Carol Montgomery Brosnac, MA, LMFT, Licensed Marriage and Family Therapist (MFC 51190)
5637 N Figarden #116 Fresno, Ca. 93722 -cell (559)999.8948 -fax(888)534-1695 cmbrosnac.psychotherapy@gmail.com
www.facebook.com/carolmontgomerybrosnaclmft

Client Intake Packet

Client Information:

Last name: _____ First name: _____
DOB: _____ Age: _____ Gender: _____ SS#: _____ Race: _____
Marital Status: _____ Employment Status: _____

Address: _____ Apt # _____
City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Can a message be left? *At Home:* ☐yes ☐no
Cell Phone: (_____) _____ Can a message be left? *On Cell:* ☐yes ☐no
Work Phone: (_____) _____ Can a message be left? *At Work:* ☐yes ☐no
Number preferred to be contacted at: ☐Home ☐Work ☐Cell
E-Mail Address: _____ Can a message be left? *E-mail:* ☐yes ☐no

Emergency Contact: _____Relation: _____
Address: _____ Apt # _____
City: _____ State: _____ Zip: _____
Number(s) (_____)_____ (_____)_____

Presenting Problem:

Please briefly indicate the concern(s) that bring you into counseling at this time:_____
_____
_____
_____
Is this problem impacting your: ☐ Work ☐ School ☐ Social life ☐ Relationships ☐ Ability to function

How long have you been dealing with this concern? _____

What has helped your progress? _____

What has impaired your progress? _____

What specific goals would you like to work on in therapy (please make goals: specific, measurable, objective, and/or behaviorally oriented):

1. _____
   _____
2. _____
   _____
3. _____
   _____

How did you learn about my practice? _____

Strengths/Supports/Coping Tools/Self Care: What do you do to take care of yourself mentally, emotionally, spiritually, &/or physically? _____
_____
_____

Who do you turn to for support? _____

Family History/Information:

Are your parents: _____ Married/Partnered _____ Separated _____ Divorced (year____) ____Never Married
Your current status: _____ Married/Partnered _____ Separated _____ Divorced (year_____) _____Single

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	Name	Age	De-ceased yes=✓	Live with yes=✓	Occupation (or if student list school & grade)	Quality of Relationship – i.e. Good = G, Fair = F, Poor = P, Estranged = E, Enmeshed = M, Strained/Conflictual = S, Non-existent = n/a
Mother:						**G F P E M S n/a**
Father:						**G F P E M S n/a**
Step-Mother(s):						**G F P E M S n/a**
Step-Father(s):						**G F P E M S n/a**
Siblings:						**G F P E M S n/a**
						G F P E M S n/a
						G F P E M S n/a
						G F P E M S n/a
Spouse(s)/Partner(s) & length of relationship: Include former relationships	**Current:**					**G F P E M S n/a**
						G F P E M S n/a
						G F P E M S n/a
Children:						**G F P E M S n/a**
						G F P E M S n/a
						G F P E M S n/a
						G F P E M S n/a

Custody Arrangements: ☐ N/A
If you are a parent (or if you are a minor and you/your parents are divorced), what is the time share/custody arrangement (i.e. do you have them on weekends & holidays, etc):_____
_____

Psychiatric/Psychological/Counseling Treatment History: ☐ Check here if this is your first and only experience.

Have you *ever* been hospitalized or received in-patient treatment for a mental health or substance abuse issue? ☐Yes ☐ No - if Yes – please give details (i.e. year, facility, reason, treatment given) :
_____
_____
_____

Have you *ever* received other mental health services (i.e. psychiatric care or counseling/therapy) of any kind? ☐Yes ☐ No – if Yes please give details (i.e. year & frequency of visits, practitioner name, what you were being treated for/diagnosis, what treatment was given such as medication, therapy, etc):
_____
_____
_____

Can above listed practitioners or facilities be contacted about the care you received? ☐Yes ☐ No

Please indicate any family history of psychological symptoms or disturbances (i.e. depression, anxiety, psychosis, addiction, etc): ☐ N/A_____
_____

Medical: ☐ I do not have a regular doctor – but my last medical exam was _____

Primary Care Physician: _____

How long with this physician? _____ Date of Last Visit: _____ Phone #: _____

Are they aware you are seeking counseling? ☐yes ☐no Can they be contacted? ☐yes ☐no

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Describe Current Medical Problems: ☐ N/A

Medical Problem	When Diagnosed	Effects on you?

