Mari Mora, MA, LMFT

Individual / Child / EMDR Therapy

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Client Registration (General Information)

Client Name:_____DOB:_____ Age:_____ Today's Date:_____

Marital Status: S M D W Other:_____ Sex:_____

Current Status: ___Student ___Employed ___Unemployed ___Homemaker ___Retired ___Other

If student, Full Time or Part Time? FT PT School attended:_____

If employed, Full Time or Part Time? FT PT

Occupation/Place of Employment:_____

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Phone Number:_____ Alternative Phone:_____

If person filling out form is not client, check here: ___ Relationship to client:_____

Address & Contact Information

Home Address:_____ Apt/Suite:_____City:_____

State:_____ Zip:_____ Email Addres:_____

Home Phone: _____

Ok to call? YES NO Ok to leave message? YES NO Ok to text? YES NO

Cell Phone:_____

Ok to call? YES NO Ok to leave message? YES NO Ok to text? YES NO

Work Phone: _____

Ok to call? YES NO Ok to leave message? YES NO Ok to text? YES NO

Preferred phone? _____cell _____home _____work

Briefly describe your reason for seeking help:_____

_____

_____

_____

_____

Have you received any type of outpatient psychological assistance (counseling, therapy, etc.) in the past? YES_____ NO _____

Treating therapists name: _____

Focus of treatment:_____

_____

_____

Duration of Treatment:_____

Have you received inpatient care for emotional or alcohol/drug difficulties in the past?

YES_____ NO_____

Where:_____I

f yes, what was the reason for seeking assistance?_____

_____

_____

Describe any major changes in your life in the past two years: _____

_____

_____

Please circle any of the following areas in which you are having difficulty:

Depression	Anxiety	Shyness	Sexual Problems	Being a Parent
Boredom	Friends	Self-Control	Self Harm	Health
Suicidal Thoughts	Drug Use	Alcohol Use	Isolation	Stress
Divorce	Marriage	Dating Skills	Memory	Concentration
Chronic Pain	Headaches	Relationships	Mood Swings	Eating Problems
Sleep	Panic Attacks	Racism	Making Decisions	Irritability
Energy	Loneliness	Legal Matters	Digestive Problems	Perfectionism
Education	Social Skills	Self Esteem	Insomnia	Miscarriage
Unhappiness	Assertiveness	Nervousness	Career	Legal Matters
Infertility	Nightmares	PTSD	Family Conflict	

Other:_____

List all medication you are now taking. Prescriptions (including birth control pills) and nonprescription (such as aspirin, allergy medication, etc.)

Medication Dosage (amount & times per day) Reason

1. _____
2. _____
3. _____

Name of Physician: _____

Address: _____

Phone: _____ FAX: _____

Date of last visit: _____ Reason for Visit: _____

List any health problems: _____

_____

May I contact your doctor in order to consult? (Circle one) YES NO

If yes, please sign and date: _____ _____
(Signature) (Date)

Have you seen a psychiatrist? YES NO

Name of most recent psychiatrist: _____

Address: _____

Phone: _____ FAX: _____

Date of last visit: _____

Reason for Visit: _____

_____

_____

May I contact your psychiatrist in order to consult? (Circle one) YES NO

If yes, please sign and date: _____ _____
(Signature) (Date)

Do you smoke cigarettes (circle one): YES NO If yes, how much? _____

Do you smoke vape pens (circle one): YES NO If yes, how much? _____

Do you drink caffeinated drinks (coffee, tea, soda)? YES NO

If yes, how much? _____

Do you drink alcoholic beverages? (Circle one) YES NO

If yes, describe average intake: _____

How much time do you spend on phones/computers: _____

Do you exercise regularly? (Circle one) YES NO

If yes, please specify type of exercise: _____

List the people currently living in your home:

Name	Age	Relationship	Occupation

Who may I thank for this referral? _____

Informed Consent for Treatment

PLEASE READ CAREFULLY AND INITIAL THE FOLLOWING:

CONFIDENTIALITY

_____ Your communications with a therapist are confidential. The information you share in therapy will not be communicated to others without your consent except where disclosure is required by law. Disclosure may be required in the following circumstances: (1) Where there is reasonable suspicion of child or elder abuse; (2) Where there is a reasonable suspicion that the patient presents a danger of violence to others; or (3) where the patient is likely to harm him/ herself unless protective measures are taken. In such instances, the confidentiality does not prevail since for the therapist to do nothing would endanger the patient's life and/ or the welfare of another. (4) Disclosure may also be required pursuant to a legal proceeding though every effort will be taken to protect your confidential information.

_____In the event the therapist has an individual contact with a client (where more than one patient has already been seen together such as during family or couples therapy) and information is shared with the therapist that materially affects the treatment, this information may need to be with the other individual(s).

CONSENT FOR TREATMENT

_____I consent to the therapy that my therapist deems advisable or necessary in the treatment of my case. I understand the treatment planning and procedures are agreed upon mutually between the therapist and myself.

_____**CONSULTATION/ SUPERVISION:** Mari Mora, MA, LMFT often consults with other professionals regarding patients; however, patient names or other identifying information is never mentioned. The patient's identity remains anonymous, and confidentiality is fully maintained.

