PATIENT INTAKE FORMS

*All information completed below is to allow for your treatment and is considered private and confidential*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: Gender: female male

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: @ .com (OK to email? Yes No )

***Email communications are not considered secure or private. Please limit email communications to inquiry and* scheduling only.**

Social Security Number: xxx-xx-\_\_\_\_\_\_

Relationship Status: [ ]  Single [ ]  Married [ ]  Divorced [ ]  Partnered [ ]  Widowed

Please help me to understand what your hopes from therapy are. Any other information you think would be helpful for me to better know you (use the back side of this sheet if you need more room):

Who can I thank for your referral?

HEALTH INFORMATION

Current health concerns and medications:

Serious illnesses or hospitalizations, include dates:

Dates: Name of provider:

Current or prior substance abuse treatment or 12 step Recovery?

Dates. treatment provider and length of sobriety:

EMERGENCY CONTACT

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ASSIGNMENT, FINANCIAL AGREEMENT, and SIGNATURE RELEASE

**Please initial each statement and sign at the bottom**

 I understand that I am financially responsible for all charges.

 I understand that I may request a superbill to submit to my insurance company.

 I understand that the offices of Laara Israhel, LMFT reserves the right to charge the client, or responsible party, 100 % of billable amount, directly for missed appointments or those not cancelled 48 hours in advance.

 I, understand that I am responsible for late cancellation, missed appointment fees, or other fees deemed client responsibility.

Patient printed name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (or Responsible Party) Date

INTRODUCTION

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and ask any questions that you may have regarding its contents prior to beginning therapy.

From the get-go, therapy is difficult. You should also experience a sense of hope mingled with a sense of possibility for change or improvement within the first few sessions. If you do not sense this, please let laara know for it is important information for the therapeutic process to be effective.

THERAPEUTIC CONTRACT

Most people start therapy because something in their lives is not working and trying to resolve it on their own has not helped. Laara’s goal is to join in partnership to help all clients find ways to identify and voice their needs and increase effectiveness in meeting them. Participating in therapy can result in any number of benefits to you including a better understanding of your personal goals and values; improved interpersonal relationships; and resolution of the specific concerns that led you to seek therapy. However, during the process people may experience considerable initial discomfort as new awareness’s blossom and change begins to occur.

Change may be easy and swift, but often it is gradual, an undoing of old patterns that have long been hardwired into the internal/unconscious parts of self. It takes patience and courage to look at the old wiring and create new ways which can effectively for the present-day self.

As part of my therapeutic process, I use several techniques including, but not limited to: AEDP, EFT, IFS, Mindfulness, Somatic based healing, CBT, Solutions focused and Psychodynamic and psychoeducation. I have advanced training in AEDP – Accelerated Experiential Dynamic Psychotherapy and Gottman Method Couples Therapy.

Client's Rights

You have the right to a confidential relationship with your therapist. Within certain legal limits information revealed by you during therapy will be kept completely confidential and will not be revealed to any person without your written permission unless otherwise stated by law.

1. You have the right to know the content of your records at any time and I have the obligation to provide you with the complete records or a summary of their content. I am required to keep appropriate records for 10 years. I keep brief records noting you were here, your reasons for the visit, the goals and progress made and diagnosis.
2. Upon request any part of your records on file to any person you specify can be released. I will tell you when you make your request whether or not I think releasing that information to that agency or person might be harmful to you. If you are being seen as a couple, both partners must sign any releases.
3. Under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:
4. Revealing to me active child abuse or neglect. If an alleged perpetrator is in contact with minors and there is a reasonable suspicion that he/she may still be abusing minors. Active physical, sexual, financial abuse or abandonment of a dependent adult or an elder is taking place.
5. If you threaten serious harm or death to another person, I am required to warn the intended victim and notify the appropriate law enforcement agencies.
6. If you are in therapy or are being tested by order of the court, the results of the treatment or tests ordered must be revealed to that court. I do not write any court documents or interface with the courts directly. I do not provide documentation in Workman’s Comp cases if you are being seen through your Employee Assistance Program (EAP).
7. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena.
8. If you are in a lawsuit claiming emotional harm, the opposing side may subpoena your therapy records.

