SoCal THERAPY CENTER

818-804-0322

Client Registration

Client's Name:		**Client's Date of Birth:**	00/00/0000
Client's Age:		**Social Security #:**	000-00-0000
Street Address:		**City, State, Zip Code:**	
Home Phone:	000-000-0000	**Ok to leave message:**	Select ->
Work Phone:	000-000-0000	**Ok to leave message:**	Select ->
Client Mobile Phone:	000-000-0000	**Ok to leave message:**	Select ->
Client Email Address:		**Ok to use email correspondence?**	Select ->
Insurance Company:	Select -> Other:	**Insurance ID #:**	
Emergency Contact Name:		**Emergency Contact Phone:**	000-000-0000

Physician:		**Phone #:**	000-000-0000	**Date of Last Appointment:**	M/D/Y
Psychiatrist:		**Phone#:**	000-000-0000	**Date of Last Appointment:**	M/D/Y

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What do you need help with?	
Symptoms:	

Depressed Mood	☐	Decreased Libido	☐
Sadness	☐	Low Self-Esteem	☐
Irritable Mood	☐	Psychomotor Agitation	☐
Decreased Interest or Pleasure	☐	Decreased Concentration	☐
Excessive Guilt	☐	Indecisiveness	☐
Recurrent Thoughts of Death	☐	Weight Gain	☐
Feeling Hopeless	☐	Weight Loss when not dieting	☐
Feeling Worthless	☐	Decreased Energy or Fatigue	☐
Increased Sleep	☐	Periods of High Energy	☐
Decreased Sleep	☐	Impulsive Behavior	☐
Increased Appetite	☐	Tearfulness	☐

Date of First Symptoms:	
Previous Therapy?	Select ->
Current Medication:	

How did you hear about our services?

Insurance Referral: ☐ Internet Search: ☐

Website: ☐ Referred by:

Other:

May we contact them to say thank you? Select ->

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If client is a minor, please complete the information below for all parents or guardians:

Parent/Guardian #1:

Name:		**Date of Birth:**	00/00/0000
Relationship to Client:	Select ->	**Social Security #:**	000-00-0000
Street Address:		**City, State, Zip Code:**	
Home Phone:		**Ok to leave message:**	Select ->
Work Phone:		**Ok to leave message:**	Select ->
Client Mobile Phone:		**Ok to leave message:**	Select ->
Parent's Email Address:		**Ok to use email correspondence?**	Select ->
Insurance Company:	Select -> Other:	**Insurance ID #:**	
Type of Insurance Policy	Select ->	**How much time does client live at this address?**	

Parent/Guardian #2:

Name:		**Date of Birth:**	00/00/0000
Relationship to Client:	Select ->	**Social Security #:**	000-00-0000
Street Address:		**City, State, Zip Code:**	
Home Phone:		**Ok to leave message:**	Select ->
Work Phone:		**Ok to leave message:**	Select ->
Cellular Phone:		**Ok to leave message:**	Select ->
Parent's Email Address:		**Ok to use email correspondence?**	Select ->
Insurance Company:	Select -> Other:	**Insurance ID #:**	
Type of Insurance Policy	Select ->	**How much time does client live at this address?**	

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I, _____ (name of responsible party) have been given a copy of Informed Consent for Psychotherapy. I have been given the opportunity to have any and all questions answered relevant to the proposed psychotherapy. I agree to enter into a course of therapy with SoCal Therapy Center, Inc. as of M/D/Y _____ (date) at a rate of $_____ (to be completed by therapist) per 50 minutes payable at the time of services.

Signed: _____ Date: M/D/Y _____

Therapist Background & Qualifications:

Therapist: Beth Jakubanis, LCSW
License: LCS 28234

The therapist is licensed by the Board of Behavioral Sciences in the State of California.

Information about SoCal Therapy Center, Inc.
SoCal Therapy Center is a group therapy practice. The group practice is owned and operated by Beth Jakubanis, LCSW.

