Heidi Hanson, LMFT
Psychotherapist; #115474
(805)664-1015

Today's Date:_____ Referred By: _____
Clients Name:_____ Age:_____
Date of Birth:_____ ID# _____ Marital status:_____
Address:_____
City:_____ State:_____ Zip:_____
Client's Employer:_____ Is client a Student? Yes___or No___
Spouse/Partner's Name:_____ Date of Birth:_____ Main phone: _____ E-mail:_____
Preferred Language:_____ Preferred Contact Method: Text: ____ Phone:____ Emergency Contact: _____Phone:_____ Relationship to client: _____ Preferred Language:_____ Any Court involvement? _____ Type?_____
Health Insurance Company:_____ Insurance ID#: _____Insured Date Of Birth: _____

CONSENT FOR TREATMENT

I, _____authorize and request Heidi Hanson, LMFT, to provide treatment and/or diagnostic procedures which, now or during the course of my/my child's care as a client, are deemed advisable. The frequency and type of treatment will be decided between the therapist and myself.

Please initial that you understand each of the statements below:

I understand that my treatment therapist is a Licensed Marriage and Family Therapist.
I understand that, while there is an expectation that I/my child will benefit from psychotherapy, there is no guarantee that this will occur.

- Please Initial Here _____

I understand that maximum benefit will occur with consistent attendance and that I may feel conflicted about my/my child's therapy as the process, at times, can be uncomfortable.

- Please Initial Here _____

I will notify if I have decided to end treatment. Therapy can be terminated for any reason, at any time.

- Please Initial Here _____

TELEHEALTH INFORMED CONSENT

I _____ [name of patient] hereby consent to engaging in telemedicine with Heidi Hanson, LMFT, as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, assessment, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information, both orally and visually.

I have read and fully understand this Consent for Treatment form

Signature:_____Date:_____ (Client or Parent/Guardian)

Signature:_____Date:_____

Authorization to Release Confidential Information

I, [Name of Patient] _____("Patient") hereby authorize]_____Heidi Hanson, LMFT_____("Provider") to release confidential information obtained during the course of my treatment to [name or function of the person(s) or entities to whom information is to be released]
_____("Recipient").

This Authorization permits the release of the following information:

____ Diagnosis ____ Treatment Plan ____ Progress to Date
____ Prognosis Clinical ____ Test Results ____ Dates of Treatment
__ Any and All Information Necessary
____ Other (specify)

_____

I authorize the release of the information described above for the following purpose(s):
___Case Managment_____

The specific uses and limitations on the types of information to be released are as follows:

_____
_____
_____

The specific uses and limitations on the use of the information by Recipient are as follows:

_____
_____
_____

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.
The Authorization shall remain valid until: _____ (,"Expiration Date")
By: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, CONSENT FOR TREATMENT AND OFFICE POLICIES

By signing this form, you acknowledge receipt of my Notice of Privacy Practices, and executed copies of the Consent for Treatment and Office Policies forms that I have given to you.
We have reviewed the Consent for Treatment and Office Policies forms.
My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.
My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me as listed above.
If you have any questions about my Notice of Privacy Practices, please contact me.
I acknowledge receipt of the Notice of Privacy Practices and executed copies of the Consent for Treatment and Office Policies of the private practice of Heidi Hanson, LMFT.
Client Name:_____
Signature: _____Date:_____
(Client/Parent/Conservator/Guardian)
Signature: _____Date:_____

OFFICE POLICIES

Payment: Full payment for service is due the day of each session unless other prior arrangements have been made. Please notify us if any problem arises during therapy regarding your ability to pay for services.

Confidentiality: All information disclosed within sessions, including that of a minor, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law.

Disclosure may be required in the following circumstances:

1. When there is reasonable suspicion of abuse of a child or a dependent or elder adult.
2. When the client communicates a threat of bodily injury to others.
3. When the client is suicidal.
4. When disclosure is required pursuant to a legal proceeding (e.g., court subpoena).

Our Notice of Privacy Practices (attached) provides specifics on safeguarding your information.
Emergency Procedures: If you need to contact me between sessions, please call and leave a message. Reasonable effort will be exerted to return your call as quickly as possible during business hours.
If you cannot reach me and it is a true emergency, please call 911.

NOTICE TO CLIENTS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of Licensed Marriage and Family Therapists. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Professional Fees

Individual/Family/ Consultations/Reports/Phone/ Email/50 - 55 minute sessions: $130 - $180 (Sliding Scale)

All fees are applicable unless other arrangements have been made with therapist.

Cost/Session:_$180.00_____ Financially Responsible Party:_____ Date:_____

I acknowledge that I have carefully read and understand the above policies and procedures and agree to comply with them.

_____ PRINT NAME: Client or Parent/Guardian
_____ PRINT NAME: Client or Parent/Guardian
_____ _____ DATE SIGNATURE
_____ _____