



Nicole Kahn, M.A., Ed.M, LMFT

INFORMED CONSENT

This Informed Consent Form is intended to provide sufficient information for you to make informed choices about entering and continuing therapeutic treatment. The specifics of the treatment goals and the steps to achieve these goals will be discussed at the first appointment. Your participation and understanding of the treatment goals is essential for the best benefit of therapy. If you ever have any questions about the nature of the treatment or anything else about psychotherapy, please do not hesitate to ask.

THERAPIST'S EDUCATION AND TRAINING

Your therapist, Nicole A. Kahn, M.A, Ed.M., L.M.F.T., is a Marriage and Family Therapist. She obtained her graduate degrees from Columbia University—one of the leading institutions in research, theoretical and clinical training in her field. She is a Clinical Member of CAMFT—the California Association for Marriage and Family Therapy—and a Licensed Marriage and Family Therapist in the State of California. A copy of her Curriculum Vitae, with more detailed education and training, is available upon request.

WHAT TO EXPECT – BENEFITS AND RISKS

There are benefits and risks in seeking individual, marital or family therapy. Some of the potential benefits of therapy include developing your ability to handle or cope with your relationships and providing you with greater insight into your personal goals and values. In working to achieve these benefits, however, you may address issues or make changes that you may experience as distressing. These risks of therapy include, but are not limited to: feelings or circumstances becoming worse before they get better; changes in your emotional state, such as feelings of depression or anxiety; the possibility of hallucinations or dissociations; changes in perception or behavior; and changes in occupational, social, or personal relationships.

THE USE OF SOMATIC EXPERIENCING®

When appropriate, and according to my clinical judgment, I will (or may) propose the use of Somatic Experiencing® (SE) in our work together. SE is a short-term naturalistic approach to the resolution and healing of trauma developed by Dr. Peter Levine and is supported by research. It is based upon the observation that wild prey animals, though threatened routinely, are rarely traumatized. Animals in the wild utilize innate mechanisms to regulate and discharge the high levels of energy arousal associated with defensive survival behaviors. These mechanisms provide animals with a built-in "immunity" to trauma that enables them to return to normal in the aftermath of highly "charged" life-threatening experiences. SE employs awareness of body sensation to help people "renegotiate" and heal rather than re-live or re-enact trauma. SE's guidance of the bodily "felt sense," allows the highly aroused survival energies to be safely experienced and gradually discharged. SE may employ touch in support of the renegotiation process. SE "titrates" experience (breaks down into small, incremental steps), rather than evoking catharsis - which can overwhelm the regulatory mechanisms of the organism. For more detailed information about SE, please request references from me.

SE can result in a number of benefits to you, such as relief of traumatic stress symptoms, increased resiliency, and resourcefulness. Like any other treatment it may also have unintended negative side effects, such as sleep disturbances, frightening memories, or unfamiliar and uncomfortable body sensations. Such reactions are not uncommon and can be attended to in the course of our work together. It is important you are aware that there are other forms of body-oriented and somatic psychotherapy modalities that may also be helpful to you, such as EMDR, Sensorimotor Psychotherapy, or Bodydynamics. Obviously, there are also many non-somatic focused forms of psychotherapy and counseling that you can choose from. My own education and training in SE includes becoming a certified SE practitioner. It is your responsibility to tell me when you are uncomfortable with any parts of the treatment. If you have any questions about SE or other treatments, please ask and I will do my best to answer your questions in full. You have the right to refuse or terminate treatment at all times, or to refuse touch, SE techniques, or any other intervention I may propose or employ.

RIGHTS OF CONFIDENTIALITY

Your therapist pledges to uphold privacy and confidentiality concerning your treatment process and records as outlined by California Statute. Nicole will do everything within her power to protect the physical records of treatment and the information contained therein, including safeguarding their use, transportation and storage. It is understood that all information between client and therapist is held strictly confidential, and the therapist will not release any information about therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State Laws.
2. The client presents an imminent danger to self.
3. The client presents an imminent danger to others.
4. Child/Elder abuse/neglect is suspected.
5. As necessary for continuity of care.
6. If a judge determines that our discussions are not confidential, a judge may request specific information.
7. As requested by a court appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3, and #4, the therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If I participate in group counseling, I agree not to discuss any details of the group outside of the counseling sessions.

PATIENT CONSENT TO RELEASE OF INFORMATION

I consent to information release about my case (or my child's case) with the referral source and appropriate Wellness Kliniek practitioners with whom I am currently receiving services for the purposes of treatment. Where applicable, I further consent to the release of information to my health plan for claims, certification/case management/quality improvement and other health plan purposes.

