Lorna Hecht, MFT MFC35604

591 Camino De La Reina, Suite 918, San Diego, CA 92108

619-838-4551

lornahechtmft@gmail.com, lornahecht.com

CLIENT INTAKE (One Form To Be Completed by Each Client)

Date_____

Name_____

Birthdate_____Age_____

Address_____

City/State/Zip_____

Phone_____

E-Mail_____

Occupation_____

Spouse/Partner_____

Physician_____Phone#_____

Current Medications and Dosages including nonprescription

_____

_____

Date of last Medical Exam_____Results_____

_____

Dates of previous psychotherapy_____

Name(s) of Previous Therapist_____

How did you get my name?

_____

Person to be contacted in case of emergency:

Name: _____

Phone#:_____

THERAPEUTIC CONTRACT

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The Therapy Process: 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 your part and may result in your experiencing emotional discomfort. Change will sometimes be easy and swift, but it can also be slow and frustrating. Remembering and resolving significant life events in therapy can bring on 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. My theoretical perspective is Bowen Family Systems Theory. You can get more information about the work I do from my website and the internet.

Client's Rights: You have the right to a confidential relationship with me. Within certain legal limits (see below), 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. You have the right to ask questions about any of the procedures used in the course of your therapy. Should you choose not to continue therapy with me, I will provide you with the names of other qualified professionals whose services you may prefer.

You have the right to terminate therapy 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:

● When I believe therapy is no longer beneficial to you.

● When I believe that you would be better served by another professional.

● When you have not paid for the last two sessions with me, unless we have made special prior arrangements.

● When you have failed to show up for your last two therapy sessions without a 24- hour notice.

● 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 a new professional with information they request. If any of these situations apply, I will send a 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, Sheldon Zablow, M.D. will contact you to discuss what would be best for you at that time.

Confidentiality and Reporting: All information between client and therapist is held to be confidential with the following exceptions:

1. If the client has authorized a release of information by signed consent.

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2. If the client presents a threat of physical danger to him/herself or others, or child, elder adult, or dependent adult abuse is reasonably suspected, the appropriate authorities must be contacted.
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 a client is in a lawsuit claiming emotional harm, the opposing side may subpoena therapy records.
5. If a client is in therapy or is being tested by order of the court, the results of the treatment or test ordered must be revealed to that court.
6. For couples and families in therapy: If one member of the family or couple shares something with the therapist which is unknown to the other (s), it is acknowledged that such withheld information may radically undermine the potential of the therapeutic work. Therefore, it is up to the discretion of the therapist whether or not therapy can continue under such circumstances. It is, however, the philosophy of this therapist that it is not the responsibility of the therapist to disclose information that is best discussed directly between the involved family members.
7. From time to time, I will seek consultation from a peer or mentor about my cases. In that situation names are not used but some details may be disclosed for the purposes of maintaining a high level of client care.
8. Any record that contains information about more than one person will need written consent by all parties before release to a 3rd party.

CONSENT FOR TREATMENT

I_____ authorize and request that Lorna Hecht-Zablow, M.F.T. carry out psychotherapy and, diagnostic procedures, and/or treatment which now or during the course of my care as a client are advisable.

FINANCIAL AGREEMENT

Cancellation Policy: If I need to cancel or change an appointment I will give as much advance notice as possible. I agree to pay $65.00 for a missed appointment if, for any reason, I have not given at least 24 hours notice and understand that insurance cannot be billed for missed appointments.

Initials_____

I agree to pay for my sessions;

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Out of pocket_____Fee_____

By insurance_____
Copay_____

My payment is due in cash or by check at the beginning of each session. Mastercard and Visa are also accepted. I understand that I am contracting to pay only for completed therapy sessions, or sessions I miss without providing 24-hour notice.

Insurance Reimbursement: I agree to provide all relevant insurance information for insurance billing. I understand Lorna employs an outside bookkeeping service that handles all insurance claims. It is my responsibility to understand the terms of my insurance coverage. I am responsible for all treatment fees in the case that insurance does not reimburse in a timely manner or if the terms of reimbursement change unexpectedly. I am responsible for all deductibles and copayments.

(By signing this informed consent you agree to take financial responsibility for any time and effort that may result from my involvement in a legal case to which you are a party.)

OFFICE POLICIES

Session Length: Treatment sessions are 50 minutes or as otherwise mandated by my insurance provider.

Payment for Service: I agree to pay for services at the time they are rendered unless other arrangements have been made. I will notify Lorna if any problem arises regarding my ability to make timely payment.

Office Hours: If I need to reach me Lorna between sessions, I understand I can leave her a message by phone, email or text and my call will be returned as soon as Lorna is available.

Emergency Procedure: An emergency is an unexpected event that requires immediate attention and can be a threat to my health. If an urgent situation arises, I will state this when I leave my message for Lorna. She will return the call as soon as possible, but this is not meant for life threatening situations. If I am experiencing a life threatening emergency, I agree to call 911 immediately. I can also call my physician or admit myself to a hospital for observation.

I HAVE READ AND UNDERSTAND THE FINANCIAL AGREEMENT, CONSENT FOR TREATMENT, AND OFFICE POLICIES FORM.

Date_____

Client Signature_____