Client Information

Connections with the Heart
Margaret Mickelson, LMFT, ATR
228 West Main Street
Tustin, California 92780
949-303-9053

Client name: _____ *Date of birth:* _____
Address: _____
City: _____
E-mail Address: _____
Work Telephone: _____ *Home Telephone:* _____
Cell Number: _____ *OK to leave messages? yes___ no____*
Employer: _____
School: _____
Marital Status: ___married ___single ___divorced ___widowed
Emergency Contact/relationship: _____ *phone:* _____
Relevant medical conditions: _____
Medications (dosage, names of prescribing professionals): _____
_____
Allergies/adverse reactions to treatments: _____
Primary care physician: _____
Address: _____ *City:* _____ *Zip code:* _____
Primary reason for seeking therapy today (please include any prior history of therapy for mental health): _____
_____
_____
_____
Who may I thank for your referral? _____
Client's signature: _____ *Date:* _____

Margaret G. Mickelson, LMFT, ATR
Licensed Marriage, Family and Child Therapist
LMFT 35838
Registered Art Therapist
ATR 01-016
228 West Main Street
Tustin, California 92780
949-303-9053

AGREEMENT FOR SERVICE / INFORMED CONSENT (ADULTS)

Welcome to my practice. This document contains important information about my professional services and policies. Please read the entire document carefully and feel free to ask any questions you may have regarding its contents.

Introduction

This informed consent for therapy is intended to provide you (name of client) _____ with important information regarding the practices, policies and procedures of Margaret Mickelson, LMFT, ATR (herein "therapist"), and to clarify the terms of the professional therapeutic relationship between therapist and client. Any questions or concerns regarding the contents of this agreement should be discussed with me prior to signing it. I welcome your questions.

Therapist Background and Qualifications

I hold a dual qualification as a licensed marriage and family therapist and a registered art therapist. I am certified in EMDR.

- Licensed Marriage and Family Therapist (LMFT 35838), licensed with the California Board of Behavioral Science in June of 1999.
- Registered Art Therapist (ATR), registry number 01-016. This registration was issued by the Art Therapy Credentials Board in January of 2001.
- EMDR Certified Therapist. (Eye Movement Desensitization and Reprocessing). I was certified in June 2016 by the EMDR International Association.
- I am a member of the California Association of Marriage and Family Therapists.
- I served as Clinical Director at Olive Crest for 15 years caring for diverse populations within the non-profit community.

My theoretical orientation may be described as an integrative and multi-discipline approach.

About the therapy process:

Psychotherapy is a process in which we both explore a myriad of issues, events, experiences and memories for the purpose of creating positive change so you may experience your life more fully. We will co-create your goals for therapy. This provides an opportunity to better, and more deeply understand and reclaim yourself and rewrite the trauma you survived in your life. Much of therapy includes the use of the AIP model of therapy, in which the goal is to adapt to and integrate your life experiences. Psychotherapy is a joint effort between us. Progress and success may vary depending upon the particular problems or issues being addressed, as well as other factors.

Participating in therapy may result in a number of benefits to you. It is helpful to understand what personal goals you hold for your therapy journey. What would you like to accomplish? What changes and growth do you hope to see? This may include resolving PTSD symptoms, alleviating depressive affect, imparting hope; understanding that grief is a journey to be respected and honored; reducing anxiety and embracing internal calmness; identifying and increasing support around you. Life is too difficult to do alone. We need each other. Such benefits may also require substantial effort on your part, including an active participation in the therapeutic process, honesty, and a willingness to both own and rewrite your life. There is no guarantee that therapy will yield any or all of the benefits listed above, but hopefully we will see ongoing improvement as we review your growth along the journey.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events. Although the therapy process may evoke strong feelings, I am a strong believer in safety, containment, and finding the pace that works for you. Your feedback and insights are an important part of the therapeutic process.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice.
As such, I may participate in clinical, ethical, and legal consultation with appropriate professionals.
During such consultations, I will not reveal any personally identifying information.

Records and Record Keeping

I take notes during session. These notes constitute my clinical and business records, which by law, I am required to maintain. Therapist will maintain client's records for seven years following termination of therapy. However, after seven years, client records will be destroyed in a manner that preserves the client's confidentiality.

Your Right To Confidentiality

As a psychotherapy client, you have a right to confidentiality with respect to information related to our work together. Accordingly, information shared between us will generally remain confidential.

