Tides of Healing
COUNSELING SERVICES
Caitlin MacCalla, M.A, LMFT

Address: 4010 Moorpark Ave. #118, San Jose, CA. 95117
Main: (650) 799-1762
Email: cmaccalla.lmft@gmail.com
Web: www.tidesofhealing.com

AGREEMENT FOR SERVICE / INFORMED CONSENT

Introduction:

This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by Caitlin MacCalla, M.A, LMFT, for:

_____

[name of client seeking services and herein to be referred to as "Patient"]

with important information regarding the practices, policies and procedures Caitlin MacCalla, M.A, LMFT (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Therapist Background and Qualifications

At an appropriate time, your therapist will discuss her professional background with patient and representative and provide both with information regarding her experience, education, special interests, and professional orientation. Patient and representative are free to ask questions at any time about your therapist's background, experience and professional orientation. Therapist has been practicing as a Licensed Marriage and Family Therapist since 2008 and has spent more than 18 years in the field working primarily with adolescents and families. Therapist area of expertise include, but are not limited to: adolescent mental health, couples work, divorce, parenting/co-parenting, blended family issues, forensic psychology, families in dependency system, blended family issues, female empowerment work, trauma and depression/anxiety. Therapist draws from Narrative therapy, Cognitive Behavioral Therapy, Family Systems, and Solution Focused Therapy.

Therapist recognizes the importance of acknowledging systems of oppression that impact our mental health, the importance of cultural humility in the therapeutic relationship, and the necessity of being anti-racist as an effective clinician. Therapist is deeply invested in ongoing personal work and trainings to ensure her treatment of clients remains free of personal biases.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Patient or Patient's family members or caregivers.

Records and Record Keeping

Therapist may take notes during session and will also produce other notes and records regarding Patient's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter her normal record keeping process

at the request of any patient or representative. Should Patient request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient, with a treatment summary in lieu of actual records. Therapist also reserves 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. Therapist will maintain Patient's records for ten years following termination of therapy, or when Patient is 21 years of age, whichever is longer. However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

Confidentiality

All communications between patient and therapist will be held in strict confidence unless patient provides written permission to release information about patient's treatment. If patient participates in marital or family therapy, your therapist will not disclose confidential information about patient's treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, your therapist will not disclose information communicated privately to her by one family member, to any other family member without written permission.)

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

Patient Litigation

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient, and another individual, or entity, are parties. Therapist has a policy of not communicating with attorney's and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's, or Representative's, legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Representative agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made herself available for such an appearance at Therapist's usual and customary hourly rate of $500.00. In addition, Therapist will not make any recommendation as to custody or visitation regarding Patient. Therapist will make efforts to be uninvolved in any custody dispute between Patient's parents. Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc..), neither you (client) nor your attorneys, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon. Your therapist will speak to lawyers or court-ordered evaluators only with written permission from both parents when both share legal custody. She will not write reports or letters to the court without a court order. Nor will she make any recommendations for custody. Therapists fee for any work related to court matters, including but not limited to letters to the court, or communication with lawyers or evaluators, is $500 per hour, billed in increments of 5 minutes.

Psychotherapist-Patient Privilege

The information disclosed by Patient, 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 Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by a person with the authority to waive the privilege on Patient's behalf. When a patient is a minor child, the holder of the psychotherapist-patient privilege is either the minor, a court appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law. Representative is encouraged to discuss any concerns regarding the psychotherapist-patient privilege with his/her attorney. Patient, or Representative, 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. Patient, or Representative, should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

Fee and Fee Arrangements

Individual Sessions (In person & Teletherapy)

- Free for 30 minute Consultation
- $165 for a 45-50 minute session
- $200 for a 90 minute Extended session

Family or Couples Sessions (In person & Teletherapy)

- Free for 30 minute Consultation
- $200 for a 90 minute session

Sliding scale fee available at request.

Sessions longer than 50-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Patient 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 Therapist. Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure. Therapist accepts cash, credit card and checks. Therapist reserves the right to periodically adjust fee. Representative will be notified of any fee adjustment in advance. From time-to-time, Therapist may engage in telephone contact with patient for purposes other than scheduling sessions. Patient 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 Patients request and with Patient's advance written authorization. Representative is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.

Insurance

Patient is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. Patient is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles. Therapist is not a contracted provider with any insurance company, managed care organization. However, should Patient have a PPO with out of network benefits, Therapist will provide Representative with a statement called a "Superbill", which Patient can submit to the third-party of his/her choice to seek reimbursement of fees already paid. The "Superbill" is not a bill, it will have one column with the amount paid and one column with the amount charged. This is sent out at the end of the month and typically takes 5-7 business days to be sent out.

