

**HEALING SPIRIT PSYCHOTHERAPY SERVICES
Palo Alto, CA**

Client Information

Legal Name: _____

Preferred Name: _____

Age: _____ Date of Birth: _____

Address: _____

Phone: _____

Referred by: _____

Emergency Contact Person: _____

Emergency Contact Phone: _____

Single _____ Partnered _____

Significant Other/Partner's Name: _____

Additional Partners: _____

How do you identify? Orientation: _____

Gender: _____ Preferred Gender Pronoun _____

Employer: _____

If a student, the name of your school: _____

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Current Medical Conditions: _____

Current Medications: _____

Payment Amount per Therapy Hour (50 min) \$

I understand that I am responsible for the full amount of any bill for services provided.

If I choose to pay by credit card/debit card/HSA/FSA card, to maintain confidentiality, the charge will appear in my statement as payable to Ivy.

Name: _____

Signature: _____ Date: _____

Guardian Name: _____

Guardian Signature: _____ Date: _____

HEALING SPIRIT PSYCHOTHERAPY SERVICES

Palo Alto, CA

Consent to Treatment/Confidentiality Statement

Welcome to Healing Spirit Psychotherapy Services! We are pleased to have the opportunity to serve you and hope that this document will provide information helpful in making an informed decision concerning our services. Your signature at the bottom will indicate that you understand our policies and procedures, so please read this carefully. Your therapist will go over the material with you and will be happy to answer questions at any time. Please keep a copy of this document for your reference.

The following questions are some of the questions we are most commonly asked by new clients:

How often will we meet?

Most of our clients are seen once a week, but this varies depending on the individual and his/her reason for seeking services. Sessions are 50 minutes long, and we will make every effort to schedule them at a time convenient for you.

What happens if I miss an appointment or if I am late?

Coming regularly and on time is an important aspect of this work. We understand that the realities of life often make it difficult to attend sessions. Children get sick, cars break down, and plans get changed. However, once we make an appointment with you, we set aside that time for your use. Thus, we have developed clear but fair attendance policies that must be followed by all clients. If you miss or cancel an appointment with less than 24-hours notice, you will be charged the full fee for that appointment. If you are unable to attend your appointment at our office, on occasion and with your therapist's consent, you may arrange to have your session on the telephone.

If clients cancel sessions frequently, the therapist will discuss with you the value of continuing to schedule new sessions.

If you are late for your appointment, you will be seen for the balance of your time but charged for a full session.

It is rare that we would be late starting a session, but in the unlikely event that this happens, if your schedule permits, we will try to see you for your full session time. If we cannot do this, we will see you for the time remaining of your session and

adjust your fee. If our lateness can be anticipated, we will make every effort to contact you so that you can adjust your schedule accordingly. If you choose to reschedule your appointment due to my lateness, we will be happy to do so and will not bill you for the session we miss.

What are my financial responsibilities?

Payment is due at the time services are rendered, unless we have made other arrangements in advance. Personal checks, credit cards and cash are accepted. A monthly invoice may be provided upon request, which you can use to seek reimbursement from your insurance company if you choose. We are out-of-network providers. Please pay at the beginning of the session rather than at the end.

How can I reach my therapist between sessions?

To reach your therapist or leave a message about cancelling or rescheduling a session, please call (510) 736 5115. You can leave a confidential message of any length. Please leave your name and phone number, even if you think your therapist already has it. They will check for messages at least once a day. If you need a response, leave some good times to reach you on your message. However, because it may take 24 hours to get back to you, if it is an emergency, rather than leaving a message, please call 911 or go to your local emergency room.

What are the Charges for Home Visits, Telephone Contacts, Emergency Appointments and Collateral Contacts

Occasionally it is advisable for a session to be held in your home. Our out of office fee is double the standard fee for 50 minute hour sessions and is only available under limited circumstances. This fee includes travel time.

Brief telephone calls in which you advise us of a schedule change or ask for a specific piece of information are encouraged. If the duration of the call is less than five minutes, you will not be charged. If the situation requires telephone consultation that exceeds five minutes, there will be a prorated fee for the telephone contact.

If, with your permission, we contact other people on your behalf (such as family members, or other health care professionals) and consult with them in person or by telephone, the fees for scheduled in-office and out-of-office sessions as well as telephone contacts will apply.

Time spent writing non-legal letters and reports related to your psychotherapy treatment will be charged at the same rate per hour as therapy in 30 minute increments.

What Happens when my Therapist is on Vacation?

Your therapist may take vacation time, which could be as many as three weeks at once. We will give you as much advance notice as possible and will link you with other supports while we are away.

How Confidential are my Sessions?

We consider a confidential relationship to be the cornerstone of psychotherapy. The laws of the State of California ensure the confidentiality of our work together. In general, what we talk about may not be revealed to anyone else without your specific permission. There are only a few exceptions:

1. If your therapist suspects that a child, elder, or dependent adult is being abused in which case your therapist must report this to the authorities immediately. This may include sexual contact that involves a child, adolescent or adult. It may also include knowingly developing, duplicating, downloading, streaming or accessing some form of photographic recording of a child engaged in obscene sexual conduct (this includes photographs of naked children).
2. If your therapist suspects that you are suicidal the therapist is required to notify legal authorities and make reasonable attempts to notify the family of the client.
3. If your therapist suspects that you are a danger to others or their property, the therapist is required to forewarn that person and to notify the police.
4. If your records are subpoenaed by a court of law.
5. If you are working with a therapist under supervision, your case will be discussed and information shared with the supervisor and other therapists at Healing Spirit. Signing this form gives permission to do so.
6. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.
7. When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the

services (diagnosis, treatment plan, case notes, testing, etc) is not disclosed. If a debt remains unpaid, it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and my name.