Exceptions to Confidentiality

The information disclosed by you is generally confidential and will not be released to any third party without written authorization from you, except where required or permitted by law.
Exceptions to confidentiality include, but are not limited to: reporting child abuse, elder and dependent adult abuse, or when a client makes a serious threat of violence towards a reasonably identifiable victim. Similarly, in the event that I believe you present a serious and imminent danger to yourself, another person or the public, I may be required to disclose information to emergency medical services, law enforcement, and/or another third party that can help to reduce or prevent that danger.

Patient Litigation

This therapist will not voluntarily participate in any litigation, or custody dispute in which you the client and/or another individual, or entity, are parties. This therapist has a policy of not communicating with client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in client's legal matters. This therapist will generally not provide records or testimony unless compelled to do so. Should this therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an

action involving client, client agrees to reimburse this therapist for any time spent for preparation, travel, or other time in which this therapist has made herself available for such an appearance (including cancellations made to be available). Therapist's fee for litigation related expenses will be billed at $500.00 per hour.

Psychotherapist-Patient Privilege

The information disclosed by the client, 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 client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the client is the holder of the psychotherapist-patient privilege. If this therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, this therapist will assert the psychotherapist-patient privilege on client's behalf until instructed, in writing, to do otherwise by client or client's representative. Client should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Client should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

Fee and Fee Arrangements

The usual and customary fee for service is $175.00 per 50-minute session. Sessions longer than 50-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Client will be notified of any fee adjustment in advance.

The agreed upon fee between therapist and client is_____. This therapist reserves the right to periodically adjust fee. Client will be notified of any fee adjustment in advance.

From time-to-time, therapist may engage in telephone contact with client for purposes other than scheduling sessions. Client is 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, therapist may engage in telephone contact with third parties at client's request and with client's advance written authorization. Client is 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 each session. Therapist accepts cash, checks and electronic payments (Zelle).

Insurance

Client is ultimately responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. Client is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles.
This therapist is not a contracted provider with any insurance company/managed care organization. Should client choose to use his/her insurance, this therapist will provide client with a statement, which client can submit to the third-party of his/her choice to seek reimbursement of fees already paid to this therapist.

Cancellation Policy

Client is responsible for payment of the agreed upon fee for any missed session(s). Client is also

responsible for payment of the agreed upon fee for any session(s) for which client failed to give at least 24 hours notice of cancellation. Cancellation notice may be left on therapist's voice mail at 949/303-9053.

Therapist Availability

My business phone is a cell phone. You may leave text messages regarding appointments; however, please do not put personal information on text messages (for your own privacy/confidentiality; as text messages are unencrypted). You are welcome to schedule an additional session if you need to discuss personal issues. I am not able to provide emergency assistance. Please call 911 or go to your nearest emergency room for medical or psychiatric assistance. I will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately.

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 therapist's scope of competence or practice, or client is not making adequate progress in therapy. Client has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, this therapist will generally recommend that you participate in at least one termination sessions. This session is intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done.

Acknowledgement

By signing below, client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Informed Consent. Client has discussed such terms and conditions with this therapist, and has had any questions with regard to its terms and conditions answered to client's satisfaction. Client agrees to abide by the terms and conditions of this Informed Consent and consents to participate in psychotherapy with this therapist. Moreover, client agrees to hold this therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, 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 therapist 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

Notice of Privacy Practices

I. 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.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (*if applicable*). You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at (*insert website address, if applicable*).

III. HOW I MAY USE AND DISCLOSE YOUR PHI.
I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

2. To Obtain Payment for 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 or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. For Health Care Operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

4. Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your

consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.

3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.

4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. 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.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. **The Right to Request Restrictions on My Uses and Disclosures**. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to

family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. The Right to Choose How I Send PHI to You. You have the right to request that I send confidential information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI. In most cases, you have the right to inspect and receive a copy of the PHI that I that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Receive a List of the Disclosures I Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003.

I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section Vl below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: _____.

VII. EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on April 14, 2003.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have given to you. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at 949/303-9053.

If you have any questions about my *Notice of Privacy Practices,* please contact me at: 228 West Main Street, Tustin, California 92780.

I acknowledge receipt of the *Notice of Privacy Practices* of *Margaret Mickelson, LMFT.*

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

Margaret Mickelson, LMFT, ATR
Connections with the Heart
228 West Main Street
Tustin, California 92780
949-303-9053

Insurance Information:

Policy holder: _____

Policy holder date of birth: _____

Address/Street: _____

City, State, Zip: _____

Insurance Carrier: _____

Policy Number: _____

Group Number: _____

Client relationship to Policy Holder: _____

Client's name and date of birth (please include parents' and child's information when applicable):

1. Name: _____ Date of birth: _____

2. Name: _____ Date of birth: _____

3. Name: _____ Date of birth: _____