2738 Camino Capistrano, Ste. 3
San Clemente, CA 92672
949-891-2127
lisa@lisaklipfelmft.com

Date: _____ Referred by: _____

Would you be willing to sign a release to referral source? __ yes __no

Name: _____ Date of Birth: ____/_____/_____

Parents (if minor): __married __divorced __foster parent __non-parent caregiver

Family Information

Mother_____	**Father**_____
Date of Birth: ____/_____/_____	Date of Birth: ____/_____/_____
Phone (H): (_____) _____	Phone (H): (_____) _____
Phone (C): (_____) _____	Phone (C): (_____) _____
Phone (W): (_____) _____	Phone (W): (_____) _____
Address:_____	Address:_____
City, Zip _____	City, Zip _____
Occupation_____	Occupation_____

Siblings Name(s) Age/DOB Address/phone (if different) School

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Area of Concern

What ***issues or concerns*** caused you to seek treatment? Please describe

_____

_____

What specific **goals** do you have regarding treatment? _____

What *concerns or fears* might you have **about treatment**? _____

Medical History

Physician's Name _____ Phone_____

Address_____ City, Zip _____

Psychiatrist's Name_____ Phone _____

Address_____ City, Zip _____

When was client's last physical? ____/_____ Overall health __good __fair __poor

__Yes __No Is client taking any **medications**? _____

If yes, please list what medications, dosage, direction and reason for medication

Medical History

__Yes __No Does client have any **allergies** to medications or foods? _____

If yes, please indicate what they are allergic to and response (rash, breathing, etc)

__Yes __No Is client on a **special diet**? _____

If yes, please list what restrictions and reason

__High __Moderate __Low Amount of **physical exercise** you (client) gets?

__Yes __No Does client have any **serious illnesses**? _____

__Yes __No Does client have any **medical conditions** that affect his/her mental health treatment? Or any **medical/physical symptoms** you attribute to a mental, emotions, or stress-related condition? _____

Psychological History

__Yes __No Has client been in **therapy** before? _____

If yes, please list when, length of treatment, focus and name of therapist _____

__Yes __No Has client had **psychological tests** done before? _____

If yes, please list what tests, when, & who administered them _____

__Yes __No Has client or any member of family **attempted suicide** before?

If yes, please elaborate _____

__Yes __No Has client or any family member been subject to verbal, physical, emotional, or sexual abuse?

If yes, please elaborate _____

__Yes __No Has client or any member of family been a victim of a **violent crime**?

If yes, please elaborate _____

__Yes __No Any **family history** of depression, anxiety, or mental health disorders?

If yes, indicate who and what _____

Substance Use History

__Yes __No Does client or any household members **smoke**?

If yes, indicate who _____

__Yes __No Does client or family member drink **alcohol**?

If yes, indicate who, frequency and amount _____

__Yes __No Does client or family members **use illegal drugs**?

If yes, indicate who, frequency and amount _____

__Yes __No Any **family history** of substance abuse or addiction?

If yes, indicate who and what _____

Legal History

__Yes __No Has client or any family member been **arrested**? _____

__Yes __No Is client or any family member currently **probation**? _____

__Yes __No Has client or any family member ever been involved in a **lawsuit**?

If yes, who, when, reason _____

Please feel free to include any additional information, that you believe is relevant to your mental health treatment, not requested here. The therapist will request that you sign releases for current and previous treating mental health providers. The therapist will review this form, and ask for further clarification of the information above.

