Tessa Richardson, LCSW #24253
43575 Mission Blvd PMB 1012
Fremont, CA 94539
415-515-5576
tessarichardson@richardsontherapy.com
www.richardsontherapy.com

Professional Disclosure Statement

Psychotherapy can be a very special opportunity to understand more deeply the struggles you are experiencing, and to make the changes which are important to you. Therapy can be a fascinating and stimulating process. It can also be difficult and at times painful. While there are no guarantees, your active participation will contribute greatly to this process.

Professional Qualifications
I hold a Master of Science in Social Work from the University of Wisconsin-Madison. My BS is also in Social Work, also from the University of Wisconsin-Madison. My clinical experience prior to private practice includes working with children and families as a behavioral health provider at a community clinic for the uninsured. Prior to that, I provided individual and group therapy to adult men and women in the San Francisco county jails. I am a licensed clinical social worker in the state of California since 2007 and in Wisconsin since 2022.

My approach to therapy
I combine Western psychotherapy with mindfulness-based practices. Mindfulness is a skill that involves slowing down in order to notice--moment by moment, with curiosity and kindness--what you are doing, thinking, and feeling, so that if you like, you can make desired changes. Since our bodies are connected to our beliefs and feelings, by slowing down and bringing awareness to our bodies, the path towards healing can be revealed. Traditional psychotherapy primarily pays attention to thoughts, emotions and behaviors. In body-oriented psychotherapy, attention is also given to sensations and felt experiences in the body. It may be as simple as bringing attention and awareness to a felt sensation, or it might entail "taking over" a particular tension or holding, in order to explore what lies beneath. The goal of therapy is to encourage communication among parts and to bring attention to those parts that are lost, hidden or isolated. Body-oriented psychotherapy can provide an added dimension to the therapeutic process by presenting information that is often overlooked. With the partnership of the conscious mind, it can provide a deeper and more efficient path to work directly with the unconscious mind, facilitating self-discovery and transformation. I am trained and certified in EMDR and the Hakomi method and find both to be powerful ways to bring transformation and healing. I am also trained in Internal Family Systems, Sensorimotor Psychotherapy, and Emotion Focused Therapy for Couples. I participate in regular professional training practice groups and consultation throughout the year.

During our initial one to two sessions, we will both be getting to know each other and can both decide if I am the best person to provide the services you seek. If I feel that I can be of assistance, I will offer you some first impressions of what our work might include. In deciding whether you would like to continue, you should evaluate this information along with your own sense of whether you feel comfortable with me. If in my opinion I cannot be of help to you, I will let you know this and will do my best to give you referrals that you can contact.

Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty and openness in order to change your thoughts, feelings and/or behavior. I will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond honestly. Sometimes

more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc, or experiencing anxiety, depression, insomnia, etc. I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about or handling situations. This can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes, another family member views a decision that is positive for one family member quite negatively. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy I am likely to draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches include, but are not limited to behavioral, cognitive-behavioral, psychodynamic, system/family, psycho-educational or body oriented. I provide neither custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within my scope of practice.

If at any time during the course of therapy you have questions about my procedures, their risks, my expertise, or about the treatment plan, please don't hesitate to ask when they arise so that we can discuss them. I will also be happy to provide you with names of other qualified professionals whose services you might prefer. If at any point I assess that I am not effective in helping you, I will discuss it with you, and if appropriate, I will terminate treatment and give you referrals which may be of help to you.

Confidentiality
In therapy, everything we speak about will be held strictly confidential with the following exceptions:

a. you authorize the release of information in writing
b. I'm concerned that you may pose a serious danger to yourself or others
c. I need to release information to your insurance company for billing and/or authorization purposes
d. abuse of a child, elder, or dependent adult is suspected
e. I am court ordered to release information
f. I seek individual or group consultation. In this case, your full name will never be disclosed.

Touch in Therapy
I am trained in some therapeutic modalities that can incorporate touch as part of psychotherapy. This sort of touch is always non-sexual in nature. It is always optional and never required for treatment services. If I consider that using a therapeutic intervention that incorporates touch could potentially be beneficial for your treatment, I will explain the prospective intervention to you and ask your permission before touching you. You always have the right to decline or refuse to be touched without any fear or concern about reprisal.