Current Medications: ☐ N/A

Medication	Dose & Frequency	Prescribed By Whom?	Why?	Duration?

Please indicate any current medical issues or symptoms that you have not told your doctor about: ☐ N/A _____

_____

Please describe relevant past medical history (i.e. hysterectomy, cancer, strokes, heart attacks): ☐ N/A _____

_____

Please indicate any significant family medical history: ☐ N/A, ☐ cancer, ☐ cardiac disease, ☐ thyroid or endocrine problems, ☐ HBP, ☐ stroke, ☐ other: _____

** Please indicate any and all medications and other substances to which you are allergic, as well as seasonal allergies:

_____

Risks:

Are you currently feeling like you want to hurt or kill yourself? ☐yes ☐no Do you have a plan? ☐yes ☐no
Are you currently feeling like you want to hurt or kill someone else? ☐yes ☐no Do you have a plan? ☐yes ☐no
Do you purposefully, physically hurt yourself? ☐yes ☐no – If yes – how: _____
Are you currently being abused? ☐yes ☐no If yes, how? ☐physically ☐sexually ☐emotionally/mentally
By who?_____
Are you currently involved in or being exposed to a relationship that contains domestic violence? ☐yes ☐no
Do you have a history of any of the previous risks? ☐yes ☐no If yes, please explain: _____

_____

Substance Use History:

Substance	**Current Use?**	**Quantity of servings per week:**	**Do you feel it's a problem for you?**	**Have you had treatment for it?**
Alcohol	Y / N		Y / N	Y / N
Nicotine/cigarettes	Y / N		Y / N	Y / N
Pot/Marajuana	Y / N		Y / N	Y / N
Crack/ Coke	Y / N		Y / N	Y / N
Opiates/Heroin	Y / N		Y / N	Y / N
Benzodiazepines	Y / N		Y / N	Y / N
Uppers/Speed	Y / N		Y / N	Y / N
Methamphetamine	Y / N		Y / N	Y / N
Prescription misuse/abuse	Y / N		Y / N	Y / N
Other:	Y / N		Y / N	Y / N

In the last three months, have you felt you should cut down or stop drinking or *using drugs? ❍Yes ❍ No*
In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or *using drugs? ❍Yes ❍ No*
In the last three months, have you felt guilty or bad about how much you drink *or use drugs*? *❍Yes ❍ No*
In the last three months, have you been waking up wanting to have an alcoholic drink or *use drugs*? *❍Yes ❍ No*

Is someone else's substance use affecting you? If yes, explain: _____

Traumatic Events: ☐ N/A

Event/What	How long ago?	Is it affecting you now? How?
		☐ flashbacks ☐ nightmares ☐ intrusive thoughts ☐ fear/ numbness ☐triggered by noises or other reminders ☐ other:
		☐ flashbacks ☐ nightmares ☐ intrusive thoughts ☐ fear/ numbness ☐triggered by noises or other reminders ☐ other:
		☐ flashbacks ☐ nightmares ☐ intrusive thoughts ☐ fear/ numbness ☐triggered by noises or other reminders ☐ other:

Loss History: (i.e. death of a loved one or pet, divorce, job, etc) ☐ N/A

Who/What	How long ago?	Is it affecting you now? How?

Religious/Spiritual affiliation: ☐ N/A. Please note your orientation: _____

Sexual Orientation: _____

Educational Background: ☐ Currently a PT student ☐ Currently a FT student
Highest level of education completed: _____ Where:_____

Military History: ☐ N/A. Have you, your spouse, or any of your family ever been in the military? Please explain:
_____

How has this impacted you &/or your family? _____
_____

Occupation/Employment: ☐ Employed FT ☐ Employed PT ☐ Unemployed ☐ Disabled ☐ Retired
☐ Student (for the sake of this form if you are a student that can be considered your employment if you do not have a job)

Occupation _____ Place of employment_____

Duration of employment/disability/unemployment: _____ years

How do you feel about your job?_____

Financial:
Are you currently experiencing financial difficulties? **Y/N** If yes, explain: _____
_____

Additional Information:

Is there anything I didn't ask that would be important for me to know (i.e. legal issues, etc)? ☐ N/A If so please explain:
_____
_____

By signing below, I certify that the above information is correct and complete to the best of my knowledge.

