Creative Counseling Santa Barbara

LISA CONN AKONI, MA. MFT 44495
933 Castillo St, Santa Barbara CA 93101
(805) 714-4055

Consent to Treat Minor

Child's Name:_________________________________ **Gender**: _______ **Age**: ____ **DOB**: ___/___/___ **SS#**: _____-____-_______

Address:____ Zip Code:_________ Phone: ___________________

Ok to send mail? Yes No

Primary Care Doctor ____________________ **Date last seen** ______ **Psychiatrist** _______________ **Date last seen** __________

Please list any medications prescribed: ____

List any head injuries or major illnesses; past or present: ____

List any previous mental health diagnoses:____

School:____________________ Grade: ______ IEP or Special Education Accommodations? ________ GPA: _______

Father's Name: ___________________________ SS#: _____-____-_______ DOB ___/___/___ Phone____________ (OK to call Y/N)

Address or Write Same as Above:_________________________________ Zip Code:__________

Mother's Name: _______________________________ SS#: _____-____-_______ DOB ___/___/___

Address or Write Same as Above:_________________________________ Zip Code:__________ Phone ____________(OK to call Y/N)

Circle all that apply to child and family:

Divorce **Legal Separation** **Custody** **Guardianship** **Restraining Orders** **Current Litigation Issues** **Probation**

Any issues concerning Divorce, Custody, Guardianship, Probation and/or Restraining Orders will require all documents to be presented on first visit to verify any legal issues and/or custody of child. Copies of these documents will be kept with minor's records.

I, (print name) __________________________, am the mother/father/legal guardian (circle one) of _______________________________, and I authorize Lisa Conn, MFT to provide psychotherapy to said minor. I also agree to be legally responsible for any charges said minor may incur during therapy with Lisa Conn. _______ ***(initial here)***

Parent Signature: ___________________________________ **Date:** ___/___/___ ***(Must be signed for services to begin)***

Child/Teen Signature: ___________________________________ **Date:** ___/___/___ ***(Must be signed for services to begin).***

Witness Signature: _____________________________ ***Date:*** **:** ___/___/___ **Lisa Conn, MFT 44495**

In Case of Emergency Contact:

Name: _______________________________ Relationship: ______________________ Phone: _________________

Name: _______________________________ Relationship: ______________________ Phone: _________________

How did you hear about me?____

Therapeutic Contract

Lisa Conn Akoni, MFT 44495

Probable Length of Services: Although some clients elect to pursue long-term in depth treatment, many issues can be resolved within 12-24 sessions. Of course, the success of any treatment depends on the identified goals, ability, motivation, willingness and engagement of the person being treated. For this reason, I can make no guarantees about treatment length or success.

Risk of Services: As with any change in your life, you should be aware that outcomes of therapy can be unpredictable. However, it has been my experience that the overwhelming majority of engage clients improve their situations through therapy. Counseling is intended to induce change in your life, and when change occurs it may disrupt your accustomed manner of living and/or your relationships with others. You should also know that positive change takes work and you may be asked to try things that are challenging for you. Some individuals will reach their goals fairly quickly and without much discomfort; while others need additional time and feel more stress through the process. The experience of each individual is impossible to predict as each person has their own unique strengths and needs. Therapy can also provoke feelings of affection and/or conflict toward the therapist which, if needed, will be addressed in session.

My Therapeutic Approach: I believe each person already embodies the resiliency to get them through difficult times; I am here to help highlight and strengthen your skills and resiliencies so you can overcome any challenges you may be facing. I **"meet you where you are;"** meaning I take the lead from you regarding what goals you want to accomplish while in therapy and honor your level of comfort with the process. I utilize the following therapeutic approaches:

1. **Cognitive/DBT Therapy**: A collaborative approach where thoughts, beliefs and reactions are identified and any thoughts that are causing clients difficulty in their lives are explored and reframed.
2. **Behavioral Therapy**: Used to address dangerous or destructive behaviors (aggression, opposition, threats, running away, self-harm, eating disorders etc.) in children and teens or adults. This approach focuses directly on the behaviors and uses techniques such as emotion regulation skill building, role play, or in-the-moment coaching to decrease unwanted behaviors.
3. **Empowerment & Person-Centered Therapy**: Emphasizes the importance of a safe and positive relationship between therapist and client(s), and assists clients in identifying their choices, individual values, unique strengths/resiliencies and self-responsibility in their lives.

