agency. These laws are meant to protect children and dependent adults from being hurt.

4. Also, if I have a reasonable suspicion that you have knowingly developed, duplicated, printed, downloaded, streamed, accessed through any electronic or digital media, or exchanged, a film, photograph, videotape, video recording, negative, or slide in which a child (under the age of 18) is engaged in an act of obscene sexual conduct, I am legally mandated to report this suspected abuse to the appropriate agency. (CA Penal Code Sec 11165.1 – rev. 1-1-15)

5. I may occasionally find it helpful to consult with other licensed professionals about your case. In such circumstances, I will make every effort to avoid revealing any identifying information about you. This consultant, of course, is also legally bound to keep the information we discuss confidential. Unless you object, I will not inform you of these consultations unless I feel that it is important to our work together.

6. If I receive a subpoena or a court order asking for your records, I may be required to give the court the specific information it requires. If I am subpoenaed my first action will be to call you to discuss the situation.

7. If you are/will become involved in any kind of lawsuit or legal proceeding, and you or your attorney wish me to testify as to your emotional or mental health, you may not be able to keep your records or therapy confidential in court. Also, if you bring legal action against your psychologist, you will not be able to keep your records or therapy private in court. You may wish to discuss these matters with an attorney.

Please note: ***I do not provide custody evaluation recommendation or legal advice, as these activities do not fall within my scope of practice.***

8. If you are seeing me in couples, family, or group therapy I ask that every participant in the therapy promise to keep whatever happens in the therapy confidential. This means that each person involved in the therapy should not discuss what is said or done in therapy with anyone who is not part of the treatment. You should note that I can not guarantee that group members will keep this promise.

Confidentiality of E-Mail Communication

It is very important to be aware that e-mail and cell phone communication can be accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular are vulnerable to such unauthorized access.

Faxes can easily be sent erroneously to the wrong address. Please notify me if you decide to avoid or limit in any way the use of any or all of the above mentioned communication devices. **Please do not use e-mail or Faxes for emergencies.**

Consent For Permission to Use Email, Texting or Other Electronic Technology Communication

(Initial if you agree)

______I permit Mindful Therapy Practice to communicate with me via electronic technologies including, but not limited to email and text messaging. This will only be for the transmission of session time or blank document transmission. I understand that the risks of communicating via electronic technologies include:
• Messages can be delivered to the wrong recipient either because of a mis-route, or because it is delivered to a non-secure mailbox.
• Messages can be intercepted by someone hacking email. While this is may be less probable, it is still a distinct vulnerability.
• I am aware of the risks of having medical information sent to me via electronic messaging systems. It is my responsibility to inform my treating staff if I change my electronic address. I will continue to receive information via electronic means unless this consent is revoked. Revocations and changes of my electronic address must be made in writing and submitted to the program in which I am being treated.
I agree NOT to communicate emergencies via email, texting or other electronic technologies.

Release of Information

If you or I decide that it is in the best interest of your treatment that I provide or receive information concerning your case with another treatment professional, insurance company, or other relevant individuals (i.e., teachers, relatives, etc.), I require that you sign a written authorization for this exchange of information. We will discuss this process before you sign this consent.

Couples with Children

Couples therapy can be very effective in resolving conflicts and differences between partners. Sometimes, however, a couple may decide to separate or divorce during or after the therapy. In order to make your therapy safer and provide our work together with the best chance of success, I would like you **both** to agree **not** to use anything said in the therapy, any therapy notes, or me as your therapist, in any possible custody related or divorce related legal proceeding. By signing this consent, you both agree to this condition.

Pre-Teens and Teenagers as Clients

If you are under eighteen years of age you should know that the law may provide your parents with the right to review your treatment records. It is my policy to request an agreement with parents that they consent to waive their right to access your records. If they agree, I will provide them only general and thematic information about how the therapy is progressing. However, if I believe that you are engaging in **ongoing** actions or behaviors which may cause you **serious** physical or psychological harm I reserve the right to inform your parents of these issues. I will only discuss such matters with your parents **after** you and I have discussed these issues and have exhausted all other avenues to address these dangerous behaviors or actions. If I decide that I must discuss such an issue with your parents, we will decide together the best way for me to do this.

I agree to the plan outlined in the above two paragraphs: __________ ______

DATE Pt Initials

Telephone & Emergency Services

If you need to contact me between sessions, you may call my cell phone at any time at (626) 893-0480 and leave a message. I will return your call as soon as possible. I check my messages regularly. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, please call 911 or the **San Diego Access and Crisis Line (888) 724-7240.**

Acknowledgement and Consent

By signing this form I acknowledge that I have read, understand, and consent to the above stipulations and policies, and that I have discussed and clarified to my satisfaction any questions I have had regarding this information with my therapist.