Client Signature: _____ Date _____

Legal Guardian Signature: _____ Date _____

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Current Symptoms in last week to 2 weeks	n/a	mild	moderate	severe
Depressed mood (sad, irritable, blue, down, etc) that last most of the day	☐	☐	☐	☐
Loss of interest or pleasure in normally enjoyable things	☐	☐	☐	☐
Change in appetite or weight (i.e. significantly changing weight without trying)	☐	☐	☐	☐
Failing to keep up with important daily activities (i.e. bills, showers, etc)	☐	☐	☐	☐
Sleep disturbance (too much or too little)	☐	☐	☐	☐
Decrease/Increase in physical activity (that is uncharacteristic of you normally)	☐	☐	☐	☐
Fatigue or loss of energy (i.e. I can't bring myself to do anything)	☐	☐	☐	☐
Feeling worthless or excessively guilty	☐	☐	☐	☐
Impaired concentration or distractibility	☐	☐	☐	☐
Withdrawn	☐	☐	☐	☐
Suicidal thinking	☐	☐	☐	☐
Thoughts of death	☐	☐	☐	☐
Irritable or elevated mood (i.e. frenzied/manic, wound up, aggravated for days)	☐	☐	☐	☐
Significant mood or energy swings (each swing last 4 + days – people notice)	☐	☐	☐	☐
Inflated self esteem (i.e. I feel I can do in 1 hr what takes someone else 4 hrs to do)	☐	☐	☐	☐
Pressure of speech (i.e. I just keep talking and talking)	☐	☐	☐	☐
Racing thoughts (i.e. my thoughts spin, race and/or keep me up at night)	☐	☐	☐	☐
Excessive spending (i.e. I only have $20 extra a month - I spend $200 instead)	☐	☐	☐	☐
Acting out home (i.e. sneaking out, yelling, being disrespectful)	☐	☐	☐	☐
Acting out school &/or work (i.e. getting in fights, being argumentative, rebellious, etc)	☐	☐	☐	☐
Acting out sexually (risky behaviors – i.e. multiple partners, unprotected sex)	☐	☐	☐	☐
Acting out stealing (taking things that don't belong to me)	☐	☐	☐	☐
Acting out self mutilation (i.e. cutting, burning, scratching myself)	☐	☐	☐	☐
Using drugs or alcohol excessively (i.e. taking meds/drugs not prescribed or more than prescribed; drinking until drunk; mixing drugs & alcohol; numbing out)	☐	☐	☐	☐
Hyperactivity (i.e. I can't sit still)	☐	☐	☐	☐
Impulsivity (i.e. I don't think before I act)	☐	☐	☐	☐
Excessive fear or worry (i.e. I worry about a lot of different things)	☐	☐	☐	☐
Elevated heart rate when anxious or upset (i.e. my heart races)	☐	☐	☐	☐
Sweating when anxious or upset (i.e. when it's not hot sweating uncontrollably)	☐	☐	☐	☐
Shaking when anxious or upset (i.e. my body shakes uncontrollably)	☐	☐	☐	☐
Shortness of breath when anxious or upset (i.e. feel like can't catch my breath)	☐	☐	☐	☐
Choking when anxious or upset	☐	☐	☐	☐
Chest pain when anxious or upset	☐	☐	☐	☐
Nausea when anxious or upset	☐	☐	☐	☐
Lightheaded when anxious or upset	☐	☐	☐	☐
Feeling of unreality when anxious or upset	☐	☐	☐	☐
Numbness or tingling when anxious or upset	☐	☐	☐	☐
Fear of losing control because I'm feeling anxious or upset	☐	☐	☐	☐
Chills or hot flashes when anxious or upset	☐	☐	☐	☐
Feeling of impending doom (i.e. feeling something terrible is going to happen)	☐	☐	☐	☐
Avoidance of social situations due to panic/intense anxiety	☐	☐	☐	☐
Recurring unwanted thoughts that cause distress	☐	☐	☐	☐
Repetitive behaviors (i.e. counting, checking locks, skin picking, hair pulling, etc)	☐	☐	☐	☐
Reliving life threatening events	☐	☐	☐	☐
Auditory hallucinations (hearing things not really there)	☐	☐	☐	☐
Visual hallucinations (seeing things not really there)	☐	☐	☐	☐
Cognitive impairment (forgetting important things or events, the date, people, short or long term memory loss, loosing words often, etc)	☐	☐	☐	☐

