Lorrine Ruth Carrara, MS, LMFT
Licensed Marriage and Family Therapist, LMFT #106060
(831) 246-4546

INFORMED CONSENT CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies and how they may affect you. Please read it carefully and make note of any questions you want to discuss with me. Once you sign this document, it will become a binding agreement between us and also provide your consent for us to begin therapy.

Therapy is a unique and highly individual experience with the outcome determined by the effort and motivation you bring to work towards a change in yourself and how you see the world around you. It can result in a number of benefits to you and can potentially help in your ability to detect, challenge, and change beliefs and attitudes that create, maintain, and worsen feelings of depression, anxiety, panic, anger, frustration, etc. Therapy also has the potential to help you gain new or deeper understanding about your issues and learn new ways of coping with and solving them.

However, there is no guarantee that therapy will yield positive or intended results. Because feelings will be explored, you may feel a range of emotions that can be intense and uncomfortable at times. During the course of therapy, some of your assumptions, perceptions, or behaviors may be challenged, which can cause you to feel very upset, angry, depressed, uncomfortable, confused, or disappointed. I encourage you to explore those feelings during our sessions, as they are part of the therapeutic process. In the attempt to resolve issues that originally brought you to therapy, unintended changes in your personal and interpersonal relationships may result.

Our therapeutic relationship is strictly voluntary. At any time during our work together, you have the right to decide to end treatment. If you are thinking about ending therapy, I encourage you to discuss it with me, and if you wish, I will be glad to provide you with the names of other mental health providers. During the course of therapy, if I assess that I am either unable or not effective in helping you reach your therapeutic goals, I will discuss this with you, and if appropriate, terminate treatment. I will provide you with appropriate referrals and assist you in the transition to a new therapist if you so desire.

Meetings

Each session lasts 50 minutes and will begin at the time agreed with you. Typically, therapy sessions take place on a weekly basis, at a mutually agreed time.

Cancellations and Rescheduling

If you need to cancel or reschedule a meeting, please notify me by telephoning me at (831) 246-4546 at least 24 hours in advance of our scheduled meeting or you will be responsible for full payment for the session.

Fees and Payment

Your session fee is $_____. Payment of this fee needs to be ***made at the beginning of each session in full*** unless other arrangements have been made. Please bring your check ready (made payable to Lorrine Carrara) so that we can maximize your therapy time. Your session fee may be increased annually. In the event of any fee changes, you will be notified at least 30 days prior to such changes. If you are using your insurance, you are still responsible for paying your deductible (if any) and copayment at the session.

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Insurance

I take Anthem Medi-Cal and Beacon Medi-Cal, Holman Group, Optum, and Magellan (Blue Shield). Many other insurance plans cover psychotherapy. I'm happy to provide a super-bill for "out of network" insurances. Please remember to bring your insurance card with you to the first session. Please, be aware that it is your responsibility to call the insurance company to verify your mental health benefits, obtain any needed authorizations and referrals. Additionally, you are responsible for all deductibles, co-pays, as well as the payment of any claims that the insurance company may reject.

Additional Fees

Extended sessions and telephone conversations that exceed ten minutes will be charged a fee based on your regular session fee. Written reports, evaluations authorized or requested by you, or copying of your file follow this same policy.

Contacting me

You may contact me at (831) 246-4546 Monday through Friday until 9pm. I will try my best to reach you within 24 hours of your phone call. On weekends or holidays, I will only return calls in the cases of emergency, otherwise I will return calls on Monday or the day after the holiday. Phone calls are generally limited to 10 minutes, beyond this time you will be charged at a prorated amount of my usual fee.

Email Usage

By nature, therapy is confidential. You can have the confidence that your insights, vulnerable experiences, and feelings will not be repeated outside the therapeutic relationship established.

Characteristically, email correspondence is NOT confidential. Though Internet security measures can be effective, it is never 100% seal proof.

My policy regarding email usage is as follows:

- Email correspondence with me is NOT secure.
- Email correspondence is NOT a substitute for person-to-person therapeutic treatment, unless discussed with me in advance and in person.
- Email correspondence will not play a part in your therapy.
- I will not respond to your emails in general. Anything stated in an email from you will be discussed in session, and in session only.
- Email correspondence is NOT to be used in the case of an emergency to contact me.
- If you need to contact me with something that demands immediate attention, you will do so by voicemail at the following number: (831) 246-4546, call 911, or go to the emergency room. If it becomes necessary, I will terminate treatment if email usage is or becomes inappropriate.