Your Rights: Treatment is entirely voluntary, and you have the right to terminate treatment at any time. I have the right to terminate therapy with you under the following conditions:

1. If I believe that therapy is no longer beneficial to you.
2. If I believe that you will be better served by another professional
3. If you have not paid for at least two sessions, unless special arrangements have been made
4. When you have failed to show up for two consecutive therapy sessions without a 24-hour notice
5. You are seeing another therapist, and participating in treatment with me would jeopardize our relationship and work with that therapist. *(If you are seeing another therapist I will require that you sign a consent form to release information so I can communicate with the other therapist).*

If for any reason our services terminate, I will provide you with the names of other qualified professionals.

Limits of Confidentiality: All information that you disclose to me within our sessions is confidential and will not be revealed to anyone without your written permission (or your parents' permission if you are under 18), except for the following reasons:

1. Where there is a reasonable suspicion of child abuse, dependent adult abuse or elder adult abuse.
2. If you reveal to me that an alleged perpetrator is in contact with minors and there is a reasonable suspicion that he or she may still be abusing minors.
3. Where there is a reasonable suspicion that you may present a danger of violence to others.
4. Where there is a reasonable suspicion that you are likely to harm yourself unless protective measures are taken.
   In all of the above cases, the psychotherapist is either allowed or required by law to break confidentiality in order to protect you, or someone you might endanger from harm.
5. I can release all or portions of your records to any person or entity you specify. I will inform you whether or not I think releasing that information to that agency or person might be harmful to you.
6. If a court of law issues a subpoena or an order, I am required by law to comply with the subpoena or order.

Records: Your clinical file will consist of (a) legal forms such as this document, (b) a record of visits and payments, and (c) clinical progress notes (these progress notes will contain enough information about your treatment to justify it, should such justification ever become an issue).

**You have the right to view your records at any time. I have the right to provide you with the complete records or a summary of their content.*

In all cases therapy never includes sexual contact or conduct between therapist and client!

Office Policies

Insurance: At this time, I do not accept or bill insurance

Cancellation or late arrival: Since an appointment reserves time specifically for you, a 24-hours' notice is required for rescheduling or canceling of an appointment. For any appointments that are missed or canceled without 24 hours' notice, outside of an agreed upon emergency, you will be charged a fee equal to our agreed upon session fee and you will be responsible for the bill. Additionally, if you are late, we will meet for whatever amount of your time remains and you will be charged for the full 50 minutes.

Telephone calls: You are welcome to leave messages at any time on my cell phone. If you need to speak with me regarding a therapeutic issue in between sessions you can leave a message on my confidential voicemail and we can determine if a brief phone consultation or scheduling another session is needed. If there is an urgent issue, I will call you back within 24 hours (please leave message briefly stating nature of call). Remember that, in general, telephone calls are not meant to take the place of an office visit; if you require extended time (15 minutes +) on the phone I will bill you for my time at a pro-rated fee equal to your regular session fee. In special circumstances, I am agreeable to providing treatment over the phone at the same hourly rate as we have agreed upon for your office visits.

Clean and Sober Policy: Therapy can only be effective with a willing and able client. Clients are expected to be able to participate meaningfully during our sessions. I assert the right to terminate any session if I believe that a client is under the influence or has used substances that impairs his/her ability to participate in treatment. If a session is terminated due to substance use, this is considered a no-show and the client will be charged a fee equal to your regular session fee.

E-mail: I discourage the use of e-mail with established clients but will occasionally use for special circumstances.

Text Messaging: Text messaging may be used for certain administrative situations such as canceling and scheduling an appointment and for some minor clinical issues. However, due to the risks to confidentiality and communication limitations, I discourage frequent or in depth use of texting for clinical issues.

Payment for Service: Sessions are **$175.00 for individual and $200.00 for family/couple** session (*per therapeutic hour-50 minutes*). If we go over the 50 min therapeutic hour, your fee will be prorated accordingly. **Initial session will require 1.5 - 2 hours for first session** and will be prorated accordingly. You are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify me ahead of time if any problem arises regarding your ability to make timely payment.