Cancelation Policy
I understand that cancellations and re-scheduled sessions will be subject to a full charge **if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE.**

I grant permission for case consultations with other professionals as long as standard care is exercised to protect my privacy and confidentiality. I have been advised regarding the limits of above stated confidentiality and I agree that I will not authorize the execution of a subpoena for any purpose. I hereby authorize my therapist to resist subpoenas executed by any other person or persons in order to protect and insure my privacy and confidentiality.

I have read and understand the information contained in the Client Information Sheet and initial registration package. I have been given the opportunity to have any and all question answered relevant to the proposed psychotherapy.

_____ _____
Client/Parent/Guardian Signature Witness

M/D/Y _____ M/D/Y _____
Date Date

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INFORMED CONSENT FOR PSYCHOTHERAPY

CLIENT INFORMATION SHEET

General Information:

The therapeutic relationship is a mutual endeavor to which the therapist contributes knowledge and skill in psychology and to which the client brings specialized personal knowledge and a commitment to work on his/her own problems. The goals of psychotherapy are both general and specific. General goals include promoting a greater self-awareness of the client's feelings, motivations, behavior and interactions with other persons in his/her life. This awareness and understanding will hopefully promote clarification of personal goals, values and priorities and thus, enable him/her to cope with life tasks in a more directed and fulfilling manner. Specific goals in psychotherapy depend on the unique circumstances of each client.

The techniques utilized in the process of psychotherapy may include the disclosure by the client of deeply personal thoughts, feelings and experiences. The therapist may provide feedback to the client in order to generate insight and provide new coping skills. At times, the therapist may offer confrontation of certain beliefs, attitudes, or behaviors and as device that will allow the client to risk new behaviors beyond his/her present level of function.

Research supports the overall effectiveness of psychotherapy but it is also clear that psychotherapy is not effective in all cases. Many factors seem to influence the effectiveness of psychotherapy and we will continually monitor your progress and make adjustments as necessary. You can improve the effectiveness of your therapy by attending sessions regularly. It is also possible that changes brought about by your psychotherapy will be experienced by you or your family members as undesirable or uncomfortable, sometimes because change is uncomfortable in and of itself, and sometimes because changes can upset a given family equilibrium. Any concerns in this regard should be discussed with your therapist.

Billing

The standard fee is **$275** per 50 minute session unless otherwise agreed upon. All fees are payable at the time of service unless other arrangements are agreed upon in advance. The therapist will request that you place a credit card on file to establish a convenient method of payment and for use in the event that a missed session fee is incurred. A detailed invoice of charges can be obtained for the purpose of submitting to an insurance carrier or other third party payer for reimbursement. There will be no fee for this service on current bills. However, an outstanding account may be charged a $5.00 service fee for each statement. Past due accounts may be additionally subjected to interest charges of 5% per month if a balance is neglected for more than 30 days. In the case of a third party payer, the client is fully responsible for all charges not covered by insurance. If the balance is past due 90 days, it is subject to go to collections.

A $10 service charge will be charged for any checks returned for any reason for special handling.

Cancellations and re-scheduled sessions will be subject to a full charge if notification is NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

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Fee Schedule

Time Frame		Fee
50	minutes	$275
75	minutes	$412
90	minutes	$495

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours. The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to increase the length of your sessions need to be discussed and scheduled in advance.

From time to time, the therapist may engage in telephone contact with the client or other parties for purposes other than scheduling sessions. Insurance companies do not reimburse the therapist for these activities. The client 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, the therapist may engage in telephone contact with third parties at the client's request and with the client's advanced written release providing authorization. Client is responsible for payment of the agreed upon fee (on a pro-rata basis) for any telephone calls longer than ten minutes.

House Calls

If you request the therapist to come to your home to provide services, you will be asked to pay for transportation fees at a rate of $150 per 50 min (pro-rated). This will be in addition to the session fee of $275 per 50 min.

Confidentiality

The session content and all relevant materials to the client's treatment will be strictly held confidential unless the client requests in writing to have all or portions of such content released to a specifically named persons/persons. Limitations of such client held privilege of confidentiality exist and are itemized below.

