Jamie Kohanyi, M.A., MFT

312 S. Cedros Ave Suite 334

Solana Beach, CA 92075 Ph (619) 518-3415

Psychotherapy Informed Consent

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 that you may have regarding its contents. At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

Risks and Benefits

Progress and success of therapy may vary depending upon the particular issues being addressed as well as many other factors. Therapy may involve some discomfort including recalling and discussing unpleasant feelings/experiences, and may evoke strong feelings of sadness, anger, fear, etc. Therapy may result in unintended outcomes such as personal or professional relationship change. During the therapy process, many people find that they feel worse before they feel better.

Therapeutic Relationship

Though you may form a close connection with your therapist, there is a difference between a personal and professional relationship. Your therapist will not engage in relationships separate and distinct from clinical care during or immediately thereafter the course of therapy which would cause harm to the relationship. Your therapist is committed to managing their own responses to the therapeutic process through a variety of means including but not limited to supervision groups, peer consultations, CAMFT recommendations, continuing education, research, reading, and personal therapy.

Records and Record-Keeping

This therapist will produce notes/records regarding your therapy. Should you request a copy of your records, such a request must be made in writing. Your therapist reserves the right, under California law, to provide you with a therapy summary in lieu of actual records. This therapist will keep your records for 7 years after termination of therapy at which time they will be destroyed in a manner preserving your confidentiality.

Fees and Insurance

The fee for service is $____ per 45 minute therapy session. Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure. Please inform your therapist if you wish to utilize health insurance to pay for services. If your therapist/provider is a contracted provider for your insurance company, your therapist/provider will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co- payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist/provider is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with your therapist. If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. Your therapist may correspond with you via email or text which may not be secure means and your signature below indicates that you are comfortable corresponding via these digital methods. If you participate in couples or family therapy, your therapist maintains a "no secrets" policy. This means that information about your treatment and/or information communicated privately to your therapist by one participant may not remain confidential and be disclosed to all parties involved in the therapeutic process. This is at the discretion of the therapist. There are other exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment.

Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist by voicemail and not by text message at least 24 hrs. in advance of your appointment. If you do not provide your therapist with at least 24 hours notice in advance, you are responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

Therapist Availability/Emergencies/Harm to Self

Your therapist makes every attempt to return calls or text messages within 24 working hours (8AM-6PM Monday through Friday). Therefore, if you leave a message on a Friday, you will not be called back until Monday. You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis: Crisis Hotline: (800) 479-3339 You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. By signing below, you agree in the the event of an emergency involving a threat to your safety or the safety of others, I will call 911 to request emergency assistance rather than engaging in self-injurious behavior.

Therapist Communications

Your therapist may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

____My therapist may call me at my home. My home phone number is: ( ) _____

____My therapist may call me on my cell phone. My cell phone number is: ( ) _____

____My therapist may call me at work. My work phone number is: ( ) _____

____My therapist may communicate with me by email. My email address is: _____

____My therapist may send a fax to me. My fax number is: ( ) _____

About the Therapy Process

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion. Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask your therapist to address any questions or concerns that you have about this information before you sign.

Release of Liability

By signing below, I state that I have voluntarily sought psychotherapy. I am under no obligation to accept or reject any of the counseling that I may receive from Jamie Kohanyi MA, MFT.

Furthermore, I release Jamie Kohanyi MA, MFT of any and all liability including: death, loss, damage, claims, actions or judgments of any kind which may arise in connection with the counseling which I have received or will receive.

I have read this disclaimer and release of liability and understand that I have executed it as my free and voluntary act.

_____

Name of Patient (or Legal Guardian)

_____

Signature of Patient (or Legal Guardian) **Date: ___/___/___**

Jamie Kohanyi MA, MFT
312 South Cedros Ave Suite 334
Solana Beach, CA 92075
6193842996

Basic Information:

Name: _____ Birth Date: ____ /____ /____ Gender: Male Female

Name of Parent/Legal Guardian if under 18: _____ Are there children under 18 in your home: Yes No

Marital Status:

Never Married Domestic Partnership Married Separated Divorced Widowed

Significant Other's Name: _____

Your Address: _____

Phone: _____ Email:_____

May I leave a message? Yes No May I email you? Yes No

Are you satisfied with your education and profession? Yes No Describe what you do:

_____

If you work with minors (under 18) or elderly (those over 65) please describe your duties:

_____

Provider Information: (Please attach a signed release of information for each provider)

Previous Therapist: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Dietitian: _____ Phone: _____

Therapy:

What brings you to therapy at this time?

How would you know therapy was effective?

Have you ever received a mental health diagnosis before? If so, what was it and do you agree with the diagnosis?

Health Information (Please attach your most recent bloodwork or lab results):

Check if you ever experienced any of these symptoms?

No Yes Chest pains/heart problems/palpitations
No Yes Osteoporosis/osteopina/bone fractures or pain
No Yes Dizziness/blackouts/fainting/weakness/fatigue/loss of consciousness
No Yes Chrohn's disease/Ulcerative colitis
No Yes Cold intolerance
No Yes Gastrointestinal problems (constipation, diarrhea, bleeding)
No Yes Swelling of hands, feet, cheeks, nodes, or glands
No Yes Diabetes
No Yes Thyroid condition
No Yes Dehydration/malnutrition
No Yes Missed or irregular menses
No Yes Insomnia/nightmares/sleepwalking/night terrors/difficulty falling/staying asleep
No Yes Chronic pain/fatigue/muscle tension
No Yes Sexually avoidant/inorgasmic/erectile dysfunction
No Yes Skin picking/hair pulling
No Yes Indigestion/diarrhea/constipation/nausea/gastrointestinal distress
No Yes Numbness/trembling/shaking
No Yes Weight gain/loss
No Yes Agitated/restless/hyperactive/impulsive

If you answer yes to any of the questions below, please give details in the area beneath:

Any hospitalization or residential/inpatient programs for medical/psychiatric reasons?

