WINDOWS OF OPPORTUNITY
CLIENT INFORMATION FORM

CLIENT INFORMATION

Name:_____

Address:_____

_____

City, State, Zip:_____

Date of Birth:_____

Primary Care Physician:_____
Phone:_____
Address:_____

Marital Status: (**please circle**)

Single Married Divorced Widowed Partnered

Parent/guardian's name and address:

_____

_____

_____

Phone: _____

PAYMENT AGREEMENT

I understand that I am responsible for paying all charges in full at the time of services. **Payment is due at the beginning of your session.** Please note, we do not deal with, directly bill insurances, accept assignment or payment from any insurance, use HICFA forms, or verify coverage at all. We do not call or return calls from insurances.

Signed: _____

Dated: _____

Phone Numbers

Home:_____

Work:_____

Cell:_____

Best way to contact: (**circle**)

Home Work Cell Email

E-mail address:_____

Referral source:_____
Initial to give permission to contact referral source:_____

Names and Ages of Children:_____

_____

EMERGENCY CONTACT NAME & PHONE:

Upon request, we can provide a receipt or statement so that you can obtain reimbursement from your insurance or flex spending account if you believe have coverage. **Most intern serves are not reimbursed by insurances. It is your responsibility to verify this.**

Please makes check to: Windows of Opportunity Counseling Services.

PAYMENT DUE BEFORE SESSION STARTS

CANCELLATION POLICY

We have a 48-hour cancellation policy for non-emergency cancellations. We charge full fee for late cancellations or no-shows. Thank you for your consideration. Monday appointments must be cancelled by Thursday @ 5pm.

Initial_____

WINDOWS of OPPORTUNITY COUNSELING SERVICES
Psychotherapy Contract for Lisa Call, MFT Intern (IMF99660)
Supervisor: Evelyn Schmechtig-Cochran, MFT (MFC33292)

OUTPATIENT SERVICES

This document contains important information about professional services and business policies. Please read it carefully and jot down any questions that you may have so that you can discuss them at the next meeting. Once you sign this, it will constitute a binding agreement between you and your therapist and her supervisor.

MARRIAGE, FAMILY, AND INDIVIDUAL COUNSELING AND PSYCHOTHERAPY

Psychotherapy is not easily described in general statements. It varies depending on the personality of both the therapist and the client and the particular problems that the client brings. There are a number of different approaches that can be utilized to address the problems you hope to address. We use general systems theory and attachment based interventions as well as cognitive, behavioral, and supportive techniques. Please remember, psychotherapy is not like visiting a medical doctor in that it requires a very active effort on your part. In order to be most successful, you will have to work both during your sessions and at home. With couples or family therapy, the unit of treatment is the couple or the family and not the individual. Because of this, we maintain a "**no secrets policy**."

MEETINGS/ TERMINATION

It is normal practice to conduct an evaluation, which will last from 1 to 3 sessions. After that one session per week at a mutually agreed time will be scheduled. If you are late for a session, you do not get any make up time. Treatment is terminated when you and Lisa agree that your presenting problem and any related issues have been resolved. However, if it is determined, that treatment is ineffective or beyond Lisa's scope, she may elect to terminate therapy. Naturally, if this happens you will be given several referrals to competent therapists so that you may continue your treatment. Also, remember that at any time during your therapy, you have the right and may elect to discontinue. If you terminate prematurely and against advice, it is policy to contact you by either letter or telephone and advise you to continue or give referrals.

PROFESSIONAL FEES/ BILLING AND PAYMENTS/ WE ACCEPT CASH OR CHECK

Individual (53 mins.): $155.00.
Couple/Family (75 mins.): $205.00

We offer $5.00 discount for cash or check payments.

THE FEE FOR A NON-EMERGENCY LATE CANCELLATION OR A NO SHOW TO AN APPOINTMENT IS THE NORMAL COST OF YOUR SESSION. 48 HOURS NOTICE OF CANCELLATOIN IS REQUIRED TO AVOID FEE.

INITIAL AND
DATE:_____

CONTACTING YOUR THERAPIST

Lisa is not available by direct telephone. Please contact her by email at lisa@Windowsofopportunitycounseling.org. She will return your email with a call within 24 hours. Her supervisor can be contacted at evelyn@windowsofopportunitycounseling.org or 510-979-0200

#1. If you are difficult to reach, please leave some times when you will be available. If you cannot reach Lisa and you feel that you cannot wait for your call to be returned, you should call your family physician, the emergency room at the nearest hospital and ask for the mental health professional on call, or the Alameda County Hotline @ 800-309-2131. If Lisa is unavailable for an extended time, you will be provided with the name of a trusted colleague to contact if needed.

