Rosanna Reyes Feet, MFT **(619) 717-2970**
Licensed Marriage and Family Therapist MFC 44002

Agreement For Services/Informed Consent

Introduction:

This Agreement is intended to provide [name of Client]____
(herein "Client") with important information regarding the practices, policies and procedures of *Rosanna Reyes Feet, MFT* (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Client. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

About the Therapy Process

It is Therapist's intention to provide services that will assist Client in reaching his/her goals. Psychotherapy is a process in which Therapist and Client discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Client can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Client may be experiencing. Psychotherapy is a joint effort between Client and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Please be aware that although therapy is designed to be helpful, it may at times be difficult and uncomfortable.

Confidentiality

The information disclosed by Client is generally confidential and will not be released to any third party without written authorization from Client, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a Client makes a serious threat of violence towards a reasonably identifiable victim, when a Client is dangerous to him/herself or the person or property of another, or when a valid court order is issued for medical records.

Financial Terms and Insurance

Upon verification of Client's health plan/insurance coverage and policy limits, Insurance carrier will be billed for Client and Therapist will be paid directly by the carrier. Client will be responsible for any applicable deductibles and co payment at the time of service. By signing below, Client agrees to make these payments at each appointment; and understands that if in case Client is not eligible at the time services are rendered, Client is responsible for payment, even if the determination is made after services are rendered. **Returned checks are subject to a $30 fee**. Please note that the amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of Client's specific insurance plan. Client should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions.

FEE/CHARGE FOR LATE CANCELLED/MISSED APPOINTMENTS/ REQUEST OF RECORDS.

BY INITIALING AT THE END OF THIS LINE, I ACKNOWLEDGE THAT IN THE EVENT OF A "NO SHOW" OR FAILURE TO GIVE 24-HOUR NOTICE (within business days Monday – Friday) PRIOR TO A CANCELLATION, I AGREE TO PAY A $60.00 FEE FOR NO-SHOW/LATE CANCELLATION. THIS CHARGE IS SOLELY MY RESPONSIBILITY AND WILL NOT BE PAID BY MY INSURANCE. __________ **initial**

I ACKNOWLEDGE THAT IN THE EVENT I SIGN TO REQUEST MY RECORDS TO BE RELEASED, I AGREE TO PAY A $30 FEE FOR RELEASE OF RECORDS AND/OR SUMMARY OF RECORDS. _________ **initial**

Client Litigation

Therapist will not voluntarily participate in any litigation, or custody dispute in which Client and another individual, or entity, are parties. Therapist has a policy of not communicating with Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Client's legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Client, Client agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of $160.00.

Court appearance/ legal involvement will likely result in the need to terminate therapy and refer Client to another therapist.

Please sign the following, if using insurance plan or Employee Assistance Program

"I authorize the release of any information (including treatment summaries and diagnosis) necessary to process insurance or Employee Assistance claims, or to request additional sessions. I authorize payment of benefits to be made to Rosanna Reyes Feet, MFT for services provided."

Client's signature: ____

General consent for treatment (if a client is a minor)
"On the client's behalf, I (legal guardian, legal representative) authorize Rosanna Reyes Feet, MFT to deliver mental health services to the client. I accept that the child's records are confidential and that by law, I cannot have access to the child's records if such access would be detrimental to the child."

____

Client (legal guardian) initials

Minors and Confidentiality
Communications between Therapist and clients 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, Therapist may discuss the treatment progress of a minor Client with the parent or caretaker. Please ask or discuss with Therapist any questions or concerns with regards to this topic. Therapist generally requires the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for psychotherapy, Therapist will require that Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services.

Therapist Availability/Emergencies
Client may leave Therapist a voicemail message at any time. Non urgent phone calls are returned during workdays (Monday through Friday) within 48 hours. Therapist is not available to return calls on Saturdays or Sundays or after 7:00 pm (M-F). 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 OR San Diego Crisis Hotline: 1-888-724-7240, Veterans Crisis Line: 800-273-8255.**

Termination of Therapy
Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Client needs are outside of Therapist's scope of competence or practice, or Client is not making adequate progress in therapy. Client has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist may recommend treatment alternatives. Treatment alternatives may include, among other possibilities, referral or changing Client's treatment plan.

Communicating with Therapist

Y N	Therapist may send mail to Client's home address.	**Y N**	Therapist may send mail to Client's work address.
Y N	Therapist may communicate with Client by **email, text** (including appointment reminders). Client's email is: ______________________________ (Client understands that email is not a completely private form of communication.)	**Y N**	Therapist may send a fax to Client. Client's fax no. is ___________________________
Y N	Therapist may call Client at: Home___________________ Message ok? Y or N Cell phone_______________ Message ok? Y or N		Work: Message ok? Y or N

Acknowledgement

By signing below, Client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Client's satisfaction. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Client acknowledges that he/she has been given a copy of the therapist's Health Insurance Portability and Accountability Act (HIPAA) Patient Notice of Privacy Practices which describes how records and information about my treatment will be handled.