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Emergencies

If you are experiencing a life-threatening emergency and need to talk to someone immediately, you can call 911, the Suicide Prevention Hotline at (800) 273-TALK (8255), the police, or your local hospital emergency room and ask for the psychologist or psychiatrist on call.

Confidentiality

Everything you say and share in session is strictly confidential. However, there are some exceptions to the rule of confidentiality.

I am required by law to report:

- Threats of harm to another or oneself
- Suspected child or elder abuse (past or present)
- By court order

Other exceptions include:

- Per your signed release

I may discuss your case with supervisors or peer counselors, in order to provide excellence in the service I give and in accordance with accepted professional behavior. In doing so, I will keep your identity or any details allowing your identification confidential.

When working with minors, confidentiality will be kept unless there is a concern that the child is in danger to itself, someone else, or has been harmed. In these cases the parent(s) will be notified of the concern and if possibly, I will have discussed the matter with the minor and have done my best to handle any objections he/she may have. During treatment, I will provided parents with only general information about the progress of treatment and the attendance of scheduled sessions.

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Agreement

I have read this information fully and completely, I have discussed any questions I had about the information, and I understand the information. I acknowledge that it is my choice to participate in psychotherapy (or have my child participate). I realize that the outcome of therapy depends upon my personal investment in the therapy process. I have familiarized myself with the fees and charges for services provided by Lorrine Ruth Carrara, M.S., M.F.T., and I understand and agree that the therapeutic services rendered will be charged to me and not to any third-party payer. I acknowledge responsibility for payment of these services.

Signature of Client	Date
Signature of Client	Date
Signature of Parent	Date
Signature of Minor	Date
Signature of Therapist	Date

New Client Intake/Assessment Form

Consent for treatment of a Minor

I, _____, attest that I am the [Please Print Your Name]

□ Legal Custodial Parent (or) □ Legal Guardian of _____[Name of Minor Child]

and I give **Lorrine Carrara, LMFT** permission to provide treatment for the minor.

Confidentiality Statement

We understand the limits to confidentiality and have been provided with a copy of this statement.

For the Parent/Guardian: The right of confidentiality is maintained with three exceptions:

1. The professional has reason to believe you will harm yourself.
2. The professional has reason to believe that you will harm others, including the minor.
3. The professional has reason to believe that someone or something is harming your minor child, including the parent(s) or guardian(s).

For the Child: The right to confidentiality is maintained with three exceptions:

1. The professional has reason to believe you will harm yourself.
2. The professional has reason to believe you will harm others.
3. The professional has reason to believe that someone or something is harming you, including the parent(s) or guardian(s).

☐ *My signature below attests to the fact that I am the legal custodial parent of the minor to receive treatment.*

Sign: _____

Signature of Minor: _____

Signature of Therapist: _____

Date _____

New Client Intake/Assessment Form

Client's Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Cell Phone: _____ **Emergency Contact:** _____ **Phone:** _____

Do I have your permission to leave a voice message? Yes No
Do I have your permission to send a text message to your cell phone? Yes No
Do I have your permission to contact you via email? Yes No

Age: _____ **Date of Birth:** _____ **Gender:** _____

Do you have a Primary Care Physician and/or Psychiatrist? Circle: Yes No

Name of Doctor(s): _____
Name of Psychiatrist(s): _____

Would you like your therapist to coordinate care with your physician? Circle: Yes No

Please state briefly why you are seeking treatment at this time: _____

_____

_____

Please check any of the following behaviors and characteristics you would like to occur less in your life:

	Anxious		Helpless Feelings		Relational Problems
	Appetite Disturbance		Homicidal Thoughts/Plans		Rigid Thinking
	Avoidance		Impatience		Sleep problems (wakeful/falling)
	Blames Others		Impulsive		Social Deficits
	Careless/Reckless		Inattention		Substance Use Problems
	Crying Spells		Irritability		Suicidal Thoughts/Plans
	Cutting/Self Injury		Lack of motivation		Temper Tantrums
	Day dreaming		Legal problems		Uncooperative
	Defiant/Oppositional		Lying		Verbal Anger
	Depressed mood		Mind racing		Weight loss/Weight gain
	Destroys Property		Moody/Mood swings		Withdrawn
	Difficulty with change		Nightmares		Worthlessness/Guilt
	Distrusts Others		Obsessions/Rituals		Other:
	Fear/Panic		Physical Aggression		Other:
	Hallucinations		Physical complaints		