Any partial-hospitalization/intensive outpatient programs for medical/psychiatric reasons?

Diet and exercise:

Do you weigh yourself? No Yes
Your highest weight:____Age ____ Lowest weight:____Age ____ Desired weight: ____
Does stress lead to overeating? No Yes
Any vomiting after eating? No Yes
Do you use enemas, diuretics, diet pills or laxatives? No Yes
Do you need to exercise after eating certain foods? No Yes
Does stress lead to undereating? (ie eating half meals, skipping meals) No Yes
Do you engage in fasts, diets, or cleanses for health reasons? No Yes
Are you on a special diet (vegan, vegetarian, gluten-free, Paleo, etc)? No Yes
Describe your exercise habits:

Family History

In the section below, describe any family history of mental health issues/family dysfunction:

Mother	Daugher(s)
Father	Stepdaughter(s)
Stepfather	Son(s)
Stepmother	Stepson(s)
Sister(s)	Maternal Grandparent(s)
Brothers(s)	Paternal Grandparent(s)

Step/half-sister(s) Aunts/Uncles

Step/half-brother(s) Cousins

Substances:

Please list any prescription or OTC medication you take including herbs?

Substance	Quantity	Frequency	Year began	Last use

Have alcohol/cigarettes ever caused problems for you (even if it's just bothered those around you)?

No Yes

Have you ever tried to cut down on your drinking/cigarettes? No Yes

Indicate any street or prescription drugs used in an amount or way that wasn't prescribed:

Substance	Quantity	Frequency	Year began	Last use
Cocaine				
Cannabis				
Sedatives				
Hallucinogens				
Amphetamines				
Steroids				
Opiates				
Heroin				
Methadone				
Other:				

Safety:

When did you feel the safest and most comfortable in your life?

When did you feel the least safe and comfortable in your life?

Do you ever feel like harming or killing yourself? If, so how and when?

Do you ever feel like harming or killing another? If so, how and when?

Have you ever been involved in a lawsuit? If so, how and when?

Lifestyle: Please estimate of how many hours per week you spend doing the following each week:

Working in your primary job____

Parenting/Caretaking of others ____

Doing household chores, bills, etc ____

TV, Movies, Internet ____

Physical recreation or exercise of some kind ____

Hobbies (crafts, games, music, dancing, reading, etc) ____

Social activity with friends, family ____

Church, charity, spiritual or inspirational activities ____

Quiet, non-productive, or relaxing time ____

Sleep ____

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619.384.2996

Authorization for Two-Way Release of Information
[Please use one form for each provider including MDs, dietitians, psychiatrists, previous treatment, etc.]

Client Name: _____

Client Date of Birth: _____

Client Address: _____

Client Phone: _____

I, _____ authorize Jamie Kohanyi, M.A. MFT to receive and release information from or to the person, agency or facility named below, either verbally, in writing, or by electronic means:

Name: _____

Address:_____

Phone:_____

Fax:_____

Information to be released: _____

Are there any specific limitations on information to be released: (if so, please detail:)
_____

_____

Expiration of authorization: _____

Note: If no date is given this release will expire one year from the date signed.

I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to receive treatment or services from Jamie Kohanyi M.A., MFT and/or the other named person, facility or agency. However, lack of ability to share or obtain information may prevent Jamie Kohanyi M.A., MFT from providing appropriate and necessary care.

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present it to Jamie Kohanyi M.A., MFT. I understand that the revocation will not apply to information that has already been released pursuant to this authorization.

A copy of this authorization shall be considered as valid as the original.

_____ _____
Patient or Legal Guardian Signature Date:

Jamie Kohanyi M.A., MFT
312 South Cedros Avenue
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CREDIT CARD AUTHORIZATION FORM AND CANCELLATION POLICY

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time. This credit card will be charged for therapy sessions unless alternative payment has been presented at the time of services rendered or other arrangements have been made. In case of late cancellations, no shows for scheduled sessions, or if a check is returned unpaid, you will be charged the full session fee of $120. An additional $35 is assessed for returned checks.

I, _____, am authorizing Jamie Kohanyi M.A., MFT to use my credit card information to charge my credit card in the event that I do not notify her by voicemail (not text or email) at least 24 hours in advance of my inability to attend a scheduled therapy appointment or if a check is returned.

Card Type (circle one): Visa MasterCard AMEX

Card #:_____ Expiration Date:_____

Name as Printed on Card:_____

Verification/Security Code (3 digit code on back of card by signature line):_____

Billing Address:_____

City:_____ State: _____ Zip:_____

Signature:_____Date:_____

By signing below, I agree to the cancellation policy and am authorizing **Jamie Kohanyi M.A., MFT** to charge for scheduled appointments which will appear on my statement as Progressive Recovery Counseling Services.

Signature:_____ Date:_____