COUPLESTLC
EMOTIONALLY FOCUSED THERAPY

2246 N. State College St.
Fullerton CA, 92831
e-mail: jack@couplestlc.com **phone:** 714-725-7121

Informed Consent & Disclosure Statement

Introduction
This document provides information about Couples TLC and services I provide. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents.

Information about me
I work with teenagers, individuals, couples, and families. I am a Licensed Marriage and Family Therapist in the State of California: Jack Gershfeld, LMFT License #: 94477. I am an Adjunct Faculty at Pepperdine University, Psychology Department where I teach Couples Therapy, Behavior Theory and Research Methods. I am the sole proprietor of Couples TLC.

Fee and Payment
A separate document will be provided with the information about my fees. I may adjust fees from time to time. You will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by agreement with me.

You are expected to pay for services at the time services are rendered. I accept cash, checks, and can send a digital invoice to be paid by credit card. If you need other arrangements, please let me know.

Insurance and Employee Assistance Programs

Please note that most insurance companies do not cover couples therapy.

My Availability
You can contact me by text message at the following phone #: 714-725-7121 or by e-mail: jack@couplestlc.com. I will make every effort to reply within 24 hours. I am unable to provide crisis services. If you are feeling unsafe or require immediate medical or psychiatric assistance, please call 911 immediately or go to the nearest emergency room.

Confidentiality
All communications between you and I will be held in strict confidence unless you provide a written permission to release information about your treatment. If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all persons who participated in the treatment with you, provide their written authorization to release information.

There are exceptions to confidentiality. For example, I am required to report instances of suspected child or elder abuse. I may be required or permitted to break confidentiality when I have determined that you present a serious danger of physical violence to another person or when you are a danger to self.

Appointment Scheduling and Cancellation Policies

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Therapy sessions are scheduled to occur one time per week at the same time. To cancel or reschedule your appointment, please notify me at least 24 hrs. in advance of your appointment by sending a text message to (714) 725-7121.

Therapist Communications

I may need to communicate with you by telephone, mail, text or other means. Please indicate your preference by checking one of the choices listed 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.

____ You may call me on my cell. My cell phone number is: ________________________________
____ You may send me text messages and text reminders.
____ You may send regular mail to me at my home address.
____ You may communicate with me by email.

My email address is: ____

Records and Record Keeping

I take notes during the 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 your request. Should you request a copy of my records, such a request must be made in writing. I have 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. I will maintain your records for ten years following termination of therapy. After ten years, your records will be deleted.

Litigation

I will not voluntarily participate in any litigation, or custody dispute in which you and another individual, or entity, are parties. My policy is to not communicate with your attorney and I will not write or sign letters, reports, declarations, or affidavits to be used in your legal matters. I will not provide records or testimony unless compelled to do so.

Video Recording

Recording therapy sessions is an essential tool for me to properly provide the ongoing therapy. I review tapes regularly to maintain a high quality of service at no additional cost to you. Video recordings help me to help you to successfully achieve your therapy goal.

Professional Supervision

Professional mentoring is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals.

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Therapist-Client Privilege

The information disclosed by you, as well as any records created, is subject to the Therapist-Client privilege. The Therapist - Client privilege results from the special relationship between you and me in the eyes of the law. You are the holder of the Therapist-Client privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the Therapist-Clients privilege on your behalf until instructed, in writing, to do otherwise by you or your representative. You should be aware that you may be waving the Therapist-Clients 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 Therapist-Client privilege with your attorney.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for therapy termination in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or I determine that you are not benefiting from the treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral to another therapist, changing your treatment plan, or terminating your therapy.

Acknowledgement

By signing below, you acknowledge that you reviewed and fully understands the terms of this Agreement.

I have discussed such terms and conditions with you, and I answered your questions about this agreement to your satisfaction. You agree to follow the terms of this Agreement and consent to participate in psychotherapy with me. Moreover, you agree to hold me 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.

______________________________	______________________________
Your Name	Your Name
______________________________	______________________________
Sign	Sign
Date: ___/___/___	Date: ___/___/___

Please initial each page ____________ / ______________

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Client Intake Questionnaire

Fill out one form for each person. (Spouse, parents, children, siblings etc.)