8. Insurance companies and other third-party payers are given information that they request regarding services to clients. Information which may be requested includes types of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes and summaries.
9. Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.
10. When couples, groups or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. The information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjoint family or couples sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.
11. In the event in which we must telephone or text you for purposes such as appointment cancellations or reminders or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone or text and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say our full name or the nature of the call, but rather our first name only.

If the information below is not provided to us, we will first ask to speak to you (or your guardian) without identifying myself. If the person answering the phone asks for more identifying information, we will say that it is a personal call and only give our first name. If we reach an answering machine or voice mail we will follow the same guidelines.

Please check where you may be reached by phone. Include phone numbers and how you would like me to identify myself when phoning or texting you.

___ CELL	Phone Number: _____ How should we identify ourselves? _____ _____
	May we say our names? _____ Yes _____ No
___ HOME	Phone Number: _____ How should we identify ourselves? _____ _____
	May we say our names? _____ Yes _____ No
___ WORK	Phone Number: _____ How should we identify ourselves? _____ _____
	May we say our names? _____ Yes _____ No

Can therapy harm me or my family?

The therapy process can be a very painful, upsetting, and difficult experience. Some clients find that they become quite sad, upset, angry, or emotionally aroused due to the material that comes up in therapy. This is often a normal and important part of the healing process. Sometimes, the difficult feelings are not helpful and the work needs to be changed in some way. It is essential that you develop a trusting relationship with your therapist and feel free to discuss your feelings about what is happening in therapy with them. If you do not feel that they are responsive to your needs, please ask for a consultation with Dr. Ormond or call her at (510) 736 5115. We very much value your feedback.

What if I do not feel comfortable with my therapist or do not feel I am making progress?

It is very important that you and/or your family receive the best treatment possible while at Healing Spirit. You should feel your therapist is caring, responsive, focuses on your goals for therapy, and uses methods that you agree with. Research shows that clients who get the best results from therapy are those who have a positive relationship with their therapists. If you do not feel, by the third or fourth session, that your relationship is positive, it is extremely important for you to talk to your therapist about any discomfort you have. Let them know how you are feeling and ask about things that you would like to be different. In fact, at every point in the therapy process, honest feedback is crucial and will help your therapist to know how to be most helpful to you. Do not worry about hurting your therapist's feelings. If you do not feel your therapist is responsive or you are unable to resolve the issue, you may call Dr. Ormond to request an opportunity to meeting with a different therapist. As an informed consumer, you certainly have

the right to make sure that your needs are being met and have the right to request a change in therapist without being subjected to any discrimination or any penalty. If you feel you have a good relationship with your therapist but are not making sufficient progress, make sure that you discuss this with your therapist in your sessions. If you wish, you can schedule a meeting with your therapist and (if applicable) their supervisor to discuss your concerns. Often a lack of progress means that the therapist needs to alter their approach to working with you.

A Final Word

The relationship between a psychotherapist and client is a very personal and individualized partnership. We want you to know what you find helpful, and what may be getting in the way of our working together. Periodically your therapist will discuss your progress with you and your feelings about treatment. Please be honest and share with them how to make this the best possible experience for you.

I understand the contents above, and I agree to accept treatment. I also agree to the conditions described above. I acknowledge that I have been offered a copy of this agreement.

Client's signature

Date

Parent's signature

Date

Therapist's signature

Date

Client declined a copy of this agreement: _____

**Healing Spirit Psychotherapy Services
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Authorization to Release Information

I, (name of client) _____, (hereinafter
“Client”) hereby authorize HEALING SPIRIT PSYCHOTHERAPY SERVICES to
_____ Send _____ Receive the following _____ to _____ from the following
agencies or people:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

- | | |
|---|--|
| <input type="checkbox"/> Academic testing results | <input type="checkbox"/> Psychological testing results |
| <input type="checkbox"/> Behavior programs | <input type="checkbox"/> Service plans |
| <input type="checkbox"/> Case notes | <input type="checkbox"/> Summary reports |
| <input type="checkbox"/> Intelligence testing results | <input type="checkbox"/> Vocational testing results |
| <input type="checkbox"/> Medical reports | <input type="checkbox"/> Entire record |
| <input type="checkbox"/> Personality profiles | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Progress reports | _____ |
| <input type="checkbox"/> Psychological reports | _____ |

The above information will be used for the following purposes:

- Planning appropriate treatment or program
- Continuing appropriate treatment or program
- Determining eligibility for benefits or program
- Case review

____ Updating files
____ Other (specify) _____

I understand that I have a right to receive a copy of this authorization. I understand that I have the right to revoke this authorization at any time unless the provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by provider to be effective. I understand that after one year this consent automatically expires. I have been informed what information will be given, its purpose and who will receive the information.

The therapist shall not condition treatment upon Client signing authorization and the Client has the right to refuse to sign this form.

Client's signature: _____ Date: _____

Parent/guardian signature: _____ Date: _____

Witness (if client is unable to sign): _____ Date: _____

Person informing client of rights: _____ Date: _____

Mail to: _____

Address: _____

City: _____ State: _____ Zip: _____