All of the information below is important to your care! Please help me help you by being specific and thorough.

Client Information

Name_____**Date of Birth**_____**Age**_____

Address_____
Street Apartment # City State Zip Code

Is it okay to send mail to you at the above address that will not disclose that it is from a psychotherapist's office? Yes___ No ___

Social Security Number: _____ (required if you are using insurance)

Phone Numbers:
Home ( ) _____ **Cell number** ( ) _____

Okay to call you at home and leave my name and brief message? Yes___ No____
Okay to call your cell and leave my name and brief message? Yes___ No__
Okay to call you at work and leave my name and brief message? Yes____ No____

Who referred you or how did you find out about my services? _____

Please tell me why you chose me?

_____

Marital Status: single___ married____ separated____ divorced_____
widowed ____ living together____

Employer Name and Occupation_____
Primary Care Physician Name_____
Address_____ Telephone number_____
Date of last complete physical examination_____
Current prescription medications and dosages: _____
_____
Please list any physical conditions that you are currently being treated for: _____
_____

Psychiatric History:
Have you ever received psychiatric or psychological treatment of any kind before?
Yes_____ No_____

When and how long were you in treatment? _____

Where were you in treatment? _____

Who were your therapist and/or psychiatrist? _____

Was your previous psychotherapy experience a positive one? Please describe what worked or didn't work about your last psychotherapy experience:

_____

_____

Did your doctor prescribe medicine at that time? Yes ____ No _____

If yes, please state type and dosage _____

Family History:

Describe any significant medical or psychiatric conditions of your parents and siblings: (Examples: family history of depression, manic depression, alcoholism, suicide)

_____

_____

Please describe your reasons for seeking counseling (including date/month the problem started):

_____

_____

_____

Was there any event that contributed to the problem(s) noted above?

_____

_____

Please rate the level of problems you are experiencing in the following areas:

Physical Health	None	Mild	Moderate	Severe	Comments
Anxiety	None	Mild	Moderate	Severe	Comments
Mood	None	Mild	Moderate	Severe	Comments
Sleeping Habits	None	Mild	Moderate	Severe	Comments

Ability to control
Anger None Mild Moderate Severe Comments

Any current suicidal thoughts? _____No_____Yes

Previous suicide attempt? _____No_____Yes. If yes, when and how: _____

Any homicidal thoughts? _____No _____Yes

Any domestic violence? _____No _____Yes, please specify_____

Substance Use	**Amount/Type Currently Using**	**Most Ever Used**
Coffee (cups/day)	_____	_____
Cigarettes (packs/day)	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

Substance Use History

Have you ever abused alcohol? _____yes_____no_____when_____last use (date)

Have you ever abused drugs? _____yes_____no_____when_____last use (date)

Do you have a history of blackouts, seizures, or withdrawal symptoms? ___yes___no

*Note**: Therapy doesn't work if you are thinking about something else.** Please be sure to turn **off** your cell phone before your session and put it away as you enter the office. It is a critical to only focus on your therapy to get benefit. Also, it will help you maximize your session time. Many people interpret this request to mean it's okay to leave the phone on vibrate but then it vibrates or lights up at just the wrong moment!! Thanks for respecting this request and maximizing your therapy time.*

Consent for Treatment

I authorize and request that Kathy Jarosz, LCSW carry out evaluation, diagnosis, and treatments which now or during the course of my care as a client are advisable. I understand that the purpose of these procedures will be explained to me at my request and subject to my agreement. All cases begin with an assessment period to determine if Kathy's practice and

services are a good fit for you. If it is not, Kathy will attempt to refer you or provide you with resources to find an appropriate referral. I also understand that while the course of psychotherapy is designed to be helpful, it may at times be difficult and uncomfortable.

Confidentiality

I understand that all information between me and Kathy Jarosz, LCSW is held strictly confidential, and Kathy Jarosz will not release any information about my treatment unless permitted by law or herein stated:

1. I agree in writing to permit such a release,
2. I present a physical danger to myself,
3. I present a danger to others,
4. Child or elder abuse/neglect is suspected.

I understand that under the latter 2 circumstances a therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken.

In Case of Emergency

In the event that you have a psychiatric emergency, please dial 911 or go to your local emergency room, or call Marin General Hospital psychiatric crisis clinic at 415-473-6666. Since my practice is solo, I cannot provide 24/7 coverage. Please note that if you travel out of the area, I am unable to provide you with crisis support while on a trip.

