

Disclosure Statement and Nature of the Professional Therapeutic Relationship

Welcome to my practice. I have prepared this document so that you can be fully informed. Please read it carefully. Although it deals with difficult, anxiety provoking subjects, it is important that you consider it carefully. If you have any questions or concerns, please do not hesitate to raise them in the future.

Our first few sessions will involve an evaluation of your needs, my assessment of my abilities to meet those needs, as well as an opportunity for you to experience working with me. Therapy can involve a large commitment of time, money and energy, so it is wise to be very careful about the therapist you select. If you have questions about my procedures, training, or experience, we can discuss them whenever they arise throughout the course of therapy.

Since the length of treatment for different problems vary widely among individuals, I cannot give you exact information about the length of your treatment. However I will be happy to discuss your progress and its implications for treatment length at any time during the course of therapy.

Confidentiality Policy

Confidentiality is the cornerstone of the therapeutic relationship. Nothing will be discussed outside of our sessions except for the following if applicable:

1. If I have reason to believe that a child under the age of 18 or an adult over the age of 65 or dependent adult is suffering serious physical, sexual or emotional injury as a result of abuse or neglect. A mandatory exception to the confidentiality agreement states I must file a report with the appropriate governmental agency;
2. If I believe that you are threatening immediate harm to yourself, and you are unwilling or unable to follow my treatment recommendations. A permitted exception to the confidentiality agreement allows me to seek your involuntary admission to an appropriate hospital, or contact a family member or other person who can help protect you;
3. Thirdly, if you threaten physical violence against another person or their property. A mandatory exception (California Civil Code Section 43.92) to the confidentiality agreement states I take reasonable action to protect that person or their property. This can include notifying the potential victim, notifying the police, or seeking involuntary hospital admission;
4. If my records are court ordered by subpoena, I must surrender them.

In the rare event that these circumstances arise, although I am not required to inform you or seek your permission, it is my practice to discuss these matters as fully as possible with clients.

In the event we see each other outside the office, my policy is not to acknowledge you to preserve the confidential nature of the relationship. However, I do welcome you saying hello if you choose to.

I use two credit card processing services, PayPal and Square, Inc. My name along with my title will appear on your credit card statements should you use this form of payment. Please understand that may impact your confidentiality if others in your life have access to your financial records.

Confidentiality can be also be affected by using electronic communication between sessions for business issues such as rescheduling appointments, etc. I welcome the use of text and email messaging for this purpose and caution you to be aware that those messages may become intercepted electronically or read by others, breaking confidentiality.

Payment, Attendance and Cancellation Policies

All payments are to be paid at the time of service. For your convenience I can accept credit card payments through PayPal via my website or in Person using a Square, Inc. terminal. I suggest that clients work directly with their own health plans to receive reimbursement for “out of network providers”. Any missed sessions or late cancelations will be billed directly to you. I require a credit card on file for guarantee of payment in the case of missed sessions or late cancelations only.

Your fee has been set at: \$120.00 \$90.00 MediCal CPS VOC

Each session will be 50 minutes unless both parties deem an extended session of 90 minutes appropriate - found to be helpful in many couples or family sessions and all EMDR sessions. Additional fees are structured based on the following: extended sessions are prorated from agreed upon fee; record requests are prorated based upon agreed upon fee; requested professional (legal, medical, hospital) telephone or in person consultations are charged at \$200/hour including travel time; telephone sessions lasting longer than 10 minutes are billed at \$1.00/minute.

From time to time I will need to update my fees according to necessary costs, etc. I will notify you in writing in advance of any such fee change.

In order to avoid paying the full fee for a canceled session **I require notification within 24 hours** in the form of voice mail, text or email messages.

I will consider two (2) missed sessions without adequate notice to be a termination of services and will note it in the record and with the appropriate referral sources. Outstanding balances will be sent to collections if not paid.

Contacting Me

If I am unable to answer your contact, I will make every effort to return your message within 1 business day, unless it is an emergency. If you are difficult to reach, please leave some times when you will be available.

If I will be out of town or otherwise unavailable for an extended time, I will provide you with the name and number of a colleague whom you can contact for support if necessary. In the event of an emergency please consider the following numbers: Crisis Unit at Marin: 499-6666; Marin 24-hour Suicide Hotline: 499-1193; or 911.

Jodi Klugman-Rabb M.S., M.F.T. 40563
1036 Sir Francis Drake Boulevard, Kentfield, California 94904

Intake Information Sheet

Name: _____ Date: _____

Physical Address: _____ Mailing: _____
(if different)

Email Address: _____ @ _____

Home Telephone: _____ Cell Telephone: _____

Can a confidential message be left at these numbers? Home: **Y** **N** Cell: **Y** **N**

I Am: **Separated** **Divorced** **Widowed** **Single**
Married **Exclusive** **Living Together**

Name of Spouse or Partner: _____

For Clients Using Insurance: Out of Network Reimbursement

Account #: _____ ID #: _____
Date of Birth: _____ Copay: _____
Social Security #: _____ Plan: _____

<i>Children</i>	Name	Age	D.O.B.	Live with...

Your Occupation: _____

Psychotropic Medications: _____
& Dosage _____

I Was Referred By: _____ From: **CPS** **Probation** **Court**
Friend **Insurance** **Other**

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Credit Card Form

In order to guarantee payment, I require that a credit card be kept on file in the case of missed sessions or late cancellations only, in which case the card will be charged automatically. I am not able to charge insurance companies or third parties for missed sessions or late cancellations.

Card Information		Billable	
credit card number	expiration		
name on card	security code		
Signature	Date		

Jodi Klugman-Rabb, M.S., M.F.T. 40563
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(415) 652-7644

Educational/Occupational History

Highest Degree of Educational Attainment: _____

Major Focus: _____

Special Educational Needs: _____

				Date
Prior/Current Releases/Expulsions from Schools:	Middle School	Y	N	_____
	High School	Y	N	_____
	University	Y	N	_____

	Date
Prior/Current Releases from Jobs:	_____

Current Occupation: _____

Position Held: _____

Occupational Goals: _____

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Psychiatric History

Psychiatric Hospitalizations

Hospital	Diagnosis	Outcome

Day Treatments

Facility	Reason	Outcome

Current Medications: _____

Current Psychiatrist: _____

Address: _____
Street City, State Zip Code

Telephone: _____ Facsimile: _____

Email: _____

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Abuse History

	Current	Historical
Physical		
Sexual		
Emotional		
Verbal		
Domestic Violence		
Child		
Dependent Adult		

Medical Attention Necessary? Y N _____

Legal Action Taken? Y N _____