Intake Questionare

Cynthia Psaila MS, LMFT 83299
707-207-4814 ~ cynthiap.mft@gmail.com ~ Cynthiapsaila.com

Name: _____Date_____ Patient DOB_____

Address: _____

Phone: Home_____Cell_____

Email: _____

Emergency contact information:

Name_____Phone_____Relation_____

Who referred you? Or how did you hear about my service?

What precipitated your call? Is there a crisis, conflict, or challenge?

Issues that you would like help with:

Brief description of how you think I can help you:

Have you been in psychotherapy or counseling before? When, and for how long?

Are you experiencing physical symptoms? If so, are you in a medical doctors care?

Please list any medication you are currently taking:

Consent to Treatment of Minor
Cynthia Psaila M.S., LMFT

(I) I/We, the undersigned parent(s) of _____, a minor, do hereby consent for counseling services, including but not limited to assessment, consultation, and/or psychotherapy, to be provided to said minor by Cynthia Psaila LMFT according to the policies and terms contained in the Informed Consent Policies form.

(II) I/We understand that the success of treatment depends on the minor's ability to trust the therapist. Consequently, your child's therapist keeps confidential what your child says in the same way that confidentiality is kept with an adult patient. As a parent you have the right to understand the nature of the activities and progress with your child. Your child's therapist, in the exercise of his or her professional judgment, may discuss aspects of the treatment and/or progress of a minor patient, with you. However will not release specific information that the child provides during the course of therapy except where the child presents a danger to him/herself or to others, is gravely disabled, or when disclosure is otherwise required by law.

This authorization or consent to treatment shall remain effective until the minor reaches the age of majority unless otherwise revoked in writing.

Name of Parent/Guardian:_____

Name of Parent/Guardian:_____

Address:_____

City:_____State_____Zip Code:_____

Home Phone:_____Work Phone:_____

Signature of Parent/Guardian:_____Date:_____

Signature of Parent/Guardian:_____Date:_____

Office Policies and Informed Consent
Cynthia Psaila MS, LMFT 83299
707-207-4814 ~ CynthiaP.mft@gmail.com ~ cynthiapsaila.com

This form provides you with information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPAA pre-emptive analysis. (Revised 1/05) Much of the information will not be pertinent to your case, but it is important to understand all the possibilities.

Confidentiality: All information disclosed within sessions and in the written records pertaining to those sessions is confidential and may not be revealed to anyone without your written permission, except where law requires disclosure.

Consultation: I may consult with other professionals regarding certain cases, however the identity of the clients will remain completely anonymous, and confidentiality will be fully maintained**.**

When disclosure is required by law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled or when a client's family member communicates to the therapist that the client presents a danger to others.

Danger to self or others: If I believed you to be a danger to yourself or others, I may have to breach confidentiality. I would try to discuss this with you and would disclose information only as a last resort, disclosing only information sufficient to protect you or those that I believe to be in danger, no more and no less.

Reporting Requirements: I am a mandatory reporter for child, dependent adult, and elder abuse. This state has very strict reporting requirements regarding child, dependent and elder abuse. Abuse can include, but is not limited to, physical abuse, sexual abuse or exploitation, neglect, viewing and/or downloading of child pornography or other images of sexual exploitation of minors, and/or financial exploitation. This is also true if the senders and recipient are minors texting sexual content or photographs to another minor. If you disclose information that leads me reasonably that abuse of a child, dependent adult, or elder abuse has occurred, I am required by law to report the suspected abuse.

When disclosure may be required: Disclosure may be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the therapy records and/or testimony by a therapist. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family

members, unless otherwise agreed upon. The therapist will use her clinical judgment when revealing such information. The therapist will not release records to any outside party unless she is authorized to do so by all adult family members who were part of the treatment.

Litigation limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that: should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf will call on Cynthia Psaila LMFT to testify in court or at any other proceeding. Nor will a disclosure of the notes/records be requested unless otherwise agreed upon.

Emails, cell phones, computers and faxes: It is very important to be aware that computers, email and cell phone communications can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Additionally, my email is not encrypted. If you communicate confidential or highly private information via email, I will assume that you have made an informed decision. Please do not use email or faxes for emergencies.