_____**THE PROCESS OF THERAPY/EVALUATION:** Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits; however, requires effort on your part. Psychotherapy *requires* your very active involvement, honest, and openness in order to change your thoughts, feelings and/or behavior. Mari Mora, MA, LMFT will ask for feedback and views on your therapy, its progress and other aspects of the therapy. She will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. Mari Mora, MA, LMFT may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which may cause you to feel very upset, angry, depressed, challenged or

disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. A decision viewed positively by one person can at times, be viewed negatively by another. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, Mari Mora, MA, LMFT is likely to draw on various psychological approaches according, in part, to the problem that is being treated and an assessment of what will best benefit you. These approaches include but are not limited to, behavioral, cognitive-behavioral, psychodynamic, existential, family systems, interpersonal & social rhythm, developmental (adult, child, family), or psycho-educational.

FINANCIAL AGREEMENT

_____I understand that the fee for service is $240.00 for Individual 45-minute session ($320 for one hour or family sessions). I agree to this fee and assume personal responsibility for full payment. I understand that payment is expected at the time of service. Any additional time, including phone calls (calls over 5 minutes), will be charged on a prorated basis. Please have payment ready at the beginning of our session. Thank You!

_____I agree to provide credit card information that can be used for payment in the event that I do not have an alternative payment source, miss a session or chose to use a credit card as a primary source of payment. (See attached Credit Card Authorization Form).

_____Any fees incurred by Mari Mora L FT from credit card companies, collection agencies or banks due to insufficient funds, payment disputes, or non-payment of fees will be passed along to the client. A $30.00 fee will be charged for any declined card or returned check.

_____CANCELLATIONS: The scheduling of a regular appointment involves the reservation of time specifically for you. Cancelled appointments made within **48 hours** prior to the start of your scheduled session will be assessed the full fee.

___ For Zoom sessions, Mari Mora LMFT will wait 15 minutes prior to logging off if I do not show. The full fee will be processed.

____I raise my therapy fee $15 once yearly to accommodate for inflation, advancements in my training, and increased business expenses

_____In the event litigation becomes necessary for the collection of fees owed, I agree to pay such costs in addition to the fees owed, including, but not limited to, the reasonable fees of an attorney.

_____Upon request, I will receive a billing form that I can use to submit to my insurance company for direct reimbursement.

_____I have received a copy of this consent for treatment.

____I agree that I am responsible for the charges for services provided by this therapist to me (or this client) although other persons or insurance companies may make payments on my (or this client's) account. By providing my signature below, I am authorizing Mari Mora to keep a copy of my credit card on file for use to comply with the policies referenced above.

I HAVE READ AND AGREE TO THE ABOVE POLICIES.

Printed name: _____

Signature: _____ Date: _____

Printed Name of Client (if you are not the client):_____

Teletherapy Informed Consent Form

1) "Teletherapy" includes consultation, treatment, emails, telephone conversations, and other medical information using interactive audio, video, or data communications. It's often known as "on-line counseling."

2) Teletherapy occurs in the state of California (USA), and is governed by the laws of that state. In a manner of speaking, I am using this modality to visit my therapist in their California office, where we meet to do our work.

3) The laws that protect the confidentiality of my medical information also apply to teletherapy. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. I will not include others in the session or have others in the room unless agreed upon.

4) I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

5) In the event our teletherapy is not in my best interests, my therapist will explain that to me and suggest some alternative options better suited to my needs.

6) I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I am responsible for information security on my computer. If I decide to keep copies of our e-mails or communication on my computer, it's up to me to keep that information secure.

7) While teletherapy is a great way to get help with many of life's problems, overwhelming or potentially dangerous challenges are best met with face-to-face professional support. I understand that our teletherapy is neither a universal substitute, nor the same as, face-to-face psychotherapy treatment. I accept the distinctions made using teletherapy vs. face-to-face psychotherapy.

8) Before commencing Teletherapy, I have thoroughly considered all of the above, I have obtained whatever additional input and/or professional advice I deemed necessary or appropriate to participating in Teletherapy. By my signature below, I hereby consent to receiving Teletherapy. My signature on this Acknowledgement and Consent is free from pressure or influence from any person or entity.

Patient Name_____ (Printed Clearly)

Patient Signature _____ Date:_____

Therapist's Signature _____ Date:_____

Credit Card on File Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting me. Please note, that I do not take patients on, or agree to continue therapy with existing patients, without having a card on file. This authorization will remain in effect until cancelled, and/ or until you are terminating treatment and have paid any money owed. This form will be securely stored in your clinical file and may be updated upon request at any time.

Credit Card Information
Card Type: □ MasterCard □ VISA □ Discover □ AMEX □ Other _____ Cardholder Name (as shown on card): _____ Card Number: _____ Expiration Date (mm/yy): _____ CVV (security code): _____ Cardholder ZIP Code (from credit card billing address): _____

Please Initial:

_____Charge for a 45-Minute Session is $240.00. Any additional time added to a session will be charged on a prorated basis. Phone calls longer than 5 minutes are charged on a prorated basis.

_____Until treatment is terminated, I give Mari Mora, MA, LMFT authorization to charge my credit card when another payment source is not provided to cover the cost of any treatment that has been provided. It is understood that at anytime I can revoke authorization for charges covering future sessions by contacting Mari Mora, MA, LMFT at (949) 229-5156.

____ The HIPAA complaint application, Ivy Pay, is used to process payment. I will provide a credit card on this app unless otherwise noted.

_____ _____

Cardholder's Signature Date