Jodi Klugman-Rabb, LMFT, LPC

Improving feelings, thoughts and behavior

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 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

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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 Square for online scheduling and to process credit card services. Payments can also be made with Venmo or PayPal (neither is confidential) in addition to cash or check. My name along with my title will appear on your financial statements should you use these forms of payment. Please understand that may impact confidentiality if others in your life have access to your financial records or settings are not set to *private*.

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 a mobile 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. Collections may be pursued if balances go unpaid for longer than 6 months.

My base fee is $175.00 for each 50-minute session, or $260 for 80 minute sessions. Additional services such as record requests, requested professional consultations (legal, medical, hospital) via telephone, email or in person are charged at $200/hour including travel time; telehealth sessions are billed at the base rate.

Fees are updated 10% annually on January 1st reflecting cost of living increases, etc. You will be notified in writing 30 days in advance of any such fee change. This document fulfills the The No Surprises Act of 2022 requiring statement of good faith estimates.

In order to avoid paying the full fee for a canceled session **I require notification within 48 hours** in the form of voice mail, text or email messages. Appointments are not considered canceled unless you have direct confirmation from me. Please take your financial responsibility seriously.

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.

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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 period of 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: 415-499-6666; Marin 24-hour Suicide Hotline: 415-499-1193; Napa Psychiatric Emergency Response 707-253-4711 or 911**.

In signing this document, I state that I understand and accept the obligations, which Jodi Klugman-Rabb must adhere to under the law as a licensed psychotherapist in the state of California. By signing this document, it indicates that I have read the information in this document and agree to abide by its terms during our professional relationship, and that I have received a copy.

_____ _____

Client's Signature Date Client's Signature Date

Jodi Klugman-Rabb

_____

Therapist's Signature Date

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.

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Jodi Klugman-Rabb, LMFT, LPC
Marin & Napa Counties

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*** ***Polyamorous/Lifestyle***

Name of Spouse or Partner: _____

Name and # of Emergency Contact: _____

Your Social Security Number: _____

Your Occupation: _____

Psychotropic Medications: _____ _____
& Dosage

_____ _____

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

Goals for Therapy: _____

_____

Children

Full Name	Age	D.O.B.	Foster Care	Live w/ Me	Adopted

For Clients Using Out of Network Insurance Benefits

Account #: _____ ID #: _____

Date of Birth: _____ Telephone: _____

Social Security #: _____ Plan: _____

Jodi Klugman-Rabb, LMFT

Treatment Goals

Circle all that apply

Reducie a fear
Have more pleasurable activities
Improve communications with my:
others *spouse* *Friends*
children *Coworkers*
Reduce uncomfortable thoughts
Express myself more assertively
Learn how to relax
Manage my health better
Tolerate my mistakes better
Tolerate other's mistakes better
Feel less guilty
Feel less depressed
Better accepting loss/death
Increase my conversational skills
Learn how I come across to others
Not take disappointments so hard
Doubt myself less
Think more positively
Improve my sexual relationship
Control my eating or weight
Control my alcolhol use
Change a habit
Control my drug use
Better manage my pain
Learn how to improve relationships
Be more positive
Learn effective parenting skills
Improve my sleep
Reduce sensitivity to criticism
Talk out a pending decision
Problem solving techniques
Reduce panic attacks
Increase self-esteem
Reduce family difficulties
Reduce job difficulties
Better manage my temper
Take initiative more often
Learn assertiveness skills
Decrease procrastination
Better manage my time
Derease perfectionism
Reduce emotionality
Allow myself to express feelings more
Feel more self-confidence
Discuss thoughts of self-harm
Discuss thoughts of harming others
Adjust better to past/recent issues
Improve self-awareness
Worry less

Other:

Please prioritize which top 3 you would like to address in treatment:

1 _____

2 _____

3 _____

Jodi Klugman-Rabb, LMFT, LPC

Marin & Napa Counties & via Teletherapy
415-652-7644 jodikrabb@gmail.com jkrabb.com

CONSENT TO USE TELETHERAPY OR TELEPHONE SESSIONS

There are many types of telehealth platforms. I use the HIPAA compliant Zoom platform for teletherapy for its security, video clarity and reliability. Telephone sessions are possible but not preferable. Please initial the following and sign below.

