INTRODUCTORY FORM

(Please type or print clearly)

Client Name(s) _____

Age _____ Date of Birth _____

Gender/Preferred Pronoun _____

If child, client's parent/guardian _____

Home address _____

City, State, Zip _____

Home Phone _____

Cell Phone _____

Other Phone _____

Email _____

OK to leave a confidential msg on cell phone? YES NO

Circle: SINGLE DIVORCED MARRIED PARTNERED

Work Status/Profession _____

Who lives in the home (Please include all adults, children, and pets)

_____

Children:

Name _____ DOB _____ Lives in home? _____
Name _____ DOB _____ Lives in home? _____
Name _____ DOB _____ Lives in home? _____
Name _____ DOB _____ Lives in home? _____

Emergency Contact: Name _____
Relationship _____
Cell _____

Preferred Payment: CHECK VENMO

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INFORMED CONSENT FOR THERAPY

Welcome! I look forward to going on this journey with you. The following pages describe my policies and provide information on what you can expect during our work. Please read each item carefully and initial each item, and feel free to discuss questions you have at any time, as these pages constitute an agreement between us. I have an LCSW in Licensed Clinical Social Work in the State of California. My areas of specialized training include Sensorimotor Psychotherapy, Integrative Body Psychotherapy, trauma, adoptions, and foster care. I encourage you to ask me questions at any time about therapy, my background, techniques, modalities, suggestions, and what to expect from sessions. I am always happy to discuss why I'm doing what I am doing, as I believe in having open lines of communication between us.

At the start of our work together, we will meet, either remotely or in-person, for a process of gathering background information and to explore your goals, hopes, symptoms, and current challenges. If you are a partner in a relationship, there is information contained here that will explain how we can navigate this work together. If you are a parent bringing your child to therapy, you are an important part of this process: supporting your child, collaborating with me, and being involved may maximize therapeutic gains and increase the likelihood of success.

I am here to support you throughout this process and look forward to our work together!

(Initial) _____ _____ On Time
I agree to arrive on time to in-person and remote appointments. Sessions are planned in advance and should not occur spontaneously. Sessions generally last 50, 75, or 90 minutes, unless we have made arrangements for a different timeframe. I understand that my therapist will end my sessions on time, even if I arrive late to a session.

(Initial) _____ _____ Cancellations
If I am unable to make an appointment, I will email my therapist 48 hours in advance on weekdays, or by Thursday for Monday appointments. If an appointment is missed or cancelled without 48 hours prior notice, my therapist will charge me for the session via the method of payment typically used. In the event that my therapist is unable to keep our appointment, she will contact me via phone or email to cancel and reschedule the session.

(Initial) _____ _____ Texting and Email
I know that my therapist uses emails and text for purposes of scheduling only, with limited exception, in order to protect my privacy and those of my family. I know that there are risks to using texting and email, including but not limited to mis-delivery, email account being hacked, and giving other parties and providers access to email content and addresses.

(Initial) _____ _____ Fee Information

I am responsible for paying for my remote or in-person session on the day I receive service. My therapist's fee is $175/per 50 minute session, $230/75 minute session, and $275/90 minute session. If we meet for a longer session, I understand I will be billed on a prorated hourly fee. Unplanned phone calls under 10 minutes are not charged, but if we spend more than 10 minutes in a week on the phone, if I leave more than 10 minutes of phone messages in a week, or if my therapist spends more than 10 minutes reading and responding to emails or other correspondence from me during a week, I know that she will bill me on a prorated basis in 10 minute increments. I understand that my therapist does not bill insurance providers, will provide a Superbill if requested, that she cannot accommodate future billing, and will not accept barter for therapy. If I refuse to pay my debt, my therapist reserves the right to give my name and amount due to a collection agency and to discontinue services with me. My therapist's Venmo account name is @Rhona-Rosenblatt.

(Initial) _____ _____ Release of Information

My therapist will need permission to collaborate on my case with others, such as my doctor, psychiatrist, teacher, family members, and other therapists. In order to do this, my therapist will request advance written permission from me. If I ever want my therapist to share information with someone else, I will ask my therapist to sign a Release of Information so that she can communicate freely with that person. If my therapist does not receive a signed Release of Information, she will not be able to communicate with others, and therefore may not be able to continue treating me and may discontinue treatment as a result.