Records and your right to review them: Both the law and the standards of the therapy profession require that I keep appropriate treatment records for at least 7 years. Unless otherwise agreed to, the clinical records are retained only as long as is mandated by California law. If you have concerns regarding treatment records, please discuss them with me.

As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when the therapist assesses that releasing such information might be harmful in any way. There are two standards for withholding records, one for minors and another for adults. For minors, the standard is "Where the health care provider determines that access to the patient records requested by the representative would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being…" (*Health & Safety Code §* 123115(a)(2).) For adults, the standard is: "When a health care provider determines there is a substantial risk of significant adverse or detrimental consequences to a patient in seeing or receiving a copy of mental health records requested by the patient. . ." In such a case the therapist provides the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, upon your request the therapist will release information to any agency/person you specify, unless again the therapist assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couples and family therapy, the therapist will release records only with signed authorizations from all the adults (or all those who legally can authorize such a

release) involved in the treatment. In the case of a minor child the parents with legal custody hold the privilege for the records of the child/children.

Telephone and emergency procedures: If you need to contact Cynthia Psaila LMFT between sessions, please leave a private voice mail at (707) 207-4814 and your call will be returned as soon as possible, or you can email her at CynthiaP.mft@gmail.com. I check my messages once per 24 hour period unless I am out of town. If an emergency situation arises, indicate it clearly in your message and if you need support right away call Psychiatric Emergency Services: Santa Rosa - (707) 565-4970; Sonoma 24-hr. crisis line- (800) 746-8181; or the Police at 911. Please do not use email or faxes for emergencies. I do not always check my email daily.

Payments and fees: Clients are expected to pay Cynthia Psaila LMFT a standard fee of $175 per 50 minute session (court involved cases and family therapy may be billed at a different rate). Other services such as travel time, telephone conversations, report writing, and consultation with other professionals will be billed at the same rate, unless indicated and agreed upon otherwise. Please tell me if any problems arise during the course of therapy regarding your ability to make timely payments. Payment is due at time of service unless otherwise agreed. A statement of services and payments can be provided monthly at your request. If you choose to submit this to insurance, there is no guarantee of reimbursement as I am not an insurance provider. Payments can be made by cash, check or credit card. Please speak with me directly if you would like to keep a credit card on file and we can discuss your options. If the cost of therapy becomes prohibitive, I do have a limited number of sliding scale openings that we can discuss further at your request.

The process of therapy/evaluation and risks of treatment: Participation in therapy can result in a number of benefits to you, including improved interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits requires effort on your part. Therapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. The therapist will ask for your feedback and views on your treatment, its progress and other aspects of the therapy. You will be expected to respond openly and honestly to the best of your ability. Sometimes more than one approach can be helpful in dealing with a certain situation. During treatment, the recollection of or discussion about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort. This can be in the form of strong feelings of anger, sadness, worry, fear, etc. Other reactions include high anxiety, depression, insomnia, etc. The therapist may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations. This challenge can cause you to feel very upset, angry, depressed or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Therapy may result in decisions about changing behaviors, employment, substance use,

schooling, housing or relationships. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that therapy will yield positive or intended results. During the course of therapy, I may draw on various psychological approaches according, in part, to the problem that is being treated and the assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, cognitive, psychodynamic, narrative, family system, developmental (adult, child, family), humanistic or psycho-educational. This therapist does not provide custody evaluations, medication or prescription recommendations, or legal advice, as these do not fall within the scope of practice. Crisis creates vulnerability. Every effort is made to empower the client to make their own decisions and to create options for them to choose from. Informed consent is an important component to the work. These choices are a crucial part of the treatment regardless of the stage of the treatment process. It is possible that the work in this treatment may reveal hidden issues that are distressing and disruptive. In some cases the issues can readily be addressed in the context of the therapy process. In other cases adjunct work with an existing therapist or referrals to new therapists or agencies is important component for ongoing growth.