Other symptoms you are experiencing that are not listed: _____

_____

These symptoms are: ☐distressing ☐not distressing

These symptoms are affecting my: ☐ work ☐ school ☐ relationships ☐ability to function normally in daily life

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I (we), _____ (the responsible party), am voluntarily seeking treatment for _____(the insured/covered person/client), from Carol Montgomery Brosnac, MA, LMFT & may terminate services at any time.

For the purposes of this informed consent for treatment:

Carol Montgomery Brosnac, MA, LMFT will from now on be referred to as "my therapist" or "my counselor". "My therapist" and "my counselor" is used when referring to the patient's/client's counselor. "I" or "my" is referring to the patient/client(s) and/or the responsible party. Health insurance will be abbreviated to "Ins." Company will be abbreviated to "Co." Appointment will be abbreviated to "appt".

About Confidentiality

Please read the HIPAA agreement included in this packet for full details related to confidentiality and the use of your information.

1. What I discuss in therapy is confidential. My therapist will not disclose my information to anyone without a release of information except as required by law (i.e. as described in the HIPAA agreement) or as required for payment (see "About Insurance section).
2. Minors are protected by confidentiality in the same ways that adults are. This ensures a feeling of trust & safety which is required to engage in the therapeutic process.
3. My therapist will encourage minor clients to communicate with their parent(s)/guardian(s). I understand my therapist will not disclose information shared in session by minors other than as related to the following:

- as allowed by the minors
- goals, progress, safety concerns, mental health/medical related treatment needs
- as required to by law (same as above)

4. My therapist, in keeping with generally accepted standards of practice, may seek confidential clinical supervision &/or clinical peer consultation regarding my treatment, with other mental health professionals in a confidential setting. The purpose of such consultation is to assure quality of care. Every effort is made to protect my identity & my name is never revealed.
5. My therapist communicates by verbal , written, & electronic formats including, but not limited to email, fax, texts, & cell phones. Additionally, I understand that my therapist communicates with others involved in my care in the above mentioned formats. While I understand that my therapist uses anti-virus, anti-spyware, encryption, & other forms of internet security, I understand she cannot guarantee that the communications via the Internet are secure. I also understand that cell phones are not a secure form of communication – so cell calls, texts, & any other transmissions may not be secure. If there are any restrictions in the way that I wish to be communicated with or about, I must inform my therapist in writing of my wishes.
6. Should I require a copy of my clinical records be sent to another party (i.e. to my doctor), I will submit a release of information.
7. I am entitled to request a copy of my own medical records at any time via written request from my therapist. I understand that my therapist has the right to refuse the release of those records to me should she feel it would be clinically inappropriate. I understand that I will have the right to appeal that decision with my therapist. If my therapist still declines to release my records to me I have the right to file grievance with the California Department of Health.

About Insurance and EAP Companies

1. I understand that mental health providers are required to submit psychiatric diagnosis &/or a "treatment plan" including diagnosis, description of the problem, personal background information, treatment goals, therapy methods & in some cases even session notes (as in the case of Ceridian's Work-Life Services & Military One Source) Ins. Co. when clients/members elect to use either their EAP &/or Ins. Co. benefits for mental health services.
2. I understand that Ins. Co. reserve the right to audit their member's charts at any time (i.e. to monitor compliance for "medically necessary" treatment).
3. I permit my therapist to submit any information required if I elect to use my Ins. benefits. I understand that I have the right to ask about the diagnosis being submitted.
4. I understand that once this information is submitted to my Ins. Co. it becomes a part of my permanent medical record & that it may be computerized or entered into a national medical information data bank. Once, submitted to my Ins. Co., my therapist has nothing to do with how it's used or maintained by my Ins. Co. & cannot be held liable for how the information is used thereafter by them.

