Julie Christensen M.A., L.M.F.T.
Licensed Marriage and Family Therapist MFC#48350
6520 Lonetree Blvd. Suite 1034
Rocklin, CA 95765
julie@itspossibletherapy.com
916-276-4354

Client Information

Name ________________________________ **Home Tel.** ________________________________

Address ________________________________ **Cell Tel.** ________________________________

________________________________ **Email** ________________________________
(City, State, Zip Code, County)

Place of Bus. ______________________________ **Occupation** ______________________________

Date of Birth ______________________

Age _____ **Cultural Identity** ________________

Education Completed ______________________

Marital Status _____________________

Names/Ages of Children **Names/Ages of Children**

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

Referred By ____

May I contact them to thank them for your referral? ( ) Yes ( ) No

Contact: ___________________________ **Phone:** _____________________________

Your Initials: ___________

Areas of Concern

What issues/concerns causes you to seek treatment? Please describe. ______________________________

____

____

What are your specific goals with regard to your treatment?______________________________

____

____

Do you have any particular concerns/fears with regard to treatment? ______________________________

____

Psychological History

If you have received previous counseling, what was the focus of treatment? ______________________________

____

Have you ever been hospitalized for mental or emotional problems? ___________________

When and for how long? ______________________ Why were you hospitalized? ______________________________

____

Name and location of hospital(s)____

Have you ever attempted suicide? ______ When? ______ Describe the circumstances that led to that attempt.

____

Current List of Medications

____

____

____

Medical History

Have you ever been diagnosed with a serious illness? Please describe______________________________

____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe.

____

____

Are you experiencing problems with any of the following? (Check any items that apply to you)

___ Thoughts about suicide or self-harm: ___ currently ___ in the past

___ Thoughts about killing or hurting someone: ___ currently ___ in the past

___ Problems sleeping: ___ falling asleep ___ staying asleep ___ waking too early

___ Sleeping: ___ Hours in a 24 hr. period for ___ days – weeks – months this episode.

___ Problems eating: ___ eating too much ___ eating too little ___ not eating at all ___ binging/purging

___ Changes in energy level: ___ decreased energy ___ increased energy ___ no energy ___ easily fatigued

___ Restlessness: ___ pacing ___ wringing hands ___ ___ shaking legs

___ Social withdrawal: ___ isolating from others ___ feeling detached from others

___ Low Motivation: ___ no motivation

___ Loss of interest in activities: ___ no pleasure from anything

___ Poor hygiene/grooming (ie: bathing less often, not changing clothes daily, wearing pajamas all day)

___ Poor impulse control or out of control behavior. Explain ____

Other Information

Please describe your spiritual identity/orientation. ____

Do you have any current legal issues? ____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. ____

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Credit Card Authorization

By signing this agreement, I am authorizing Julie Christensen to bill my credit card for all professional services rendered to the "Client." I agree that I will not dispute those charges which may include, but are not limited to:

- Sessions held by phone or video
- Cancelling appointment with less than 48-hour notice from session start time
- Appointment "no show"
- Telephone calls more than 10 minutes unless previously agreed upon
- Fees associated with legal cases
- Completing paperwork at your request

Credit Card Type (check one): ___ Visa ___ Mastercard ___ Discover ___ AMEX ___FSA

Card Number: ____

Expiration Date: ____

Security Code: ____

Cardholder Name: ____

Billing Zipcode: __________________

Cardholder Signature: _______________________________________ Date: _____________

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Consent to Release Information

I, ______________________________, hereby grant Julie Christensen M.A., L.M.F.T. permission to talk to the following individuals regarding my treatment:

Support People:

1. _____________________________________ (Name & Phone) for the purpose of: ____________________
____

2. _____________________________________ (Name & Phone) for the purpose of: ____________________
____

Psychiatrist:

______________________________________ (Name & Phone) for the purpose of: _____________________
____

Primary Care Physician:

_____________________________________ (Name & Phone) for the purpose of: ______________________
____

Therapist:

____________________________________ (Name & Phone) for the purpose of: _______________________
____

This authorization allows disclosure of information needed for the above-mentioned purpose only. It shall be valid as of today and shall expire twenty-four months later. Authorization for any, or all, of the above individuals may be revoked by you by asking me and initialing next my notation. The information disclosed may be subject to re-disclosure by the recipient and may no longer be protected.