Patient should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. Patient should also be aware that they are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with your therapist.

If for some reason Patient finds that they are unable to continue paying for your therapy, they should inform the therapist. Patient's therapist will help you to consider any options that may be available to you and patient at that time.

Cancellation Policy

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Patient's therapist may suggest a different amount of therapy depending on the nature and severity of patient's concerns. Patient's consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, Representative is expected to notify patient's therapist at least 12 hours in advance of patient's appointment. If you do not provide patient's therapist with at least 12 hours' notice in advance, Representative is responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or canceled sessions.

Cancellation notice should be left on Therapist's voice mail at **(650) 799-1762**

Therapist Availability

Patient is welcome to phone therapist in between sessions. However, as a general rule, it is therapist belief that important issues are better addressed within regularly scheduled sessions.

Patient may leave a message for patient's therapist at any time on her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Therapist 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. Non-urgent phone calls are returned during the therapist's normal workdays within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail. Therapist is unable to provide 24-hour crisis service. In the event of a medical or psychiatric emergency or emergency involving a threat to your safety or the safety of others, the patient should call 911 and request emergency assistance, or go to the nearest emergency room.

You should be aware that your therapist is generally available to return phone calls within approximately 24 hours. Your therapist is not able to return phone calls after 8:00 pm (PST). Your therapist is not available to return phone calls on Sunday or otherwise noted by therapist directly.

Teletherapy (online counseling)

It is important that patient understands that teletherapy includes consultation, treatment, transfer of personal and health information, emails, telephone conversations and education using interactive audio, video and data communications. Patient needs to be aware that the security of my email transmissions cannot be assured.

Patient has a right to confidentiality with teletherapy under the same laws that protect the confidentiality of my personal and health information for in-person psychotherapy. Any information disclosed by me during the course of either my office-based psychotherapy or my remote teletherapy, therefore, is generally confidential. Patient understands that there are unique risks specific to teletherapy services including, but not limited to: the possibility of disruption, distortion or unauthorized access during transmission of personal information due to internet/electronic/technical failures beyond the control of Therapist.

Patient understands that there are limitations of teletherapy, including but not limited to: Therapist being unable to always accurately assess patient non-verbal communication.

Patient understands that they are solely responsible for the privacy and confidentiality in their surrounding environment while engaged in teletherapy and will exercise appropriate privacy measures. Patient also understands that they the right to withhold or withdraw consent at any time without affecting their right to future care or treatment.

Termination of Therapy

The length of patient's treatment and the timing of the eventual termination of their treatment depend on the specifics of their treatment plan and the progress they achieve. It is a good idea to plan for patient's termination, in collaboration with their therapist. Patient's therapist will discuss a plan for termination with Representative and patient as you approach the completion of patient's treatment goals.

Patient may discontinue therapy at any time. If patient or their therapist determines that they are not benefitting from the treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Therapist reserves the right to terminate therapy at her 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, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient or Representative has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient or Representative.

Acknowledgement

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Representative has discussed such terms and conditions with Therapist and has had any questions with regard to its terms and conditions answered to Representative's satisfaction. Patient agrees to abide by the terms

and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Patient agrees to hold Therapist 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 signature indicates that you have read this agreement for services carefully and understand its contents. Please ask your therapist to address any questions or concerns that you have about this information before you sign.

_____

Patient Name (please print)

_____

Signature of Patient (if Patient is 12 or older)

Date: _____

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New Client Intake Form

Today's Date: _____

Last Name:_____ First:_____Middle Initial: _____

Age:_____Date of Birth: _____

Address: _____
Street City Zip code

Phone Number_____(Cell/hm/wk) OK to leave message? Yes ☐ No ☐

Email: _____

Emergency Contact:_____/_____
Name / Relationship Telephone [Hm / C / Wk]

Religion/Spiritual Preference: _____

Are you employed: Yes ☐ No ☐ ☐ F/T ☐ P/T Occupation:_____How long? _____

Are you in school: Yes ☐ No ☐ ☐ F/T ☐ P/T Do you enjoy your work/school? Yes ☐ No ☐

Highest Level of Education: _____

Current Relationship Status: (circle and add date of event where applicable)

Single Married since_____1st/2nd/3rd Marriage_____Separated since _____

Dom. Partnership since_____ Widowed since_____Divorced since_____ Engaged since _____

Relationship Satisfaction (please circle) : Poor---Unsatisfactory---Satisfactory---Good---Excellent

Do you have children? Yes ☐ No ☐ How many?_____ Ages: _____ _____ _____ _____

Who lives in your home (family members or others)?