Discussion of treatment plan: Within a reasonable period of time after the initiation of treatment, this therapist will discuss with you a working understanding of the problem, the treatment plan, the therapeutic objectives and our view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, our expertise employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

Termination: As set forth above, after the first couple of meetings, we will reassess if my services can be of benefit to you. In the case you or I do not see benefit, I will give you a number of referrals that you can contact. If at any point during treatment, I assess that I am not effective in helping you reach the therapeutic goals, I will discuss it with you and, if appropriate, terminate treatment. In such a case, I would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you with referrals, and if I have your written consent, I will provide you with the essential information. You have the right to terminate therapy at any time.

Dual relationships: Not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs the therapist's objectivity, clinical judgment, or that is exploitative in nature. I assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. Sonoma/Glen Ellen is a small

community and many clients know each other and the therapists from the community. Consequently you may bump into someone you know in the waiting room or see your therapist in the community. As standard practice, I will not acknowledge working with anyone without his/her written permission. Nevertheless, I will discuss with you the often existing complexities, potential benefits and the difficulties that may be involved in dual or multiple relationships. It is your responsibility to communicate to your therapist if the dual or multiple relationships becomes uncomfortable for you in any way. The therapist will listen carefully and respond accordingly to your feedback and will discontinue the dual relationship if she finds it interfering with the effectiveness of the therapy or with the welfare of the client and, of course, you can do the same at any time.

Notice to Clients: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Cancellations: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hours notice is required for rescheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification.

Signature: Please sign and date below that you have read, understand, and agree to the terms of these policies.

Client name (print)_____

Client signature_____Date_____

Parent signature_____Date_____

Authorization for Release of Information
(If applicable)

I hereby authorize the release and exchange of all pertinent medical, psychological, and educational information concerning

(Client) _____

Between Cynthia Psaila LMFT and

(Name of person(s) here)_____

(Contact info)_____
for use in assessment, consultation and/or psychotherapy.

This authorization shall be valid as long as the subject above is receiving assessment, consultation and/or psychotherapy services from Cynthia Psaila LMFT. You can revoke your consent in writing at any time.

Signed _____Date:_____

(Client, Parent, or Guardian)

Signed _____Date:_____

(Client, Parent, or Guardian)

Cynthia Psaila LMFT, Inc
Licensed Marriage and Family Therapist #83299
Informed consent for Video-Psychotherapy and tele-health

- I agree to engage in video psychotherapy with my provider: Cynthia Psaila, LMFT
- I understand that video conferencing technology will not be the same as in person psychotherapy due to the fact that I am not in the same room as my provider. I also understand that in order to have the best results for these sessions, I should be in a quiet place, WiFi accessible, with limited interruptions during my appointment.
- I understand that there are potential risks to using this technology that may result in the discontinuation of the session. These may include internet connectivity issues, or other technical issues, or unexpected interruptions. My provider will make every effort to reconnect if the session is interrupted or discontinued.
- My provider agrees to inform me and obtain my consent if another person is present during the session, for any reason. I agree to inform my provider if there is another person present during the session or if I wish to record the session.
- I understand that there are alternatives to video psychotherapy, including audio or in-person meetings. (There may be exceptions to this agreement due to the COVID 19 Pandemic). For audio session the same considerations apply.
- I understand that this agreement will last for the duration of the relationship with my provider. I may revoke this consent at any time and work with my provider to find a suitable alternative.
- I understand that the same confidentiality protections, limits to confidentiality, and rules around my records apply to audio and video psychotherapy sessions as they would in-person sessions.
- I agree to come up with a safety plan, including to identify one or two emergency contacts, in the event of a crisis situation during our sessions.
- I understand that my provider may decide to terminate video psychotherapy services if she deems it is innapropriate for me to continue.

Name (adult)_____Name (Minor)_____

Sign (adult):_____Sign (minor)_____

Date:_____Date_____

Emergency contact (name, number and relation):

_____

I can accept cash, check or credit card for purchases. If you would like to bill your credit card please fill out the form below.

Credit Card authorization: I will keep this information stored in a HIPPAA compliant file and will charge your card at time of service. You may cancel this authorization at any time by contacting me directly.

Name on card:_____

Number:_____

Expiration date:_____

Billing zip code:_____

Three digit security code:_____

Signature: _____. Date:_____