Jenni Silberstein, PhD.
12401 Wilshire Blvd. #304
Los Angeles, CA 90025
(310) 922-4769

California License #35092

Client Registration

Client's Name _____ D.O.B: _____ Age: _____

Address: _____

Mother's Name: _____ D.O.B. _____ Age: _____

Address: _____

Father's Name: _____ D.O.B. _____ Age: _____

Address: _____

Mom's Cellular: _____ OK to leave a message? Yes o No o

Dad's Cellular: _____ OK to leave a message? Yes o No o

Home Phone: _____ OK to leave a message? Yes o No o

Work Phone _____ OK to leave a message? Yes o No o

Email address: _____

Client's social security number: _____

Parent's social security number _____

Parent's Employer (Insurance): _____

Insurance Company: _____ HMO o PPO o

Insurance ID Number: _____

Physician: _____ Phone Number: _____

Psychiatrist (if any): _____ Phone Number: _____

Presenting Problem: _____

Previous Therapy: _____ We love treating families at CCP! There is nothing more exciting then getting a whole family in the same room and assisting them with open communication and healthy coping strategies for both individual and family issues and group dynamics.

Briefly describe living situation: _____

Date of first symptoms: _____

What are the symptoms: _____

Current Medications: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about our services?

o Internet Search
o Psychology Today
o Good Therapy
o My Website
o Referred by _____ Phone _____
May we contact them to say thank you? o Yes o No
o Other _____

Initials _____

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I _____have been given a copy of Informed Consent for Psychotherapy. I have been given the opportunity to have any and all questions answered relevant to my/my child's proposed psychotherapy.

I agree to enter into a course of therapy with Dr. Jenni Silberstein, as of _____ (date) at a rate of $200 per 50 minutes payable at the time of services.

I understand that cancellations and re-scheduled sessions will be subject to a full charge if **NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE**.

I grant permission for case consult with other professionals as long as standard care is exercised to protect my privacy and confidentiality. 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 question answered relevant to my/my child's proposed psychotherapy.

_____ _____

Client/Parent/Guardian Signature Dr. Jenni Silberstein as witness

_____ Date _____Date

Initials _____

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INFORMED CONSENT FOR PSYCHOTHERAPY

CLIENT INFORMATION SHEET

General Information:

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 his/her own problems. 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 other persons in his/her life. This awareness and understanding will hopefully promote clarification of personal goals, values and priorities and thus, enable him/her 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 and as device that will allow the client to risk new behaviors beyond his/her 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 I 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 me.

Initials _____

Billing

My standard fee is $200 per 50 minute session unless otherwise agreed upon. A sliding fee scale may be used in setting the fee to accommodate clients with special needs who cannot pay the full fee. All fees are payable at the time of service 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 neglect 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 $10 service charge will be charged for any checks returned for any reason for special handling.

Cancellations and re-scheduled sessions will be subject to a full charge if notification is **NOT RECEIVED AT LEAST 24 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.

Fee Schedule

Time Frame Fee

50- minutes $200

75- minutes $275

100- minutes $400

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours. The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to increase the length of your sessions need to be discussed and scheduled in advance.

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 persons/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/herself 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 or fiduciary abuse.

5. Suspected neglect of the parties named in items # 3 & # 4 above.

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 with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Initials_____

Initials _____

Availability

I will be available via voicemail during standard business hours. Every effort is made to return all messages within 1 business day. If I am on vacation or it is after business hours and you are having an emergency, dial 911 or the Suicide Prevention Hotline (877) 727-4747 or go to your nearest emergency room unless we have arranged for a back-up therapist.

Initials_____

Media/Social Media Policy:

Telephone

I do not answer the phone when I am with a client. When I am unavailable, you are welcome to leave a message. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays, but sometimes it may take me up to 48 hours. It is helpful when leaving a message to indicate if you feel you need an immediate call back. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, please proceed as indicated above.

Initials_____

Email

You are welcome to email me at drjen@creativepsychology.com. You should be aware that all e-mails of clinical value will be printed and made part of your clinical file.

Initials_____

Text Message

I treat text messaging in the same way as email messages as indicated above and email as indicated above.

Initials _____

Initials _____

Issues that arise with Phone/Email/Cell Phone/Texting/Faxes

Consulting with clients exclusively over the phone or via e-mail rather than in person in the therapist's office brings up additional complexities and potential disadvantages to the therapeutic process. Treating clients exclusively via phone consultations or e-mails may put the therapist at a disadvantage because they cannot detect nonverbal cues, may not be able to accurately diagnose, may not always be aware of the resources available locally and may not be able to intervene as effectively as necessary in emergency situations. Acute crises and severe psychological disturbances, such as schizophrenia, bipolar or some types of personality disorders may not be effectively handled via phone, e-mail or other web-based communications.

Initials_____

It is very important to be aware that computers, e-mail, and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Faxes can easily be sent erroneously to the wrong address. e-mails, in particular are vulnerable to unauthorized access due to the fact that Internet servers may have unlimited and direct access to all e-mails that go through them. Additionally, my e-mails are not encrypted.

Initials_____

Please notify me if you decide to avoid or limit in any way the use of any or all communication devices, such as e-mail, cell-phone or Faxes.

Initials_____

If you communicate confidential or private information via e-mail, cell-phone or fax, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters via e-mail, cell-phone or fax.

Initials_____

Please DO NOT use e-mail, texting or Faxes for emergencies.

Initials_____

Initials____

Social Networking:

I do not accept friend requests from current or former clients on social networking sites. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise your privacy and confidentiality. For the same reason, I am requesting that clients do not communicate with me via any interactive or social networking web sites.

Initials_____

Termination:

Our relationship is strictly voluntary and you may leave the therapeutic 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.

Initials_____

About the psychotherapist:

As a consumer of mental health services you have a right to know about the qualifications of your therapist. I have a PhD in Depth Psychology, a Master's degree in Counseling Psychology, and a Master's degree in Professional Writing. I also hold a Pupil Personnel Services Credential providing me with specialized training in providing children's therapy in school settings. I have worked with a diverse population of parents, children and families for twenty years in a variety of settings including elementary, middle and high schools, women's centers, psychiatric hospitals, addictions centers and group practices and my own private practice,

Initials_____