GENERAL CONSENT FOR TREATMENT

I further authorize and request that my therapist carry out treatment that now or during the course of my care as a client are advisable. I understand that the purpose of these treatment practices will be explained to me upon my request and are subject to my agreement.

GENERAL CONSENT FOR TREATMENT (If client is a child or dependent)

On the patient's behalf, I (the legal Guardian or Legal Representative) legally authorize Nicole Kahn to deliver mental health care services to the client. I also understand that all policies in this statement apply to the client I represent. I acknowledge that my child's records are considered confidential except in the above stated exceptions.

RIGHTS OF CONFIDENTIALITY (continued from above)

STANDARD USES AND DISCLOSURES

Generally, your health information may be used and disclosed during the normal course of providing and receiving payment for your care. Your voluntary agreement to seek treatment provides this permission by law. These standard uses and disclosures include: 1) therapist's consultation with peer professionals, supervisors, attorneys, accountants, etc. (identifying information is not disclosed); 2) information about the cost of care and maintenance of treatment required by third-party payers (e.g., Insurance/Managed Care companies, State agencies, etc.); 3) completion of necessary billing, banking, and collection activities; 4) data collection, research and information for monitoring Managed Care providers by State agencies or to satisfy reporting requirements; 5) phone calls, voice messages, facsimile transmissions, written correspondence, and mailings sent to the addresses and phone numbers provided, unless specific alternate instructions are given; and 6) disclosures made during the course of therapy involving a client's partner, family, or other third parties, in which statements made in individual or group sessions may, of necessity or inadvertently, be repeated to others, unless the handling of that disclosure was previously and clearly agreed upon with your therapist. Your signature represents your understanding and consent to these standard uses and disclosures of your health information to provide and receive payment for your care.

USES AND DISCLOSURES WITH AUTHORIZATION

For uses and disclosures of your health information other than during the normal course of business operations and providing treatment, your therapist is required to have your written authorization, unless the use or disclosure falls within one of the exceptions described on page 1. If you request or are asked to provide written authorization for the release of any information regarding your treatment or records, you must submit a written, signed, and dated request for release specifying the content or material to be released, to whom, and the purpose of the release. Your therapist can provide an Exchange of Information form to sign. You may specify or limit the scope of information to be released at any time, and it will expire one year, if not otherwise specified, from the date of your signature.

Your signed consent may be required for the release of diagnostic and treatment information to any third-party payers. Any information included in your records from another source (e.g., physician, therapist, family member, etc.) will not be released without a signed authorization from that source.

You may revoke an authorization, in writing, at any time. If you do wish to revoke an authorization, your written revocation must include the date of the authorization, the name of the person/organization authorized to receive the information, your signature, and the date of the revocation.

RIGHTS REGARDING YOUR HEALTH INFORMATION

You have several rights regarding your health information: 1) You have the right to request, in writing, how you would like your therapist to restrict the uses and disclosures of your healthcare information. Your therapist will consider this request, but is not legally bound to agree to the restriction. 2) You have the right to ask, in writing, that your therapist contact or send you information at an alternate address or by an alternate means, such as contacting you only at work. You may specify how you prefer your therapist contact you when you fill out the Intake form at the beginning of therapy. Your therapist will agree to this request as long as it is reasonable to do so. 3) You are generally entitled to inspect and copy your records; however, your therapist is permitted by law to withhold all or any portion of your records a) in order to permit her to freely record diagnostic and therapeutic information regarding your treatment, or b) if she believes with reasonable certainty and in her professional judgment that seeing these records may be detrimental to your physical or mental health. You will be responsible for any costs associated with copying, mailing, and time incurred by your therapist in responding to your request to inspect or copy your records. Prior to their release, your therapist may require, at her discretion, a 50-minute session or longer to review your records with you, to be charged at the current rate. Your therapist is required by law to retain possession of treatment records for a minimum of seven (7) years. 4) If you believe there is a mistake or missing information in the record of your health information, you may request, in writing, that your therapist correct or add to the record. Your therapist may deny your request for an amendment under certain conditions outlined in the Notice of Privacy Practices. 5) You have a right to request, in writing, an accounting of disclosures—a list of what disclosures have been made of your health information—other than instances of disclosure for national security purposes; for treatment, payment or operations purposes; to law enforcement officials or correctional facilities; or for which you have given your written authorization.

