Renee Emery, MSSW, LCSW
44817 Fern Avenue
Lancaster, CA 93534
661-622-3545

PROFESSIONAL DISCLOSURE STATEMENT

Qualifications:
I am a licensed clinical social worker with a background in mental health and chemical dependency treatment. I earned a Bachelor of Science degree in psychology from Texas A&M University and a Master of Science degree in social work from the University of Texas at Arlington. I am licensed by the California Board of Behavioral Sciences (LCSW #67039) and trained in providing individual and group therapy with adults. My experience includes work in a psychiatric hospital and in an outpatient mental health center. I also had a private practice in Fort Worth, Texas prior to moving to California. I have enjoyed the privilege of working with clients who have a wide range of personal and mental health issues including depression, anxiety, anger, suicidal thoughts, addictions, relationship problems, and difficulties in adjusting to life changes and stressors.

Nature of Counseling and Psychotherapy:
The terms counseling and psychotherapy are sometimes used interchangeably. Both involve a partnership between you and the therapist to make changes that improve the quality of your life and emotional health. Counseling is sometimes a short-term partnership to overcome a specific situation or symptom. Psychotherapy may be more long-term and focuses on gaining insight into patterns of feeling, thinking, and behaving that contribute to chronic life challenges or distress. I will use both terms to refer to our sessions since our work together will include elements of both counseling and psychotherapy that help you achieve the best personal outcomes.

If you've been struggling with life stressors or relationships, counseling can provide a safe outlet to talk about those concerns, learn new coping skills, and get a handle on any emotions that are weighing you down. By developing an understanding of the way thought processes, background issues, and temperament might contribute to your current feelings and behaviors, it is possible to gain a sense of control and make purposeful choices about how to live, thereby attaining greater life satisfaction. You may have a specific challenge you wish to conquer such as depression, anxiety, relationship conflict, or stress management. You and I will work together to develop goals that can help you overcome or resolve those challenges. Throughout your time in counseling, we will frequently evaluate progress made toward goals and adjust the focus of our sessions as needed.

Client Responsibilities
An important part of your therapy will be practicing new skills that you will learn in our sessions. I will ask you to practice outside our meetings, and we will work together to set up homework assignments for you. I might ask you to do exercises, keep records, or read to help you reach your goals. You will probably have to work on relationships in your life and make long-term efforts to get the best results. These are important parts of personal change. Change will sometimes be easy and quick, but sometimes it will be slow and frustrating, and you will need to keep trying. There are no instant, painless cures and no magic pills. With practice and patience, you can learn new ways of looking at your problems that will be very helpful for changing your feelings and reactions.

Psychotherapy Relationship
During the time we work together, we will meet weekly, or as scheduled, in sessions lasting approximately 50 minutes. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our sessions will concentrate exclusively on your goals and concerns. Our contact will be limited to the counseling sessions that you arrange with me except in the case of an emergency. This is part of my effort to maintain your privacy. If I see you in a public or social setting, I promise not to approach you. My behavior will not be a personal reaction to you, but a way to maintain the confidentiality of our relationship. If you choose to approach me to briefly say hello, we will not discuss the nature or our relationship or talk about any personal issues discussed during your sessions. I respect your privacy and will uphold your confidentiality.

Effects of Psychotherapy
At any time you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from the counseling process, specific results cannot be guaranteed. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and your understanding of yourself. Some of these life changes could be temporarily distressing while others may lead to improved satisfaction with daily life and relationships The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

Client Rights
Some clients need only a few counseling sessions to achieve their goals; others may require months or years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, although I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might not be helpful. I assure you that my services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know.

Appointments
Your session is reserved for you. In the event that you will be unable to keep an appointment, please notify my office at least 48 hours in advance so that someone else may utilize this time. A $30 no-show or late cancellation fee may be assessed to your account for any missed appointments. Clients who routinely miss appointments may be considered for discharge from counseling services after missing three appointments.

_____ **(initial to accept this policy)**

Referrals
I realize that I am not able to provide appropriate treatment for all of the concerns you may have. For this reason, you and/or I may believe that a referral is needed. In that case, I will provide you with some alternatives, including programs and/or people who may be able to assist you. A verbal exploration of alternatives to counseling will also be made available to you at your request. You will be responsible for contacting and evaluating those referrals and alternatives.

