COUPLE’S INFORMATION

# 1. Partner Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 2 PartnerName: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:

Partners’ Address (if living separately please give both addresses): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phones: #1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work phone #1: Work Phone #2:

(OK to leave message? Yes No )

Partner #1: Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Partner #2: Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Email address: @ .com

Email address: @ .com

Partner #1: Social Security Number: xxx-xx-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner #2: Social Security Number: xxx-xx-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Status:  Married  Partnered

Ethnicities:

Who lives with you (including pets)?

Primary Physician’s name:

Primary Physician’s phone number:

Partner #1: Serious illnesses or hospitalizations and dates:

Partner #2: Serious illnesses or hospitalizations and dates:

Partner #1: Current medications:

mental health treatment:

#2: Current medications:

mental health treatment:

Prior Couple’s Therapy, with whom? Dates: YesNo

Why did you seek help at that time?

Current or prior substance abuse treatment or 12 step Recovery? If so please list dates and treatment provider:

Please describe what you hope to gain through counseling together at this time and any other information you think would be helpful for me to better know you:

RESPONSIBLE PARTY INFORMATION

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

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT

Emergency Contact (outside of your family): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

INSURANCE INFORMATION -

Primary Insurance name or EAP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Subscriber Name (name on card): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber ID Number or EAP authorization number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your insurance require pre-authorization? Y or N

Is there a deductible to be met at this time? Y or N Amount:

Is Copay required? Amount:

Assignment, Financial Agreement, and Signature Release

\*I, the undersigned, certify that I have insurance coverage with

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and assign directly to the therapist all insurance benefits,

if any, otherwise payable to me for the services rendered.

\*I understand that we are financially responsible for all charges whether or

not paid by insurance.

\*I hereby authorize the therapist, Laara Israhel, LMFT, or her representative,

to release all information necessary by mail, fax or telephone, to secure the

payment of benefits.

\*I understand that we are responsible for late cancellation/missed appointment fees, outstanding co-pays, deductibles, or other fees deemed client/member’s responsibilities.

I understand that therapist reserves the right to charge the patient or responsible party directly for missed appointments or those not cancelled 24 hours in advance and for returned checks. Missed appointments will be charged the billable amount. A returned check fee of $30.00 will be assessed for any checks that are returned due to non-sufficient funds.

I authorize the use of this signature on all insurance submissions.

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

Client Signature Date

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

Disclosure Statement & Agreement for Services

Introduction

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

Taking to first steps towards change can be challenging. You may find yourself admitting things to yourself that you have tried to successfully ignore. You may find that you experience stronger emotions than you have prior to commencing couples therapy. You should also experience a sense of hope and possibility of change for the better in the first few sessions. If this is not happening, please let Laara know, this is important information for the success of your couple’s therapy.

Laara has a Master’s degree in Education and a Bachelor’s degree in Dance Therapy. She has also completed Level 1, Level 2 and Level 3 with the Gottman Institute. She currently uses many of the methods of Gottman Therapy, Doubling as created by Dan Wile and Compassion Therapy. She believes, however, that her real education has come from a combination of experience as a parent, wife and life. Her professional experiences, education and training and her direct work with clients, have allowed for her to structure these experiences in a way that has been said to inform and assist clients in their relationships.

Areas of specialization: Advanced training in Gottman Method Couple’s Therapy, anxiety, depression, trauma recovery, women’s and men’s issues, grief and loss, life transitions, addiction/ addictive family recovery, 12 step recovery, body-based expression and job/career issues. I work with diverse cultures and populations.

Understanding Gottman Method Couple’s Therapy

Laara has complete 3 levels of Gottman training and uses their research based method to help couples increase their levels of trust, fun, intimacy and communication with an increased sense of well-being in their relationship.

Somethings you should know prior to your first session:

* Whenever possible sessions are a minimum of 1.5 hours. It is believed that extended sessions allow for greater progress.
* The Partners are the client and there is a no secrets policy signed by each partner
* There are certain steps involved in Gottman Method Couple’s Therapy:

1. Initial Couple interview, 1.5 to 2 hours.

2. Online assessment (a one-time fee of $29.00).

3. A feedback session where the therapist reviews the results of the Assessment and creates a treatment plan with the couple.

4. Therapy commences using the treatment goals as the structure.

THERAPEUTIC CONTRACT

Most people enter into a therapeutic relationship because something in their lives is not working and they have been unsuccessful and resolving it on their own. They seek help in the hopes of improving their lives for the better. My goal is to help you find ways to voice your needs and find ways of meeting them in a respectful, safe and caring manner.

Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on you part and may result in you experiencing considerable initial discomfort.

Change will sometimes be easy and swift, but more often it will be slow and frustrating. It took time to get here and it will probably take time to learn new behaviors.

Remembering and resolving significant life events in therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended. As part of my therapeutic process, I use several techniques including: Mindfulness, Somatic based healing, CBT, Solutions focused and Psychodynamic. I have advanced training in Gottman Method Couples Therapy and use this in my work with the couples I meet with.

