



CLIENT INFORMATION

Confidential Use Only

Legal Name: _____ Today's Date _____

Address: _____

Home Phone: _____ Permission to leave message: Yes No

Cell Phone: _____ Permission to leave message: Yes No

Email Address: _____ Birthdate: _____ Age: ____

Social Security # _____ (For Insurance Purposes Only)

Occupation: _____ Employer/School: _____

Gender: _____ Relationship Status: _____ Ethnicity: _____

Name of father/mother if minor _____

Emergency Contact Name _____ Phone _____

Relationship: _____

Name of Physician: _____ Physician Phone: _____

Coordinating care with your physician may be necessary. Do I have permission to contact your physician to collaborate for your well-being, should the need arise? Yes No

List any current medications and dosage: _____

Have you been in therapy or counseling before? Yes No

Name of previous therapist(s), if applicable: _____

How were you referred: _____

What matters would you like to work on in therapy: _____

Office Use:

Insurance: _____ Fee: _____



Fee Agreement

Appointments

It is a privilege to support you during this time. Therapy is a process that is taken seriously and I will do my best in providing you with the support that you need. Additionally, I will assist you by connecting you to other resources that may contribute to your wellness. As we begin our therapeutic relationship, I will honor our appointment times to the best of my ability by keeping any changes to a minimum. Similarly, I request that I received a minimum of 24 hour notice prior to a cancellation. Missed sessions and cancellations received less than 24 hours prior to our session will be charged the full fee. Please note that you will be given three referrals for counseling services elsewhere if there are continued cancellations or two no-shows.

Fee Policy

All fees will be determined prior to the start of treatment. Phone consultations will have a prorated fee of \$15 per every 15 minutes. Out of pocket payments will be made using cash. We are unable to process credit cards or checks. The standard fees for session apply as follow:

Individual	45-55 minute sessions	\$150
Couples/premarital	1 hour 30 minutes	\$180
Family Sessions	1 hour 30 minutes	\$200

Client Agreement

I agree to pay for all services I receive. Should I select to use insurance to an approved carrier, I agree to pay for any amount that is not covered by my health care provider. Additionally, I understand that I may be fully liable for the full fee of any incomplete sessions, missed sessions and sessions cancelled with less than 24-hour notice. I am aware that if I arrive late to a session, the session will conclude based on my original appointment time and I will be financially liable for the full rate of the session.

Videotaping

For the safety of the client and the therapist, note that this office and therapy room may be recorded. Videotapes will not be reviewed or used unless a possible crime has been committed.

Client(s) Signature: _____ Date: _____

Therapist Signature: _____ Date: _____



Consent for Evaluation and Treatment

The Therapy Process

Participating in therapy can result in benefits to you by allowing you to better understand yourself and your personal goals, values and sense of self. Therapy may also allow you to better understand your personal relationships and find resolutions related to issues that encouraged you to seek therapy. Working towards these benefits will require effort on your part that may result in your experiencing considerable discomfort. At times, change may be easy and swift and more often it will be slow and frustrating. The process of recalling unpleasant events and resolving them through therapy can bring on feelings of frustration, anger and possible depression or anxiety. When working with a partner or family member, the situation may be further complicated because of the ongoing relationships outside of the session. The duration of your therapy will be determined by clinical assessment conducted at different phases of therapy.

Your Rights

You have the right to a confidential relationship with me as your therapist. All information discussed in session will be kept confidential and released only after obtaining your written consent outside of the three mandates:

- Suicidal and/or homicidal ideations
- Abuse of a child
- Abuse of an elderly or dependent individual

Additionally, you have the right to know the content of your records at any time and I have the right to provide you with either the complete records or a summary of their content.

Upon request, I can release any part of your records on file with me to any one that you specify. Please note that I will use my clinical judgement in releasing this information especially in cases where it may harm you in any way. Moreover, you have the right to ask questions about the procedures used in the course of therapy. Additionally, you will be informed on my clinical orientation and what to expect during the intake session.

Please notify me if you do not feel that you are benefiting from working with me as your therapist. Be assured that your best interest is always in mind and you will be provided with appropriate referrals to select another therapist. This will be done without any form of retaliation and full compliance in regards to your subsequent therapeutic relationship. Similarly, I reserve the right to refer you if I do not feel that I am able to support you using the therapeutic orientations that I follow. This referral will occur with a thorough discussion of your treatment goals and your current progress.



Consent for Evaluation and Treatment

I, _____, authorize and request,
_____ to carry out therapeutic interventions, counseling services
and referrals for the purpose of my care or the care of my minor child.

The purpose of interventions and treatments will be disclosed to me and are subject to my agreement. I fully understand the therapeutic relationship I am entering with my therapist and the credentials my therapist has to conduct treatment.

Guardian/Client's Signature to authorize _____

Printed Name of Client or Guardian _____

Guardian's relationship to Client _____

Therapist's Signature _____ Date _____



Attention all Private Pay or Managed Care Members

If you will be using health insurance or out of pocket payments, you may be billed directly for no-shows or late cancellations made within 24 hours. You will be billed the amount of the session as covered by your managed care or regular rate of private pay and required to pay prior to proceeding with further treatment. Should you need to reschedule an existing appointment, please call at least 24 hours prior to the time of your appointment to reschedule and avoid the penalty.

Client Signature: _____ Date: _____



Yasamin Farhad, Ph.D., L.M.F.T

Authorization for Release of Information

I hereby authorize the release and exchange of information between

Dr. Yasamin Farhad, LMFT#81557 **And**

Staff, Associates, AMFT, ASW

451 W. Lambert Rd. Ste. 212, Brea, CA 92821

Social Services of Orange, Los Angeles, Riverside, San Bernardino Counties

All other affiliations and locations

Description of information to be disclosed:

Statement of purpose/need for this information:

This authorization expires on_____. If no date is indicated, the authorization will expire 1 year after the date of signing this form. This authorization may be revoked at any time. Please submit the request to revoke in writing to **Yasamin Farhad, Ph.D., L.M.F.T #81557**. The revocation will take effect when the request is received. A copy of this authorization may be requested at any time. A copy of this form shall be as valid as the original.

Signature of Patient/Legal Guardian

Printed Name and Relationship

Date

Witness

Date



INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- **Risks to confidentiality.** Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- **Issues related to technology.** There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- **Crisis management and intervention.** Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- **Efficacy.** Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any



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cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods should not be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology). The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology

From time to time, we may schedule in-person sessions to “check-in” with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will



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create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

Client

Date

Therapist

Date