Availability between Sessions
I am often not immediately available by telephone. When I am unavailable, my telephone is answered by electronic voice mail. I will make every effort to return your call as soon as possible, although I may not return calls on weekends or holidays, and I may not receive your call until the next day if you call after 5 p.m. If you can't wait for me to return your call, contact your family physician or the nearest hospital emergency room. If you need to speak to someone after hours or on the weekend you may call your county crisis hotline, or you may leave a message and I will return your call upon returning to the office. I request that you only email me to send necessary documents or forms, as my email is not encrypted and I do not always check it regularly.

Cancellations

If you are late for an appointment, you will have the remainder of the scheduled session available to you; we will not run over the scheduled time. It is important for the continuity of therapy that you come to all sessions. Since your appointment time is reserved exclusively for you, I have a 24-hour cancellation policy. In other words, if you cancel in less than 24 hours of the appointment time, you will be charged the full fee of the session.

Vacation Policy
I will take some vacation time during the year, usually no more than two weeks in length. I will provide you with advance notice of any upcoming vacations as well as back-up coverage available.

Fees
The fee for a 50-minute session is $215 for an individual session. Fees are due at the beginning of each session. Fees are reviewed yearly and may be raised $5 to $15 per year. I do not charge for telephone conversations of ten minutes or less, so long as they are not more frequent than twice a month. Phone consultations that exceed such frequency and/or length are billed at the prorated hourly rate. Site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. I reserve the right to assess a finance charge on past due bills, or in extremely delinquent cases to turn them over for collections. Should you elect to use your insurance mental health benefits, you should know that a diagnosis is required. Diagnosis and history will become part of your permanent medical records. These records are often accessible to other insurance companies and on occasion can be used by employers and private investigators for credit reports. Fees will be reviewed every six months. Please notify me if any problem arises during the course of your therapy regarding your ability to make timely payments.

Health Insurance & Confidentiality of Records
Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you instruct me only the minimum necessary information will be communicated to the carrier. I have no control or knowledge over what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to break ins and unauthorized access. Medical data has also been reported to be legally accessed by enforcement and other agencies, which also puts you in a vulnerable position.

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

Consultation
I consult regularly with other professionals regarding my clients; however, the client's identity remains completely anonymous, and confidentiality is fully maintained.

Consent

I have read the above information and clarified any questions I have. I agree to the stated terms. If I use insurance coverage, my signature authorizes release of information required to process claims and authorizes payment to my therapist.

Name:_____

Signature: _____

Date: _____

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with___Tessa Richardson, LCSW_ , as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at_____ to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. In case of an emergency, my location is:

_____

_____

and my emergency contact person's name, address, phone:

_____

_____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian_____

Date_____

Signature of therapist_____ Date_____

Tessa Richardson, LCSW #24253
43575 Mission Blvd PMB 1012
Fremont, CA 94539
415-515-5576
tessarichardson@richardsontherapy.com
www.richardsontherapy.com

Client Information

Client Name: _____ Birth Name: _____

Date of Birth: _____ _____

Gender: _____ Ethnicity: _____ Highest level of education completed: _____

Home phone: _____ Work phone: _____
OK to leave message? ___yes ___no OK to leave message? ___yes ___no

Email address: _____ ok to email? _____

Mailing Address: _____

City/State/Zip: _____

Emergency Contact: _____
Name Phone

Source of Income: _____ Occupation: _____ Employer: _____

Relationship status: single/never married partnered married divorced separated widowed

Living Situation: alone spouse/partner parents roommate(s) children

Name, age, and relationship of others in the home: _____

_____

_____

Primary Care Provider: _____ Phone: _____

Last Physical Exam: _____ Last Dental Exam: _____

Medical History (please circle):

High blood pressure	STD	Heart problems	HEP/Liver		
Sleep problems	Surgeries	Loss of consciousness	TB	Urinary problems	Diabetes
Skin problems	Asthma	Appetite/Weight change	W/drawal seizures	Thyroid problems	Pregnancy
Vision problems	Drug reactions	Head injury	Seizures	Kidney disease	Prosthesis
Hearing problems	Allergies _____		Other Diagnosis: _____		

Substance Use: please circle (present = in the past 2 weeks):

	Present		Past			Present		Past			Present		Past			Present		Past	
Past																			
Tobacco	Y	N	Y	N	Alcohol	Y	N	Y	N	Cocaine	Y	N	Y	N	Marijuana	Y	N	Y	N
Caffeine	Y	N	Y	N	Amphetamines	Y	N	Y	N	Hallucinogens	Y	N	Y	N	Sedatives	Y	N	Y	N
										PCP	Y	N	Y	N	Opiates	Y	N	Y	N

Current Medications (Prescribed & Over the Counter)	Dosage/frequency	Prescribed by	Date 1ST prescribed	Side effects?

