Office of Lisa Graziano, M.A., LMFT

C O N F I D E N T I A L
PERSONAL DATA SHEET

Name: _____ Date: _____

Address: _____City/Zip: _____

Home Telephone: _____ Cell: _____ Email:_____

Age: _____ Birth Date: _____ Sex: _____ Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

What brings you to therapy? What is causing you distress?

_____

_____

Have you had any previous counseling? ❒No ❒Yes

If yes, where and when? _____

Please list the name and number of a friend or relative to contact in case of emergency:

Name _____ Relationship: _____ Telephone: (____)_____

Please list all persons who currently live with you:

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Pets: _____

Please list your work history:

Current: _____

History: _____

Are you currently taking any medications? ☐No ☐Yes *If yes, please list name of the medication(s), dosage(s), and reason for medication:* _____

_____

Please list your educational background:

Elementary School(s): _____

High School(s): _____

Graduated? ☐ No ☐ Yes If yes, what year?: _____

College(s): _____

Graduated? ☐ No ☐ Yes If yes, what year?: _____ Degree(s): _____

Other Specialized Training: _____

What are your hobbies/special interests? _____

List any social organizations and/or church you belong to: _____

Do you have any legal court cases pending, or any other legal actions? ☐ No ☐ Yes

If yes, please explain: _____

Please list your family of origin (please include self in sibling chronological order):

Father's Name: _____ Age: _____ Occupation: _____
If retired, prior occupation

Mother's Name: _____ Age: _____ Occupation: _____
If retired, prior occupation

❒Self
❒Brother : _____ Age: _____ ❒Single ❒Married ❒Divorced ❒Widowed
❒Sister ❒Other _____

❒Self
❒Brother : _____ Age: _____ ❒Single ❒Married ❒Divorced ❒Widowed
❒Sister ❒Other _____

❒Self
❒Brother: _____ Age: _____ ❒Single ❒Married ❒Divorced ❒Widowed
❒Sister ❒Other _____

❒Self
❒Brother: _____ Age: _____ ❒Single ❒Married ❒Divorced ❒Widowed
❒Sister ❒Other _____

Were you raised by: ❒Both Parents ❒Single Parent ❒Relative ❒Foster Parent(s)
❒Adoptive Parents ❒Grandparents ❒Other _____

In your current family or while growing up, is or was there of any of the following?
[ ] Alcoholism [ ] Substance abuse [ ] Mental illness [ ] Prolonged physical illness
[ ] Domestic violence [ ] Emotional abuse [ ] Neglect [ ] Sexual assault or abuse [ ] Prison
[ ] Life threatening or other traumatic event(s)

BECK INVENTORY

Name: _____ Date: _____

On this questionnaire are groups of statements. Please read each group of statements carefully, then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY. Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

☐
0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

☐
0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

☐
0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 I feel I have nothing to look forward to.
3 I feel I am a complete failure as a person.

☐
0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

☐
0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

☐
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

☐
0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

☐
0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

☐
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill if I had the chance.

☐
0 I don't cry any more than usual
1 I cry more now that I used to.
2 I cry all the time now
3 I used to be able to cry, but now I can't even cry even though I want to.

☐
0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

☐
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost more of my interest in other people.
3 I have lost all of my interest in other people.

☐
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

☐
0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance than make me look unattractive.
3 I believe that I look ugly.

☐
0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

☐
0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

☐
0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

☐
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

☐
0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less: Yes ☐ No ☐

☐
0 I am no more worried about my health than usual.
1 I am worried about my physical problems such as aches and pains; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

☐
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

BURNS INVENTORY (PAGE 1)

Name: _____ Date: _____

The following is a list of symptoms that people sometimes have. Put a check (✓) in the space to the right that best describes how much that symptom or problem has bothered you DURING THE PAST WEEK.

