CHILD/ADOLESCENT INTAKE

24800 Chrisanta Dr., Ste. 220
Mission Viejo, CA 92691
(949)412-8235 marilyn@marilynviera.com

PATIENT'S NAME_____DOB_____

PARENT/GUARDIAN'S NAME (for minors)_____

ADDRESS_____

CITY_____ZIP_____

PH:_____WORK:_____CELL:_____

E-MAIL_____

CHILD'S SCHOOL_____GRADE_____PH:_____

EMPLOYER OF SUBSCRIBER:_____

SUBSCRIBER (if different):_____

SUBSCRIBER'S SSN:_____DOB_____

INSURANCE:_____INSURANCE PH:_____

INS. ID#:_____GROUP:_____

AUTHORIZATION #_____

❑CASH FEE ❑PPO ❑ EAP

COPAY $_____ # SESSIONS_____

❑DEDUCTIBLE MET ❑OWES ON DEDUCTIBLE $_____

EMERGENCY CONTACT:_____PH:_____

Has your child been in psychotherapy before?_____ Dates_____

With whom and where?_____

What brings him/her to therapy now?_____

_____

What else would you like me to know? _____

_____

Who referred you to me?_____

Marilyn K. Viera, LCSW **Lic. LCS 20570**
24800 Chrisanta Dr., Ste. 220 **Tel 949-412-8235**
Mission Viejo, CA 92691 **Fax 949-481-4145**

THERAPEUTIC CONTRACT

The Therapy Process • Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part and may result in your experiencing some discomfort. Change will sometimes be easy and swift, but can be slow and frustrating. Remembering and resolving significant life events in therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended.

Client's Rights • You have the right to a confidential relationship with me. Within certain legal limits (see #2 below), information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any person without your written permission.

1. You have the right to know the content of your records at any time and I have the right to provide you with the summary of their content. I can release a summary of records on file to any person you specify. I will tell you when you make your request whether or not I think releasing that information to that agency or person might be harmful to you. Fee is $40/15 minutes of medical record preparations or writing.

2. Under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:

a. Revealing to me active child abuse or neglect. If a perpetrator is in contact with minors and there is a reasonable suspicion that he/she may still be abusing minors. Active physical abuse of a dependent adult or an elder is taking place.

b. If you seriously threaten harm or death to another person, I am required to warn the intended victim and notify the appropriate law enforcement agencies.

c. If you are in therapy or are being tested by order of the court, the results of the treatment or tests ordered must be revealed to that court.

d. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena.

e. If you are in a lawsuit claiming emotional harm, the opposing side may subpoena your therapy records.

3. You have the right to ask questions about any of the procedures used in the course of your therapy.

4. Should you choose not to enter therapy with me, I will provide you with names of other qualified professionals whose services you might prefer.

5. You have the right to terminate therapy with me at any time without any financial, legal, or moral obligations other than those you've already incurred. I have the right to terminate therapy with you under the following conditions:

a. When I believe that therapy is no longer beneficial to you.

b. When I believe that you will be better served by another professional.

c. When you have not paid for the last two sessions.

d. When you have failed to show up for your last two therapy sessions without a 48-hour notice.

e. If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If I have written consent, I will provide that professional with information they request.

If any of these situations apply, I will send you a certified letter to your address of record to inform you of my decision and I will give you the names of several therapists for your future counseling needs.

Fees and Length of Therapy • I agree to enter therapy with Marilyn K. Viera, LCSW for 45 minute sessions.

I agree to pay the standard fee of $_____ or $_____copay for each completed forty five minute session. I will make payment in cash, credit card or by check at the time of the therapy appointment. I understand that I can leave therapy at any time and that I have no financial, legal, or moral obligation to complete additional sessions after the assessment. I am contracting only to pay for completed therapy sessions, or sessions I miss without providing 48 hour notice, and telephone time as outlined in the Office Policies section.

Date_____ Client's Signature_____

Therapist's Signature_____

Office Policies

Payment for Service: You are expected to pay for services at the beginning of your session. Payment can be made in cash, credit card, check or Health Savings account. Please notify me if any problem arises regarding your ability to make timely payment. A $30 service charge will apply to any returned checks.

Appointments and Cancellation: Cancellations and re-scheduled sessions will be subject to a full charge if not received at least 48 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. The full fee of $125.00 will be charged for missed sessions without such notification. Insurance companies do not reimburse for sessions missed. The standard time for psychotherapy is 45 minutes. Appointment times longer than this are available but must be scheduled in advance.

Office Hours: My office hours are from 8:00 AM to 6:00 PM, Monday to Thursday. Friday appointments vary. If you need to reschedule, please leave a message and I will return your call within 24 hours.

Telephone Time: If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available, however, I will attempt to return your call within 24 hours. Please note that face to face sessions are highly preferable to phone sessions. However, in the event you are out of town, sick or need additional support, phone sessions are available. After 5 minutes of telephone time, you will be charged on a prorated basis of $2.00/minute at a minimum of 3 minutes. This fee also applies to documentation review, faxes, letter writing and emails.

Emergency or Crisis: An emergency is an unexpected event that requires immediate medical attention and can be a threat to your health. If an emergency situation arises, please state this when you leave a message. If I have not called you back within 60 minutes, and the emergency requires it, please call 9-1-1 or call your physician/psychiatrist or admit yourself to the local emergency room for observation.
Crisis is when you need a quick consult on the same day. I keep a cancellation list available in case a patient requires a same day appointment. Upon availability, mini sessions of up to 15 minutes, will allow a paid consultation by phone, Facetime/Skype or email. Contact Marilyn for availability and fee.

Electronic Communication: I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee an immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or

request assistance for emergencies. **Texting should only be used for scheduling appointments only.**

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend requests on sites (such as LinkedIn, Facebook, etc) to respect your privacy.

I have read and understand these office policies.

Client's Name Printed	Date	Signature
Marilyn K. Viera, LCSW	Date	Signature

Consent for Treatment of a Minor •

I, the undersigned parent/guardian of (patient) _____, authorize and request that Marilyn K. Viera, LCSW, to carry out psychological assessment, diagnostic procedures, and/or treatment which now or during the course of his/her care as a patient are advisable.

I understand that if the minor is an adolescent, the content of his/her private session will also remain confidential. However, general directions the minor is taking in therapy and how I may be able to maximize his/her positive growth will be provided. Occasionally, I may be asked to participate in a session with the minor to assist him/her to communicate his/her progress and goals. I also understand that I will be informed of any safety concerns to the minor.

I understand this authorization may be revoked, in writing, at any time. If not previously revoked, this authorization shall remain effective one year from the date of the signature below.

Date_____ Minor/Client's Signature_____

Date_____ Parent's Signature_____

Date_____ Therapist's Signature_____