(Initial) _____ _____ Benefits and Risks

I have been advised that resolving difficult issues and learning to regulate my own intense emotions through therapeutic services can bring on strong feelings, such as anger, sadness, and fear. My therapist has informed me that making changes in my beliefs or behaviors can be scary, and sometimes even disruptive to the relationships I already have, and that my relationship with my therapist may have strong or painful feelings at times. At times during the therapy process, I am aware that attempts to resolve issues can result in disruptions or changes that were not intended by my therapist. In signing, I acknowledge that therapy has potential emotional risks, and that approaching thoughts, feelings, and memories may be painful for me. Like any professional service, therapy may not work, and for a relatively small number of people, problems may get worse, although many people find that the benefits of therapy outweigh the risks.

(Initial) _____ _____ Legal

I understand that my therapist will not voluntarily participate in any litigation or custody dispute in which I, as client, or my child as client, and another individual or entity, are parties. I acknowledge that my therapist has a general policy of not communicating with attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in a legal matter unless agreed upon at the beginning of the therapeutic relationship. My therapist will also not generally provide records or testimony unless compelled to do so. I have been advised that information about me as client, and any records created, are subject to psychotherapist-

patient privilege. The psychotherapist-patient privilege results from the unique relationship between therapist and client in the eyes of the law, akin to attorney-client privilege and doctor-patient privilege. That is, if my therapist were ever to receive a subpoena for records, deposition testimony, or testimony in a court of law, she would assert her psychotherapist-patient privilege on my/our behalf until instructed, in writing, to do otherwise by me or my representative. I am aware that I may be waiving privilege if I make my mental or emotional state an issue in a legal proceeding and know that I must address any concerns regarding this with my attorney. Should my therapist be subpoenaed or ordered by a court of law to appear as a witness in an action involving me or my child as client, I agree to reimburse her for time spent for preparation, travel, or other time in which I have made myself available for an appearance. If therapist is ever subpoenaed to appear in court for any reason, in signing this agreement, I am agreeing to pay a flat rate, non-refundable fee, at the time the subpoena is served, for $750/half day minimum, and $300/hour for every hour thereafter. I understand that my therapist is not a custody evaluator and will not provide child custody evaluations or reports to be used in court or in any divorce or custody proceeding. If my child is minor, my therapist will ask for written consent from both parents/legal guardians/foster parents, except in cases of sole legal custody.

(Initial) _____ _____ "No Secrets" Policy for Couples, Parents and Families

When my therapist agrees to treat a couple or a family, she considers the couple or family to be the treatment unit, or patient, during the course of our work. There may be times in which my therapist sees a subset of that treatment unit for one or more sessions, and these sessions may be regarded as a part of the work that my therapist is doing with the unit, unless otherwise specified. Therefore, I understand that my therapist may share information learned in an individual session or with a subset of the treatment unit with the entire unit. My therapist will use her best judgment as to whether, when, and to what extent to make disclosures to the treatment unit and, if appropriate, give the smaller unit the opportunity to make a disclosure. If I feel it necessary to share information that I want shared with no one, I am hereby advised I may consult with an individual therapist who can treat me individually. I understand that this "No Secrets" policy is intended to prevent any conflict of interest wherein an individual's interests that may not be consistent with the interests of the overall treatment unit, such as information learned in the course of an individual session that may be relevant or essential to continuing treatment of the couple or family unit. If my therapist is not free to exercise her clinical judgment regarding the need to bring this information to the family or couple, she might be placed in a situation in which she will have to terminate treatment of the couple or family. If I, or my partner, have communication or consultation with our therapist, such as via telephone, text, or email, I know that what either of us says individually is considered to be a part of a joint session, and may be disclosed in a joint session, subject to our therapist's judgment and discretion.

(Initial) _____ _____ Emergencies
I am aware that my therapist does not provide after-hours or crisis counseling and will refer me to a crisis intervention team if needed. My therapist strives to return all calls and emails within 48 hours on weekdays, and up to 72 hours on weekends. If I am experiencing an emergency when my therapist is out of town or outside of regular office hours (Weekdays 9-5), and if I believe that I cannot keep myself safe, I may call 911, the National Suicide Hotline at (800) 273-8255, or go to the nearest hospital emergency room for assistance. Once the situation has stabilized, I may contact my therapist as soon as I can safely do so.