_____ Date____/_____/_____

Signature

Date___/____/_____

__child __self __family (indicate who it applies to)

Have you (or your child, if completing for child or family) ever experienced the following symptoms? For children, try to answer as compared to other kids his age. Use the key as follows:
N - Never
S - Sometimes
O - Often
A - Always

N S O A Clothes bothersome, such as shirt tags, sock seams, or type of material
N S O A Sensitivity to noise
N S O A Clumsy
N S O A Makes careless mistakes
N S O A Difficulty with attention to task/play
N S O A Not listen when spoken to directly
N S O A Not follow through on instructions
N S O A Trouble organizing tasks/activities
N S O A Avoid, dislikes, reluctant to engage in activities that require mental effort
N S O A Easily distracted
N S O A Forgetful in daily activities
N S O A Fidgety, constant moving of hands/feet
N S O A Leaves seat in class
N S O A Runs about or climbs excessively
N S O A Difficulty playing or engaging in leisure activity quietly
N S O A Often “on the go”
N S O A Talks excessively
N S O A Blurts out answers to questions before they are completed
N S O A Difficulty waiting turn
N S O A Interrupts others
N S O A Loses temper
N S O A Argues with adults
N S O A Defies or refuses to comply with requests
N S O A Deliberately annoys people
N S O A Blames others for mistakes or misbehavior
N S O A Touchy or easily annoyed
N S O A Often angry and resentful
N S O A Spiteful or vindictive
N S O A Vomit after a meal intentionally
N S O A Feel fat
N S O A Worry a lot
N S O A Specific fear (such as spiders, heights) _____
N S O A Feel heart is pounding
N S O A Sweaty
N S O A Shaky

N S O A Short of breath/feeling of choking
N S O A Chest pain
N S O A Nausea
N S O A Dizziness
N S O A Feelings of being detached from one's self
N S O A Fear of losing control
N S O A Fear of dying
N S O A Numbness/tingling
N S O A Chills/fever
N S O A Fear of being in situations where escape might be difficult
N S O A Fear of embarrassment at school
N S O A Easily fatigued
N S O A Irritable
N S O A Muscle tension
N S O A Depressed mood
N S O A Increase/decrease in appetite
N S O A Increase/decrease in sleep
N S O A Increase/decrease in energy
N S O A Concentration difficulties
N S O A Memory loss
N S O A Feelings of hopelessness or helplessness
Yes No Grieving a loss, who_____
N S O A Hear voices, see things others don't hear or see

----------Adults Clients only----------

N S O A Attempted to cut down on alcohol or drug usage
N S O A Become angry or upset when others comment on alcohol or drug usage
N S O A Felt bad or guilty about alcohol or drug usage
N S O A Drink/use first thing in the morning
N S O A Experience sexual problems

CONSENT FOR TREATMENT

Introduction

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

About Lisa Klipfel, MFT

Lisa Klipfel is a licensed Marriage and Family Therapist in the state of California since 1999. She has a Master's degree in Marriage and Family Therapy. She also completed a 2 year program at UC San Diego for certification in play therapy. Lisa has worked in a variety of settings including group homes for teenagers who were homeless, had substance use issues, teen mothers, abused kids and kids with severe emotional issues. She was the clinical coordinator at an adult acute psychiatric residential facility for the homeless mentally ill for 5 years. In addition, while at the San Diego Regional Center, she coordinated services for those with autism, mental retardation, epilepsy and cerebral palsy. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

Ethics

- Your therapist is a clinical member of the California Association of Marriage and Family Therapists (CAMFT). Your therapist follows the ethical guidelines set out by CAMFT, and would gladly provide you a copy of these guidelines upon request.
- Lisa is licensed by the state of California as a Marriage and Family Therapist, license #35517. This is a sole proprietor business, Lisa Klipfel, MFT.

Confidentiality

- All communications between the therapist and the client will be held in strict confidence unless the client provides written permission to release information about the treatment. There are limits to confidentiality are which are outlined in the Notice of Privacy Policies.
- If you would like your therapist to coordinate care with other professionals or agencies, such as a doctor, psychiatrist, etc, please let your therapist know you would like to sign a release form.

Minors and Confidentiality

- Communications 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, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Therapy will be the most beneficial, especially with teens, if the information in therapy is kept private an not disclosed to the parents.
- Disclosure to parents: Confidentiality may be breached In cases where a child expresses danger to self or others. Additional topics that parents want disclosed should be brought up in the beginning of therapy, so an agreement can be made by all parties. Please refer to Notice of Privacy Policies.
- Progress reports: The therapist and the parents, legal guardians and/or caregivers will discuss how goals will be set and the frequency/modality of progress reports to the parents, legal guardians and/or caregivers.

