Beth Hossfeld, MFT

License #MF22260
6 Knoll Lane, Suite F, Mill Valley, CA 94941 (415) 388-0644
beth.hossfeld@gmail.com

Brief Information Sheet

ADULT CLIENT(S) OR PARENT(S):
NAME: First: _____Last:_____ Birthdate:_____

First: _____ Last:_____ Birthdate:_____

CHILDREN: (*additional children can be written on back*)
NAME: First: _____Last:_____ Birthdate:_____

First: _____ Last:_____ Birthdate:_____

TELEPHONE: H: _____W: _____Is Work # confidential? Y/N

EMAIL: (please print clearly) _____

ADDRESS: Street: _____ City: _____ Zip Code: _____

OCCUPATION: _____

WORK ADDRESS: _____

EMERGENCY CONTACT: Name: _____Telephone: _____

What is your primary concern in seeking psychotherapy or counseling at this time?

Prior History of Psychotherapy or Counseling: YES / NO If yes, was it helpful?

Prior History of Psychological Problems: YES / NO If yes, briefly describe the problem(s).

MEDICATION: Has anyone in your family ever used any medications to treat a psychological problem? **YES / NO**
If yes, which ones: _____
Was the treatment successful? _____
Treating Physicians name: _____
Current Medications being used: _____

MEDICAL HISTORY: Do you have any past or current medical conditions that I should know about?
YES / NO If yes, please describe:

FAMILY HISTORY: Is there a family history of mental illness or alcohol/substance abuse?
YES / NO If yes, please describe:

SUBSTANCE ABUSE: Is there a personal history, for you or child, of alcohol/substance abuse? **YES / NO**
If yes, please describe:

CHILD ABUSE: Is there a personal history of child abuse for you or your child? **YES / NO** If yes, please describe:

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CONSENT FOR TREATMENT

I, _____, authorize and request that Beth Hossfeld, MFT provide individual, couple, family, and/or group therapy for: me, (or for my son/daughter _____). The frequency and type of treatment will be decided between Beth Hossfeld and me.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur.

I understand that the maximum benefit will occur with consistent attendance and that at times I (or my child) may feel conflicted about the therapy as the process can sometimes be uncomfortable.

I have read and fully understand this Consent for Treatment Form.

Date: _____

Client Signature: _____

Client Signature: _____

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OFFICE POLICIES

1. **Payment**: Payment is due at the beginning of each session unless other arrangements are made. The fee is $_____ and may change yearly. I will provide monthly statements for insurance reimbursement, upon request.

2. **Insurance:** If insurance issued, clients should remember that professional services are rendered and charged to the client and not to the insurance company. I will provide you with an insurance copy of your bill which you can submit to your insurance company for reimbursement.

3. **Cancellation:** The scheduling of an appointment involves the reservation of time specifically for us. To avoid being charged for a missed session, please inform me of your cancellation at least 24 hours in advance.

4. **Phone and Emergency Procedures:** If you need to contact me between sessions, please leave messages at (415) 388-0644. I return most calls within 24 hours. If an emergency situation arises, call the Marin Crisis line at (415) 499-6666 or 9-1-1.

5. **Confidentiality:** All information disclosed within sessions, including that of minors, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:
   1. When there is a reasonable suspicion of child abuse or abuse to a dependent or elder adult.
   2. When the client communicates a threat of bodily injury to others.
   3. When the client is suicidal.
   4. When disclosure is <u>required</u> pursuant to a legal proceeding.

6. **Collaboration:** It is my practice, and within the standard of quality health care, to request a release of information whenever a client is in the care of a medical professional for treatment related to a psychological condition, or receiving medication that aims to treat such a condition.

7. **Consultation**: I receive regular professional consultation. In such cases, neither your name nor any identifying information about you is revealed.

8. **Out of Office**: When I am out of town or otherwise unavailable, a qualified professional will cover for me by checking with the voicemail system and returning any urgent calls.

8. **Alternative Technology:** E-mail communications and cell phone calls are considered "non-secure", therefore these exchanges cannot be guaranteed to be confidential. I will use email for scheduling or administrative purposes ONLY, and I will always tell you if I am calling from a cell phone.

I HAVE READ AND UNDERSTAND THESE OFFICE POLICIES.

DATE: _____

CLIENT SIGNATURE: _____

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RELEASE OF INFORMATION*

**This form pertains to permission to speak with any individual which you and/or I believe is in the best interest of the client(s)' therapy. This person may be another therapist, physician, teacher, tutor, or extended family member or other involved person.*

I, _____, hereby give permission to

Beth Hossfeld, MFT, to speak with _____, regarding

_____ (Self, Child, Family) for the purpose of

_____that would be helpful in the service of treatment for the

above.

Professional: _____
Address: _____
Telephone: _____

I understand that I may cancel this release at any time, and that it is otherwise valid for one year following the date of signature.

Signed _____(Client, or Parent)
Date _____

Signed _____Beth Hossfeld, MFT
Date _____