Category I: Anxious Feelings	0 Not at All	1 Sometimes	2 Moderately	3 A Lot
1. Anxiety, nervousness, worry or fear				
2. Feeling that things around you are strange, unreal or foggy				
3. Feeling detached from all or part of your body				
4. Sudden unexpected panic spells				
5. Apprehension or a sense of impending doom				
6. Feeling tense, stressed, "uptight" or on edge				

Category II: Anxious Thoughts	0 Not at All	1 Sometimes	2 Moderately	3 A Lot
7. Difficulty concentrating				
8. Racing thoughts or having your mind jump from one thing to the next				
9. Frightening fantasies or daydreams				
10. Feeling that you're on the verge of losing control				
11. Fears of cracking up or going crazy				
12. Fears of fainting or passing out				
13. Fears of physical illness or heart attacks or dying				
14. Concerns about looking foolish or inadequate in front of others				
15. Fears of being alone, isolated or abandoned				
16. Fears of criticism or disapproval				
17. Fears that something terrible is about to happen				

- Continued on Page 2 -

BURNS INVENTORY (PAGE 2)

Name: _____ Date: _____

The following is a list of symptoms that people sometimes have. Put a check (✓) in the space to the right that best describes how much that symptom or problem has bothered you DURING THE PAST WEEK.

Category III: Physical Symptoms	0 Not at All	1 Sometimes	2 Moderately	3 A Lot
18. Skipping or racing or pounding of the heart (sometimes called "palpitations")				
19. Pain, pressure or tightness in the chest				
20. Tingling or numbness in the toes or fingers				
21. Butterflies or discomfort in the stomach				
22. Constipation or diarrhea				
23. Restlessness or jumpiness				
24. Tight, tense muscles				
25. Sweating not brought on by heat				
26. A lump in the throat				
27. Trembling or shaking				
28. Rubbery or "jelly" legs				
29. Feeling dizzy, lightheaded or off balance				
30. Choking or smothering sensations or difficulty breathing.				
31. Headaches or pains in the neck or back				
32. Hot flashes or cold chills				
33. Feeling tired, weak or easily exhausted				

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LISA A. GRAZIANO, M.A., LMFT
Licensed Marriage and Family Therapist | License No. LMFT 34315
Individual and Relationship Therapy ・Children and Adolescents ・Families of Children with Special Needs
514 N. Prospect Avenue, Suite 111-Lower Level | Redondo Beach, CA 90277
(310) 764-8011 | LisaGrazianoLMFT@gmail.com | www.LisaGrazianoLMFT.com

Agreement for Services | Informed Consent

This document is intended to provide you with important information regarding your treatment and clarify the terms of the professional therapeutic relationship between a Therapist and a Patient. Please read the entire document carefully. Any questions or concerns regarding the contents of this agreement should be discussed with your Therapist before you sign it.

About the Therapy Process and the Risks and Benefits of Therapy

Psychotherapy is a process in which the Therapist and the Patient discuss a host of issues, events, experiences and memories so that the Patient can experience his or her life more fully. Psychotherapy provides an opportunity to better and more deeply understand oneself, as well as any problems or difficulties you may be experiencing. Psychotherapy is a joint effort between the Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Due to the varying nature and severity of problems and the individuality of each Patient, therapists are not able to predict the length of your therapy or guarantee a specific outcome or result.

Participating in therapy may result in a number of benefits to the Patient, including but not limited to reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work and family settings, increased capacity for intimacy, and increased self confidence.

Participating in therapy may also involve some discomfort including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which the Therapist will challenge the Patient's perceptions and assumptions, and offer different perspectives. The issues presented by the Patient may result in unintended outcomes, including changes in personal relationships. Patients should be aware that any decision on the status of his or her personal relationships is the responsibility of the Patient. There are no guarantees about what a Patient will experience, or when or how fast a Patient will feel improved.

