Disclosure Information For:
Las Vegas Family Therapy LLC
Karen M. Anderson MS,
Licensed Marriage and Family Therapist
Licensed Alcohol and Drug Counselor

Welcome! This paperwork has been prepared for you to inform you of my qualifications and what you can expect from me as a therapist. It explains my therapeutic approach, services, fees, policies and your rights as a client. Additionally this disclosure statement provides you with information about my education, training, and experience. After you have read this statement, you will be asked to sign a statement of acknowledgement stating that you have received it and you will be provided a copy for your records, if requested.

Biographical Information: Welcome to my practice! My name is Karen Anderson and I graduated with a Master of Science in Marriage and Family Therapy from the University of Nevada, Las Vegas. During my academic work I was the recipient of the UNLV Excellence in Marriage and Family Therapy Practice award and am currently registered with the State of Nevada as a Licensed Marriage and Family Therapist as well as a Licensed Alcohol and Drug Counselor.

Combined with my educational requirements I have taken level I & II of Eye-movement Desensitization Reprocessing Therapy (EMDR), EMDR advanced clinical training and am currently a certified EMDR Trauma Therapist. I am also a part time instructor with the University of Nevada Las Vegas and an AAMFT Approved Supervisor in Training.

Therapeutic Approach: As a marriage and family therapist my training has been from a systems perspective. Systems therapy works with the relationship and cycles of interaction between persons. Within the context of systems that may be affecting one's life, issues such as gender, culture, and spirituality are considered. During our first couple of sessions, we will set specific goals to accomplish based on your presenting problem. I will gather data on your presenting problem and we will work together to find solutions. I believe that therapy not only takes place in the therapy room, but also between sessions. Therefore, a part of your therapeutic process may include assignments outside the therapy room.

I work with individuals, couples, families and groups. The approaches that I use in treatment vary. I primarily use an existential humanistic approach with an integration of different treatment modalities and techniques. I believe the relationship between the therapist and the client is paramount for productive treatment and ultimately for healing to occur. Typically treatment consists of:

1. An assessment, which may include any or all of the following: interviews, observation, review of records, behavior rating scales, biological, psychological and social history, and/or mental health evaluation.
2. Development of a treatment plan, which includes goals and objectives, therapeutic interventions and estimated length of treatment.
3. Implementation of treatment plan.
4. Ongoing assessment, discussion of progress, and revisions to the treatment plan as appropriate.
5. Completion or termination of treatment when satisfactory progress has been made or treatment goals are achieved.
6. Aftercare planning for follow-up care to maintain gains and prevent relapse if needed or desired by the client.

Appointments, Fees, Payment: As a therapist in a private practice, I must operate as a small business. Therefore, I want you to know clearly the fees, payment and charges for my business. Sessions are 50 minutes in length and one session will be $150 and will be due at the end of each session. Any time incurred due to court proceedings, which includes court preparation time, travel time, providing written documentation, and testifying will also be billed at the same session rate/ per 50 minutes. Partial hours will be prorated.

Your scheduled appointment time is reserved especially for you. If you are unable to make your appointment, please provide a minimum of 24 hours' notice of cancellation or rescheduling to me directly by calling 702-485-8470. Failure to give a minimum of 24 hours notice of cancellation or failure to show up (No Show) for a scheduled appointment will result in you being charged your full session rate (rate listed above). If you do not book another session within 10 days you will be billed at the address listed on the front of the intake form. Any outstanding monies owed will need to be paid before a future session may be booked. Please initial that you have read this section specific to cancellation of appointments: ______________

Request for Additional Reports/Letters/Documentation/Legal Issues: Completing assessment paperwork, treatment plans, progress/psychotherapy case notes, brief phone calls and/or letters are included in your fee. However, if phone calls are frequent or extensive (longer than 15 minutes); if you require additional letters, reports, documentation; of if court attendance is required, the charge will be based on the fee of $150 per hour and you agree to be billed for said time. As well I do not appear in court for child-custody, divorce litigation without a signed judge's court order. **Initial ________________**

Other Fees/Charges: You are responsible for all fees/charges incurred and will be billed for all charges not previously paid by you.

Insurance: I do not accept insurance.

Refunds: No refunds are provided for services already rendered.

Emergencies: If I will be out of town for a significant length of time, another therapist may be available for interim treatment. I will discuss this possibility with you before a prolonged absence I might have. On some occasions I may leave contact information on my answering machine for another therapist who will be available in my absence.

Confidentiality: My professional code of American Association of Marriage and Family Therapist ethics and the Nevada statutes prevent me from disclosing information that is shared in therapy or releasing information without your written consent. If you are here for couples of family therapy, all persons involved in the therapy process are required to provide written consent before information can be released; however, I cannot guarantee the confidentiality of other participants who are involved in your therapy process. The only exceptions to confidentiality are stated in the family therapy consumer section of this disclosure statement.

