Jennifer LaVancha. M.A.
Licensed Marriage and Family Therapist #140768
Phone: 407-718-3758
Email: Jennifer.familycounseling@gmail.com
www.JenniferLaVancha.com

Minor Counseling Application/Intake Form

Minor's Name _____Date of Birth_____
Address _____
City_____State_____Zip_____
Minor's Cell # _____Email _____
Parent(s)/Guardian(s) Name(s)_____
Home #_____Cell#_____
Email _____

Emergency Contact (Besides Parent/Guardian)
Name: _____Contact #_____
Relationship _____
Address_____

Adults with Whom Minor Lives with:
Name_____ Relationship_____
Name _____Relationship_____

Siblings/Minors with whom Minor live with:
Name_____ Age _____
Name _____Age _____
Name _____Age _____

JENNIFER LAVANCHA
FAMILY COUNSELING

Further Information:

Presenting Symptoms, Issues, or Concerns - *required*

Physical and Medical History, Current and Past Medications - *required*

Psychiatric, Mental Health History, and Hospitalizations - *required*

History of Self-Harm or Suicidal Thoughts or Attempts

Personal Spiritual/Faith Beliefs, if any

Anything else you would like me to know?

Goals for Counseling

I would like to receive a receipt after each appointment sent to the email listed above.
___ Yes ___ No

I would like to receive a copy of HIPAA practices and compliance.
___ Yes ___ No

I agree to the counseling fee of $150.00 per individual session.
(Please Initial) ___ Yes ___ No

I agree to the counseling fee of $175.00 per couple/family.
(Please Initial) ___ Yes ___ No

___ (Please Initial) I agree to the above statements that everything written is accurate.

Print Name_____

Signature _____**Date:** _____

Minor Confidentiality and Consent to Treat

Communications between therapists and clients 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, in the exercise of my professional judgment, I may discuss the treatment progress of a minor patient with the parent or caretaker. Minor clients and their parents are urged to discuss any questions or concerns that they have on this topic.

By signing this I give permission to Jennifer LaVancha, MA, Licensed Marriage and Family Therapist #140768 to provide treatment, which may include individual and/or family therapy for the minor. I also understand that I will be informed of the child's progress and/or if I feel the client is a danger to herself/himself or to others.

Parent/Guardian Signature **Date**

Signature of Minor **Date**

Jennifer LaVancha, M.A., LMFT #140768 **Date**
Macie Litchfield Counseling

Informed Consent

Disclosure Statement and Agreement for Services

Welcome!

Thank you for choosing Jennifer LaVancha as your Licensed Marriage and Family Therapist. I am looking forward to working with you! This document is intended to provide important information to you regarding your treatment, confidentiality, and your rights and responsibilities. Please read the entire document carefully and be sure to ask any questions you may have regarding its contents.

Information About Your Therapist

I am a Licensed Marriage and Family Therapist #140768. I graduated from Pepperdine University with a Master's degree in Counseling Psychology with an emphasis in Marriage and Family Therapy. I received my Bachelor's degree in Psychology with a Minor in Human and Family Development from Arizona State University. I first knew that I wanted to go into the helping profession at a young age. I grew up watching as my parents provided a loving home to children in the foster care system. My upbringing and life experiences have contributed to my interest in working with complicated family dynamics, at-risk youth, trust, relationship issues, and trauma survivors. I believe that every person has something valuable to offer the world that is uniquely theirs. It takes a tremendous amount of courage to reach out for help when life becomes too difficult. I want to join you during your heavy season by creating a space, just for you, to be heard and understood. My goal for treatment is to develop a safe and inviting space where clients can access tools, resources, and the support necessary to embrace their full potential. I consider myself a person-centered therapist; however, I've found that integrating elements from various approaches helps to customize treatment plans to my clients' needs. I utilize Cognitive Behavioral Therapy approaches, as well as elements of Existential and Narrative therapy. I am also trained in Brainspotting and use this therapeutic technique to help heal clients from their traumatic experiences. I am a wife, a mother of three children, and four fur babies. In my spare time, I love to read and journal while drinking a great cup of coffee. You might catch me bike riding, practicing yoga, and spending time with my family. I love to travel and be outdoors. I am originally from Central Florida, and I'm a huge Disney fan!

Notice To Clients

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Investments and Payments
Payments can be made at the time of session. Jennifer LaVancha offers sessions at:

<u>$150.00 for 50-minute Full Individual session</u>
<u>$175.00 for 50-minute Families/Couples</u>
I do not accept insurance at this time.