Information About This Practice

The name of this practice is: Psychotherapy Office of Lisa A. Graziano, M.A., LMFT_ _
The individual therapist who operates this practice is: __Lisa A. Graziano, M.A., LMFT
Name of Therapist License Type License Number _____LMFT 34315_____

Information About Your Therapist

At an appropriate time, your therapist will discuss her professional background with you and provide you with information regarding her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation. Your therapist is a:

☑ Licensed Marriage and Family Therapist
❑ Marriage and Family Therapist Associate or Intern*
❑ Marriage and Family Therapist Trainee*
❑ Psychological Assistant*

*If your therapist is a Marriage and Family Therapist Associate/Intern, Marriage and Family Therapist Trainee, or Psychological Assistant his/her practice is conducted under the supervision of a licensed mental health professional. Clinical Supervisor Name, License type, Number: _____ _____ _____

Session Length and Fees

The fee for an Initial Consultation is $ 80
The fee for service is $ 180 per individual therapy session.
The fee for service is $ 180 per conjoint (marital/family) therapy session.
The fee for service is $ 180 per group therapy session.

Sessions are approximately 50 minutes in length. Sessions longer than 60 minutes are charged for the additional time pro rata. Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome.

Fees are payable at the time that services are rendered. I accept cash and checks. Please ask me if you wish to discuss a written agreement that specifies an alternative payment procedure.

I reserve the right to periodically adjust my fee. Patients will be notified of any fee adjustments in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations or other third-party payors, or by agreement with me.

From time to time I may engage in telephone contact with Patients for purposes other than scheduling sessions, for example returning a message at the Patient's request. Patients are responsible for payment of the agreed-upon fee (on a pro rata basis) for any telephone calls longer than fifteen minutes. In addition, from time to time I may engage in telephone contact with third-parties at the Patient's request and with the Patient's advance written authorization. Patients are responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than fifteen minutes.

If you become involved in a legal proceeding that requires my participation you will be responsible for all of my professional time, including preparation and transportation costs, and if I am called to testify by another party. My rate is $540 for a half day (3 hours) and $1080 for a full day (6 hours). Fees must be paid in advance and are not reimbursed by medical insurance.

I do not submit bills to insurance companies. I will, however, provide Patients with a Superbill that the Patient can submit to their insurance company to request reimbursement from the insurance company for the session(s) for which Patients have paid me. Please tell me if you would like Superbills and I am happy to provide them to you.

You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although I am happy to help you pursue insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with me.

If for some reason you find that you are unable to continue paying for your therapy, let me know so that we may explore options that may be available to you.

Missed Sessions and Cancellation Policy

If you are late to your appointment we will still have to end the session on time for the courtesy of my next patient. The fee remains the same because your fee is based on the amount of time reserved, not the amount of time used. Insurance will generally not pay for a missed session, and if you miss a session or cancel lat your insurance company will not cover the fee for that session. If you have a set session time and you fail to show up or cancel in advance for three consecutive weeks, I will presume you are no longer interested in that time slot and will make it available to other patients. Patients are responsible for payment of the agreed upon fee for any missed session(s). Patients are also responsible for payment of the agreed-upon fee for any session(s) for which the Patient failed to give me at least 24 hours notice of cancellation. Cancellation notices should be left on my voicemail at 310-764-8011.

Confidentiality

The information disclosed by the Patient is generally confidential and will not be released to any third party without written authorization from the Patient except where required or permitted by law. Exceptions to confidentiality include but are not limited to reporting child, elder and dependent abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him or herself or the person or property of another. In certain legal situations, such as in a child custody case or when your emotional condition is an issue (for example, in a Worker's Compensation or personal injury case), the judge may order me to testify. In the event that an account with me goes unpaid, it is legal for me to disclose your name, dates of sessions, and amount due to a collection agency or small claims court as necessary.

I occasionally practice with other mental health professionals and I may employ administrative staff. I may need to share protected information with these individuals for both clinical and administrative purposes, or in the event I have an emergency and another clinician needs to contact you to notify you of a cancelled appointment. All mental health professionals are bound by the same rules of confidentiality. All members have been given training about protecting your privacy and have agreed not to release confidential information outside of my practice without appropriate Authorization for Disclosure or one of the above listed mandates and/or emergencies.

