

**Thea Brown**

**Sherman Oaks - Woodland Hills - Glendale**

**Contact: (424) 465-2762**

CLIENT REGISTRATION

First Name\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone Number\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it ok to leave a message? Y/N

Email Address\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist (If any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assigned (Legal) Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender Identity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sexual Orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Racial Identity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have kids? Y/N If so, how many? \_\_\_\_\_\_\_\_\_\_\_\_ What age (s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presenting Problem\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Therapy\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of first symptoms\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other pertinent drug/alcohol history? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly describe living situation\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Employment\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to contact in emergency\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of first office visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **I have been given a copy of an Informed Consent for Psychotherapy. I have been given the opportunity to have any and all questions answered relevant to my proposed psychotherapy. I understand that my participation in psychotherapy is strictly voluntary, and that it is my right to terminate treatment\*:**

 Initial Here\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **I agree to enter into a course of group therapy with Thea Brown, at a rate of $250 per month payable at the first meeting of every month\*:**

 Initial Here\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I understand that cancellations and re-scheduled sessions will be subject to a full charge if NOT RECEIVED AT LEAST 48 HOURS IN ADVANCE.

 I grant permission for case consultation with other professionals as long as standard care is exercised to protect my privacy and confidentiality. I understand that if I elect to use medical insurance benefits for these services my insurance company will be informed of a medical diagnosis and certain relevant aspects of my treatment, including procedure codes, and other standard pertinent history and prognosis information.

 I have been advised regarding the limits of above stated confidentiality and I agree that I will not authorize the execution of a subpoena for any purpose. I hereby authorize my therapist to resist subpoenas executed by any other person or persons in order to protect and insure my privacy and confidentiality.

 I have read and understand the information contained in the Client Information Sheet. I have been given the opportunity to have any and all questions answered relevant to my proposed psychotherapy.

 Client Signature\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL INFORMATION**

As an Associate Marriage and Family Therapist supervised by Silva Depanian, LMFT (MFC#1218644). I adhere to the legal and ethical standards set forth by the Board of Behavioral Sciences.

The therapeutic relationship is a mutual endeavor to which the therapist contributes knowledge and skill in psychology, and to which the client brings specialized personal knowledge and a commitment to work on their struggles. The goals of psychotherapy are both general and specific. General goals include promoting a greater self-awareness of the client’s feelings, motivations, behavior and interactions with others in their life. This awareness and understanding will hopefully promote clarification of personal goals, values and priorities and thus, enable them to cope with life tasks in a more directed and fulfilling manner. Specific goals in psychotherapy depend on the unique circumstances of each client.

The techniques utilized in the process of psychotherapy may include the disclosure by the client of deeply personal thoughts, feelings and experiences. The therapist may provide feedback to the client in order to generate insight and provide new coping skills. At times, the therapist may offer confrontation of certain beliefs, attitudes, or behaviors as a device that will allow the client to risk new behaviors beyond their present level of function.

Research supports the overall effectiveness of psychotherapy, but it is also clear that psychotherapy is not effective in all cases. Many factors seem to influence the effectiveness of psychotherapy, and counselors will continually monitor your progress and make adjustments as necessary. You can improve the effectiveness of your therapy by attending sessions regularly. It is also possible that changes brought about by your psychotherapy will be experienced by you or your family members as undesirable or uncomfortable, sometimes because change is uncomfortable in and of itself and sometimes because changes can upset a given family equilibrium. Any concerns in this regard should be discussed with your counselor.

 **Initials:** \_\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT FOR PSYCHOTHERAPY**

CLIENT INFORMATION SHEET

**Welcome to the Social Anxiety Group facilitated by Thea Brown, AMFT.**

In deciding to become a member of Thea Brown’s psychotherapy group for adults who experience social anxiety, I agree to be responsible for the following contract:

**Attendance**

• The first session is on a trial basis to determine whether this group will be a good fit for me.

• To come on time and stay for the entire session; in the event of necessary absence or lateness, to tell or notify the group in advance. Start time is 7:00 PM and ends at 8:30 PM, and runs weekly, unless the group decides otherwise. This group is ongoing, and allows for new members to join at any time.

**Confidentiality**

• To respect as confidential what goes on in the group. This means that in speaking of this group outside of the meeting room, I agree to do so in a way that protects the identity of other group members.

**Payments**

• To pay for each month’s meetings in advance at the beginning of each calendar month, and to pay for all sessions for the month, whether I attend or not.

• No insurance will be billed from the therapist’s behalf. If I want a superbill to turn into the insurance for possible reimbursement, I will request for one in advance so that I can be provided with the necessary paperwork.

**Termination**

• To inform group participants when I start considering the idea of termination.

• To leave enough time (usually 2 meetings) to say good-bye and allow for expression of my own and other group members’ feelings regarding my leaving.

**Group Process**

• To let other members affect me and be willing to talk openly and honestly about my reactions as I become aware of them.

• To use the group process to work actively on problems that brought me into therapy and/or to work on problems that are identified in the course of therapy.

• To use a fair share of the time. The group time is 90 minutes in length. When I share personal issues, I will try to be mindful of the time to allow others to share as well.

• To put thought and feelings into words, not actions.

• Mutual respect is essential to maintaining the safety of the group. It is okay to disagree with others, but it is not okay to treat members disrespectfully.

• To arrange for individual therapy sessions when an issue is not amenable to the group process.

*Some meetings will have an agenda including behavioral and cognitive work, however, ultimately it is for the group members to decide what to talk about, and part of therapy is to understand your contribution to the way the group develops.*

NOTICE TO CLIENTS

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

**ABOUT THE SOCIAL ANXIETY SUPPORT GROUP**

By participating in this group, you will learn about yourself and improve your interpersonal relationships. Feelings of anxiety in social situations will be addressed.