General:

Your Name ___________________________________ Today's Date_______________________

Age ________ Date of birth ______________ Occupation ________________________

Spouse/Partner's Name ____________________________ Today's Date____________________

Age ________ Date of birth ______________ Occupation ________________________

Married: Y N Divorced: Y N Live Together: Y N Long distance relationship: Y N

Address ____

Home/Cell phone __________________________ Work phone _______________________

E-mail _______________________________________ Referred by _____________________

Marital status ____________________________ Educational level _____________________

Names and ages of children (if any)

Your children: ____

____

____

____

Other: ____

____

____

Emergency contact information (Name, Phone): ___________________________________

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Areas of Concern:

What causes you to seek therapy? Please describe:

____

____

____

Do you have concerns worries about psychological therapies?

____

____

Psychological History:

Have you ever received mental health treatment before? ____________________________

When and for how long? ____

What was the focus of treatment? ____

Have you ever been subjected to one or more psychological tests? ___________________

If so, by whom? ____

Have you ever been hospitalized for psychological problems? ________________________

When and for how long? ____

Why were you hospitalized? ____

Name of treating therapist, address, telephone number ____________________________

Are you currently taking any prescription medications? Yes No

List medication names and doses: ____

Prescribed by whom? ____

How long have you been on the medications? ____

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Have you ever taken any medications for psychological condition? ____________________

List medication names and doses?

____

When and for how long?

____

Have you ever attempted suicide?   Yes   No

When? ____

Describe the circumstances that led to that attempt. _____________________________

____

____

Are you currently having any suicidal thoughts?

Please describe ____

____

Personal Experience

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.

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____

Have you ever been a victim of a violent crime? Please describe ___________________

____

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Medical History

Have you ever been diagnosed with a serious illness? Please describe ________________

____

____

Do you have any medical conditions that may affect your psychological therapy?

____

Please describe your overall health today: _______________________________________

____

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

____

____

Have you ever been in a 12-step program? Please describe. _________________________

____

Do you smoke? Yes No How much? ____________ For how long? _______________

Do you drink alcohol? Yes No

On average, how much alcohol do you consume in a week? _____________

Do you currently use illegal drugs? Please describe your use: ______________________

____

Have you ever used illegal drugs? Please describe. ______________________________

____

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Family Information

Mother's name, age, living/deceased, Your age at the time of mother's death, description of relationship with mother. ____

____

____

Father's name, age, living/deceased, your age at the time of father's death, description of relationship with father. ____

____

____

Names and ages of all siblings: ____

____

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____

Please describe your spiritual identity/orientation: _______________________________

Please describe your interests/hobbies ____

____

Please feel free to include any other information that you believe may be relevant:

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Relationship Information

Please describe relationship with your partner:

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Please describe relationship with your family:

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Please describe relationship with your partners family:

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Please describe relationship with your children:

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Please return this questionnaire before the first session. Thank you.

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Limitation on Confidentiality in Couple Therapy

When I work with couples, I consider both of you, as one unit, to be my client. If I get a request from a third party for your treatment records, I will seek the authorization from both of you before I release them or I will assert the therapist-client privilege on both of your behalfs.

During the course of my work, I may see each of you individually for one or more sessions. These sessions are a part of the work that I am doing with both of you and are confidential, however, I may need to share the information from an individual session with both of you.

I will use my best judgment as to when, and to what extent I will make disclosures to both of you, and will also, if appropriate, first give the individual the opportunity to make the disclosure. If you need to talk about matters that you absolutely do not want to be shared, I can provide each of you with a referral to a therapist who can treat you individually and maintain individual confidentiality.

This policy is intended to enable me to continue to work with both of you by preventing a conflict of interest that may arise when an individual's interests may not be consistent with the interests of both of you.

If I am not free to exercise my clinical judgment regarding the need to bring disclosed information to both of you, I will not be able to continue the treatment.

We, ____________________________ and _______________________________ acknowledge that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Jack Gershfeld, LMFT, and that we enter couple therapy in agreement with this policy.

Date: _________ Name __________________ Signature_____________________

Date: _________ Name __________________ Signature_____________________