Your rights as a family therapy consumer:

1. To receive information concerning the methods of therapy employed, the techniques used, the duration of therapy (if known), and the fee structure provided.
2. To seek a second opinion. If needed, I can provide you with names of other qualified professionals.
3. To terminate therapy at any time without moral, legal, or financial obligations other than those already accrued.
4. To know that in a professional psychotherapeutic relationship sexual intimacy between the therapist and client is never appropriate.
5. To know that our therapeutic relationship is confidential except under the following conditions:
    a. If you threaten bodily harm or death to yourself or another person
    b. If you reveal information about physical abuse, sexual abuse or neglect in regard to a child or elderly person.
    c. If you are in court-ordered therapy.
    d. If a court of law issues a legitimate court-ordered subpoena by a judge or a judge breaks your confidentiality.

   e. If you are under the age of 18, in the State of Nevada, parents have access to information in regards to their child's medical records.
6. If you request, any part of your records can be released to any person or agency if you have signed an authorization for me to do so.

Acknowledgement

By signing below, I acknowledge that I have received a copy of Karen Anderson MFT disclosure statement.

As well as agree that:

1. **I have read and understood the above policies.**
2. **I have read and understand the financial obligations and cancellation policies.**
3. **I have been informed of my therapist's credentials and my rights as a client.**

1. Signed: ____________________ ____________________

Client or parent/guardian ***please print*** Client Date of Birth

Signed: ____________________ ____________________

Signature Date

2. Signed: ____________________ ____________________

Client or parent/guardian ***please print*** Date of Birth

Signed: ____________________ ____________________

Signature Date

Refusal to Sign Acknowledgement

__________________________ ____________________

Client Signature Date

__________________________ ____________________

Karen M. Anderson MFT Date

Consent to Treatment

As a client of Karen M. Anderson MFT, I understand that:

1. I have the right to refuse any or all parts of the treatment plan, with the exception of emergency treatment.
2. Consent to any or all parts of the treatment plan may be withdrawn at any time.
3. I will be informed of the nature, consequences and purposes of the treatment plan, and any alternative plans and resources available.
4. All counseling/therapy sessions are confidential other than the situations outlined in the disclosure statement.
5. As a client of Karen M. Anderson MFT, I have read my rights and acknowledge receipt of a copy of her disclosure statement.
6. I have been fully informed of the above, understood the process, and agree to accept such treatment and to cooperate in its implementation.

______________________________ ______________

Client or Parent/guardian Signature Date

______________________________ ______________

Client or Parent/guardian Signature Date

______________________________ ______________

Karen M. Anderson MFT, LADC Date

HIPPA Privacy Statement

I. Uses and Disclosure for Treatment, Payment, and Health Care Operations
Las Vegas Counseling Center may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. We are required by law to maintain the privacy of HI and to provide you with our legal duties and privacy practices with respect to PHI> we are required to abide by the terms of this notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the Revised Notice of Privacy Practices by sending you a copy in the mail upon request at your next appointment.

II. Uses and Disclosures Requiring Authorization
We may use of disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when we asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing psychotherapy notes. "Psychotherapy notes" are notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent Nor Authorization.
We may use of disclose PHI without your consent or authorization in the following circumstances: (1) Child Abuse/Neglect; (2) Elder Abuse/Neglect; (3) Health Oversight (Nevada Licensing Board requesting records); (4) Judicial or Administrative Proceedings (Judge Court Order); (5) Serious Threat to Health or Safety to self or others; (6) Workers Compensation (if you file a claim)

Client Printed Name: ____

Signature: ____
(If a child or adolescent under age 18, parent or legal guardian must sign)

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Name: ____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

____
(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: ____

Current Address: ____
____

(May I send correspondence to the above address? □Yes □No

Home Phone: (_______)____________ May we leave a message? □Yes □No

Cell/Other Phone: (_______)____________ May we leave a message? □Yes □No

E-mail: ___________________________________ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): ____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No □ Yes, previous therapist/practitioner:
____

Are you currently taking any prescription medication?

□ Yes □ No Please list:

___

___

Have you ever been prescribed psychiatric medication?
□ Yes □ No Please list and provide dates:

___

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

___

2. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

___

3. How many times per week do you generally exercise? ___

What types of exercise to you participate in: ___

4. Please list any difficulties you experience with your appetite or eating patterns.

___

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No □ Yes
If yes, for approximately how long? ___

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No □ Yes
If yes, when did you begin experiencing this? ___

7. Are you currently experiencing any chronic pain?
□ No □ Yes

If yes, please describe? ______________________________

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes If yes, for how long?

On a scale of 1-10, how would you rate your relationship? ___________

11. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? Occupation?

Do you enjoy your work? Is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weakness?

5. What would you like to accomplish out of your time in therapy?