5. I understand that if I do not want to release diagnostic information to my Ins.Co. that I must advise my therapist not to file any claims with my Ins. Co. & that I always have the right to pay for my services myself to avoid the complexities which are described above.
6. Each Ins. Co. has contracted reimbursement rates established with their contracted providers. If a provider chooses to contract with an Ins. Co., that provider has agreed to accept their reimbursement rates regardless of the counselor's billed rates. The counselor cannot balance bill the client for sessions as per the counselor's contract with the Ins. Co. The provider can bill the client for non covered services (i.e. such as no show fees).

About Fees & Payments

Note: **Please understand that each of these points have had to be added over time not because the therapist enjoys being punitive or unreasonable but because the therapist needs to protect her time & business.**

1. I understand my payment (regardless of whether it's a copayment, coinsurance, or private payment) is due at the time of session unless otherwise discussed & agreed upon ahead of the session in question.
2. Co-payments are required by Ins. Co. to be collected at the time the service is rendered.
3. I understand that ultimately I am responsible for the payment of my fees (not my EAP &/or Ins. Co.) should the EAP &/or Ins. Co. elect not to pay for any reason (i.e. if I did not attain an authorization for sessions from my Ins. Co.). These fees will be due within 30 days of the Ins. Co.'s rejection.
4. I understand that if I have a scheduled appt. & I need to cancel it, I will do so at least 24 hours in advance or more if possible. I will call to inform my therapist if I cannot come to my appointment. If I do not provide 24 hours notice (< 24 h CX/RS) or I no show (NS) for an appt. without a valid excuse, I will be charged $30 for the appt. If I fail to provide 24 hours notice or no show more than 3 times, I will be charged the full session fee every time an appointment is missed from that point and forward. I understand that my Ins. Co. cannot/will not be billed for < 24h CX/RS &/or NS & that I am fully responsible for the payment. *A "valid excuse" would be if there was an act of nature preventing your arrival, a communicable illness (i.e. cold, flu, etc), if you were hospitalized (or otherwise medically incapacitated), if you were involved in an emergency, or if any of these things happened to a close family member that you take care of.*
5. At the time of receiving this agreement my therapist will give me a credit card authorization form to fill out. If I do not have a credit card or if I do not wish to fill out the credit card authorization form, my therapist will accept a check in the amount of $30 to have on retainer for payment should I miss an appt. This check will be kept securely in my file until such time as an appointment is missed (at which time it will be cashed) or I terminate therapy. Once I terminate therapy the check can be given back to me &/or shredded by my therapist.
6. I understand that my therapist only typically accepts cash or check (at this time the credit card option is only reserved for collecting outstanding fees/payments). If my check bounces, I may be asked to pay cash from that point forward for any further sessions & I may be asked to pay any fees charged by the therapist's bank for the bounced check (typically $30).
7. I understand that if I do not fulfill my financial obligations within 30 days (unless otherwise arranged with my therapist), that my therapist has the right to pursue payment via a collections agency &/or has the right to report outstanding balances to the credit bureaus.
8. I understand that I (not my Ins. Co.) will be held responsible for the following fees should they occur and that I will be notified ahead of time by my therapist if I am to be charged:

- $300 an hour if my therapist is made to appear in court on my behalf via a subpoena
- $25 per quarter hour with a quarter hour minimum for phone consultations surpassing 10 minutes in length or that are excessive in nature.
- $25 per quarter hour should my therapist be requested or required to write up case summaries to other professionals/parties regarding my care. Charges associated with these services will be due prior to the other professionals/parties receiving my therapist's documentation.
- $1 per page should my records be requested to be faxed, mailed, &/or emailed to other professionals/parties regarding my care. Charges associated with these services will be due prior to the other professionals/parties receiving my therapist's documentation.
- postage to send my documents to other parties.

9. Counselor's billable rates are as follows: Diagnostic Intake/Interview 50-60 min with 30 min administrative time (90801) $150; Individual Psychotherapy 45-50 minutes with 10-15 min administrative time (90806) $100; Conjoint/Family Psychotherapy 45-50 min with 10-15 min administrative time (90847) $125; Family Psychotherapy without the Client Present 45-50 min with 10-15 min administrative time (90846) $125; Crisis Intervention 60-100 minutes with 20-30 min administrative time (90808) $200. Clients not utilizing insurance benefits qualify for a courtesy cash discount due to counselor not having the extra administrative tasks of working with Ins. or EAP companies. Those rates are as follows 90801= $100; 90806 = $70; 90847 = $80; 90846 = $80; and 90808 = $140.

