Karen Sullivan, MFT
MFC # 41413
K1therapy@gmail.com

3137 Dwight Road, Ste 600
Elk Grove, CA 95758
916-267-0368

Client Information:

Name: ___________________________DOB: _________SSN#_____________________
Phone: Home: _____________ Cell: _________________ Work: ______________
Address: _________________________ City/State: ________________ Zip: ___________
E-mail: _______________________
Which is the best means to contact you? ________________
Emergency Contact: Name: ___________________________ Phone: ________________
Address: _________________________ Relation to you: __________
Occupation: _______________ Place of Employment: ______________________________
Insurance Company: __________________ ID#: __________________________________
Policy Holder: _______________________Holder's ID and DOB:
____
Marital status: _________ Spouse/Partners Name: ___________Time together;________
Children, names and ages:
_____________________ ___________________ __________________ ______________
_____________________ ___________________ __________________ ______________
Other persons living in your household:
____
Past Medical issues:
____
____
Current Medical issues including allergies:
____

Physician: _________________________________ Phone: __________________________
Current medications: Name and dosages
____
Hospitalizations: ____
Have you previously participated in therapy? For how long and when? Name of therapist?
____
____
Reason for seeking therapy:
____
____
____
Faith affliation?____
Ethnic/Cultural affiliations? ____
Hobbies/Interests/Volunteer? ____
Level of Education/Training: ____
Any further information you wish to share:
____
____
____

Signature of Applicant: ____________________________ Date: ______________________

6/21/2012ks

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Informed Consent for Treatment:

Services provided are performed by a Licensed Marriage and Family Therapist, and therapy will relate to issues of relationships and family concerns. If one chooses to participate in psychotherapy, it is important to note that unpleasant and unwanted feelings of anxiety, anger, fear, and guilt may arise during the process. Past memories may be difficult to face as well. Life decisions regarding changes in relationships, lifestyles may be considered and present as challenges. If you have questions or concerns with regard to the effects of treatment, please talk to me about them.

Confidentiality:

All information will be confidential, and will not be shared except as required by law or by a Court mandate. As a mandated reported the following are required reports:

1. Suspicion of possible child abuse or neglect
2. Suspicion of possible abuse or neglect of a dependent adult
3. Concern that a client is a danger to himself/herself or others
4. Expression of a serious threat of harm to an identifiable person must be revealed to that person and the police
5. Court order request for treatment information

Client's Rights:

Clients have the right to be treated with respect and fair treatment at all times regardless of race, religion, gender, ethnicity, age, disability, or source of payment. They have the right to question therapeutic procedures, and to a clear explanation of their condition and treatment options. They may request information about my training and experience as it is relevant to their therapeutic needs. They have a right to confidentiality as outlined above, and information with other providers will be shared only with a signed release from the client. Issues of confidentiality between parents and children and dependent adults will be addressed with sensitivity to the client and the therapeutic needs of the client, and with professional judgment of the therapist. Clients may file a complaint with the Board of Behavioral Science or their individual insurance company freely if they have a concern.

Fees and Services:

Initial visit:	60-80 minutes	$100.00
Individual:	50 minutes	90.00
Group:	50 minutes	40.00
Couples:	60 minutes	90.00

I am willing to discuss a sliding scale fee for services, and the decision to reduce fees will be based on income and current family financial issues.

Payment for services is expected at the end of the session, and can be made in cash, checks, by Credit cards of MC, VISA, Discover, and Debit cards with those identifiers. Checks should be made out to Karen Sullivan.

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If there is a need for special reports for school, courts, or other designated needs, the charge will relate to the amount of time needed and the urgency of the report and will be negotiated directly with you. Billing for insurance companies will be completed with on-line services, and signature on this form will indicated permission to submit the necessary health related information. The information usually includes a diagnosis and treatment plan information which may be stored in their computer system. I have no control over what they do with that information, and if you have questions about that, please contact your insurance company. If you would rather make payment without the help of the insurance company, you are free to do so at the rate schedule above.

I request that you cancel appointments within 24 hours so that other appointments can be scheduled during that time. Failure to do that within the 24 hours will result in a fee of $20.00 unless I agree that the inability to attend was unavoidable. A pattern of missed appointments will need to be discussed.

I typically do not charge for phone calls, or time spent on E-mails, but if it appears there is a need for frequent contact, I will discuss charges with the individual.

Secrets Policy:
I have a "No Secrets" policy as defined by not allowing secrets between myself and one of two people that I may be seeing conjointly. If there are issues that one finds difficult to address with the other person in session, I will assist with suggests and strategies to introduce the information with the least discomfort possible.

Messages:
I be reached at 916-267-0368, will return messages within 24 hours. I check my voice mail at least once daily. Please leave the number where you want to be reached, best times to call, and any information you think is relevant. If you are in a crisis and I am not immediately available, please call 911, local emergency mental health services, or your care manager at your insurance company for immediate assistance.

This signature confirms that I have read the above information, and agree to treatment based on the terms and conditions listed. If the services are being provided for an underage child, or dependent adult for whom you are responsible, please write their name on the designated line.

Signature: ____________________ Date: _____________
Signature: ____________________ Date: _____________

Child or Dependent Adult: __________________ Your relationship: ___________

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