Federal Law under the Patriot Act states that when the federal government believes an individual to be a threat to national security the government may access an individual's therapy records with a federal warrant. In the unlikely event that this occurs, I am prohibited from disclosing to the patient that this has occurred.

Confidentiality with Family and Couples Therapy

When working with family members and couples, I ask all parties to sign releases of information so that I may share relevant information and give important feedback to all those participating in treatment. In situations where *one* family member or *one* partner requests that I release information about the family or couple's sessions, it is my policy not to release information unless all family members (or both members of the couple) sign an authorization allowing me to do so.

I utilize a "no-secrets" policy when conducting family or marital/couples therapy. This means that if you participate in family, and/or marital/couples 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. Please feel free to ask me about my "no secrets" policy and how it may apply to you.

Minors and Parents

Patients under 18 years of age who are not emancipated generally require parental consent in order to begin treatment. Parental consent must come from a parent or guardian with legal custody. If your minor is the subject of a divorced union I require that you bring a copy of your most recent custody agreement in order to initiate consent for treatment.

Communications between Therapists and Patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, I may exercise my professional judgment to discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with me.

Psychotherapist-Patient Privilege

The information disclosed by the Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege is a legal term and results from the special relationship between the Therapist and the Patient in the eyes of the law; it is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the Patient is the holder of the privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege on the Patient's behalf until instructed, in writing, to do otherwise by the Patient or the Patient's representative. The Patient should be aware that he or she might be waiving the psychotherapist-patient privilege if he or she makes mental or emotional state an issue in a legal proceeding. Patients should address any concerns you may have regarding the psychotherapist-patient privilege with your attorney.

There are exceptions to privilege, which include but are not limited to: 1) if a patient is a danger to self or others, 2) a judge issues a court order, 3) a patient introduces his or her mental condition into testimony, 4) someone is under 16 and the victim of a crime, 5) the court is using therapy to establish sanity or competence to stand trial, 6) a patient has treated information as though it is not confidential, 7) information pertaining to the Patriot Act, 8) information listed on a health insurance claim form or child abuse report, 9) a patient files a complaint or lawsuit against me.

Professional Consultation

I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations I will not reveal any personally identifying information regarding a Patient. For professional consultations with people with whom you have asked or allowed me to speak (e.g., physicians, attorneys, teachers, therapists, etc.), I charge in quarter-hour segments for calls that are more than fifteen minutes. In general I do not write letters or reports for Patients but in the event that I do, I will charge for time writing letters or reports about your case or reading extensive reports. I will notify you about these charges before beginning these activities. These are charges that insurance companies usually do not cover. If you become involved in legal proceedings that may require my participation you will be expected to pay for my professional time even if I am called to testify by another party.

Clinical records are maintained in a secure, confidential manner during treatment for up to ten years following the termination of treatment. After ten years clinical records will be destroyed in a confidential manner and cannot be accessed. If within the ten years following treatment I am no longer in practice or upon my death I will designate another mental health professional to continue to securely keep and maintain my records and you will be notified of that therapist's name just in case you have the need to access records at a later time.

Records and Record Keeping

I may take notes during session and will also produce other notes and records regarding your treatment. These notes constitute my clinical and business records which, by law, I am required to maintain. Such records are my sole property. I will not alter the normal record keeping process at the request of any Patient. Should a Patient request a copy of my records, such a request must be made in writing. I reserve the right, under California law, to provide the Patient with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. A fee will be charged to copy or produce a summary equal to my customary hourly rate, minimum of 1 hour, plus an additional 25 cents per page copied or produced. I will maintain all Patients' records for ten years following termination of therapy. After ten years all Patients' records will be destroyed in a manner that preserves the Patients' confidentiality.

