



Please describe briefly, the problem(s)/symptom(s) that bring you into counseling \_\_\_\_\_

Symptoms/Chief Complaints:

	<u>Good</u>	<u>Fair</u>	<u>Poor</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Sleep:	( )	( )	( )	Restless:	( )	( )	Nightmares:	( )	( )
Appetite:	( )	( )	( )	Weight loss:	( )	( )	Weight gain:	( )	( )
Energy level:	( )	( )	( )	Low energy:	( )	( )	Hyper:	( )	( )
Sexual interest:	( )	( )	( )	_____					
Attention level:	( )	( )	( )	_____					

	<u>Yes</u>	<u>No</u>
Crying spells:	( )	( )
Sadness:	( )	( )
Depression:	( )	( )
Suicidal thoughts:	( )	( )
Homicidal thoughts:	( )	( )

Have you ever had a problem like this before? [ ] Yes [ ] No

If so, when did it happen and how did you deal with it \_\_\_\_\_

Have you ever physically harmed anyone? [ ] Yes [ ] No

If yes, please specifically explain \_\_\_\_\_

Have you ever been arrested for a crime? [ ] Yes [ ] No

If yes, please specifically explain \_\_\_\_\_

Has anyone in your family (parents, siblings) had a diagnosed psychological or emotional problem?

[ ] Yes [ ] No

If yes, please specify \_\_\_\_\_

Has anyone in your family (parents, siblings) had a substance abuse problem? [  ] Yes [  ] No

If yes, who, what problem, when? \_\_\_\_\_

\_\_\_\_\_

Have you ever been in psychotherapy/counseling before? [  ] Yes [  ] No

If yes, give dates and type \_\_\_\_\_

Have you ever been hospitalized for psychological/emotional difficulties or/and eating disorder, alcohol/drugs, surgery or childbirth? [  ] Yes [  ] No

If yes, give dates and reason \_\_\_\_\_

\_\_\_\_\_

Has any physician ever prescribed medication for psychological problems/emotional difficulties or an eating disorder? [  ] Yes [  ] No

If yes, who dates and type of medication \_\_\_\_\_

\_\_\_\_\_

Are you currently using any prescribed or non-prescribed medication? [  ] Yes [  ] No

If yes, name of medication, dosage and reason prescribed \_\_\_\_\_

\_\_\_\_\_

# KENT TOUSSAINT, MA MFT

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## AGREEMENT FOR SERVICE/INFORMED CONSENT

### **Introduction**

This agreement is intended to provide \_\_\_\_\_ (herein "Patient") with important information regarding the practices, policies and procedures of Kent Toussaint, MA Marriage and Family Therapist MFC #44685 (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this agreement should be discussed with the Therapist prior to signing it.

### **Risks and Benefits of Therapy**

Psychotherapy is a process in which Therapist and Patient, and sometimes other family members, discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient 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 Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to Patient, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge the perceptions and assumptions of the patient or other family members, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships.

During the therapeutic process, many patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth may be easy and swift at times, but may also be slow and frustrating. Patient should address any concerns he/she has regarding progress in therapy with Therapist.

\_\_\_\_\_ Initials

### **Professional Consultation**

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Patient or Patient's family or caregivers.

### **Records and Record Keeping**

Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient. Should Patient request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

### **Confidentiality**

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

### **Patient Litigation**

Therapist will not voluntarily participate in any litigation or custody dispute in which Patient and another individual, or entity, are parties. Therapist has a policy of not communicating with Patient's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient'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 Patient, Patient 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.

### **Psychotherapist-Patient Privilege**

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship formed between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by Patient or a person with the authority to waive the privilege on patient's behalf. Patient is encouraged to discuss any concerns regarding the psychotherapist-patient privilege with his/her attorney. Patient should be aware that he/she

might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding.

### **Fee and Fee Arrangements**

The usual and customary fee for service is \$160.00 per 50-minute session. Sessions longer than 50-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Patient will be notified of any fee adjustment in advance.

The agreed upon fee between Therapist and Patient is \$160.00. Therapist reserves the right to periodically adjust fee. Representative will be notified of any fee adjustments in advance.

From time-to-time, Therapist may engage in telephone contact with Patient for purposes other than scheduling sessions. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at the request of Patient and with the advance written authorization of Patient. Patient is responsible for payment of the agreed-upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.

Patients are expected to pay for services at the time services are rendered.

### **Insurance**

Therapist is not a contracted provider with any insurance company or managed care organization. Should Patient choose to use his/her insurance, Therapist will provide Patient with a statement, which Patient can submit to the third-party of his/her choice to seek reimbursement of fees already paid.

### **Cancellation Policy**

Patient is responsible for payment of the agreed upon fee for any missed sessions. Patient is also responsible for payment of the agreed upon fee for any sessions for which Patient failed to give Therapist at least 24 hours notice of cancellation. Cancellation notice should be left on Therapist's voice mail at (818) 983-7728.

### **Therapist Availability**

Therapist's office is equipped with a confidential voice mail machine that allows Patient to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee that calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, Patient should call 911, or go to the nearest emergency room.

### **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, Patient needs are outside the Therapist's scope of practice or competence, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's

decision to terminate therapy, Therapist will generally recommend that Patient participate in one or more termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals when appropriate.

**Acknowledgement**

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this agreement. Patient has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from injury or complications whatsoever, save negligence, that may result from such treatment.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payer.

\_\_\_\_\_  
Name of Responsible Party

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_ Initials