Cancellation/No-Show Policy

Your appointment time is reserved especially for you. Please call us at 310-968-6648 to cancel your appointment at least **24 hours** prior to your scheduled appointment. If you fail to show up for your appointment, or give us less than 24 hours notice **you will be charged a $65.00 fee**. We must charge you this fee because other clients may be on a waiting list, or may be looking for the opportunity to reschedule for a different time.

Thank you.

X _____

Signature & Date

Patient Questionnaire/Intake

General:

Date: _____

Name: _____

Address: _____

City & Zip _____

Home phone _____

Work phone _____

E-mail _____ Referred by _____

Age _____ Date of birth _____

Marital status _____ Educational level _____

Occupation _____ Names and ages of children_____

_____

Emergency contact information _____

Explanation of how patient may be contacted by therapist _____

Financial Information:

Annual household income _____ Do you own or rent? _____

How do you intend to pay for treatment? (cash, check, charge, insurance) _____

If planning to use health insurance:

Name of insurance company _____

Policy number _____ Group number _____

Telephone number _____

Areas of Concern

What issues/concerns causes you to seek treatment? Please describe.

_____

_____

_____

Do you have any specific goals with regard to your

treatment?_____

_____

_____

Do you have any particular concerns/fears with regard to treatment?

_____

_____

_____

_____

Psychological History

Have you ever received mental health treatment before? _____

When and for how long? _____

What was the focus of treatment?_____

Name of treating therapist(s), address(es), telephone number(s) _____

_____

Inform patient that authorization for release of confidential information will be needed so that any former therapist may be contacted.

Have you ever been subjected to one or more psychological tests?

_____

If so, by whom? _____

Name of person(s) administered psychological tests, address(es), telephone number

_____

_____

Inform patient that authorization for release of confidential information will be needed so that any test administrator may be contacted.

Have you ever been hospitalized for mental or emotional problems? _____

When and for how long? _____

Why were you hospitalized? _____

Name of treating therapist, address, telephone number _____

Inform patient that authorization for release of confidential information will be needed so that any former therapists may be contacted.

Are you currently taking any prescription medications? _____

Prescribed by whom? _____

How long have you been on the medications? _____

Have you ever taken any medications for a mental or emotional condition? _____

When and for how long? _____

Inform patient that authorization for release of confidential information will be needed so that health care provider may be contacted.

Have you ever attempted suicide? _____

When? _____

Describe the circumstances that led to that attempt. _____

_____

_____

Are you currently having any suicidal thoughts? Please describe _____

Please describe your childhood _____.

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.

Have you ever been a victim of a violent crime? Please describe _____

Medical History

Have you ever been diagnosed with a serious illness? Please describe_____

Do you have any medical conditions that may affect your mental health treatment? _____

Please describe your overall health today. _____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. _____

Have you ever been in a 12-step program? Please describe. _____

Do you smoke? _____ How much? _____ For how long? _____
Do you drink alcohol? _____
On average, how much alcohol do you consume in a week?_____
Do you currently use illegal drugs? Please describe your use _____

Have you ever used illegal drugs? Please describe. _____

_____

_____

Family of Origin History

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. _____

Other Information

Please describe your spiritual identity/orientation. _____

Please describe your interests/hobbies _____

Are you now or have you ever been involved in a lawsuit? _____

Please describe. _____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. _____

Introduction

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

Information about Your Therapist

At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

Your therapist is a:

_X_Licensed Marriage and Family Therapist

___Licensed Clinical Social Worker

___Licensed Psychologist

___Marriage and Family Therapist Registered Intern*

___Marriage and Family Therapist Trainee*

___Associate Clinical Social Worker*

___Psychological Assistant*

___Registered Psychologist*

* If your therapist is a Marriage and Family Therapist Registered Intern, Marriage and Family Therapist Trainee, Associate Clinical Social Worker, Psychological Assistant or Registered Psychologist, his/her practice is conducted under the supervision of a licensed mental health professional. The clinical supervisor's name, license type and licensure are listed below:

_____	_____	_____
Name of Clinical Supervisor (if applicable)	License Type	License Number

(Note: If the therapy practice uses a fictitious business name, the name and license designation of the business owners must be disclosed. Similarly, if the business is a professional corporation, the patient must be informed of that fact.)

Information About This Practice (as applicable)

The name of this practice is: _____

The individual therapist(s) who operate this practice is/are:

_____	_____	_____
Name of Therapist	License Type	License Number
_____	_____	_____
Name of Therapist	License Type	License Number

_____ This practice is a Licensed Marriage and Family Therapist Corporation.
_____ This practice is a Licensed Clinical Social Worker Corporation.
_____ This practice is a Psychological Corporation.

Fees and Insurance

The fee for service is $_____ per individual therapy session.

The fee for service is $_____ per conjoint (marital /family) therapy session.

The fee for service is $_____ per group therapy session.