4. You have the right to ask questions about any of the procedures used in the course of your therapy.

5. Should you choose not to enter therapy with me, I will provide, at your request, a list with names of other qualified professionals whose services you may prefer.

6. You have the right to terminate therapy with me at any time without any financial, legal, or moral obligations other than those you've already incurred. I have the right to terminate therapy with you under the following conditions:

1. When I believe that therapy is no longer beneficial to you.
2. When I believe that another professional will better serve you.
3. When you have not paid for the last two sessions, unless special arrangements have been made with me.
4. When you have failed to show up for your last two therapy sessions without a 24-hour notice.
5. If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If I have written consent, I will provide that professional with information they request.
6. When you fail to cooperate with the proposed treatment plan.

As life can bring unexpected circumstances, should I be unable to continue your therapy, I will contact you to discuss what would be best for you at that time.

Fees and Length of Therapy

It is the policy of this office to request payment at the time services are provided unless other arrangements are made in advance. Sliding scale may be available upon request.

I agree to pay the standard fee for each completed session, unless other agreements are made. I will make payment at the time of the therapy appointment unless other arrangements are made. I understand that I can leave therapy at any time and that I have no financial, legal, or moral obligation to complete the maximum number of sessions listed in this contract. I am contracting only to pay for completed therapy sessions, or sessions I miss without providing 48-hour notice.

I have read and understand the above information, agree to the terms and conditions and acknowledge receipt of a copy of this form, upon request.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: date:

Therapist's Signature: *Laara Israhel*  Date: , 202 .

Consent for Treatment

I authorize and request that Laara Israhel, MFT, carry out treatment which now or during the course of my care as a patient are advisable.

I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read and fully understand this Consent for Treatment form.

Date Client's Signature

Date Therapist's Signature *Laara Israhel*

OFFICE POLICIES

Cancellation: An appointment reserves a time specifically for you, a minimum of 48-hours’notice is required for rescheduling g or cancellation of an appointment. The full fee will be charged for missed sessions without such notification.

Office Hours: Office hours are by appointment. Laara meets with clients Wednesday, Thursday, Friday and Saturday.

Payment for Service: Fees will be discussed prior to your first session. Please discuss with your therapist any hardship situation that may interfere with your participation in therapy due to financial demands.

Telephone Time: Contact between sessions is available. Calls lasting more than 5 minutes will be charged at a pro-rated amount based on the agreed session fee. Telephone and HIPAA Compliant video conferencing appointments are available.

Sessions Greater Than 50 Minutes: Sessions beyond the scheduled fifty minutes will be charged a prorated amount to the nearest quarter hour, unless prior arrangements have made.

Letter Writing*:* It is the policy of this office to avoid the complexity of any letter writing for courts or other situations. In situations where a letter is written there is a charge of $155.00/per hour.

Emergency Procedure: An emergency is an unexpected event that requires immediate attention and can be a threat to your health. If an emergency situation arises, contact the local crisis line, 9-1-1, or go to a local emergency room.

I have read and understand these office policies.

Name Printed:

Date: Signature:

Date: Signature: *Laara Israhel, LMFT*

Education

The Fresno State College, 1970 – 1972

Center for Movement Therapy and The Evergreen State College 1989-1991, BA

Seattle Pacific University, 1994 – 1998, M.Ed, School Counseling

Advanced Training in Couples Therapy through the Gottman Institute and Emotionally Focused Therapy, and AEDP, Mindfulness Meditation and Spiritual Direction

Laara Israhel, LMFT #50309

Baywood-Los Osos, California 93402

“Most people spend their lives fighting against what they don’t want, rather than fighting for what they do want."

No one every tells the ocean that it is doing something wrong because it goes in and out – laara 7/2024

Thank you for the privilege of working with you.