Availability Outside of Sessions
You may leave a confidential voice mail message at any time. I will return most calls within the same day. Our work together will be done in the therapy office rather than by phone. If you call with questions or concerns, we may speak briefly, and you will be encouraged to schedule an appointment if you have not already done so. Telephone calls lasting 10 minutes or more will be charged at a rate of $25 per 10 minutes. Please be aware that insurance will likely not cover this service so you will be responsible for any fees associated with telephone communication.

_____ **(initial to accept this policy)**

Electronic Communication
E-mail and text messages are an important part of daily life for many of us, but they are often not a secure way to communicate. To protect your privacy, please do not include any personal or detailed information about your situation in an e-mail or a text message. I cannot guarantee the security of any information transmitted via email or text, and I am not responsible for the confidentiality of information shared via those means. E-mail and texts are also not an alternative or supplement to your regular therapy appointments and I am unable to address therapy issues using those technologies.

_____ **(initial to accept this policy)**

Emergencies
If you have an emergency situation during office hours, please call first so you can receive as prompt attention as possible and allow me to adjust the day's schedule if possible. I offer 24-hour emergency phone coverage at 661-622-3545.
IN CASES WHERE YOU BELIEVE YOU ARE A DANGER TO YOURSELF OR OTHERS, PLEASE CALL 9-1-1 IMMEDIATELY.

Few experiences in life can be as enriching as the journey of self-discovery and personal transformation. My goal is to help you along your own path of progress as you become the person you desire to be.

By your signature below, you are indicating that you read and understood this statement, and that any questions you had about this statement were answered to your satisfaction. By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

Printed Name of Client	Signature of Client	Date

Signature of Counselor	Date

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

Payment for services rendered is the responsibility of the client. All fees are due at the time of service. I accept cash, checks, and all major credit cards**. If I am in-network with your insurance company, I will file claims for payment with them**. It is clearly understood by both the client and therapist that verification of benefits does not guarantee payment. If you are part of a plan that has a contract with this therapist, you will be responsible for paying any deductible and co-payment established by the contract. You are responsible for payment for any services not covered by your insurance.

If you choose not to use insurance and I am contracted with your insurance company, I will not file claims for payment with them. You agree that you will not request reimbursement from your insurance company at a later date after opting not to use your benefits.

If I am not contracted with your insurance carrier, you will be responsible for paying any and all counseling and service fees. If you have out-of-network benefits, your insurance company may reimburse you for your counseling visits. Upon request, I will provide you with detailed receipts for our sessions that can be submitted for reimbursement with your insurance carrier or to your flexible spending account manager. It is your responsibility to contact the insurance company to determine what forms or information is required.

Renee Emery, MSSW, LCSW makes no guarantees regarding insurance reimbursement eligibility or rates. Your insurance coverage is a contract between you and your insurance carrier. Rates of coverage and reimbursement for both in-network and out-of-network behavioral health services will vary by plan.

Services are billed at the following rates:

Evaluative Interview	60-80 minutes	$120.00
Individual Therapy	45-50 minutes	$95.00
Telephone Communication	each 10 minutes	$25.00
Document Preparation	up to 10 pages	$30.00

By your signature below, you are indicating that you have read and understood this statement, and that you agree to pay for all charges for behavioral health care provided by <u>Renee Emery, MSSW, LCSW</u>.

Printed Name of Client	Signature of Client	Date

Renee Emery, MSSW, LCSW
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NEW CLIENT INFORMATION			
Name (last, first, middle):	Preferred Name:	Date of Birth:	
Address:	City:	State:	Zip:
Home phone:	Is it okay to call and leave a message?	❑ Yes ❑ No	
Cell phone:	Is it okay to call and leave a message? Is it okay to text appointment reminders?	❑ Yes ❑ No ❑ Yes ❑ No	
E-mail:	Is it okay to email appointment reminders?	❑ Yes ❑ No	
Primary emergency contact name:	Relationship to you:	Phone number:	
Secondary emergency contact name:	Relationship to you:	Phone number:	

INSURANCE INFORMATION		
Insurance company:	ID Number:	Group Number:

POLICY HOLDER'S INFORMATION (Please complete if policy holder is someone other than the client.)			
Name (last, first, middle):	Date of birth:	Relationship to you:	
Home phone:	Cell phone:		
Address:	City:	State:	Zip:

