Lisa A. Jameson, LMFT
Licensed Marriage and Family Therapist
716 E. Main St. Suite B
Turlock, CA 95380
Tel (209) 667-5898

Patient Registration

Welcome to my psychotherapy practice! On the following pages is information you should be aware of before we begin. Feel free to download these forms and bring the completed copies to your initial session. I will also have copies of these necessary forms for you in my office if you forget or prefer to fill them out in my office. Please feel free to ask any questions you might have regarding these policies.

Today's Date_____

Name _____DOB_____

Name _____DOB_____

Address_____

_____

_____

Home Phone_____*

Cell Phone_____*

*On occasion I may need to leave a message for you at one of these numbers. Please let me know if this will pose a problem for you.

PLEASE NOTE: I DO NOT TEXT OR EMAIL WITH MY PATIENTS AS I AM NOT ASSURED OF CONFIDENTIALITY.

This form can be completed on the computer then print out and sign to bring to your first appointment. Firefox seems to have trouble with PDFs lately, so if you are having difficulty completing it, try opening in Chrome or Internet Explorer. Hit the "tab" key to move from one field to the next.

Lisa A. Jameson, LMFT
Licensed Marriage and Family Therapist, #MFC22983
716 E. Main St, Ste. B, Turlock, California 95380 (209) 667-5898

Welcome to my psychotherapy practice! Information regarding my services and policies is provided below for your information and agreement.

Name Date

Street Address Date of Birth

City, State, Zip Code

☐ Home Phone* ☐ Cell Phone*

*On occasion there may be reason to leave a message regarding our appointment(s). Please let me know which number you prefer I leave a message on by checking one box above

Informed Consent for Treatment:

I,_____, authorize and request that my (or my child's) therapist, Lisa A. Jameson, LMFT, provide psychological examination, assessment, diagnostic procedures and/or interventions that now or during the course of my (or my child's) treatment as a patient are advisable. The frequency and type of psychotherapy will be decided between my therapist and me.

_____

Signature

Lisa A. Jameson, LMFT
Licensed Marriage and Family Therapist
716 E. Main St., Ste. B
Turlock, CA 95380 Tel: (209) 667-5898

INFORMED CONSENT FOR TREATMENT

I, _____, authorize and request that my (or my child's) therapist, Lisa A. Jameson, LMFT, provide psychological examination, assessment, intervention and/or diagnostic procedures that now or during the course of my or my child's care as a patient are advisable. The frequency and type of assessment and treatment will be decided between my therapist and me.

I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

I understand that there is an expectation that my child or I will benefit from this assessment and/or interventions but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

CONFIDENTIALITY: All information disclosed within sessions, including that of minors, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:

- When there is reasonable suspicion of abuse to a child, dependent or elder adult.
- When the client or credible third person communicates a serious threat of bodily harm to others.
- When the therapist has a reasonable belief that the client may be a danger to him or herself, others or property of others.
- When disclosure is otherwise required by law.

I receive regular professional consultation. In such cases, neither your name or any identifying information about you is revealed.

EMERGENCY TREATMENT: If you have a life threatening emergency, please call 911. I am not able to provide 24 hour availability. I usually return calls within 24 hours or the next business day. When I am out of town or otherwise unavailable, a qualified professional will cover for me. My answering service will know who is covering for me. The phone number for my answering service is (209) 632-9935. This information is also available to you on my office voicemail message.

PAYMENT: Payment is due at the end of each session unless other arrangements are made with me. Please notify me if any problem arises during the course of your therapy regarding your ability to make timely payment. My fee is $130.00 per 50 minute session. I reserve the right to make periodic adjustments to this fee.

CANCELLED/MISSED APPOINTMENTS: A scheduled appointment means that time is reserved specifically for you. If an appointment is missed or cancelled with less than twenty-four (24) hours' notice, you will be billed for the full session according to your fee schedule.

DELINQUENT ACCOUNTS: If your account becomes delinquent (past 30 days) we may begin collection procedures. We will attempt to contact you directly. However, if your account remains delinquent we may utilize the services of an outside collection agency, we may retain an attorney, or small claims court action may be taken.

LITIGATION CHARGES: If I am required to attend a deposition, hearing or other legal proceeding in the capacity as your current or past therapist, you will be billed at $130.00 per hour for my time, including preparation and travel time as well as time I spend at the legal proceeding. If you are a current or past client, my testimony will not include any forensic opinions.

TELEPHONE CONTACT: Telephone calls exceeding 10 minutes will be billed on a pro rata basis based upon your 50 minute session fee. At your request and with your written authorization, I may communicate with people other than you. If any of these calls exceed 10 minutes, you will be billed on a pro rata basis based on your 50 minute session fee.

EMAIL/TEXTING: I am not set up to accept, review or respond to emails or texts from you or someone on your behalf. I am concerned about how to protect confidentiality in these forms of communication.

TERMINATION OF THERAPY SERVICES: I may terminate therapy services at my discretion. I may consider termination if:

- I do not believe that I can provide you with effective treatment
- Your needs are outside the scope of my experience or training
- You desire to terminate treatment or we mutually agree it is time to terminate treatment
- You fail to comply with my treatment recommendations
- A conflict of interest develops
- You fail to pay my fee on a timely basis
- You or I believe it is in your best interest

If either you or I decide it is time to terminate therapy services, I will recommend at least one closure session.

ADDRESS CHANGES: Please advise me if you change your address, or telephone number(s).

Please note: Each professional in the building I practice in is a sole practitioner. This is not a partnership, group practice or any other kind of business organization.

ACKNOWLEDGEMENT AND AGREEMENT FOR INFORMED CONSENT: I have read and fully understand this Consent for Treatment form.

Client/Parent/Guardian Name Client/Parent/Guardian Signature Date