Couple & Family Therapy and Confidentiality

- Secrets: There are times when a therapist is contacted outside of a couple or family session, where a secret is revealed. The therapist will not be the bearer of secrets and will have the party discuss any secrets with the rest of the therapeutic entity. This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family.
- Release of information for couple and families - If you participate in marital or family therapy, your therapist 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.
- Visitors: Occasionally, a client will bring in a "visitor" to session, such as an additional family member, boyfriend, who is not the primary client. This visitor is not considered a client. Although the nature of the session will be held confidential, the visitor will not be entitled to confidentiality or privilege under the law. This may apply to some parents, when the therapist is mainly working with the child.

Exceptions to Confidentiality

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. 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, papers 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. Please read the Notice of Privacy Practices for an expansion on these limitations and exceptions.

Minors and Consent

- Parents legally married or legal guardians: One parent can sign the consent to treat a minor, if there are no other legal documents indicating otherwise.
- Divorced Parents: When treatment is for a child of divorced parents, the presenting parent must bring the court documents indicating who has legal rights to consent for mental health services at the initial session. If these papers cannot be produced, no further sessions will be scheduled until they are available. At times the custody order will have specifications about mental health treatment of the minor(s), which may be different than physical custody, or legal custody. It is customary to gain the consent of both parents who have joint legal custody.
- Emancipated minors: Emancipated minors sign their own consent for mental health treatment.

Fees

- Full fee for therapy services is $115 per therapy hour.
- Monthly advanced payment fee is available paid by the 7th of the month. Please note the cancelation policy below. With this plan, if you cancel a weekly appointment (with notice), you will be credited $115 for the following month. With this plan, a late cancel or no show appointment will be credited with $50 for the following month.
- A therapy hour is 50 minutes, although sometimes 45 minutes with children.
- Report writing is $115 per hour. Your therapist does not generally write reports.
- Telephone therapy services are $30 per 15 minute increment, beyond 5 minutes for routine appointment setting.
- Email therapy services are $30 per email exchange. An email exchange is defined as a receipt of an email with a resulting responding email by the therapist for therapy services.
- Late cancel fee or missed appointment fee is $50. There is a $35 returned check fee, or credit card denial.
- Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure. Fees are collected prior to the start of each session. You can request weekly or monthly credit card billing.
- Balances: If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. The accrual of balances can disrupt the therapeutic relationship. Your therapist will help you to consider any options that may be available to you at that time. Therapy may be terminated due to large unpaid balances, but client would be referred to another therapist or agency for continuity of care. If unpaid balances continue to be a problem, collection may be pursued through a collection agency, small claims court, or other standard collection means. In the event that litigation becomes necessary for the collection of fees owed, the client agrees to pay the fees associated with collecting fees, including but not limited to collection agency fees or reasonable attorney fees.

Insurance

- Your therapist will directly bill any insurance company upon request.
- Your therapist is not currently a contracted provider for any insurance company, but can vary through out the year.
- If you bill your insurance directly, you may request a “super bill” which you can submit to your insurance company for reimbursement of services from your insurance company.
- Health insurance plans generally limit mental health coverage to certain diagnosable mental conditions, certain modalities and typically require the treatment to be “medically necessary”. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist is happy to assist your efforts to understand insurance reimbursement, she is unable to guarantee whether your insurance will provide payment for the services provided to you.
- Please note that your health insurance may request specific health information, such as diagnosis, modality of treatment, treatment plan, and/or additional private health information.

Appointment Scheduling and Cancellation Policies

- Frequency: Sessions are typically scheduled one time per week at the same time and day. At times a different frequency may be suggested depending on the nature and severity of your concerns. Your consistent attendance and engagement greatly contributes to a successful outcome.
- Cancellation: If you need to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hrs. in advance of your appointment. Online scheduling is available. If you do not provide your therapist with at least 24 hours notice in advance, you are responsible for the late cancel fee. Please understand that your insurance company will not pay for missed or cancelled sessions.
- Standing Appointments: If a client doe not show up for a standing appointment, no further standing appointment will exist.