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.

2. If a client threatens grave bodily harm or death to another person.

3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.

4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses or fiduciary abuse.

5. Suspected neglect of the parties named in items # 3 & # 4 above.

6. If a court of law issues a legitimate subpoena for information stated on the subpoena.

7. If a client is in therapy or being treated by order of a court of law or if information is obtained for the purpose of rendering an expert's report to an attorney.

Initials_____

8. If a client involves a therapist in a conspiracy to commit a crime or a conspiracy to avoid detection from prosecution.

Occasionally, therapist may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If you accidentally see your therapist outside of the therapy office, he/she will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to us, and we do not wish to jeopardize your privacy. However, if you acknowledge your therapist first, he/she will be more than happy to speak with you but will not to engage in any lengthy discussions in public or outside of the therapy office.

Availability
The therapist will be available via voicemail during standard business hours. Every effort is made to return all messages within 1 business day. If your therapist is on vacation or it is after business hours and you are having an emergency, dial 911 or the Suicide Prevention Hotline (877) 727-4747 or go to your nearest emergency room unless arrangements for a back-up therapist have been provided.

Media/Social Media Policy:

By Telephone
When contacting your Therapist always call our office number at (818) 804-0322. We do not answer the phone when we are with clients. When your therapist is unavailable, you are welcome to leave a message. He/she will make every effort to return your call on the same day you make it, with the exception of weekends and holidays, but sometimes it may take up to 48 hours. It is helpful when leaving a message to indicate if you feel you need an immediate call back. If you are difficult to reach, please offer some times when you will be available. If you are unable to reach your therapist and feel that you can't wait for them to return your call, please proceed as indicated above.

E-Mail
If you communicate confidential or private information via e-mail, cell-phone or fax, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters via e-mail, cell-phone or fax. You should be aware that all e-mails of clinical value will be printed and made part of your clinical file. If you choose to communicate with your therapist via email keep in mind that emails are not confidential, emails may not be received/returned for up to 3-5 business days.

Text Messages
Text messaging is treated in the same manner as a voice message or e-mail as indicated above as indicated above.

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Social Networking:

The therapist does not accept friend requests from current or former clients on social networking sites. SoCal Therapy Center believes that adding clients as friends on these sites and/or communicating via such sites is likely to compromise your privacy and confidentiality. For the same reason, it is requested that clients do not communicate with their therapist via any interactive or social networking web sites.

Issues that arise with Phone/Email/Cell Phone/Texting/Faxes

Consulting with clients exclusively over the phone or via e-mail rather than in person in the therapist's office brings up additional complexities and potential disadvantages to the therapeutic process. Treating clients exclusively via phone consultations or e-mails may put the therapist at a disadvantage because they cannot detect nonverbal cues, may not be able to accurately diagnose, may not always be aware of the resources available locally and may not be able to intervene as effectively as necessary in emergency situations. Acute crises and severe psychological disturbances, such as schizophrenia, bipolar or some types of personality disorders may not be effectively handled via phone, e-mail or other web based communications.

It is very important to be aware that computers, e-mail, and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Faxes can easily be sent erroneously to the wrong address. E-mails, in particular are vulnerable to unauthorized access due to the fact that Internet servers may have unlimited and direct access to all e-mails that go through them. Additionally, our e-mails are not encrypted.

Please notify me if you decide to avoid or limit in any way the use of any or all communication devices, such as e-mail, cell-phone or Faxes.

If you communicate confidential or private information via e-mail, cell-phone or fax, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters via e-mail, cell-phone or fax.

Please DO NOT use e-mail, texting or Faxes for emergencies.

Termination

Our relationship is strictly voluntary and you may leave the therapeutic relationship anytime you wish. However, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. SoCal Therapy Center may terminate treatment after appropriate discussion with you and a termination process if it is determined that the psychotherapy is not being effectively used or if you are in default on payment. SoCal Therapy Center will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, you will be provided with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral.

Initials_____