(Initial) _____ _____ Safety Plan
If needed, we will set up a written Safety Plan that will include specific steps to follow if I begin to feel upset or in crisis. I know that my therapist will expect me to make every effort to carry out these steps as a way of supporting me. I know that it is less likely that my treatment will be successful if I do not utilize this plan. I know that use of a crisis response plan and a willingness to fully engage in the treatment process will reduce risks and increase effectiveness of my treatment. I recognize and understand the potential need for a treatment team and family involvement if they need to be contacted for my safety and well-being. I recognize the need for an honest and trusting relationship in treatment which allows me to be direct and specific when problems with treatment compliance emerge.

(Initial) _____ _____ Weekends, Vacations, Holidays
I know that my therapist does not work weekends or most holidays and sometimes takes a vacation. I understand that my therapist works part-time and is sometimes away from the office to attend professional meetings, trainings, and tend to personal commitments that keep her away from telephone, email, and text, and therefore may not receive or respond to messages. If she is to be away or inaccessible for an extended period, she will inform me and provide me with the name and contact information for an alternate therapist who I may contact in her absence if I choose to do so, or I may choose to wait for her return for non-emergency situations arising in her absence. Because I have been advised that my therapist is sometimes away for intervals of a few weeks at a time, if she believes it to be in my best interest to see a clinician more regularly accessible, she may refer me to a clinic setting with on-call staff or provide me with referrals to other providers who may be more accessible.

(initial) _____ _____ Confidentiality/Acknowledgment of Requirement to Report
Within the limitations of this document, the information that I reveal during our professional relationship will be kept confidential and will not be released to anyone without my written consent. However, certain conditions do require that confidentiality and privileged communication be breached, including:

1. If there is a reason to believe I represent a danger to myself, in which case I understand my therapist may need to break confidentiality and call the police, members of my treatment team, or other mental health professionals. My therapist may or may not be obligated to do this and may explore other options before taking these steps. If I remain

unwilling to take steps to guarantee my own safety, my therapist will likely call for outside assistance.

2. If there is a reason to believe that I represent an imminent danger to another person, I know that she must attempt to inform that person and warn them of my intention, and that she also must contact the police and ask them to protect the intended victim.
3. If there is reason to believe that a child in my care is at risk for child abuse or neglect, if there is reference to online sexual messages containing images of or being sent to minors, or suspicion of elder abuse or neglect, I know that my therapist may contact Child Protective Service or Adult Protective Services and/or the police, and that she may or may not inform me that she is taking this action.
4. If I tell my therapist of the behavior of another named mental health provider and informs me that this person has engaged in sexual contact with a patient, or is impaired from safe practice in some manner by cognitive, emotional, behavioral, or health problems, then the law may require me to report this to the applicable licensing board, and my therapist may or may not be able to inform me before taking this step. My confidentiality may or may not remain protected under the law in this reporting.
5. If a legitimate court order is issued, I understand that my therapist may be legally obligated to comply with that order, which may compromise my confidentiality.

(initial) _____ _____ Confidentiality in Child/Adolescent Therapy

If my child is a minor, his/her right to confidentiality is limited by my therapist's legal right to share information with me/us as guardians. However, since an effective therapeutic relationship often involves the provision of a safe place to discuss challenges, we are hereby agreeing in advance the type of information that will likely be shared. In general, my therapist believes it is important to inform parents if a child is involved in any activity that is acutely harmful to self, but my therapist may not reveal information or activity that does not seem to present imminent risk of serious harm. For example, if my minor child reveals that he/she has been regularly operating a motor vehicle while under the influence of a substance, my therapist will discuss with my child on how to best inform me/us as parents (i.e. therapist informs, child informs, or therapist and child together). However, if my child reveals a limited experimentation with marijuana, the therapist may not inform me. I also understand that my therapist cannot share information with my child's school without written permission to do so. It may be helpful in some situations for my therapist to collaborate with my child's teacher, school counselor, psychiatrist, or other helping professionals, and in order to do so a Release of Information will be required, and if not provided, services may need to be terminated.