Individual Sessions and conjoint (marital /family) sessions are approximately 50 minutes in length

Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure.

Please inform your therapist if you wish to utilize health insurance to pay for services. If your therapist/provider is a contracted provider for your insurance company, your therapist/provider will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist/provider is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with your therapist.

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, your therapist will not disclose information communicated privately to him or her by one family member, to any other family member without written permission.)

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

"No Secrets" policy for couples :

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment.

If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that your therapist utilizes a "no-secrets" policy when**

conducting family or marital/couples therapy. This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask your therapist about his or her "no secrets" policy and how it may apply to you

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hrs. in advance of your appointment. If you do not provide your therapist with at least 24 hours notice in advance, you are responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

(Alternative message(s) for therapists who have limited availability)

You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call.

You should be aware that your therapist is generally available to return phone calls within approximately ___24___hours. Your therapist is not able to return phone calls after ____7__P.M.

Your therapist is not available to return phone calls on Saturdays or Sundays.

If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail message.

In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Therapist Communications

Your therapist may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

INFORMED CONSENT

_____ My therapist may call me at my home. My home phone number is: ( ) _____

_____My therapist may call me on my cell phone. My cell phone number is: ( ) _____

_____My therapist may call me at work. My work phone number is: ( ) _____

_____My therapist may send mail to me at my home address.

_____My therapist may send mail to me at my work address.

_____My therapist may communicate with me by email. My email address is: _____

_____My therapist may send a fax to me. My fax number is: ( ) _____

About the Therapy Process

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask your therapist to address any questions or concerns that you have about this information before you sign!

_____

Name of Patient

Date: ___/___/___

Bethie Kohanchi Kohanbash M.A.LMFT
Licensed Marriage and Family Therapist
MFCC 48582
12304 Santa Monica Blvd. #215 A
310-968-6648

AGREEMENT FOR SERVICE / INFORMED CONSENT

Introduction

This Agreement is intended to provide _____ (herein "Patient") with important information regarding the practices, polices and procedures of Bethie Kohanbash (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Therapist Background and Qualifications

Therapist has been practicing as a licensed marriage and family therapist (LMFT) for two years, working mostly with couples, individuals, children and sever mental illness, etc.

Risks and Benefits of Therapy

Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient 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 Patient may be experiencing. Psychotherapy is a joint effort between Patient 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 Patient, 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 Patient, 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.

Signature Date

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 Patient's perceptions and assumptions, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient.

During the therapeutic process, many patients 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. Patient 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 Patient.

Records and Record Keeping

Therapist may take notes during session, and will also produce other notes and records regarding Patient'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 Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient. Should Patient request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient 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 health care provider. Therapist will maintain Patient's records for ten years following termination of therapy. However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

Confidentiality

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, 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 patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

Patient Litigation

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient and another individual, or entity, are parties. Therapist has a policy of not communicating with Patient's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient'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 Patient, Patient agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of $140.00 .

Psychotherapist-Patient Privilege

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by Patient or Patient's representative. Patient

should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

Fee and Fee Arrangements

The usual and customary fee for service is $140.00 per 50-minute session. Sessions longer than 50-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Patient will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payer's, or by agreement with Therapist.

The agreed upon fee between Therapist and Patient is _____. Therapist reserves the right to periodically adjust fee. Patient will be notified of any fee adjustment in advance.

From time-to-time, Therapist may engage in telephone contact with Patient for purposes other than scheduling sessions. Patient 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, Therapist may engage in telephone contact with third parties at Patient's request and with Patient's advance written authorization. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.

Patients are expected to pay for services at the time services are rendered. Therapist accepts cash, checks.

Insurance

Patient is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payer. Patient is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles.

Therapist is not a contracted provider with any insurance company, managed care organization. Should Patient choose to use his/her insurance, Therapist will provide Patient with a statement, which Patient can submit to the third-party of his/her choice to seek reimbursement of fees already paid.

Cancellation Policy

Patient is responsible for payment of the agreed upon fee for any missed session(s). Patient is also responsible for payment of the agreed upon fee for any session(s) for which Patient failed to give Therapist at least 24 hours notice of cancellation. Cancellation notice should be left on Therapist's voice mail at 310-968-6648.

Therapist Availability

Therapist's office is equipped with a confidential voice mail system that allows Patient 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 Patient is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

Termination of Therapy

Therapist reserves the right to terminate therapy at his/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, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient 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 Patient.

Acknowledgement

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient 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.

_____

_____

Patient Name (please print)

_____ _____

Signature of Patient (or authorized representative) Date

_____

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

_____

Name of Responsible Party (Please print)

_____

Signature of Responsible Party Date

Authorization to Release Confidential Information

I, [Name of Patient] _____ ("Patient")
hereby authorize [Name of Provider] _____ ("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):

_____

_____

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: _____
(Patient or Patient's Representative)