Client Signature _______________________________________ Date ______________________

Therapist Signature ____________________________________ Date ______________________

Expiration Date ______________________

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AGREEMENT FOR SERVICE / INFORMED CONSENT

Introduction

This Agreement is intended to provide (your name) ______________________________________ with important information regarding the practices, policies, and procedures of Julie Christensen and to clarify the terms of the professional therapeutic relationship between us. If you have any questions or concerns regarding the contents of this Agreement, please bring them to your next appointment.

Therapist Background and Qualifications

I have been practicing as a licensed marriage and family therapist (LMFT) for 24+ years, working with clients. My theoretical orientation can best be described as eclectic employing such theories as: cognitive behavioral, EMDR, EFT, experiential, family systems, gestalt, humanistic, Jungian, transpersonal, ecopsychology, and others too. I tailor treatment to fit each client's situation.

Risks and Benefits of Therapy

Psychotherapy is a process in which the therapist and client discuss a myriad of issues, events, experiences, and memories for the purpose of creating positive change so the client can experience their life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as any problems or difficulties the client may be experiencing. Psychotherapy is a joint effort between the client and the therapist. Progress and success may vary depending upon the problems or issues being addressed, as well as many other factors.

Participating in therapy may result in several benefits to you, 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. Such benefits may also require substantial effort on your part, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts, and behaviors. There is no guarantee that therapy will yield any or all the benefits listed above.

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 I will challenge your perceptions and assumptions and offer different perspectives. The issues presented by you may result in unintended outcomes, including changes in your personal relationships. You should be aware that any decision on the status of your personal relationships is your responsibility. During the therapeutic process, you may find that you feel worse before you feel better.

Risks and Benefits of Therapy cont.
This is generally a normal course of events. Personal growth and change may be easy and swift at times but may also be slow and frustrating. Please address any concerns you have regarding your progress in therapy with me.

Professional Consultation
Professional consultation is an important component of a healthy psychotherapy practice.
When I participate in clinical, ethical, and legal consultation with appropriate professionals I will not reveal any personally identifying information regarding you.

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 my normal record keeping process at the request of any patient. Should you request a copy of my records, such a request must be made in writing. I reserve the right, under California law, to provide you 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. Should you, or any third party, request a copy of your records or a treatment summary, you agree to reimburse me for time spent preparing your records at my usual and customary hourly rate at the time of your request. Currently, my hourly rate for this service is $300.00. I will maintain your records for seven years following termination of therapy. However, after seven years, your records will be destroyed in a manner that preserves your confidentiality.

Confidentiality
The information disclosed by a client is generally confidential and will not be released to any third party without written authorization from the client, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, using a third-party billing or collection company, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a client is dangerous to him/herself or the person or property of another.

Patient Litigation
I will not voluntarily participate in any litigation, or custody dispute in which you or another individual, or entity, are parties. I have a policy of not communicating with client's attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in a client'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 you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate at the time of the case. Currently, my hourly rate is $300.00.

Psychotherapist-Patient Privilege
The information disclosed by you, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and 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 psychotherapist-patient 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 your behalf until instructed, in writing, to do otherwise by you or your representative. You should be aware that you might be waiving the psychotherapist-patient privilege if you make your mental or emotional state an issue in a legal proceeding. You should address any concerns you might have regarding the psychotherapist-patient privilege with your attorney.

Fee and Fee Arrangements
The usual and customary fee for service is $175.00 per 45-minute session. Sessions longer than 45 minutes are charged for the additional time pro rata. I reserve the right to periodically adjust this fee. You will be notified of any fee adjustment 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.

The agreed upon fee between (your name) _____________________ and myself is $175. I reserve the right to periodically adjust the fee. You will be notified of any fee adjustment in advance.

From time-to-time, I may engage in telephone contact with you for purposes other than scheduling sessions. Unless otherwise agreed on, you are responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, I may engage in telephone contact with third parties at your request and with your advance written authorization. You are responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.

Clients are expected to pay for services at the beginning of session. I accept credit cards (see attached credit card authorization form). You agree to maintain a current credit authorization on file. There is a $20 fee for chargebacks. Additional fees may be incurred if your account is sent to collections.

Insurance
You are responsible for all fees not reimbursed by your insurance company, managed care organization, or any other third-party payor. You are responsible for verifying and understanding the limits of your coverage, as well as your co-payments and deductibles.

I accept PPO insurance plans that I am not contracted with and will provide you with a monthly statement which you can submit to the third-party of your choice to seek reimbursement of fees already paid.

My Medicare Provider Status
Please be aware that I am an opted-out provider. This means that I am not contracted with Medicare. Medicare will not reimburse you for the cost of my services. If you are a Medicare beneficiary, we will need to enter into a private contract for therapy services for me to treat you.