I accept cash, check, Venmo or PayPal *(see website https://www.creativecounselingsantabarbara.com/make-payment for PayPal payment).*

I, _________________________________ agree to be legally responsible for any charges that may occur for_____________________________
(please print name of responsible party) *(please print name of client)*
during psychotherapy with Lisa Conn. _______ ***(initial here)***

I understand that I, personally, will be billed for any missed or cancelled appointments (without 24-hour notice). _______ ***(initial here)***

_________________________________ ___/___/___
Responsible Payer Signature *Date*

Consent for Treatment: I ___________________________, authorize and request that Lisa Conn, MFT, carry out psychotherapeutic examinations, diagnostic procedures, and/or treatment for my minor child. I understand that the purpose of any procedure will be fully explained and be subject to my agreement.

I have read, understand and fully agree with the "Office Policies" and the "Therapeutic Contract".

_________________________________ ___/___/___
Parent signature *Date*

_________________________________ ___/___/___
Child/Teen signature *Date*

_________________________________ ___/___/___
Lisa Conn Akoni *Date*

In case of an emergency or you are at risk of harming yourself or others please contact the 24-Hour Access Line 1 (888) 868-1649, or call 911 immediately.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND SIGN THE LAST PAGE.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal law that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronic, on paper, or orally, are kept properly confidential. HIPAA gives you, the client, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

Each time you meet with your psychotherapist, a record is made which may contain your symptoms, diagnoses, treatment, a plan for future treatment, and billing-related information. Usually, less information is recorded if you are not using insurance to pay for treatment. This notice applies to all of the records of your care generated by Lisa Conn, MFT.

Psychotherapist Responsibilities: Lisa Conn, MFT is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. I am required to abide by the terms of this notice and notify you if I make changes to this notice, which may be at any time.

How I May Use and Disclose Medical Information About You:
Treatment: I may use and disclose medical information about you to provide, coordinate, and manage your treatment or services. I may disclose medical information about you to doctors, other therapists, or others who are involved in your treatment only with your written authorization. For example, if a referral is made to another health care provider. I may provide oral information and copies of various reports that should assist her or him in treating you.

Payment: I may use and disclose medical information about you in order to obtain reimbursement for services, to confirm insurance coverage, for billing or collection activities, and for utilization review. An example of this would be sending a bill for your sessions to your insurance company.

Health Care Operations: I may use and disclose, as needed, your health information in order to support my business activities, licensing, legal advice, and customer service. For example, I may call you by name in the waiting area. Additionally, there are other business professionals using the offices and you may encounter them upon arrival and departure from our sessions.

Other Uses and Disclosures: I may use and disclose your health information in an emergency situation to prevent harm to yourself or others. An example would be mandated reporting of abuse to children, the elderly, a disabled person, or when a judge orders the release of information. Only the minimum amount of information relevant to your health care will be disclosed.
I may create and distribute de-identified health information by removing all references to individually identifiable details.
I may contact you to provide appointment reminders, or to offer information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Your Rights: You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer (Lisa Conn, MFT):
1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to inspect and copy your protected health information.
3. The right to amend your protected health information.
4. The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint to me or with the federal government at the address below, about violations of the provisions of this notice or the policies and procedures of my practice. I will not retaliate against you for filing a complaint.

Department of Health & Human Services, Office of Civil Rights
200 Independence Avenue S.W. Washington, D.C. 20201.
1-877-696-6775 or (202) 619-0257

If you have any questions about this notice, please contact:
Lisa Conn, MFT.
(805) 714-4055
This notice is effective as of October 1st, 2016

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, ________________________________,
Print Name of Client or Parent/Guardian if minor

acknowledge that I have received a copy of the Notice of Privacy Practices for Lisa Conn Akoni, MFT.

_________________________	_________________________	__________
Print Name	Signature	Date

For Office Use Only

I attempted to obtain written acknowledgement of receipt of my Notice of Privacy Practices, but acknowledgement could not be obtained because:
Individual refused to sign.
Communications barriers prohibited obtaining the acknowledgement.
An emergency situation prevented me from obtaining acknowledgement.
Other (please specify)
____
____
____

This form will be retained in your medical record. This form is educational only, does not constitute legal advice, and covers only federal, not state, law.