Jan Rosser, M.A., LMFT
10315 Woodley Avenue, Suite 125
Granada Hills, California 91344
(818) 378-9289

Thank you for placing your trust in me as a psychotherapist! I take your trust very seriously. This document contains important information about my practice. Please take a few minutes to read it carefully, and ask me questions.

Agreement for Service/Informed Consent

Fee and Fee Arrangements
The usual and customary fee for service is $175.00 per 50-minute session. Sessions longer than 50 minutes are charged the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Client will be notified of any fee adjustment in advance. Therapist reserves the right to charge for other professional services provided, including report writing, consultations with other professionals, phone sessions with Client, and preparation of records and treatment summaries. The fee will be a prorated percentage of the hourly fee.

Clients are expected to pay for services at the time services are rendered. Fees are due **at the beginning** of each session. Fees are payable in cash or check (payable to Jan Rosser, LMFT). If Client has an outstanding bill, Therapist may suspend therapy until bill is paid in full. Therapist reserves the right to legally pursue collection of an overdue bill after reasonable measures have been taken to collect payment. This might include involving a collections agency or small claims court.

Insurance
Therapist is not a contracted provider with any insurance company or managed care organization. Therapist does not accept insurance or bill any insurance company directly. Client must pay Therapist in full for services at the time they are provided. Should Client choose to use his/her insurance, Therapist will provide Client with a statement that Client can submit to the third party of his/her choice to seek reimbursement of fees already paid.

Cancellation Policy
Client is responsible for payment of the Therapist's **full hourly fee** for any missed sessions for which Client failed to give Therapist a minimum of **24 hours notice** of cancellation. Cancellation notice should be left on Therapist's voicemail at (818) 378-9289.

Therapist Availability
Therapist's practice is equipped with a confidential voicemail system that allows Clients 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 the calls will be returned

immediately. Therapist is unable to provide 24-hour crisis service. In the event that Client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

Risks and Benefits of Therapy

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.

Participating in therapy may result in a number of benefits to Client, 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, work, and family settings, increased capacity for intimacy and increased self-confidence. Such benefits may also require substantial effort on the part of the Client, 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. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Client's perceptions and assumptions, and offer different perspectives. The issues presented by Client may result in unintended outcomes, including changes in personal relationships. Client should be aware that any decision on the status of his/her personal relationships is the responsibility of the Client.

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

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 Client.

Records and Record Keeping

Therapist may take notes during session, and will also produce other notes and records regarding Client'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 the Therapist. Therapist will not alter her normal record keeping process at

the request of the Client. Should Client request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Client 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 healthcare provider. Therapist will maintain Client's records for ten years following termination of therapy. However, after ten years, Client's records will be destroyed in a manner that preserves Client's confidentiality.

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, or when a client is a danger to him/herself or the person or property of another.

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 herself available for such an appearance at Therapist's usual and customary hourly rate of $175.00.

Psychotherapist-Client Privilege

The information disclosed by Client, as well as any records created, is subject to the psychotherapist-client privilege. The psychotherapist-client privilege results from the special relationship between Therapist and Client in the eyes of the law. It is akin to the attorney-client privilege or doctor-patient privilege. Typically, the client is the holder of the psychotherapist-client privilege. If Therapist receives a subpoena for records, deposition testimony or testimony in a court of law, Therapist will assert the psychotherapist-client privilege on Client's behalf until instructed, in writing, to do otherwise by Client or Client's representative. Client should be aware that he/she might be waiving the psychotherapist-client privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Client should address any concerns he/she might have regarding psychotherapist-client privilege with his/her attorney.

Termination of Therapy

Therapist reserves the right to terminate therapy at 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's needs are outside the 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 will generally recommend that Client participate in at least one, or possibly 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 to Client.

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. Moreover, Client agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Client Name (please print)

_____DATE_____

Signature of Client (or authorized representative)

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

_____

Client Name (please print)

_____DATE_____

Signature of Client (or authorized representative)

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Client Information

Name: _____ Birth date: _____

Address: _____ City: _____ Zip: _____

Phone: Home: _____ Work: _____

Cell: _____

Marital Status: ___Married ___ Separated ___ Divorced ___ Single

If married, how long?_____Occupation: _____

Spouse Name: _____

Children: Full Name Age Living at home?

1. _____ _____ _____

2. _____ _____ _____

3. _____ _____ _____

Emergency Contact Name/Phone: _____

Emergency Contact Person's relationship to you: _____

Are you under a doctor's care? Yes ___ No __ Name: _____

If any, please list any current medications (and amounts) you are taking:

Medication Amount Reason for Taking

_____

_____

_____

Do you have any side effects/reactions to your medication? (If yes, please list):

_____

_____

How did you hear about me? _____

_____

Intake Evaluation Form

In order for your therapist to become more familiar with you and your areas of concern, we would appreciate you taking time to complete this form. If there are questions you do not feel comfortable answer at this time, please skip them for now and you can discuss them with your therapist during your session.

Client's Family of Origin:

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother.

_____

_____

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father.

_____

_____

Names and ages of siblings.