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About My Therapist and Her Responsibilities

My therapist:

- Has a Master of Arts in Psychology with an Emphasis on Marriage and Family Therapy from Chapman University. She is a Psychotherapist (LMFT). She is a former Secretary of the Board of Directors for the Long Beach\ South Bay Chapter of CAMFT. She is currently a member of the Central San Joaquin Valley Chapter of CAMFT.
- will bill for services provided to me to the appropriate, designated party (i.e. my EAP and/or Ins. Co. or me if I am not using Ins. or it is not a Ins. billable item).
- will go over my goals, symptoms, &/or diagnosis with me and suggest various types of treatment.
- will explain the advantages & risks as necessary/appropriate.
- will ensure that another licensed therapist will be made available to me via telephone in the event of my having an urgent need when my therapist goes on vacation or has some type of other situation in which she'd be unreachable or unavailable.
- will adhere to all state & federal laws pertaining to the practice of Mental Health & Marriage & Family Therapy services including but not limited to HIPAA.
- will maintain my clinical records for the legally required 7 years.
- will keep scheduled appointments with me unless she has an unforeseen emergency – in which case she will inform me as soon as she is able about the need to cancel the appointment.
- will inform me in writing if there are to be any changes to this agreement.

About My Responsibilities as Client,

I understand that:

- it is my responsibility to understand my mental health Ins. benefits & to notify my therapist of any changes in my benefits as soon as I am aware of such changes.
- I am responsible to notify my therapist of any changes to my address, phone number(s), medical conditions, medications, employment & symptoms.
- it is my responsibility to pay for services not covered by my and/or Ins. Co. unless restricted by contract (i.e. no shows, late cancellations, returned checks, etc).
- it is important to be on time to my appts. & that I will call my therapist if I am running behind.
- when I schedule an appt. it will be with the full intention of keeping it regardless of my right to cancel within 24 hours as I understand that when I schedule with my counselor she is setting that time aside for me which prevents her from giving the time to her other clients &/or making other plans.
- I may reach my therapist by her cell phone (559)999 - 8948 or her email cmbrosnac.psychotherapy@gmail.com. When when leaving a message or email, I will briefly leave my *full contact information* and the reason for my call/email.
- in general, contact with my therapist outside of session time is reserved for emergencies or scheduling purposes only (non-emergency issues should be journaled & presented at the next scheduled session).
- My therapist is only available after normal office/business hours/days to aid in adverting emergency situations (i.e. immediate consultation needed to avert harm to self or others). If I have an urgent situation that arises, I will leave a brief but detailed message & can expect a call within 12 hours (my therapist will always attempt to respond to me as soon as is possible).
- if I have a true or life threatening emergency that I am to call 911 or if appropriate go to my nearest ER
- My therapist and I alone, are responsible for my treatment & no other therapist in affiliation with my therapist will be responsible for any aspect of my ongoing treatment. -
- if I am using my Ins. Co., my therapist & I are responsible to come up with a treatment plan/goals that address the symptoms of my mental health condition that is making counseling "medically necessary". These goals must be measurable & objective (behaviorally based) & will need to be reviewed regularly (about every 3 sessions).
- if I am using my Ins. Co., I will be required to complete assessments on a regular basis to monitor my mental health condition to ensure that there is progress and that treatment is still required.
- it is my responsibility to ask questions if I do not understand my treatment plan.
- therapy does not guarantee resolving my circumstances/problems/issues. I understand that therapy can run the risk at times of creating uncomfortable feelings & can even sometimes worsen my symptoms/circumstances as sometimes changing does. (i.e.- couples counseling does not guarantee that the couple's relationship will be saved. i.e. – discussing past traumatic situations can elicit painful feelings on the way to feeling relief.)