_____There are concerns about telehealth platforms. The primary concerns of telehealth sessions are confidentiality and privacy, HIPAA compliance, dropped calls, and other potential interruption(s) of communication due to technology issues. At the present time, there is no definitive evidence that telehealth meets HIPAA security requirements and BAA (Business Associate Agreement) is required. Although most telehealth programs are HIPAA compliant, using these platforms is a risk due to security breaches and this release informs you of that risk as well as releases TCTI from any associated liability.

_____The HITECH Act of 2011 added more ways to enforce HIPPA and added more regulations and penalties. These new regulations have added importance to the BAA. Several experts have cited HITECH Act to raise a concern that teletherapy programs don't always provide a protocol for trail audits or breach notification. Trail audits are a means of logging information to keep records. Breach notification relates to whenever data was accessed by unauthorized people or even an attempt to gain access to the session. Interactive technology platforms are supposed to notify the government when a breach or breach attempt occurs. However, not all platforms have or use the mechanism.

_____During a telehealth session, both locations (client and clinician) are considered a treatment room. Both parties need appropriate audio and visual equipment and privacy. Both parties will take precaution to maintain privacy and permission is required for either party to record the session. All HIPPA requirements apply to the session except when client consent (such as this consent) has been granted for a possible confidentiality breach or HIPPA violation: any platforms other than Zoom are considered not secure or HIPAA compliant, including Skype and FaceTime.

My initials above and signature below indicate that I have read the above description regarding the use of teletherapy. After reading the above, I agree to receive telehealth counseling and I understand the risks associated. I give my informed consent for the use of telehealth and I take FULL responsibility in the event of a breach of confidentiality or other telehealth-related concerns. I fully release Jodi Klugman-Rabb, LMFT from any liability associated with use of teletherapy.

Client Name (Printed): _____

Client Signature: _____ Date _____

Clinician Signature _____ Date _____

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Credit Card Form

In order to guarantee payment and book sessions, a credit card on file is required in the case of missed sessions or late cancelations only, in which case the card will be charged automatically.

Card Information		Billable
	exp	$
	expiration date	
credit card number		
	cvv	
	security code	
name on card		
		Zip Code
Signature	Date	

Jodi Klugman-Rabb, L MFT, LPC
Marin & Napa Counties

Psychiatric History

Psychiatric Hospitalizations

Hospital	Diagnosis	Outcome

Day Treatments

Facility	Reason	Outcome

Psychiatric Evaluation Completed? Y N By: _____

Current Meds & Dosage: _____ _____

_____ _____

Current Psychiatrist: _____

Address: _____
Street City, State Zip Code

Telephone: _____ Facsimile: _____

Email: _____ Release of Info? Y N

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Authorization for Release of Confidential Information and Professional Consultation (HIPAA)

By completing this form, you are authorizing the disclosure and/or use of individually identifiable health information, as outlined below, consistent with California and Federal law concerning the privacy of such information. All information requested must be provided for this authorization to be valid.

Client Name:_____
DOB:_____ authorizes Jodi Klugman-Rabb, LMFT, LPC to (circle all that apply):

- Release or disclose records and/or information to
- Obtain or use records and/or information from

  To:_____

  Telephone: _____ Email: _____

  Address:_____

Specific Information to be released/obtained:

- Third party payors (CFS, VOC) limited to billing & attendance
- Psychiatric treatment and/or records
- Prior or current therapeutic treatment and/or records

Please specify information to be excluded:

Your Rights:

- You may refuse to sign this Authorization; we can discuss how a refusal may negatively affect treatment.
- You may revoke this Authorization only by delivering your revocation in writing to me. Your revocation will be effective when I receive it. However, this revocation will not extend to the information that was already obtained or released prior to the revocation.
- You have the right to receive a copy of this Authorization.

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- You may inspect or obtain a copy of your mental health information, within the limits of California and
  federal laws.

- Neither treatment/payment will be conditioned on your providing or refusing to provide this authorization.
  Please note: If you have authorized the disclosure of your mental health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written consent as specifically permitted by law. This authorization shall become effective immediately and expire one year after initial authorization. A photocopy or facsimile of this form is to be considered as valid as the original.

Signature of Client(s) _____ Date _____

Signature of Therapist_Jodi Klugman Rabb_____ Date _____