Patient Rights

HIPAA provides Patients with several new or expanded rights with regard to your clinical records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorize; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures in your records; and the right to a paper copy of this agreement; the attached notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Patient Litigation

I will not voluntarily participate in any litigation or custody dispute in which a Patient and another individual or entity is a party. I have a policy of not communicating with a Patient's attorney and will generally not write or sign letters, reports, declarations or affidavits to be used in a Patient's legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed or ordered by a court of law to appear as a witness in an action involving a Patient, the Patient agrees to reimburse me at my customary hourly rate for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance.

Complaints

Complaints of unethical or unlawful practice may be made with the Board of Behavioral Sciences located at 1625 North Market Boulevard, Suite S200, Sacramento, CA 95834 | 916-574-7830.

Vacation Coverage

If I am out of town and unavailable I will arrange for a qualified professional to cover for me. Simply check my voicemail for information about who to contact. I will also let my patients know in advance when I will be out of the office unless an emergency situation arises such as a sudden illness, in which case a qualified professional will notify you and discuss treatment options.

Therapist Availability and Communications

My office is equipped with a confidential voicemail system that allows Patients to leave a message at any time. Telephone messages from Patients between office visits are welcome. If you want me to return your call, you must specifically ask me to call you and leave your name and phone number(s), along with a brief message concerning the nature of your call. I will make every effort to return calls within 24 hours (or by the next business day) but cannot guarantee calls will be returned immediately; I am not able to provide 24-hour crisis intervention service. I will attempt to keep these types of contacts brief due to the belief that important issues are better addressed within regularly scheduled sessions.

If you have an urgent need to speak with me, indicate that fact in your message. **In the event you feel unsafe, require immediate medical or psychiatric help involving a threat to your safety or the safety of others, you should call 911 to request emergency assistance or go to the nearest emergency room.**

You should be aware of the following additional resources available to you if you are in crisis:

Los Angeles County Human Services Hotline	211
National Suicide Prevention Lifeline	800-273-8255
Los Angeles County Department of Mental Health	800-854-7771
Didi Hirsch – Suicide Prevention Hotline	877-727-4747
California Youth Crisis Line	800-843-5200
Asian Pacific Counseling and Treatment Center	213-252-2100
Los Angeles Gay and Lesbian Center	323-993-7400

Email should be considered carefully because I cannot guarantee the confidentiality of the Internet or your work or home computer. I do not respond to emails for this reason and prefer to discuss emails in session. Do not leave messages regarding appointment changes on the Internet. Voicemails are a much more effective way to reach me.

I may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform me if you do not wish to be contacted at a particular time, or place, or by a particular means. Please check all that apply:

❑ My therapist may call me at my home. My home phone number is: ( ) _____

❑ My therapist may call me on my cell phone. My cell phone number is: ( ) _____

❑ My therapist may call me at work. My work phone number is: ( ) _____

❑ My therapist may send mail to me at my home address.
My home mailing address is: _____

❑ My therapist may send mail to me at my work address.
My work mailing address is: _____

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend upon the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist.

You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

I reserve the right to terminate therapy at my discretion. Reasons for termination include but are not limited to untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of my scope of competence or practice, or the Patient is not making adequate progress in therapy. The Patient has the right to terminate therapy at his or her discretion. Upon either party's decision to terminate therapy, I will generally recommend that a Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. I will also attempt to ensure a smooth transition to another therapist by offering referrals to a Patient, if that is requested and/or appropriate.

Acknowledgement and Informed Consent

By signing below, Patient acknowledges that s/he has reviewed and fully understands the terms and conditions of the Agreement. The Patient has discussed such terms and conditions with me and has had any questions with regard to its terms and conditions answered to the Patient's satisfaction. The Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in the psychotherapy process with me. Moreover, the Patient agrees to hold me free and harmless from any claims, demands, or suites for damages from any injury or complications whatsoever, except negligence, that may result from such treatment.

_____ Date: _____

Printed Name of Patient

_____

Signature of Patient

_____ Date: _____

Printed Name of Parent or Guardian (If Under 18):

_____

Signature of Parent or Guardian (If Under 18):