Group therapy provides an atmosphere where you come together with others to share problems or concerns, to better understand your own situation, and to learn from and with each other. This group therapy will ultimately provide room for change and growth.

**Some of the many benefits of participating in the Social Anxiety Support Group include:**

1. Learning to become more comfortable within a group setting and other feared social situations.

2. Having the opportunity to role play different feared social situations in a supportive and safe environment.

3. Learning that other people have similar problems, and understanding that you’re not alone in your anxiety.

4. Perceiving how group members react to different social situations and receiving valuable and honest feedback.

5. Having encouragement to challenge yourself at your own pace in social situations.

6. Working to express problems, feelings, ideas and reactions as freely and honestly as possible.

7. Experiencing feelings of encouragement through observation of others successes in feared social situations.

8. Confronting fears and phobias directly and testing out concerns about others’ perceptions, and taking advantage of the presence of others.

9. Creating an environment to practice newly learned skills within the group.

10. Learning through helping other members overcome their fears and being a support system for one another.

Initial Here\*: \_\_\_\_\_\_\_\_\_\_\_\_

**BILLING**

My fee is $250 per month and upon initial enrollment, a fee of $25 is required at the time of registration. All monthly fees are payable at the beginning of each month unless other arrangements are agreed upon in advance. A detailed invoice of charges can be obtained for the purpose of submitting to an insurance carrier or other third- party payer for reimbursement. There will be no fee for this service on current bills however an outstanding account may be charged a $5.00 service fee for each statement. Past due accounts may be additionally subjected to interest charges of 5% per month if a balance is neglected for more than 30 days. In the case of a third-party payer, the client is fully responsible for all charges not covered by insurance. If the balance is past due 90 days, it is subject to go to collections.

A $30 fee will be charged for any disputed charges. Cancellations and re-scheduled sessions will be subject to a full charge if NOT RECEIVED AT LEAST 48 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

Credit card payments can be made through IVY Labs app. This is a HIPAA compliant system that allows for you to update your credit card information into the app, and it will allow Thea Brown, AMFT, to charge your card on file following each session, and following sessions missed or canceled less than 24 hours of the scheduled appointment.

Please remember to cancel the intake appointment 48 hours in advance. You will be responsible for the entire fee if cancellation is less than 48 hours.

Initial Here\*: \_\_\_\_\_\_\_\_\_\_\_\_

# **Good Faith Estimate**

You have the right to receive a “Good Faith Estimate” explaining how much your medical and mental health care will cost.

Under the law, healthcare providers need to give patients who don’t have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services.

You can ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.

If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit [www.cms.gov/nosurprises.](http://www.cms.gov/nosurprises)

Initials: \_\_\_\_\_\_\_

**CONFIDENTIALITY**

The session content and all relevant materials to the client’s treatment will be strictly held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client-held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer
of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the
purpose of rendering an expert’s report to an attorney.
8. If a client involves a therapist in a conspiracy to commit a crime or a conspiracy to avoid detection from
prosecution.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate to not to engage in any lengthy discussions in public or outside of the therapy office.

Initial Here\*: \_\_\_\_\_\_\_\_\_\_\_\_

**CLINICAL SUPERVISION OF ASSOCIATES**

When I (the client) am working with one of the ACC team's Associate Marriage and Family Therapists, Associate Clinical Social Workers or Associate Professional Clinical Counselors, I understand that the Clinical Supervisor monitors the Associate's work through weekly supervision of cases, progress notes, and/or occasional audio/video recording of sessions. The clinical supervisor may sit in on a session to better understand a case. I (the client) will receive advanced notice when audio/video recordings, and sit-ins are planned, and I will always have the final say as to whether or not I agree to be observed. All viewers of the audio/video recorded file(s), including myself, are bound by the ethical standards of the American Psychological Association. The file(s) will be treated with confidentiality by being stored on a password protected computer and will be destroyed as soon as the Associates receive their licensure and are no longer in need of supervision hours. By signing below, I am stating that I have read and understood the informed consent for audio/video recording and that I am permitting the Avedian Counseling Center to audio/video record or attend our session(s) and review the audio/video file(s) with the aforementioned individuals for supervision purposes.

# Initials: \_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 nor your attorney(s), nor anyone else acting on your behalf will call on Anita Avedian to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

Initial Here\*: \_\_\_\_\_\_\_\_\_\_\_\_

**AVAILABILITY**

Therapists will be available via voicemail during standard business hours. Any more than one phone call that goes beyond 10 minutes in any one-week period will result in you being charged the per-minute fee which is based on your regular therapy session rate. If your therapist is on vacation or it is after business hours, and you are having an emergency, dial 911 or The Suicide Prevention Hotline (877) 727-4747, unless you have arranged for a back-up therapist to be available while your therapist is on vacation.

Initial Here\*: \_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL MEDIA POLICY**

*Friending-* Please do not send requests through any social media sites, including Facebook, LinkedIn, and Twitter. Therapists don’t accept friend or contact requests from clients, including former clients since it can compromise your confidentiality.

*Fanning-* You are welcome to view our Facebook Pages, however we do not encourage you to fan or like our pages since it could compromise client confidentiality.

*Following-* We don’t encourage you to follow us on Instagram or Twitter. In the case that you do, please note that we cannot follow you in return.

Should you have any questions regarding our social media policy, please ask your therapist, and they will clarify.

Initial Here\*: \_\_\_\_\_\_\_\_\_\_\_\_

**TERMINATION**

Our relationship is strictly voluntary and you may leave the psychotherapy relationship anytime you wish. However, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Initial Here\*: \_\_\_\_\_\_\_\_\_\_\_\_