Have you ever tried to hurt yourself? ___yes ___no

If yes, when
and what happened? _____

_____

Have you ever tried to hurt someone else? ___yes ___no

If yes, when
and what happened? _____

_____

Have you ever been hospitalized for psychiatric reasons? ? ___yes ___no

If yes, where
and what happened? _____

_____

In the past 3 months have you experienced significant symptoms of (please circle):

Aggression	Crying	Fear	Irritability	Self-destructive relationships
Anger	Denial	Flashbacks	Memory problems	Self harm behaviors
Anxiety	Depression	Guilt	Nightmares	Sexual acting out
Apathy	Difficulty concentrating	Harm or threat to others	Obsessive behavior	Somatic (body) complaints
Avoidance	Disordered eating patterns	Hyperactivity	Panic	Substance abuse
Behavior problems	Dissociation	Hyperarousal	Phobias	Other: _____
Compulsive behavior	Emotional numbing	Insomnia/sleep problems	Self-blame	_____

Please add any other important information:

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7 Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?			
Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.” GAD-7 total score for the seven items ranges from 0 to 21. 0–4: minimal anxiety, 5–9: mild anxiety, 10–14: moderate anxiety, 15–21: severe anxiety

Name:_____ Date:_____

INDIVIDUAL PROBLEM CHECKLIST

Directions: Put a number next to any item which you experience. 1=mildly, 2=moderately, 3=severely

Emotional Concerns

____feeling generally anxious or nervous
____feeling panicky
____dwelling on certain thoughts or images
____having strong fears
____feeling out of control
____avoiding being with people
____fears of being alone or abandoned
____having nightmares
____flashbacks
____troubling or painful memories
____feeling numb instead of upset

____feeling depressed or sad
____being tired or lacking energy
____feeling unmotivated
____loss of interest in many things
____having trouble concentrating
____having trouble making decisions
____feeling the future looks hopeless
____feeling worthless or a failure
____feeling self critical or blaming yourself
____thoughts of hurting yourself
____feeling resentful or angry
____feeling irritable or frustrated
____feeling rage
____feeling like hurting someone

Behavioral and Physical Concerns

____not having an appetite
____eating in binges
____self induced vomiting for weight control
____often spending in binges
____engaging in risky behaviors
____temper outbursts
____impulsive reactions

____trouble being organized
____trouble finishing things
____using alcohol too much
____being alcoholic
____using drugs _
___driving under the influence
____blackouts - after drinking

Intimate Relationship Concerns

____not feeling close to partner
____trouble communicating with partner
____not trusting partner
____lack of respect by partner
____partner being secretive
____lack of fairness in relationship
____lack of affection
____unsatisfactory sexual relationship

____frequent arguments
____partner being demanding and controlling
____violent arguments
____wanting to separate
____disagreeing about children
____children having special needs
____problems with in-laws
____problems with ex-partner
____problems with step parents

Sexual Concerns

____frequent arguments
____partner being demanding and controlling
____violent arguments
____wanting to separate
____disagreeing about children
____children having special needs
____problems with in-laws
____problems with ex-partner
____problems with step parents

____issues with orgasms or erections
____feeling negatively about sex

When Growing Up to Present Time:	
____being physically abused - by whom?	____close family member dying - who?
____being emotionally abused - by whom?	____felt neglected or unloved - by whom
____being sexually abused - by whom?	____having an unhappy childhood
____having an alcoholic parent - which?	____having serious medical problems - what?
____having a drug abusing parent - which?	____having drug or alcohol problem
____having a depressed parent - which?	____having learning problems - what?
____having parents separate or divorce	____having attempted suicide - when?

Stresses During the Past Several Years	
____death of family member or friend - who?	____losing or changing job
____self or family member hospitalized - who?	____financial trouble
____moved	____legal problems
____being harassed or assaulted	____natural disaster
____separation/divorce	____other_____
Life Style and Health	
____losing weight - how much?_____	____smoking cigarettes
____gaining weight - how much?____	____lack of exercise
____trouble sleeping	____not having leisure activities
____# of hours I usually sleep: _____	____serious or chronic illness -what: _____
	_____

Please state your goals for the therapy:

1. _____
2. _____
3. _____

Patient Health Questionnaire – 9
(PHQ-9)

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?			
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Good Faith Estimate Notice

You have the right to receive a "Good Faith Estimate" explaining how much your medical and mental health care will cost.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services. You can ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.

If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

Notice To Clients in California

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of licensed clinical social workers. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.