Erika Cadenas, MA, LMFT 105596
30 E San Joaquin St Suite 102
Salinas, CA 93901
(831) 275-0786 eacadenasmft@gmail.com

Client Registration Form

Please Print Clearly Date:_____

Last Name: _____ First Name: _____ M.I._____

Age: _____ Date of Birth: _____/_____/_____ Gender: ____ Marital Status: _____

Insurance ID (if applicable):

_____

Address: _____

City:_____ State:_____ Zip:_____

Email: _____

Primary Phone: _____ check if is ok to leave a voice message/text

circle type: Home Cell Work Other _____

Alternate Phone:_____ check if is ok to leave a voice message/text

circle type: Home Cell Work Other _____

Occupation: _____ Employer: _____

School (if applicable)_____

Emergency Contact Information:

Name/relationship:_____ Phone #:_____

Primary Care Doctor:_____ Phone #: _____

Allergies:_____

_____

Medical concerns and medications taken/prescribing physician: _____

_____

Reason for seeking services today:_____

_____

_____

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Disclosure Statement, Policies, and Consent for Treatment

I am committed to providing the highest quality of counseling and psychotherapy services and honoring your rights as an informed client. In addition to your rights and responsibilities as a client receiving mental health services, there are some other important things you should know about participating in psychotherapy or professional counseling.

- Psychotherapeutic services will be provided by Erika Cadenas, Licensed Marriage and Family Therapist (LMFT)
- In addition to traditional talk therapy, I also incorporate evidence based techniques such as CBT, Solution-Focused, Art therapy, play therapy, and mindfulness techniques. We will collaboratively discuss whether these are appropriate for you based on your clinical needs.
- You have the right to ask any questions about your diagnosis and treatment, as well as about my background, education, training, and approach to therapy. You also have the right to end therapy when you feel you may no longer be benefitting or no longer be in need of it (something that we can collaboratively discuss.)
- Individual counseling sessions are approximately 50-55 minutes long in most cases.
- There are certain risks inherent in treating psycho-emotional or behavioral health problems. Potential effects, though rare and usually temporary, could include worsening of symptoms and increasing difficulty in relationships. For example, counseling may bring up feelings and thoughts that are uncomfortable or even painful. You have the right to stop the use of therapeutic techniques at any time, including taking a brief break. It is highly encouraged to maintain me informed if you are experiencing worsening of symptoms and/or distressing emotions or thoughts.
- The conversations you have with me are confidential. Information shared during psychotherapy treatment will not be disclosed without your written permission. There are certain exceptions to this rule. Legal and ethical requirements specify certain conditions in which it may be necessary for me to discuss information about your treatment with other professionals, care providers, domestic partners, law enforcement authorities or other institutions. If you have any questions about these exceptions to confidentiality, please feel free to discuss this with me before treatment begins or at any time during the therapeutic process. Such exclusions include but are not limited to the following:
    - Danger or threat of harm to yourself or another person
    - Suspected abuse or neglect of children, elders, or dependent adults
    - Receipt of a legitimate subpoena or court order

(Initial_____

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Policies, Expectations and Agreements

Rescheduling and Cancellation

A missed appointment is a loss to everyone. Please notify me of any need to cancel or reschedule your appointment ***at least 24 hours in advance.*** Please be advised, there is **a $25 dollar charge for two consecutive missed sessions without notification. (Initial_____)**

Timing

Please plan ahead for traffic and parking so that you arrive at your appointments on time. Every effort will be made to begin and end your appointments on time. However, due to the nature of psychotherapy, sometimes small delays are unavoidable. I will attempt to keep you informed if the start of your appointment will be delayed, but occasionally this is not possible.

Social Media Policy and use of Electronic Communication

Please note that I do not engage in social networking sites with current and former clients as it can blur the boundaries of treatment. Please note that content displayed on my professional website and social media pages is used solely for marketing, community building and educational purposes only. It is best to contact me directly if you have questions, comments or concerns. **(Initial_____)**

Please note that email and text messaging is not the primary source of communication. I will use text messaging and email with your verbal consent and limited to administrative purposes (i.e., confirming, canceling or rescheduling appointments.) Efforts will be made to protect confidential information. However, please be advised that electronic communication should not be assumed to be protected or remain private. Therefore, it is best practice to not use PHI (personal health information such as name, date of birth, etc.,) when using electronic communication. **(Initial_____)**

Ending Treatment/Final Session

You have the right to terminate treatment at any time. Hopefully, this will be by mutual agreement because your goals for therapy have been met. Sometimes, however, circumstances change and you may decide to end treatment for other reasons. It is advised and best practice that you have at least one final session after notifying me of your intention to stop treatment.

Fees and Payment

I will bill the designated insurance _____carrier, if applicable for services. You must notify me immediately of any change in your status for eligibility of services. Any portion of the fee for which you are responsible (i.e. co-pay) is due at the end of every session. Please note that while there may be an initial copay for billed services, it is not considered paid in full until it is processed by your insurance carrier. Any remaining portion not reimbursed by your insurance will be your responsibility. Fees may be paid in cash, check or visa/mastercard. Returned checks will be assessed a service charge of $15. Your co-pay per session is: $_____**(Initial: _____)**

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My signature below indicates that I have carefully read and understand the above disclosure, policies, and expectations, and I give my consent to participate in treatment according to the terms above.
If this treatment is for a minor child, my signature provides consent to have the child (named below) participate in treatment. It also indicates that I have the legal authority to provide this consent for the treatment of this minor. If another person must also legally agree to have the minor treated (as in certain cases of shared legal custody), I will notify my therapist immediately.

Printed name of client: _____ **Date of Birth**:_____

Client or representative's signature:_____**Date**:_____

Relationship to client (if signed by representative):_____

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Telehealth Informed Consent Form

California law has long recognized telehealth as a form of delivery of health care and behavioral health services which many psychotherapists are practicing in the state of CA and the U.S.
In California, "Telehealth" is defined as a method to deliver health care services using information and communication technologies to facilitate the diagnosis, consultation, treatment, and care management while the patient and provider are at two different sites. This form of service is usually live video conferencing through a personal computer with a webcam as well as communication via phone.
I_____(client's name) hereby consent to engaging in telehealth services with Erika Cadenas, LMFT as part of my psychotherapy. I understand that "telemedicine or telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California.

I understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any benefits to which I would otherwise be entitled.
(2) The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
(3) I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
In addition, I understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my

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efforts and the efforts of my psychotherapist, my condition may not be improved and in some cases may even get worse.

If you have an emergency, feel suicidal or homicidal please follow the following steps as necessary:

1. Call 911
2. Go to the nearest hospital
3. Call the National Suicide Prevention Lifeline at (800) 273-8255

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
(5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Signature of client (legal guardian/representative if applicable)_____

Date _____