- it would be reasonable to expect to see some results/relief in my symptoms after 3 sessions. If I do not feel some relief/results by the 3rd session or I do not feel I am getting the help I need I will discuss this with my therapist. Typical therapy can last anywhere from 3 sessions to 6 months or longer, depending on the severity and complexity of the client's presenting symptoms/issues.
- I am responsible to inform my therapist if I am or if I believe there is any possibility that I may become involved in a legal situation in which my therapy could be implicated.
- **my therapist is not an expert witness under any circumstances, does not appear in court unless subpoenaed by a judge, & does not make disability determinations of any kind.**
- therapy is the process of engaging in a healthy therapeutic relationship & as such, properly terminating therapy is a necessary part of the therapeutic process. I agree to communicate with my therapist about terminating therapy & to discuss with my therapist questions or disagreements about the therapy process. I agree at minimum to a closing phone call but understand the best way to properly terminate a therapeutic relationship is by therapeutic participants to engage in a closing session.
- I may terminate therapy at any time.
- if there are no future appts. booked & there has been no contact between my therapist and I for a period of 30-45 days that my case will be considered closed. Should I desire my case to be reopened, I will need to reestablish contact with my therapist.
- I am responsible to ensure that my child(ren) understand this contract in full (if my child(ren) is a participant in therapy).

I have had the opportunity to ask any questions that I may have about this informed consent. By signing this informed consent I am agreeing to adhere to its contents and am entering into a therapeutic relationship with Carol Montgomery Brosnac, MA, LMFT.

_____	_____	_____
Signature of Responsible Party	DOB	Date
_____	_____	_____
Signature of Responsible Party	DOB	Date
_____	_____	_____
Signature of Client (if different than responsible party)	DOB	Date

Credit Card Authorization Form

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request.

I, _____, am authorizing Carol Montgomery Brosnac, MA, LMFT to use my credit card information to charge my credit card in the event that I do not notify her of my/my child's inability to attend a scheduled therapy appointment, do not cancel my/my child's appointment at least 24 hours in advance, a check related to services provided to me/my child is returned for any reason or there is an outstanding balance on my/my child's account after 30 days.

Type of Card: VISA ❒ MasterCard ❒ American Express ❒ Discover ❒

Card Number: _____-_____-_____-_____

Verification/Security Code:_____ Exp. Date: _____/_____Zip Code:_____

By signing below I am authorizing Carol Montgomery Brosnac, LMFT to charge for scheduled appointments as described above or for my/my child's outstanding balances after 30 days.

Signature:_____ Date:_____

Carol Montgomery Brosnac, MA, LMFT, Licensed Marriage and Family Therapist (MFC 51190)
5637 N Figarden #116 Fresno, Ca. 93722 -cell (559)999.8948 -fax(888)534-1695 cmbrosnac.psychotherapy@gmail.com
www.facebook.com/carolmontgomerybrosnaclmft

NOTICE OF PRIVACY PRACTICES

As required by the Health Insurance Portability and Accountability Act (HIPAA)

This Notice describes how medical and other information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

The privacy and confidentiality of your health information is very important and we are committed to protecting it to the extent we can, consistent with law and ethical standards. Your health information includes records that we create and obtain in order to provide care to you. For example, it includes a record of your counseling, any referrals made, bills, insurance claims and other payment information. You have a right to know how we use and share your personal information. This Notice tells you our responsibilities and your rights.

Carol Montgomery Brosnac, MA, LMFT provides services to residents of California. In order to provide the best possible care, employees involved in the operations of this practice may have access to your records. All employees of this practice follow these Privacy Policies.

Confidential Records

The personal information you give us goes into a confidential (private) written and/or electronic record. We use it to plan for your counseling services and to receive payment for those services. Usually we must have your permission to use or share your personal information. Sometimes, for example, in safety situations we may share it without your permission. This is further described below. The permanent record is kept on paper and/or may be converted into an electronic format. We will keep this for at least 7 years after you stop receiving services, and then your record will be destroyed.

Our Responsibilities

- We will keep your information private
- We will follow these Privacy Practices
- We will make available to you Carol Montgomery MA, LMFT Notice of Privacy Practices
- If these Privacy Practices change, we will give you a new copy at your next scheduled appointment or whenever you request one.

How We Use and Share Your Personal Information

There are three ways we use and share information about you. The three ways are to provide:

1. Services, with your consent

When you apply for services, you are asked to sign Consent for Treatment form. With this consent, we can use and share information about you in these ways:

a. For Treatment and Services

We may use and share information about you with professionals and agencies who serve you. For example, we may use information about you during professional consultation, so that we can ensure that you are getting the best services we can provide.

b. For Payment

We may use and share information about you to obtain payment for services we have provided to you. For example, we may give information to those agencies that provide funding (i.e. Vocational Rehabilitation) or to seek approval for payment from your insurance company .