Initial and Date:_____

Email, and Texting Policy

We do not text clients. Email should not be used for emergency contact or urgent messages. Our email is has is on a secure server, however, because of the lack of assuring full security, it is office policy to request that you use these methods only for scheduling and cancellations. If you choose to communicate confidential clinical information using these methods, an informed decision will be assumed, and viewed as your agreement to take the risk that content maybe intercepted. It is policy to respond to clinical matters during scheduled sessions or returned phone calls. **Initial and Date: _____.**

Confidentiality

In general, law protects the confidentiality of all communications between a client and psychotherapist, and we can only release information about our work to others with your written permission. However, there are a number of exceptions. In most judicial proceedings, you have the right to prevent your therapist from providing any information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require testimony if he/she determines that resolution of the issues before him/her demands it. **There are some situations in which counselors are legally required to take action to protect others from harm even though that requires revealing some information about a client's treatment. If it is believed that a child, an elderly person, or a disabled person is being abused, a report must be filed with the appropriate state agency. If it is believed that a client is threatening serious bodily harm to another, protective actions must be taken which may include notifying the potential victim, notifying the police or seeking appropriate hospitalization. If a client threatens to harm himself/herself, hospitalization for the client or contact of family members may be necessary. If a client reports that he or she is viewing child porn, this must be reported to the police.** A therapist is also allowed to use or disclose your personal mental health information without authorization from you for the purposes of diagnosis, treatment and treatment planning, payment, coordination of care and healthcare operations such as billing and HMO, Board of Behavioral Sciences and U.S. Department of Human Services auditing procedures. For example, a therapist may need to consult with your PCP, psychiatrist, or another licensed professional to discern our diagnosis. Also, at times, insurance plans require copies of records to determine whether or not payment is warranted under your particular policy or plan. Occasionally, health plans such as HMOs audit practices to review performance and make sure its practitioners are meeting the legal standard of care. If national security requires, a clinician maybe required to disclose client protected health information. Minors, please be aware that in California your parents may have the right to examine your records. However, it is policy to request an agreement from your parents that they consent to give

up this access. If they agree, they will be provided only with general information on how your treatment is proceeding unless there is a high risk that you will seriously harm yourself or another, in which case they will be notified of the concern. In this office, because we respect and value your privacy and even if it is not required by law, authorization or consent will almost always be sought out first before releasing any information about you to another. Naturally, emergencies are an exception to this courtesy. In general, consultation regarding cases is a regular part of this practice; and the consultant is, under California law, also legally bound to keep the information confidential. For your protection, when consultation does take place, no identifiable data will be disclosed. Finally, please note: No authorization is needed for a therapist to contact you regarding appointments, treatment alternatives or other heath related services that may be of interest to you. This may include voice mail, letters, or e-mail. **However, we ask you to give us permission to contact you using the phone numbers and e-addresses given for these and schedule matters**.

Initial and Date: _____.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client or Representative's Sign and Date below to acknowledging understanding and agreement.

1_____Date: _____

2. _____Date: _____

PERMISSION TO VIDEO TAPE EMOTIONALLY FOCUSED COUNSELING Couple SESSIONS

As an intern, I am required and in order to improve my EFT counseling skills I record my sessions. Our work in counseling with not be affected by the recording and you are free to say no. If at anytime you change your mind we can stop the recording. If a supervisor, supervisee, or researcher knows you in any way they will not review the recording and will keep confidentiality per professional guidelines.

I give Lisa Call, MFT Intern permission to record our sessions. I understand that confidentiality will be protected at all times.

1. Only for review outside of session by ESC.	_____	_____
2. For use in peer supervision.	_____	_____
3. For use with meeting with a supervisor.	_____	_____
4. For use of supervision in a group with other therapists.	_____	_____
5. For training of other therapists.	_____	_____
6. All of the above.	_____	_____

Client name:

Signature: _____

Client name:

Signature: _____

Therapist: Lisa Call, MFT Intern/ Supervisor: Evelyn Schmechtig-Cochran, LMFT

Signature:_____