Sessions longer than 50 minutes provided outside of scheduled appointments (e.g., telephone conversations, email, correspondence, etc.) will be billed at the same hourly rate on a prorated basis. I currently accept cash, check, or credit cards which will be due at the time of your session. There is a $25 service fee for bounced checks, Services may be covered in full or in part by your health insurance or employee benefit plan. I will provide (by personal request) a receipt for services or a superbill that you can submit to your insurance company for reimbursement. **Please check with your insurance company to determine your benefits and reimbursement rates as these may vary.** If for some reason you find that you are unable to continue paying for therapy, please let me know. We can discuss the options available to you including possible reduced rates for services or referrals for low-income services.

Fee increases occur every January 1st and will increase between $5-$10 per year. Current clients will receive a 30-day written notice prior to the increase of session fees.

Good Faith Estimate Notice to Clients and Prospective Clients
Under the law, healthcare providers need to give clients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services. You can ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service, or at any time during treatment. If you receive a bill that is at least $400 more than your good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, or how to dispute a bill, see your Estimate, or visit https://www.cms.gov/no surprises.

Refund Policy:
It is my intention for you to be happy with your session. Payment is due at the time of session. No refunds will be given for sessions.

Scheduling Appointments:
Sessions are typically scheduled to occur one time per week. I may suggest more or less therapy depending on the nature and severity of your concerns. You can call or text me to schedule an appointment. Your consistent attendance contributes greatly to a successful outcome. I try to be attentive to my clients. Should you need to reach me between appointments, please contact via text or email. Text messages are used ONLY for discussion of scheduling. If you want to discuss something at length with me, I may request that we wait and discuss your question at our next appointment. Please come prepared to start and end your appointments on time.

Rescheduling:
In order to reschedule or cancel an appointment, you are expected to notify me at least 24 hours in advance of your appointment time. Please contact me at 407-718-3758. If I need to reschedule a session, I will contact you via phone or text at least 24 hours before our scheduled session.

Missed Appointment/Cancellation: Our time together is important. If you need to cancel your appointment, you need to do so at least 24 hours in advance of your scheduled time via text or email directly. If you do not contact me at least 24 hours in advance, this will be considered a missed appointment and will result in a no show/late cancellation fee equal to the fee of a full session.

Confidentiality
All communication between you and Jennifer LaVancha will be held in strict confidence and will not be disclosed to anyone unless:

1. The client authorizes a release of information with a signature
2. The therapist is court-ordered to release information
3. The client presents a danger to self or others
4. Child, elder or dependent abuse is suspected

<u>*Exceptions to Confidentiality*</u>
There are specific situations in which I am legally obligated to breach confidentiality in order to protect you or others from harm. As a mandated reporter when, if I have information that indicates that a child or elderly or disabled person is being abused, I must report that information to the appropriate state agencies. If a client is an imminent risk to himself/herself or makes threats of imminent violence against another person, I'm required by law to take protective actions. I must also take steps to prevent you from committing a criminal or fraudulent act. If

such a situation occurs in our relationship, I will make every effort to discuss it with you before taking any action.

Electronic Communication and Confidentiality
I am willing to maintain and contact you via text, email, or other electronic means, although I will not do therapy through these means alone. Sessions via phone and or desired video platform can be scheduled if therapist assesses that it is an appropriate format given the client's therapeutic needs/state of mind.

As you are no doubt aware, some means of communication, such as wireless telephones and email may not be secure from eavesdropping. It is impossible to guarantee the protection of confidential information in certain circumstances involving computers. This is particularly true of email and information stored on computers that are connected to the Internet. You acknowledge that I, the therapist cannot be held responsible for instances of confidentiality through wireless telephone or computer hacking.

Please initial here if you understand the risks of communicating with your therapist by electronic means and still wish to do so. Your initials indicate that you understand the risk, and consent to electronic communications with your therapist.

Crisis/Emergency Care
Please be aware that I do not offer 24-hour emergency care or crisis-intervention services. If you feel you are experiencing an emergency or if you feel unable to keep yourself safe, please reach out to 1) Placer County Behavioral Health Crisis Center for adults (24 Hours) - 1888-886-5401; Sacramento County Mental Health Crisis Line - 1888-881-4881; or 2) the National Suicide Hotline - 1800-273-TALK (text/call 988), or go to your Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call.

If you are NOT experiencing an emergent crisis however feel you need an additional or earlier appointment please text: 916-606-7061 to schedule.