_____

_____

PROBLEMS THAT YOU ARE HAVING:

(*Please use a checkmark to indicate which of the following problems apply to you or your child*):

- ☐ Depression
- ☐ Suicidal thoughts
- ☐ Suicidal actions
- ☐ Anxiety/fears/worries
- ☐ Anger temper problems
- ☐ Alcohol/drug abuse (self)
- ☐ Alcohol/drug abuse (family)
- ☐ Job/school problems/unemployed
- ☐ Financial concerns
- ☐ Legal problems
- ☐ Death of a loved one
- ☐ Major losses/difficult changes
- ☐ Parent-child conflict (self)
- ☐ Parent-child conflict (spouse)
- ☐ Marital/relationship problems
- ☐ Sibling problems
- ☐ Violence in the family
- ☐ Communication problems
- ☐ Sexual problem
- ☐ Sexual abuse when younger
- ☐ Physical abuse when younger
- ☐ Compulsive gambling
- ☐ Eating disorder

ANY PROBLEMS WITH COPING?

(*Please use a checkmark to indicate which of the following problems apply to you or your child*):

- ☐ Sleep problems
  - o Difficulty falling asleep
  - o Waking up in the middle of the night
  - o Waking up too early
  - o Sleeping too much
  - o Nightmares
- ☐ Moody or crying more than usual
- ☐ Feeling guilty/worthless/hopeless
- ☐ Fatigue/low energy
- ☐ Hyper/too much energy
- ☐ Loss of interest in things
- ☐ Uncontrollable, disturbing thoughts
- ☐ People are out to get me
- ☐ Other (specify: _____)
- ☐ Change in appetite
  - o Gaining weight (how much _____)
  - o Losing weight (how much _____)
  - o Not hungry
  - o Vomiting after eating
  - o Nauseated
- ☐ Constipation/diarrhea
- ☐ Difficulties concentrating
- ☐ Forgetfulness
- ☐ Withdrawing from others
- ☐ Repeated actions that I cannot stop (such as washing hands/body, counting, or checking on things)
- ☐ People are picking on me

MEDICAL HISTORY

(*Please use a checkmark to indicate any of the following medical conditions that the person being seen has currently or has had in the past*)*:*

☐ Asthma	☐ Seizures	☐ Multiple sclerosis
☐ Diabetes	☐ Lupus	☐ Headaches
☐ Ulcers	☐ Stroke	☐ Previous head injury
☐ Migraines	☐ Cancer	☐ Thyroid problem
☐ Epilepsy	☐ Heart condition	☐ Gynecological problems

☐ Other (specify: _____)

☐ Drug allergies? If yes, which drugs: _____

Previous hospitalizations/surgeries (*Please list dates and reasons*).

_____

_____

Previous suicide attempts (*Please list dates and methods*). If none, write "none".

_____

_____

Current prescriptions/medications (*Please list all prescriptions medication, OTC, and herbal supplements*).

_____

_____

Family history (*Please list any major familial health problems, drug, or alcohol use*).

_____

_____

PREVIOUS COUNSELING

Have you been in counseling previously? ☐ Yes ☐ No

(*If yes, please list dates and the focus of the sessions and reason counseling was terminated*).

_____

_____

Has any member of your family been treated for the following?

Schizophrenia ☐ Yes ☐ No If yes, who?

_____

Bipolar disorder ☐ Yes ☐ No If yes, who?

_____

Major depression ☐ Yes ☐ No If yes, who?

_____

Substance abuse ☐ Yes ☐ No If yes, who?

_____

LIFESTYLE CHOICES

Do you smoke? ☐ Yes ☐ No If yes, how much?

_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Do you use other types of drugs? ☐ Yes ☐ No If yes, which ones and how much?

_____

Do you drink products containing caffeine? ☐ Yes ☐ No If yes, how much? _____

Have you ever had any legal charges? ☐ Yes ☐ No If yes, when and what charges?

_____

Do you have any weapons in your home? ☐ Yes ☐ No

RELATIONSHIPS

(*Please place a checkmark next to items that apply to you or your child*):

- ☐ Too few friends
- ☐ I talk to my friends about my problems
- ☐ I'm overly shy
- ☐ I make friends easily
- ☐ Others seem to be picking on me
- ☐ Enough friends
- ☐ I don't talk to my friends about my problems
- ☐ I find it very difficult to open up to others
- ☐ I find it hard to keep my friends
- ☐ No one really understands me

SOURCES OF STRESS

(*Please list the things/events/problems that are creating stress in your life—or your child's life—at the present time. Include significant losses and changes in your life*):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

SOURCES OF STRESS

(*Place an "X" on the following scale to indicate how well you think you are coping—or that your child is coping—with things at the present time. 100% means you are coping the best you ever have.)*

I----------I---------- I---------- I---------- I---------- I---------- I---------- I----------I

0 30 40 50 60 70 80 90 100

YOUR GOALS IN COUNSELING

(*Please list the goals that you hope to achieve in counseling—please be as specific as you can*):

1. _____
2. _____
3. _____
4. _____
5. _____

ANYTHING ELSE YOU WANT US TO KNOW?

_____

_____

_____

_____

_____ _____

Signature Date