

Nicole Kahn, M.A., Ed.M., LMFT, CIT, SEP
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 Licensed Marriage and Family Therapist, a Certified Imago Relationship Therapist and a certified Somatic Experiencing Practitioner. She obtained her graduate degrees from Columbia University—one of the leading institutions in research, theoretical and clinical training in her field. She is currently a Clinical Member of CAMFT—the California Association for Marriage and Family Therapy. 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 and a certified SE Touch 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

I pledge to uphold privacy and confidentiality concerning your treatment process and records as outlined by California Statute. I will do everything within my 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.**

HELP FOR EMERGENCIES

If you feel you need to reach your therapist urgently, you should leave a message specifically stating that it is urgent. Your therapist will do her best to return your call promptly; however, in the event that she is unable to call or see you as soon as you need, you may choose to contact an alternate source of support, including calling 911 or the following 24-hour Crisis Line: (800) 479-3339, United Behavioral Health.

SESSION FEES

The fee for a 50-minute individual therapy session is \$125 and the fee for a 75-minute couple session is \$190, payable to Nicole Kahn. Therapeutic services delivered over the phone are subject to the same hourly rate as regular sessions and will be billed on a pro-rated basis. Fees are re-evaluated and subject to change every six months. Nicole Kahn is determined to provide psychotherapy to those for whom these fees are out of reach. Please discuss any financial concerns you may have with Nicole during the initial consultation.

PAYMENT POLICY

Payment in full is expected at the time of service, unless alternate arrangements are mutually agreed upon. Payment is accepted in the form of cash or check only. When making payment by check, please have your check written before the start of the session, whenever possible. All checks returned for non-sufficient funds (NSF) are subject to a \$20 returned check fee.

CANCELLATION POLICY

You are required to give notice of cancellation at least 24 hours prior to a scheduled appointment. If you do not give 24-hour notice or fail to show for a scheduled appointment without prior notification, you will be charged the full session fee. Exceptions can be made in the event of an emergency; however, you are asked to call as soon as possible to inform me of the circumstances. I will provide an appointment card so you can verify the times and dates, unless the appointment is made over the phone or you decline to receive one.

ACCEPTANCE OF POLICIES

I, Nicole Kahn, have attempted to answer your questions about treatment satisfactorily. If you have further questions or concerns, I will do my best to answer them or find answers for you. Your signature represents a statement that you have read and understood the information above and as outlined by me, Nicole Kahn, have received a copy of this Informed Consent form, have been made aware of your rights and the privacy practices of this office, agree to comply with fees and policies and consent to the therapy process as described above. You have the right to withdraw your consent for treatment at any time.

___ Check here if you would like to receive my free e-newsletter filled with tips for total health and wellness. Your email will NOT be shared with any third parties. Email address: _____

_____	_____
Client Signature	Date
_____	_____
Client Signature	Date
_____	_____
Parent/Guardian Signature (if client is under 18)	Date