Professional Advice
Jennifer LaVancha Counseling is not to be used in lieu of licensed professional advice. You agree to seek professional guidance for legal, medical, financial, business, religious, psychological or other matters as needed. You understand that all decisions in these areas are your sole responsibility. If either of us recognizes that you have a problem that would benefit from specialized psychotherapeutic intervention, I will refer you to appropriate resources. In some

situations, I may insist that you initiate specialized psychotherapy and that I have access to your psychotherapist as a condition of my continuing as your therapist.

Record Keeping

I will maintain in a secure location a clinical chart describing your therapy goals and progress, dates and fees for sessions, and notes describing each therapy session. Your records or any portion thereof will not be released without your written consent, except possibly in situations described above. You are entitled to receive a copy or summary of your records, and a request for records must be made in writing. I reserve the right, under California law, to provide you with a treatment summary in lieu of a copy of the actual records, if I believe that seeing the full record would be emotionally damaging to you. You will be charged a prorated portion of my hourly rate for time I spend preparing and reviewing information requests.

Risks and Benefits of Therapy

Participation in therapy can result in emotional discomfort and some clients temporarily feel worse before they improve. Specific therapeutic outcomes cannot be guaranteed. Some clients find that participating in psychotherapy results in changes they didn't expect at the outset. While there are some risks, many benefits are typically experienced as a result of therapy. It can be helpful to just know that someone is there for you, understands and cares, therapy can help clarify your understanding of yourself, your values and your goals, therapy can provide a fresh perspective on a difficult problem and point you in the right direction, and therapy can result in improved relationships, both with others and yourself.

You acknowledge that you take full responsibility for yourself and all decisions made before, during and after our work together.

Family Therapy

If I am seeing you for family therapy, I reserve the rights to use my own discretion and clinical judgment in disclosing information family members choose to share with me individually. I will use my best judgement as to whether, when, and to what extent I will make disclosures and will also, if appropriate, first give the individual the opportunity to make the disclosure himself or herself. I have a "no secrets" policy which states that I will not hold secrets disclosed by individuals within a family treatment unit from other family members also involved. This could gravely impact the results of your therapeutic treatment and goals.

Entire Agreement, Assignment, Survivability and Waiver:
This Agreement contains our entire agreement. This Agreement may be modified or amended at any time as long as the amendment is in writing and signed by both of us. You may not assign your rights or obligations under this Agreement to anyone else, and the obligations under this Agreement shall survive indefinitely unless otherwise stated in this Agreement. If I choose to waive or not enforce one or more terms of this Agreement, it does not in any way limit my right to later enforce every part of this Agreement.

By signing this Agreement, you both acknowledge that you have read, understand, agree to and accept all of the terms in this Agreement. Electronic signatures of this Agreement are permitted and enforceable. You agree that you have had the opportunity to ask me any questions prior to signing, and your signature indicates that you are in agreement with all of the terms of this Agreement.

Your signature indicates that you have read this agreement for services and understand its contents. Please ask any questions or discuss concerns you may have about this information before you sign.

Signature **Date**

Signature (if more than one client) **Date**

Jennifer LaVancha, M.A., LMFT #140768 **Date**
Jennifer LaVancha Counseling

Credit Card Agreement

Please note: New clients are required to keep a valid credit card number on file. Please complete the following information and provide your credit card to the therapist at your initial session.

CC Type: MC Visa Amex Other _____

Name as shown on card _____

CC Number _____

CC Expiration Date _____

3-digit security code on the back of the card _____

Billing Zip Code associated with the card _____

This card may be charged for:
__X__ Regular session fees (at your request, as convenience to you)
__X__ Fees for cancellation without __24__ hours notice.
__X__ Delinquent session fees (fees more than 30 days overdue)

"I _____ (print name) have read and understand the terms of providing my credit card to Jennifer LaVancha Counseling, Marriage and Family Therapist #140768. I understand that my credit card may be charged for the reasons indicated above. Any questions I have about this practice have been answered."

_____

Signature **Date**

Consent to Release Confidential Information

By signing this document, I, _____, Hereby authorize the exchange of information between Jennifer LaVancha, M.A., Licensed Marriage and Family Therapist #140768 with the following individuals:

_____	_____	_____
Name	Phone	Fax
_____	_____	_____
Name	Phone	Fax

I authorize the following information to be disclosed: (Please check all that apply)

_____ Verification of dates of service
_____ Progress Notes
_____ Treatment Plans (Including Diagnosis)
_____ Other: (_____)

Purpose: The reason I am authorizing this release is:

_____ My Request

_____ Other (please describe)

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of the signature unless a different date is specified: _____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

_____	_____
Signature of Client	Date
_____	_____
Signature of Parent/Guardian if Client is a Minor	Date