Client's Rights •

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

1. You have the right to know the content of your records at any time and I have the right to provide you with the complete records or a summary of their content. I am required to keep appropriate records for 10 years. I keep brief records noting you were here, your reasons for the visit, the goals and progress made, diagnosis (for insurance purposes).
2. . If you ask me, I can release any part of your records on file to any person you specify. I will tell you when you make your request whether or not I think releasing that information to that agency or person might be harmful to you. If you are being seen as a couple, both partners must sign any releases.
3. Under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:
4. Revealing active child abuse or neglect. If an alleged perpetrator is in contact with minors and there is a reasonable suspicion that

he/she may still be abusing minors. Active physical, sexual, financial abuse or abandonment of a dependent adult or an elder is taking place.

1. If you threaten serious harm or death to yourself or another person, I am required to warn the intended victim and notify the appropriate law enforcement agencies to keep all parties safe.
2. If you are in therapy or are being tested by order of the court, the results of the treatment or tests ordered must be revealed to that court. I do not write any court documents or interface with the courts directly. I do not provide documentation in Workman’s Comp cases if you are being seen through your Employee Assistance Program (EAP).
3. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena.
4. If you are in a lawsuit claiming emotional harm, the opposing side may subpoena your therapy records.

4. You have the right to ask questions about any of the procedures used in the course of your therapy. Please do, I welcome questions at all times during therapy.

5. Should you choose not to enter therapy with me, I will provide you with names of other qualified professionals whose services you might prefer.

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

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

If any of these situations apply, I will send you a certified letter to your address of record to inform you of my decision and I will give you the names of several therapists for your future counseling needs.

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

Fees and Length of Therapy •

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

The fee charged for the first intake assessment is $200.00 and $175.00 for additional 1.5 therapeutic hour (80 minutes) sessions and $150.00 for 1 therapeutic hour (50 minutes). Health Plans contracted fees apply. Health plans, in general do not reimburse for one and one half hour sessions, the clients are responsible for the portion not covered by the health insurance.

I agree to pay $ .00.

EAP: The benefits and responsibilities of specific EAP’s apply. EAP does not reimburse for one and one half hour sessions, the additional portion is the client’s responsibility.

When an appointment is made, that time is reserved exclusively for you and your partner. If you need to cancel or reschedule an appointment, please do so 24 hours prior to the appointment, otherwise a late cancellation fee will be charged.

I agree to pay the standard fee of for each completed session, unless other agreements are made. I will make payment in cash or by check at the time of the therapy appointment, unless we have made other arrangements. I understand that the offices of Laara Israhel, LMFT bill my insurance as a courtesy and I am responsible for all therapy costs. I understand that I can leave therapy at any time and that I have no financial, legal, or moral obligation to complete the maximum number of sessions listed in this contract. I am contracting only to pay for completed therapy sessions, or session I miss without providing 24-hour notice.

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

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Printed Name: date: 20\_\_

Therapist's Signature: Laara Israhel, LMFT

Date: , 20\_\_.

Consent for Treatment

I, and authorize and request that Laara Israhel, LMFT, carry out treatment which now or during the course of my care as patients are advisable

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

Date Client's Signature

Date Client's Signature

Date Therapist's Signature Laara Israhel, LMFT

Office Policies

Payment for Service: Please notify me if any problem arises regarding your ability to make timely payment. Your fee may be paid by cash, check, or VENMO. All billing is is done as a courtesy to you. As the client you are responsible for all payments in a timely fashion.

Insurance Reimbursement: Your insurance company will be billed as a courtesy if I am an in-network provider. If I am an out of network provider and you wish, I will provide a superbill for you to submit to your insurance company. I do not bill for out of network services. Your personal health information and diagnosis is required for billing. Insurance information will be obtained prior to, or at first session to confirm eligibility and co-payment.

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

Office Hours: My office hours are by appointment, Wednesday thru Saturday. If you need to contact me between sessions, please leave a message and I will return your call, within 24 hours unless otherwise informed during the business week.

Telemental Health: There are occasions when clients prefer to do a session using the telephone or HIPAA compliant video software, this can be discussed at the time of need.

Telephone calls outside of session time, after 5 minutes will be charged, prorated, at your regular fee.

Emergency Procedure: An emergency is an unexpected event that requires immediate attention and can be a threat to your health. If an emergency situation arises, you will need to contact San Diego crisis line: 888-724-7240,

9-1-1, or go to a local emergency room. If it is not life threatening, please state this when you leave your message and I will return your call as soon as possible.. If I have not called you back within 60 minutes and the emergency persists, follow the instructions for crisis above.

I have read and understand these office policies.

Client's signature and printed name:

Client's signature and printed name:

Date:

Date: Signature: Laara Israhel LMFT #50309

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

Thank you for the privilege of working with you.