therapy

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213.479.8730

DK Therapy / Sherman Oaks
California License #100681
213.479.8730

INFORMED CONSENT FOR PSYCHOTHERAPY
CLIENT INTAKE/ REGISTRATION

Name: DOB: Age:

Address:

Cellular Phone: Is it okay to leave a message? Yes/No

Home Phone: Is it okay to leave a message? Yes/No

Work Phone: Is it okay to leave a message? Yes/No

Email Address:

Family Physician: Phone:

Psychiatrist (if any): Phone:

Presenting Problem:

Previous Therapy:

Briefly describe living situation:

Employment:

What are the symptoms:

Date of first symptoms:

Current medications:

Other pertinent drug/alcohol history:

Person to contact in emergency: Phone:

Referred by: _____ Date of first visit: _____

I, _____, have been given a copy of an Informed Consent for Psychotherapy. I have been given the opportunity to have any and all questions answered relevant to my proposed psychotherapy.

I agree to enter into a course of therapy with Dain Kloner, PsyD, LMFT, at a rate of $250 per 50 minutes payable at the time of service as of _____

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

I grant permission for case consult with other professionals as long as standard care is exercised to protect my privacy and confidentiality. I understand that if I elect to use medical insurance benefits for these services, my insurance company will be informed of a medical diagnosis and certain relevant aspects of my treatment, including procedure codes and other standard pertinent history and prognosis information.

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 safeguard my privacy and confidentiality.

I have read and understand the information contained in the Informed Consent and agree to all the terms herein. I have been given the opportunity to have any and all questions answered relevant to my proposed psychotherapy.

_____	_____
Name	Dain Kloner
_____	_____
Signature (Type Full Legal Name)	Signature/Dain Kloner as witness
_____	_____
Date	Date

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 theclient'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 a challenge to, or confrontation of, certain beliefs, attitudes, or behaviors as a means to allow the client to risk new behaviors beyond his/her present level of function for the purpose of growth.

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 I 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 system or dynamic. Any concerns in this regard should be discussed with me.

Initials _____

Billing:

My fee is $250 per 50-minute session. All fees are payable at the time of service unless other arrangements are agreed upon in advance. A detailed invoice of charges, such as a superbill, 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 $30.00 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 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. Credit card payments are made through SimplePractice. This is a HIPAA compliant system that allows for you to update your credit card information as needed, and it will allow Dain Kloner, PsyD, LMFT, to charge your card on file following each session, and following sessions missed or cancelled less than 24-hours of the scheduled appointment.

Fee Schedule:
Time-Frame Fee
50- minute session $250
75- minute session $350
90- minute session $425

For clients who wish to maintain their privacy, or who are unable to travel to the office, Dr. Kloner offers house visits at his sole discretion. Home visits are reserved for sessions lasting 90-minutes or longer and for those within 8 miles from the office listed.

Initials ☐

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 person/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.
5. Suspected neglect of the parties named in items #3 and # 4.
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.
8. If a client involves a therapist in a conspiracy to commit a crime or a conspiracy to avoid detection from prosecution. Occasionally, I 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 we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Initials ☐

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(s), nor anyone else acting on your behalf will call on Dain Kloner to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

Initials ☐

Availability:
I will be available via voicemail during standard business hours. Any more than one phone call that goes beyond 15 minutes in any 1-week period will result in you being charged on a quarter of an hour basis. This is based on your regular therapy session rate. If I am on vacation or it is after business hours, and you are having an emergency, dial 911 or The Suicide Prevention Hotline (877) 727-4747, unless we have arranged for a backup therapist to be available while I am on vacation.

Initials ☐

Social Media Policy:
Friending - Please do not send requests through any social media sites, including Facebook, LinkedIn, and Twitter. I do not accept friend or contact requests from clients, including former clients since it can compromise client confidentiality.

Following - I do not encourage you to follow me on Twitter or Instagram. In the case that you do, please note that I cannot follow you in return. Should you have any questions regarding my social media policy, please ask me, and I will clarify.

Initials ☐

Termination:
Our relationship is strictly voluntary, and you may leave the psychotherapy relationship any time 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.

I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I 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, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Initials ☐

About the therapist:
As a consumer of mental health services, you have a right to know about the qualifications of your therapist. I have a Master's degree in Clinical Psychology with an emphasis in Marriage and Family Therapy. I earned my doctorate in Marital and Family Therapy with expertise in the fields of complex trauma, compassion fatigue, and burnout. I have extensive experience facilitating cognitive-behavioral interventions to people who have high levels of anxiety and/or severe depression,

especially that which is a result of trauma. Other treatment modalities I use in my practice for which I am trained are Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR). Both are unique techniques that are considered quite effective for people who have experienced trauma, anxiety, or panic attacks and depression.

Initials _____

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. You may contact the board online at www.bbs.ca.gov or by calling (916) 574 – 7830.

If you have any questions or concerns regarding any of the above, or regarding any aspect of treatment, please feel free to raise them in our sessions.

I look forward to working with you!

I hereby authorize Dain Kloner, PsyD., LMFT, to render psychotherapeutic services, and I assume full financial obligation for such services.

I agree to give 24-hour notice and take full financial responsibility for the professional time that was reserved for me.

I understand that Dain Kloner, PsyD, LMFT, practices within the scope of Marriage and Family Therapy and is a licensed Marriage and Family Therapist.

BY SIGNING ON THE LINE BELOW, I AGREE THAT I HAVE READ THE ITEMS AND UNDERSTAND AND AGREE TO THE TERMS CONTAINED IN THIS DOCUMENT.

_____	_____
Name	Name
_____	_____
Signature (Type Full Legal Name)	Signature (Type Full Legal Name)
_____	_____
Date	Date

When you have completed this form, please email it to:
dk@dainkloner.com