After Hours Contact/Emergencies

- If an immediate mental health need arises, please contact your therapist by phone. When you leave a message, begin your message with "page for Lisa". Your therapist will attempt to contact you as soon as practically possible, but it may take up to two hours. If you are unable to wait for a return call, contact the county crisis line **(877) 727-4747**, or go to your nearest emergency room. 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.
- Do not send an email or text to your therapist for urgent health care needs. Emails and text messages may not be able to be responded to in an adequate time frame.
- While on vacation, there will be another therapist available during this time.

Communication with Your Therapist and Between Session Contact

- Telephone, email and text communication between sessions are available, but it is requested that you attempt to keep those contacts related to brief updates or scheduling issues due to the belief that important issues are best addressed within regularly scheduled sessions.
- Telephone: You may leave a message for your therapist on her confidential voicemail. Please be sure to leave your name and phone number along with a brief message concerning the nature of your call. Typically non-urgent calls are returned within 24 hours Monday through Friday. Your therapist is not typically available on Saturdays, Sundays or holidays. Phone calls lasting longer than 5 minutes most likely will be considered telephone therapy, which is a billable service.
- Email: You may use email for progress updates, referral/resource exchange or scheduling included in your weekly session fee. Once you request advice through email, you will be engaging in email therapeutic services, which is a billable service. Email services may not be secure and encryption email services are recommended to engage in email therapy services. Your therapist typically checks her email once a day. Email responses may take up to 24-36 hours. Email: lisa@lisaklipfelmft.com
- Text: You may text your therapist for scheduling changes, but please be aware that texts are not secure and can be read by others. Therapeutic services are not typically provided via text.
- Online audio and video conferencing: Audio online and video conferencing services need to be prearranged and are a billable therapeutic service. If you wish to engage in these services, please discuss security measures with your therapist.
- In Person: Your therapist may live in the same community as you. She is involved with many school and child related events. To avoid awkward social situations, she will not acknowledge you unless you first acknowledge her.

Therapist Communications with You

Your therapist may need to communicate with you by telephone, mail, email, text or other means. Typical communication between sessions include appointment reminders, scheduling, referral information, and/or requested resource information. Please indicate your preference below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

____My therapist may **call** me: ☐on my cell ( ) _____
☐ at my home ( ) _____
☐ at my work ( ) _____
____My therapist may **text** me on my *cell* phone listed above, or at ( ) _____
____My therapist may send **mail** to me ☐ at my home address ☐ at my work address
____My therapist may communicate with me by **email**. My email address is: _____

About the Therapy Process

It is your therapist's intention to provide services that will assist you/your child in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist 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 client, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

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/your child achieve(s). It is a good idea to plan for termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you/your child approach(es) the completion of the treatment goals.
You may discontinue therapy at any time. If you or your therapist determines that you/your child are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

❖❖❖❖❖❖❖❖❖❖❖❖❖❖

I hereby request that _____ be accepted for psychiatric, mental health, and/or alcohol and drug abuse treatment as described to me.

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from Lisa Klipfel, MFT. I authorize the administration of the SASSI test, a pen and paper assessment for substance abuse, as needed or indicated.
2. I have been given the Notice of Privacy Practices.
3. I have been given information regarding the cost of services from Lisa Klipfel, MFT. My fee for services is $115 per session.
4. I understand that I may address any concerns or grievances with my therapist, and if I bill my insurance directly, I may express grievances with my insurance grievance representative. I understand that I may also contact the licensing board which regulates my therapist's professional practice.
5. I am freely choosing to enter into treatment, and I understand that I may discontinue treatment at any time.
6. For minors, I _____, do hereby state that I am the natural parent with legal custody or the legal guardian of the client, _____; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask your therapist to address any questions or concerns that you have about this information before you sign!

_____ Date: ___/___/___
Name of Patient or Legal Guardian