Beth Hossfeld, LMFT
License #MF22260
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Brief Information Sheet

ADULT CLIENT(S) OR PARENT(S):
NAME: First: ________________________Last:___________________________ Birthdate:____________________

First: _______________________ Last:____________________________ Birthdate:____________________

Other Adult(s) in home and relationship to adult(s) and children:

First: _______________________Last:_____________________________Relationship to child ___________

CHILDREN:
NAME: First: ________________________Last:___________________________ Birthdate:____________________

First: _______________________ Last:____________________________ Birthdate:____________________

First: _______________________ Last:____________________________ Birthdate:____________________

TELEPHONE: H: ____________________C:_______________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 Psychotherapy or Counseling for **ADULT CLIENT? YES / NO** If yes, was it helpful?
CHILD? YES / NO If yes, was it helpful?
PARENT? YES/NO If yes, was it helpful?

Prior History of Psychological/Mental Health Needs: YES / NO If yes, for whom? _____ 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 (or your child) 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:

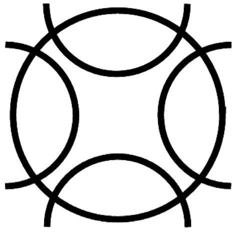
SUBSTANCE ABUSE: Is there a personal history, for you or child, of alcohol/substance abuse? **YES / NO**
If yes, please describe:

LEARNING/EDUCATION CHALLENGES: Is there a learning difference, disability, or other challenge for you/your child?
YES/NO If yes, please describe:

OCCUPATIONAL CHALLENGES: Is there an occupational concern, barrier, or challenge for you or a member of your family or household? 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:

Use this space for any other information important to include:



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CONSENT FOR TREATMENT

I, ________________________________, authorize and request that Beth Hossfeld, LMFT 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.

Client or Parent Signature: ____________________________Date: ______________________________________
(If client is under 18, Parent signature required.)

Client or Parent Signature: ____________________________Date: ______________________________________

POLICY ON LEGAL PROCEEDINGS AND THERAPY SERVICES

Legal Proceedings: When a family is confronted by parental separation or divorce, it can be hard on everyone. It is particularly hard on children. When the parental relationship is unsafe or in chronic or high conflict, it is even more important that therapy presents a safe environment. That safety is particularly endangered where a child has to worry that what he/she says in therapy will be revealed in court and used against one of his/her parents.

In order to protect that safety, I ask that we all agree that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither parent will attempt to gain advantage in any legal proceeding from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. It is unethical of me to give any opinion about which parent should have custody or what visitation arrangement will be, even if I am compelled to be a witness. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information to him/her so that the best possible decision can be made however, I will not make any recommendations about the final decision. Furthermore, if I am required to appear in court, the parent/guardian responsible for my participation agrees to reimburse me at the rate of $300 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs; this fee must be paid in advance.

I have read and fully understand Policy on Legal Proceedings and Therapy, and I agree to its stated conditions for the benefit of a successful therapy experience for your child/ren .

Client or Parent Signature: ____________________________Date: ______________________________________
(If client is under 18, Parent signature required.)

Client or Parent Signature: ____________________________Date: ______________________________________

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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 provide monthly statements for insurance reimbursement, upon request.

2. **Phone**: No fee for scheduling and short exchanges. After first 10 mins, $20. per each 10 minute increment.

3. **Insurance:** If insurance is used, 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.

4. **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. I do not charge for missed sessions due to life/death emergencies.

5. **Phone and Emergency Procedures:** If you need to contact me between sessions, please leave messages at (415) 388-0644#2. 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.

6. **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:
   a) When there is a reasonable suspicion of child abuse or abuse to a dependent or elder adult.
   b) When the client communicates a threat of bodily injury to others.
   c) When the client is suicidal.
   d) When disclosure is <u>required</u> pursuant to a legal proceeding or when required as per Patriot Act 2001 to provide records, documents, or other information to the FBI.

7. **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.

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

9. **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.

9. **Alternative Technology:** E-mail communications and cell phone calls are welcome but considered "non-secure", therefore these exchanges cannot be guaranteed to be confidential. Use these methods at your discretion. To safeguard confidentiality, I refrain from social media with my clients (Facebook, Twitter, Instagram, LinkedIn, etc.)

I HAVE READ AND UNDERSTAND THESE OFFICE POLICIES.

DATE: ________________________________

CLIENT/Parent SIGNATURE: ____

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Client Bill of Rights

You have the right to:

- Get respectful treatment that will be helpful to you.
- Have a safe treatment setting, free from sexual, physical, and emotional abuse.
- Report immoral and illegal behavior by a therapist.
- Ask for and get information about the therapist's qualifications, including his or her license, education, training, experience, membership in professional groups, special areas of practice, and limits on practice.
- Have written information, before entering therapy, about fees, method of payment, insurance coverage, number of sessions the therapist thinks will be needed, substitute therapists (in cases of vacation and emergencies), and cancellation policies.
- Refuse to answer any question or give any information you choose not to answer or give.
- Know if your therapist will discuss your case with others (for instance, supervisors, consultants, or students).
- Ask that the therapist inform you of your progress.

Clients' rights form. Adapted from Quinn (n.d.). This document is in the public domain.—From *The Paper Office*.