How long have symptoms been present for? _____

_____

_____

New Client Intake/Assessment Form

Client Mental Health and/or Chemical Dependency Treatment History (Both Current and Past)

Prior Outpatient Treatment

Dates	Clinic	Therapist	Diagnosis/Reason for Treatment

Inpatient Hospitalization for Mental Health Issues

Dates	Clinic	Therapist	Diagnosis/Reason for Treatment

Do you have any history of suicidal ideation or suicide attempt(s)? _____ Yes _____No
If yes please describe:

Do you have any current suicidal ideation? _____ Yes _____No
If yes please describe:

List any current medications (both prescribed and over-the-counter):

Medication name	Dosage	Purpose	Side effects	Benefits (e.g. Is it working?)

SUBSTANCES USED

Consider a typical week during the **past month**. Please fill in the quantity for each day of the week indicating the typical amount of alcoholic drinks or substances you usually consume on that day.

Substances	**Sun**	**Mon**	**Tues**	**Weds**	**Thurs**	**Fri**	**Sat**
Alcohol:							
Marijuana:							
Meth:							
Heroin:							
Opioids:							
Other:							
Other:							
Other:							
Other:							
Other:							

New Client Intake/Assessment Form

DEVELOPMENTAL/CHILDHOOD HISTORY

Were there any circumstances that affected your development while growing up? _____ Yes _____No
If yes please describe:

Any history of abuse (e.g. physical, emotional or sexual) or neglect? _____ Yes _____No
If yes please describe:

Anything else you would like to disclose that might be relevant to therapy?

RELATIONSHIP STATUS AND HISTORY

Marital Status
___ Single, never married
___ Engaged [ ] months
___ Married [ ] years
___ Divorced [ ] years
___ Separated [ ] years
___ Divorce in process [ ] mos.
___ Live-in for [ ] years
___ Prior marriages (self)

Intimate Relationship
___ Never been in a serious relationship
___ Not currently in serious relationship
___ Currently in a serious relationship
___ Not currently looking for serious relationship

Relationship Satisfaction
___ Very satisfied
___ Satisfied
___ Somewhat satisfied
___ Dissatisfied
___ Very dissatisfied

FAMILY INFORMATION

Parents	**Age**	**Relationship History** *List any mental health or substance use concerns and anything notable about your relationship with them.*

Siblings	**Age**	**Relationship History** *List any mental health or substance use concerns and anything notable about your relationship with them.*

New Client Intake/Assessment Form

Other Significant Relationships *(cousins, friends, etc.)*	**Age**	Relationship History *List any mental health or substance use concerns and anything notable about your relationship with them.*

RELIGION/SPIRITUALITY

Do you belong to any religious and/or spiritual group? ____Yes _____No If yes, please describe: _____

_____

Are you experiencing any religion/spirituality-related problems? ___Yes ___No If yes, please describe: _____

_____

How important is religion/spirituality to you? _____

_____

Anything else you would like to note regarding religion/spirituality? _____

_____

SOCIAL/PEER RELATIONSHIPS

Are you satisfied with your current social life? ___Yes _____ No Please describe: _____

_____

How would you describe your social tendencies? (Check all that apply)

☐	Leader	☐	Difficulty making friends	☐	Gets bullied
☐	Follower	☐	Bossy	☐	Loner
☐	Outgoing	☐	Well liked by peers	☐	Other:
☐	Shy/Reserved	☐	Bullies others	☐	Other:

LEISURE/RECREATIONAL ACTIVITIES

Describe your special areas of interest, hobbies and activities: _____

_____

_____

_____

OTHER QUESTIONS FOR THERAPY

Any additional information you think would assist in my understanding of you or your current situation?

_____

_____

_____

_____

New Client Intake/Assessment Form

What are your goals for therapy? _____

_____

_____

_____

Would you like to see any family (or others in your life) involved in your therapy? _____Yes _____ No

If yes, describe: _____

What do you consider to be your strengths? _____

_____

_____

What do you consider to be your weaknesses? _____

_____

_____