Name	Relationship to you	Age	Date of Birth	Gender

[If more room needed, please use back]

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Primary Care Physician:_____Phone:_____Date of last exam?_____

Rate your current physical health, (circle): Poor Unsatisfactory Satisfactory Good Excellent

Do you have concerns about your physical health? _____

Current Psychiatrist:_____Phone:_____Last visit? _____

Are you currently under medical or psychiatric care? ☐ Yes ☐ No If yes, please indicate with whom and the reason(s): _____

List prescribed medication(s). Use reverse of paper if necessary.

Medication	Dose	Reason for taking

Alcohol use: ☐ In recovery ☐ Non-drinker ☐ Occasional ☐ Social ☐ Regular ☐ Heavy use ☐ Alcoholic

Tobacco use: ☐ Non-user ☐ Occasional ☐ Social ☐ Regular ☐ Heavy use ☐ Cigars ☐ Chews

Street drug use: ☐ In recovery ☐ Non-user ☐ Occasional ☐ Social ☐ Regular ☐ Heavy use ☐ Addicted

List alcohol and street drugs that you currently use, or have a history of using recreationally.
*Please use the back of the sheet if you need more room.

Substance or Alcohol	How much in one sitting?	How often per day, week or month?	Current	Past

Have there been changes in your sleeping patterns in the past three months? Yes ☐ No ☐

If yes, ☐ Night time waking ☐ Sleeping too much ☐ Insomnia ☐ Other, please describe: _____

Any changes with appetite or in eating patterns recently? Yes ☐ No ☐
If yes, describe : _____

Are you experiencing sadness, grief, depression, tearfulness? Yes ☐ No ☐
If yes, describe : _____

Are you experiencing anxiety, panic, panic attacks, phobias/fears? Yes ☐ No ☐
If yes, describe : _____

Are you suffering with chronic pain? Yes ☐ No ☐ If yes, please describe :

_____

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Have you experienced abuse/trauma in your adult life, such as domestic violence, accident, rape?

Please circle all that apply:

physical emotional verbal sexual mental neglect other (explain below)

_____

Have you experienced abuse in childhood? Please circle all that apply:

physical emotional verbal sexual mental neglect abandonment bullied other

Do you currently, or have you ever physically harmed another person? Yes ☐ No ☐

If yes, please describe: _____

Are you currently involved in legal proceedings? Yes ☐ No ☐ If yes, please explain:

_____

Do you ever see or hear things other people say they can't see or hear? If yes, please explain:

_____

Have you experienced significant life changes or stressful events recently? If yes, please explain:

_____

Have you previously seen a counselor/therapist/psychologist/coach/psychiatrist? Yes ☐ No ☐

Names/Reasons/date ranges/locations: _____

_____

_____

Please circle below items if you or a family member have a current diagnosis, or a history of any of the following conditions. List family member affected, (i.e. father, mother, brother, etc.).

	Self	Family Member
Alcohol/Substance Abuse/Dependence	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorder	yes/no	
Obsessive Compulsive Disorder	yes/no	
Schizophrenia	yes/no	
Bipolar Disorder	yes/no	
Suicide Attempts	yes/no	
ADHD	yes/no	
Other	yes/no	

Other significant medical, family or psychological history you would like your therapist to know:

_____

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Have you ever attempted suicide? Yes ☐ No ☐ If yes, when? _____

Do you currently have suicidal thoughts? Yes ☐ No ☐
Suicide & Crisis Hotline: (1-855-278-4204 or 911)

Has a family member attempted suicide? Yes ☐ No ☐ If yes, who _____

when?_____Was the suicide attempt completed? Yes ☐ No ☐

Do you now, or have you ever harmed yourself, such as cutting, scratching, burning, hitting? Yes ☐ No ☐ If yes,

in what manner? _____

Have you ever been hospitalized for psychologically related reasons? Yes ☐ No ☐ If yes, please explain when/where/why:

_____

_____

Reason you are seeking counseling today, include symptoms.

_____

_____

Date symptoms first began?_____How do you hope counseling will help?

_____

What have you tried to resolve the problem up to now? What has helped? What made it worse?

_____

_____

Is there anything else you feel it is important for your therapist to know?

_____

_____

_____

_____

_____

_____

_____

_____

How to did you hear about me? (Who referred you?):

☐ Friend/relative ☐ Court/Social Services ☐ Doctor/Therapist _____

☐ Internet ☐ Other/ Specify_____

Would you like a statement to submit to your insurance company (known as a Superbill)?

Yes ☐ No ☐