(Initial) _____ _____ HIPAA/Privacy Practices

I have received and read the attached page explaining how the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) affects how records are kept and managed.

(Initial) _____ _____ Termination

If, for any reason, during the course of our work together, my therapist proposes a treatment plan which I feel I cannot or do not wish to follow, either one of us may terminate treatment at any time. If this occurs and I wish to have other referrals, my therapist will do her best to

provide them, but cannot guarantee that one of those referrals will accept me, my partner or my child as a client. If my therapist is not, in her judgment, able to help me because her skills, training, expertise, or accessibility are, in her judgment, not appropriate, she will let me know, and she will try to refer me to another therapist or support group to meet my needs. I am free to leave therapy at any time, and if I am unhappy with what is happening in therapy, I know that I can talk about it with my therapist so that she can do her best to respond to my concerns. If I, my partner, or my child, engage in violence, threaten, verbally or physically harass my therapist or any colleague or family member of my therapist, she reserves the right to terminate me unilaterally and immediately from treatment, and she may offer me referrals to other sources of care, but she cannot guarantee that they will accept me for therapy. If I believe that my therapist has behaved unethically, I can file a complaint with the state licensing board.

Client Acknowledgment and Consent

My signature below indicates that I have read and understood the information on the preceding pages and that I agree to these terms. If I have remaining questions about any information contained herein, I will not sign below until I have received satisfactory answers to those questions. By signing below, I understand my rights and responsibilities as a client, and my therapist's responsibilities to me.

I am voluntarily consenting to treatment with Rhona Rosenblatt, LCSW for myself (or my minor child). I acknowledge that I can end therapy at any time I wish.

Signatures:

Client 1: _____ Date: _____

Client 2: _____ Date: _____

Clinician: _____ Date: _____

HISTORY AND GOALS

What are some of the reasons you are seeking therapy now? What are your goals for therapy?

_____

_____

_____

Current health challenges:

_____

_____

Psychiatrist Name and Phone:

_____

Current diagnoses:

_____

Current psychiatric medications:

Medication _____ Prescribed for _____

Medication _____ Prescribed for _____

Medication _____ Prescribed for _____

Have you…

Been in therapy before? Yes No When _____

For what? _____

Been hospitalized for a psychiatric concern?	Yes	No
Been hospitalized for medical issue?	Yes	No
Been arrested?	Yes	No
Experienced/witnessed physical abuse in your family of origin?	Yes	No
Experienced/witnessed emotional abuse in your family of origin?	Yes	No
Experienced/witnessed sexual abuse in your family of origin?	Yes	No
Experienced/witnessed other trauma as a child or adult?	Yes	No
Are you interested in somatic therapy/Sensorimotor Psychotherapy?	Yes	No

Family History

Has anyone in your family been diagnosed with a mental illness?	Yes	No
Has anyone in your family ever attempted or committed suicide?	Yes	No
Has anyone in your family struggled with addiction?	Yes	No

Is there anything else you would like me to know about you?

_____

_____

_____

SYMPTOMS

Never = N Sometimes = S Often = O

	N/S/O	Since when?
Worry/tension/anxiety		
Fears/phobias		
Discomfort in social situations		
Joy/happiness		
Panic, sweating, shortness of breath, heart palpitations		
Flashbacks		
Avoidance of people/places		
Sleep disturbance, trouble falling/staying asleep, nightmares		
Loneliness, Feelings of isolation		
Increased time spent online		
Thoughts of ending life		
Sadness, Grief		
Daily tasks more difficult than in past		
Hopelessness about future		
Low self-esteem		
Decreased interest in activities		
Angry, hostile, irritable		
Rapid mood changes		
Euphoria, extra energy, racing thoughts		
Struggles at work, frequent job changes		
Challenges in romantic relationships		
Conflicts with friends		
Memory changes		
Concentration difficulties		
Obsessive thoughts/worries		
Compulsive behaviors, repetitive behaviors/rituals		
High-risk behaviors		
Alcohol		
Smoke cigarettes, vape, marijuana		
Cocaine, opiates, meth, stimulants, other		
Changes in use of prescription meds		
Binging		
Purging		
Restriction of food, concern about weight		
Concern about sexual function		
Concern about sexual orientation		