Your Medicare Coverage Status
Are you a Medicare beneficiary?
___ Yes ___ No

Cancellation Policy

You are responsible for payment of $175.00 for any session(s) for which you fail to give me at least 48 hours' notice of cancellation for any reason. If your session begins at 12:00, you must have called by 12:00 two days before. Cancellation notice should be left on my confidential voicemail at 916-276-4354, or by text, and confirmed by me. Late arrivals of 20 minutes or more are considered a no-show and subject to this late cancellation fee. Excessive cancellations may result in cancellations no longer being possible or termination.

Therapist Availability

Please leave me a voicemail at any time and I will make every effort to return your call within 24 hours (or by the next business day) but cannot guarantee the calls will be returned immediately. I am unable to provide 24-hour crisis service. In the event you are feeling unsafe or require immediate medical or psychiatric assistance, you should call 911, or go to the nearest emergency room.

Recording of Sessions

Recording of sessions through computers, phones or any device is not permitted. You are welcome to take notes. Much of what occurs in therapy is meant to be left there.

Therapist Communication

I may need to communicate with you, or you with me, by telephone, email, or other means. Please indicate which modes of communication you agree to by checking the choices 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 keep in mind in using email, text and credit cards, you are agreeing to the transmission of potential protected health information in the form of receipts you receive and that your transaction will be listed on your credit card statement. For example, will using a work email be a problem for you? Might someone else see these types of communication you don't want to? It is best to keep text and email to appointment scheduling, canceling, rescheduling, or receipts. It's best to bring therapeutic issues, or things you want to share, into your session.

_____ My therapist may call me at home.

_____ My therapist may call me on my cell phone.

_____ My therapist may text me at my cell number

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

_____ My therapist may send mail to me at my home address

_____ My therapist may communicate with me by email

If you do not choose mail being sent to your home, I do need a mailing address on file to use in case you want reports sent to you, referrals at closing or for billing statements, or business-related mail. My therapist may use the following non-home address:

____

____

Termination of 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, client needs are outside of my scope of competence or practice, excessive cancellations, or client is not making adequate progress in therapy. You also have the right to terminate therapy at your discretion. Upon either party's decision to terminate therapy, I will generally recommend that you participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both of us 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 you.

Acknowledgement
By signing below, you acknowledge that you have reviewed and fully understand the terms and conditions of this Agreement. You have discussed such terms and conditions with me and have had any questions with regard to its terms and conditions answered to your satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Julie Christensen M.A., L.M.F.T. Moreover, you agree to hold Julie Christensen free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

____
Client Name (please print)

____ ___________________________
Signature of Client (or authorized representative) Date

I understand that I am financially responsible to Julie Christensen for all charges, including unpaid charges by my insurance company or any other third-party payor.

____
Name of Responsible Party (Please print)

____ ___________________________
Signature of Responsible Party Date

Please sign below if you are using your insurance plan.
"*I authorize the release of any information (which may include notes, treatment summaries and diagnosis) necessary to process insurance or Employee Assistance claims, to determine medical necessity of treatment, quality of care, or to request additional sessions.*"

____ ___________________________
Signature of Client (or authorized representative) Date

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TELEHEALTH CONSENT FORM

I, ______________________________ (your name) hereby consent to engage in Telehealth with Julie Christensen, LMFT (Therapist). I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Informed Consent Form I received from my therapist also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons. I understand I need to use fast internet service for the best possible connection and in the case of interrupted service will need to complete the session by phone.

3. I understand that miscommunication between myself and my therapist may occur via Telehealth.

4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location. As a therapist licensed in California, Julie may only provide this service if clients are in California at the time of their session.

6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

9. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

______________________________ ____________
Client's Signature Date

____
Client's Printed Name

Julie A. Christensen, M.A., L.M.F.T.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. For your treatment. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.

2. To obtain payment for your treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.

3. For health care operations. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization.

1. Psychotherapy Notes. I do not keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501; rather, I keep a record of your treatment and you may request a copy of such record at any time, or you may request that I prepare a summary of your treatment. There are cost-based fees involved with copying the record or preparing the summary.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations mandated by law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

YOUR RIGHTS YOUR REGARDING YOUR PHI

You have the following rights with respect to your PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice, and my address and telephone number are:

6520 Lonetree Blvd. Suite 1034, Rocklin, CA 95765. 916-276-4354

You can also file a complaint with the U.S. Department of Health and Human Services

Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;

2. Calling 1-877-696-6775; or,

3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on January 1, 2023.

I have received a copy of this notice.

Client Signature: ______________________________ Date: ____________________