2. Provide information to others who need it, with your approval

If we need to share personal information about you for other reasons, we will ask you to sign an Authorization Form/Release of Information Form (ROI) to give your approval. This will tell you what information we need to share, who will receive it, and why. For example, you need to sign an Authorization Form/ROI for us to share information with your child's school if you want us to talk with the teacher. Your approval is only good until the date stated on the form, not forever. If you change your mind, tell us in writing and we will no longer share the information.

3. Provide information to others who need it, without your consent or approval

We may sometimes share personal information about you without your approval. We will do this only when it is lawful and will not share any more information than necessary. The Department of Health and Human Services requires us to list specific situations in which one's personal information might be released.

- **Appointments –** for appointment reminders or notification when an appointment must be cancelled or rescheduled.
- **Emergency Treatment** – when you need medical care in a crisis.
- **Health and Safety** – to prevent or reduce a serious threat to someone's health or safety. We will do what is necessary to protect you and others.
- **Oversight** – when we are reviewed by licensing and accreditation agencies or auditors.
- **Legal Proceedings** – in response to court orders and other legal actions.

- **Law Enforcement** – if you are missing or in danger. Law enforcement may have access to your information for legal or civil proceedings.
- **Abuse or Neglect** – to report suspected abuse, neglect or exploitation of any minor or dependent adult.
- **Government** – to government regulatory agencies, including national security and intelligence agencies.
- **Required by Law** – at other times when the law requires releasing information.
- **Public Health** – to report diseases, drug reactions or other public health concerns.
- **Funeral Directors** – to the funeral director who will take care of your body.
- **Organ Donation** – for organ, eye or tissue donation purposes.
- **Coroner**s – to a coroner or medical examiner for identification or other purposes.
- **Workers' Compensation** – to process a Workers' Compensation claim.

Your Rights
You have a right to read your record and to have a copy of its contents or a summary report. We will charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied. You have the right to correct information in the record that you believe is inaccurate by providing a correction statement.

You have the right to request that certain information not be shared, although Carol Montgomery Brosnac, MA, LMFT is not required to follow your request. If we agrees, we will comply with your request unless the information is needed for an emergency.

You have the right to confidential communications. You may request that we communicate with you in a certain way or at a certain location. For example, you may want us to only contact you at home and not at your place of employment. This request needs to be made in writing. We will make every effort to accommodate your request as long as it is reasonable. We may request that you give us an alternative means to reach you, especially if there is an emergency. If we are unable to contact you using your requested means, we may contact you using any information we have.

You have the right to receive a list of the disclosures of your personal information that have been made for reasons other than for treatment or healthcare operations. You must state the time period for which you wish to receive this information, which may not be longer than six years and not begin sooner than April 2nd 2012 (the date this practice was opened) .

You have the right to refuse certain types of treatment or services. Carol Montgomery Brosnac, MA, LMFT will be happy to give you proper referrals should you wish to obtain treatment elsewhere.

I will not use your personal information for any marketing purposes. I would only use your photo or comments in any of the practice's materials (brochures, videos, etc.) with your written permission.

If you believe your privacy rights have been violated, you may file a complaint with Carol Montgomery Brosnac, MA, LMFT or with the HHS Office of Civil Rights. You will not be penalized for making a complaint. If you have any questions, would like to request restrictions on uses and disclosure for health care treatment or operations, or would like to file a complaint, please contact Carol Montgomery Brosnac, MA, LMFT at 559.999.8948.

Your signature on the Acknowledgement Form does not indicate your agreement with the information provided. It simply acknowledges that you have received and read Carol Montgomery Brosnac, MA, LMFT, Notice of Privacy Practices.

Acknowledgement of Notice of Privacy Practices

Name: _____ DOB _____
Name: _____ DOB _____

I acknowledge that I have received a copy of the Notice of Privacy Practices of Carol Montgomery Brosnac, MA, LMFT.

_____ _____
Signature **Date**

_____ _____
Signature **Date**

_____ _____
Witness **Date**