Client Name (please print): ____

____

Signature of Client (or legal guardian/legal representative)

Date: ____

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<table>
<tr><th colspan="5">Client Information</th></tr>
<tr><td colspan="5">Client's Name:</td></tr>
<tr><td>Sex/Gender Identity:</td><td>Date of Birth</td><td>Age:</td><td colspan="2">Sexual Orientation:</td></tr>
<tr><td colspan="5">Relationship/Partnership Status: ☐ single ☐ married ☐ separated ☐divorced
☐ widowed ☐domestic partnership</td></tr>
<tr><td colspan="5">Home Address:</td></tr>
<tr><td colspan="5">Home Phone: (________) Cellular Phone: (________)</td></tr>
<tr><td colspan="5">Occupation/Student:</td></tr>
<tr><td colspan="5">Employer (School, if student):</td></tr>
<tr><td colspan="5">Work/School Phone: (________)</td></tr>
<tr><td colspan="5">E-mail Address:</td></tr>
<tr><td colspan="5">Fax Phone: (__________)</td></tr>
<tr><td colspan="5">RESPONSIBLE PARTY and/or SPOUSE'S INFORMATION</td></tr>
<tr><td colspan="5">Responsible Party:</td></tr>
<tr><td>Date of Birth:</td><td colspan="2">Age:</td><td colspan="2">Marital Status:</td></tr>
<tr><td>Single</td><td>Married</td><td>Separated</td><td>Widowed</td><td>Divorced</td></tr>
<tr><td colspan="5">Home Address:</td></tr>
<tr><td colspan="5">Home Phone: (________) Cellular Phone: (________)</td></tr>
<tr><td colspan="5">Occupation/Student:</td></tr>
<tr><td colspan="5">Employer (School, if student):</td></tr>
<tr><td colspan="5">Work/School Phone: (________)</td></tr>
<tr><td colspan="5">E-mail Address:</td></tr>
<tr><td colspan="5">Fax Phone: (__________)</td></tr>
<tr><td colspan="5">Spouse's Name:</td></tr>
<tr><td colspan="5">Date of Birth:</td></tr>
<tr><td colspan="5"></td></tr>
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INITIAL EVALUATION

Client's Name: ____________________________________ Age: _______ Sex:____ Marital Status ___________

Occupation: ____________________ Education: _________ Primary Care Physician: __________________________

Others living in the home: ______________________Emergency Contact: _________________ Phone No.: __________

PRESENTING PROBLEMS: (Please describe the reasons for seeking for counseling (include date/month the problem started.

____

____

____

HISTORY OF PRESENT ILLNESS

Please indicate how the following symptoms/problems are affecting you (leave blank if no effect)
1) Little effect 2) Some effect
3) Much effect 4) Significant effect

Rate:	Eating habits/appetite: eating more; eating less; weight change ____; binge; purge	Rate	Stealing
	Sleep: Trouble falling asleep; trouble staying asleep;		Lying
	Decrease energy/Fatigue		Truancy
	Sexual functioning		Fire setting
	Loss of interest in activities		Police/probation involvement
	Tearfulness		Spending sprees
	Hopelessness/Helplessness		Rapid heartbeat
	Decreased attention span		Phobia
	Inattentive/Distractible		Sweating
	Memory: Long term, short term		Trouble breathing
	Difficulty planning ahead		Flashbacks of traumatic event
	Opposition		Nightmares
	Anger outburst		Racing thoughts
	Impulse control; difficulty controlling physical behavior		Hearing voices
	Mood changes		Seeing things that are not there
	Anxious/nervous		
	Worry/fear		

To be Completed by the Provider

SUBSTANCE USE

Coffee (# ___cups/daily) Cigarette (# ___ per day) Alcohol (# ______drinks weekly) Date last drank:	Prescription drugs: Type: Amount: Frequency: Date last used:
Street Drugs: Type: Amount: Frequency: Date last used:	Describe impact of substance abuse use on your life
Family History of substance use	Past treatment for substance use
OTHER INFORMATION:	
What do you see as strengths:	
What do you see as weaknesses:	
Goals for treatment:	
Goals and expectations of significant others	
Motivation for treatment:	

Psychosocial History/Functioning

Rate how the problems are impacting areas of Functioning:

1) Mild 2) Moderate 3) Severe

	Marriage/Relationship		Club/group membership
	Work/School		Legal
	Family		Housing
	Financial situation		Spirituality
	Physical health		Current stressors
	Social interests		Other
	Leisure activities		

TO BE COMPLETED BY PROVIDER

Psychiatric or psychological treatment of any kind before: Yes______ No ________ If Yes what type of care was received: Inpatient: ___ Outpatient: ____ Both ______ When was the treatment: Where was the treatment:	How long was the treatment __________ Name of the therapist or doctor: Were medications prescribed at that time? If yes, what was prescribed _____________
How long was the treatment Name of therapist or doctor:	Family history of psychiatric treatment. Family members currently in psychiatric treatment:

Signature of Client

Date