HEALTHCARE PROVIDER INFORMATION	
Name of primary care physician or medical clinic: If you enter treatment with me, may I contact this provider to coordinate your care? ❑ Yes ❑ No If yes, initial here: _____	Phone:
Name of psychiatrist or other mental health provider: If you enter treatment with me, may I contact this provider to coordinate your care? ❑ Yes ❑ No If yes, initial here: _____	Phone:
Name of additional healthcare provider: Type of provider: If you enter treatment with me, may I contact this provider to coordinate your care? ❑ Yes ❑ No If yes, initial here: _____	Phone:

CONSENT FOR TREATMENT

I authorize and request that Renee Emery, MSSW, LCSW carry out psychological assessments, diagnostic procedures and/or treatments which, now or during the course of my care as a client, are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. Although the changes for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I also understand that, while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable.

Signed by client: _____ **Date:** _____

RECORDS AND CONFIDENTIALITY

All of our communication becomes part of the clinical record. Records are my physical property, but you have a right to the information within your record. Information transmitted electronically via fax, e-mail, and other means has the potential to be intercepted by individuals other than the intended recipient. If you request electronic transfer of information or if it is necessary to comply with the information requests listed below, please be aware of the potential risks to privacy. I will make every effort to protect the confidentially of your information and ensure that the information is only shared with intended parties.

All information between counselor and client is held in strict confidence by the counselor, **with the following exceptions**:

- You provide me with your consent to release information, by signature, as specified on the Release of Information Form.
- Information that must be provided to insurance companies and/or EAP entities as required for the payment of claims, certification/authorization or case management or other purposes related to the benefits of client's health plan.
- I have reasonable suspicion or you disclose that you present a physical danger or threat to yourself.
- An officer of a court of law legally requests information or you involve me in a lawsuit.
- I have reasonable suspicion or you disclose that you present a physical danger to others.
- Abuse or neglect of a child, elderly, or disabled person is suspected or disclosed.

Please note that in the last two cases, I am required by law to inform legal authorities so that protective measures can be taken.

I have read and understand the confidentiality and Notice of Privacy Practices policy statements provided to me by my counselor:

Signed by client: _____ **Date:** _____

PRESENTING CONCERNS

Please describe your reasons for seeking counseling at this time. Describe any current stressors and challenges.

GOALS AND EXPECTATIONS

List any goals you hope to accomplish by working with a therapist. What are your expectations for therapy?

MEDICAL AND LEGAL HISTORY

List any current or past medical conditions and health problems:

List prescription medications and over-the-counter medications you are currently taking (attach additional list if needed):

Name of medication	Dose	Frequency	Prescribed by

List any known allergies:

List any previous hospitalizations for medical or psychiatric reasons (attach additional list if needed):

Hospital	Month/Year	Reason

Do you have an advanced directive? ❑ Yes ❑ No **Do you have a living will?** ❑ Yes ❑ No

Have you in the past or do you currently misuse prescription drugs or use recreational drugs? ❑ Yes ❑ No

If yes, list **which drugs**, **how much**, and **how often** you use and the **date and time of last use**:

Do you drink alcohol? ❑ Yes ❑ No If yes: list **type of alcohol, how much**, and **how often** and the **date you last had a drink**:

Do you smoke cigarettes or use other tobacco? ❑ Yes ❑ No If yes, amount per day:

Do you drink coffee or soda? ❑ Yes ❑ No If yes, amount per day:

Have you ever been arrested? ❑ Yes ❑ No If yes, list reason (s):

Do you have court cases pending? ❑ Yes ❑ No **Are you currently on probation or parole?** ❑ Yes ❑ No

FAMILY AND RELATIONSHIP HISTORY

Relationship status: ❑ Single ❑ Married ❑ In a committed relationship ❑ Separated ❑ Divorced ❑ Widowed

If currently married or in a relationship, for how long? _____

How would you describe your relationship with your spouse or significant other? Please list any concerns and challenges.