Client	**Date**
Client	**Date**
Client	**Date**
Client	**Date**
Therapist	**Date**

Financial Agreement

This financial agreement is made between **Mindful Therapy Practice treating therapist Melissa Barsotti, LCSW (# 64017)** and:

___________________________________, a primary client. AND/OR

___________________________________, a parent / guardian / responsible party.

I agree to provide therapy and/or other psychological services, and the above named and undersigned client or responsible party agrees to pay for services as set forth below. **Please read and initial each of the points below thereby indicating your understanding and agreement with each of these points**:

The above named client or responsible party agrees to pay the sum of $ __________ per 50 minute psychotherapy session;

Telephone conversations of more than 15 minutes, as well as other requirements of my time, will be charged at the same rate, unless indicated and agreed otherwise. Please notify me if any problem arises during the course of therapy regarding your ability to make timely payments.

_____

Payment is expected at the time that services are rendered unless other arrangements have been made in advance with Mindful Therapy Practice treating therapist Melissa Barsotti, LCSW. From time to time, my fees will increase due to inflation and cost of living increases. When I am considering a change to my fees, I will discuss it with you beforehand.

_____

Your appointment is reserved exclusively for you. You will be charged the full fee for your session for any missed or cancelled appointments unless you provide me with at least 24 hours notice.

_____

Unless you have made special arrangements with me, **if you miss three or more appointments in a row** (2 week vacations notwithstanding) I may not be able to hold your appointment time and you may lose your time slot.

_____

The above named client or responsible party authorizes Mindful Therapy Practice treating therapist Melissa Barsotti, LCSW to discuss or release necessary and relevant information to the client/responsible party's insurance company in order to assist the client/responsible party being reimbursed by their insurance company and to insure continuity of care.

_____

A $25.00 fee will be charged on all checks returned for insufficient funds,

_____

Insurance, other than Medicare: Clients who carry insurance whose panels I am a member of will only be required to make their co-payment.

Medicare Insurance: If you have Medicare insurance without any supplemental insurance, there is a minimum co-pay you must make that varies between $15.00 to a maximum of $40.00.
If you have supplemental insurance as an addition to your Medicare, i.e. Blue Shield, Hartford, AARP, etc., then there is no co-pay that you will need to make and I will bill your supplemental carrier.

_____

Some clients may wish to submit my statements to their insurance companies, as some will provide limited reimbursement for **"off-plan providers" or "out of network."** If you submit my bill for reimbursement, please make it clear that **YOU** the member are to be reimbursed, not **ME** the provider. Within the constraints of this policy, I will do everything I can to assist you in your efforts to obtain some reimbursement for my services provided your insurance company offers such a plan.

_____

<u>Substance Use:</u> Sobriety during sessions is mandatory. Should any individual attend therapy in an intoxicated state, the session will be cancelled and payment will be required. This will also constitute a late canceled session and insurance will not be billed.

_____

My initials adjacent to the above conditions indicate that I have read, understand, and agree to all of the above points. My signature below indicates that I willingly consent to the above contract and that I have received a copy of this agreement.

________________________________ ________________
Primary Client (If Adult Case) **Date**

________________________________ ________________
Parent / Guardian/Responsible Party (If applicable) **Date**

________________________________ ________________
Parent / Guardian/Responsible Party (If applicable) **Date**

________________________________ ________________
Therapist **Date**

Privacy Practices Consent

This agreement is made between Mindful Therapy Practice treating therapist Melissa Barsotti, LCSW and

_________________________________, a client or responsible party.

Under the Health Insurance Portability Act of 1996 (HIPAA) your therapist cannot treat you or your dependent unless you sign this consent form regarding your Privacy, These procedures are in effect as of September 23, 2013. If these procedures or policies are changed in the future you will be notified.

After you have signed this consent you have the right to revoke it in writing.

I understand that during the course of my treatment with Mindful Therapy Practice treating therapist Melissa Barsotti, LCSW will be collecting what the law refers to as Protected Health Information (PHI) concerning me and/or my child. I understand that Mindful Therapy Practice treating therapist Melissa Barsotti will use this information to decide on the best treatment for me and/or my child and to best coordinate care. Mindful Therapy Practice treating therapist Melissa Barsotti may also share this information with others who provide my treatment, or use it to arrange payment for treatment. I further understand that if there is specific information that I do not want to be disclosed that I can communicate that to Melissa Barsotti, LCSW and she will do her best to honor this request.

I understand that by signing this consent form I agree to allow Mindful Therapy Practice treating therapist Melissa Barsotti, LCSW to use my information and to send it to others as outlined in the Notice of Privacy Practices. ***I have read this Notice, have received a copy of it, and understand my rights regarding privacy****.*

___________________________________ ________________
Signature of Client or Responsible Party Date

___________________________________ ________________
Signature of Client or Responsible Party Date

___________________________________ ________________
Signature of Client or Responsible Party Date

___________________________________ ________________
Signature of Therapist Date