Notice Regarding Confidentiality and Using Your Insurance or EAP

Please be aware that your insurance company or EAP may request information on your care at any time. This is often to determine medical necessity, payment or quality assurance. Please sign here to indicate your permission to provide this information if requested by your insurance or EAP. Signature_____

An important note for couples and families:

It is important to note that I utilize a **"No-Secrets"** policy when conducting couple and family work when couples want this. This means that if you participate in family or marital therapy, I am permitted to use information obtained in an individual session that you may have had with me, when working with other members of your family or spouse. The deciding factor here rests on the clinical judgment of the therapist. Please be sure to ask if you have any questions about this.

If you both agree on confidentiality between partners policy however, we can have an alternative policy at your request.

I agree with the **"No-Secrets" Policy** - please initial here_____.
I prefer that **"Secrets Be Allowed" Policy** – please initial here ____.
This was discussed during the intake appointment with therapist, please initial then____.

I will review this with you both before we start.

The Patriot Act of 2001

This Federal law requires therapists, 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.

Financial Terms: I agree to be responsible for payment of a set fee of $175 per session. Payment is to be made at the time of each session by check, cash, or Ivy app.

Insurance: *If my insurance has lapsed, or if they will not cover services for other reasons per my benefit plan, then I understand that I will be responsible for payment of the full fee unless otherwise agreed upon in advance. I understand that only medically necessary care is covered by insurance. I give you permission to bill my insurance and receive payment directly from the insurance company. I understand that insurance only covers medically necessary care for diagnosable situations, so a diagnosis will have to be submitted per your evaluation. Please sign if you are using insurance. If you fail to give me your insurance card and necessary billing, you must be responsible for the full fee. It is your responsibility to let me know which insurance company you are with and produce your card. Signature*_____

Please note: Insurance plans cover 45 minute sessions only, whether for individual or couple counseling. EAP sessions are also 45 minutes long. Mental health coverage using your medical insurance requires a diagnosis, even for couples therapy.

Scheduling: I strive to have clients own a regular appointment spot in my schedule as soon as possible and to not change it. I will be saving that spot for you and planning accordingly. If you have any changes coming up, notify me at the beginning of the session so we can plan better. Any travel effecting multiple sessions may mean you will forfeit your regular appointment time, but will be offered another time, if possible.

Cancellations: If you need to cancel, my policy is that we reschedule your appointment within the same week. The fee for cancellations without **48 hour business day notice** is $175. Cancellations through email are not accepted. Please send a check on the day of the cancellation. Late payments for any services will be charged a standard 13% interest.

Telephone Calls: Generally speaking, issues that come up between sessions should be discussed at the next session unless they are urgent or emergent issues. Sometimes during psychotherapy, clients may wish to call to clarify their weekly goals or to discuss an issue between sessions. Brief phone conversations are considered part of the psychotherapy. Telephone contact that is more extensive, beyond a brief "check in" type of call are charged at the same rate as are sessions and are discouraged unless circumstances warrant it.

Mailing List

From time to time educational materials such as newsletters and/or notices of workshops or new services may be made available to clients. Please let me know if you would be interested in being part of my mailing list. All materials will be sent with a return address but no name and no licensure designation such as "LCSW" to protect your confidentiality.
Please indicate:
I am _____, or I am not ____ interested in receiving mail to my home address.

Referrals:

Referrals are very much appreciated. Therapists build their businesses based on satisfied customers. ***Please note that even in the case of referrals you make to me, the very fact that I know you is kept private.*** **No information** about you is exchanged with people you may chose to refer to me.

Communication Between Us:

Please note that although therapist's need to have websites these days, corresponding by email is not confidential therefore I ask that you refrain from emailing me for any reason, including cancellations. Please remove my email address from your computer if you entered it.I check my phone messages very frequently, so that is the best way to reach me regarding any matter. I make myself accessible to your needs by phone, so I would appreciate it if you would respect the importance of not using email to communicate your **scheduling needs, cancellations** or **your thoughts to me**. There are **many** other drawbacks to you doing so and I would be happy to discuss those with you if you would like me to. Particularly when you are ending therapy, this is important. If you send me an email to end therapy, you will lose the opportunity to get vital follow up and resource information as well as overall benefit from the therapy process. ***How we say goodbye is as important as how we say hello!***

Social Media Policy:

For your confidentiality and privacy, please remove me from your email address book so that we are not connected online. I agree to not correspond by email for any reason: Please initial____Yes ____No

I have read the above information and it has been explained to me.

Client Signature_____Date_____

I look forward to working with you and wish you every success in your psychotherapy experience!

If you are seeing me for couples therapy, would it be okay with you if I call you several months after you finish your couples therapy, to see how you and your partner are doing? _____Yes _____No

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at 415-999-4414.

If you have any questions about my Notice of Privacy Practices, please contact me at: 415-999-4414.

I acknowledge receipt of the Notice of Privacy Practices of Kathy Jarosz LCSW.

Signature: _____Date: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including_____. However, because of _____ I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____ Date: _____