_____

_____

_____

_____

If you have children, please list:

Name	Age	Biological/Step/Adopted	Lives with

Please describe any important medical conditions and mental health or emotional difficulties experienced by your spouse/significant other, parents, siblings, and children: _____

_____

_____

_____

_____

_____

_____

Please describe any family problems while you were growing up related to drug and alcohol abuse/physical abuse/sexual abuse/emotional abuse: _____

_____

_____

_____

_____

_____

_____

Please describe any close family relationships or friendships which are important in your daily life:

Name	Relationship	Ways this person is important to me and/or helps me cope with stress

MENTAL HEALTH HISTORY

Please check any of the following words that describe how you have been feeling lately:

❑ sad ❑ anxious/worried ❑ depressed ❑ fearful ❑ guilt ❑ empty/numb ❑ angry ❑ ashamed ❑ aggressive

❑ resentful ❑ worthless ❑ tearful ❑ irritable ❑ confused ❑ jealous ❑ hopeless ❑ helpless ❑ lonely ❑ tired

❑restless ❑on edge ❑tense ❑agitated ❑ other: _____

How long have you had these feelings? ❑ 1 week ❑ 2 weeks ❑ 1 month ❑ 3-6 months ❑ 1 year ❑ other: _____

Please check any of the following that describe what you have been experiencing lately:

❑ poor concentration ❑mind going blank ❑ low energy/fatigue ❑ indecisiveness ❑ poor decision making

❑ grieving/mourning a loss ❑ relationship problems ❑ risk taking ❑ memory problems ❑ mood swings

❑ panic/anxiety attacks ❑ lack of motivation ❑ low self-esteem ❑ isolation ❑ loss of interest in activities

❑ procrastination ❑ problems functioning at home ❑ health problems ❑ headaches ❑ chronic pain ❑muscle tension

❑ job concerns ❑ legal problems ❑ financial concerns ❑ major life changes ❑ obsessive thoughts

❑ compulsive behavior ❑ hearing or seeing things that others cannot see or hear ❑ other: _____

How long have you had these challenges? ❑ 1 week ❑ 2 weeks ❑ 1 month ❑ 3-6 months ❑ 1 year ❑ other: _____

Have you ever attended counseling and/or been in an intensive outpatient or partial hospitalization program? ❑ Yes ❑ No

Name of counselor or program	Month/Year	Reason for seeking treatment

Have you ever engaged in self-harm (cutting, burning, etc.) as a way to escape or manage emotional pain? ❑ Yes ❑ No

If yes, please provide more information, including dates: _____

Have you ever considered suicide in relation to any current or past struggles? ❑ Yes ❑ No

If yes, please provide more information, including dates: _____

Have you ever attempted suicide? ❑ Yes ❑ No

If yes, please provide more information, including dates: _____

Have you had any thoughts of harming others recently or in the past or acted violently toward anyone? ❑ Yes ❑ No

If yes, please provide more information, including dates: _____

Do you have any firearms in the home or have access to firearms? ❑ Yes ❑ No

DAILY LIFE EXPERIENCES

Describe your current living situation (who you live with, satisfaction with living environment, etc): _____

_____

About how many hours per night do you sleep? _____

Describe your sleep experience (check all that apply):

❑ Difficulty falling asleep ❑ Trouble staying asleep ❑ Wake up too early in the morning ❑ Vivid dreams ❑ Nightmares

❑ Sleeping more ❑ Sleeping less ❑ Unable to sleep ❑ Sleep well, but still feel tired ❑ No problems with sleep

How many meals do you usually eat per day? _____ **How many snacks do you usually eat per day?** _____

Describe your eating habits (check all that apply):

❑ I try to eat healthy foods. ❑ I eat junk food regularly. ❑ I eat fast food or dine out regularly. ❑ I sometimes skip meals.

Describe any recent change in eating habits and weight (check all that apply):

❑ Increased appetite ❑ Decreased appetite ❑ No appetite ❑ No changes

❑ Loss of_____pounds in the last _____months ❑ Gain of_____pounds in the last_____months

How often do you exercise? _____ **Describe any regular physical activity:** _____

_____

Please list any hobbies or leisure activities you engage in regularly: _____

_____

If you are currently employed, describe your work situation (job satisfaction, stress levels, working relationships, etc.):

_____

_____

_____

What was the last level of school you completed? _____

If you are currently a student, describe your current school situation (courses taking, stress level, work load, etc.):

_____

_____

_____

Are you currently in the military? ❑ Yes ❑ No **Have you served in the military in the past?** ❑ Yes ❑ No

If applicable: Branch of military: _____ **Type of discharge:** _____

Years of service: _____

Please describe any spiritual, religious, and cultural beliefs and practices which have a positive impact on your life:

_____

_____

How do you manage stress in your daily life: _____

_____

_____