Tzippy Kohen, MS, LCPC, NCC
323-896-2693

OUTPATIENT SERVICES CONTRACT

Credentials and Clinical Background

I am a Licensed Clinical Professional Counselor in the State of Illinois and I am also a National Certified Counselor, which allows me to counsel clients. I completed my Master's in Mental Health Counseling at Capella University and my internship at the Jewish Child and Family Services providing counseling services to adults and children. For over a decade, I have been providing counseling services to children, teens and adults, as well as consulting with various local schools. Particular areas of focus include trauma, anxiety, panic, OCD, depression and relationship issues. Additionally, my background of over 15 years in education has given me extensive experience working with individuals who struggle with learning disabilities, ADHD, behavioral challenges and poor motivation.

Therapeutic Process

The therapeutic process is a journey in which the client and counselor work to resolve client issues, increase skills, and improve attitudes in order to actualize potential, achieve goals and enhance quality of life. The first several sessions will be devoted toward clarifying issues, identifying treatment options and developing a therapeutic alliance. I may ask your permission to contact previous providers to obtain treatment information. My approach is solution focused and is based upon theories of ACT (acceptance and commitment therapy), EXRP (exposure and response prevention therapy). I am also trained in EMDR and may suggest its use if applicable.

Fees, Cancellations, and Insurance Reimbursement

My fee is $140 per 50-minute therapy session. Payment via cash or check is due at the conclusion of each session. Failure to pay may result in the suspension of services until outstanding fees have been paid.

In the event that you are unable to keep your appointment, you must notify me 24 hours in advance. If I do not receive advance notice, you will be financially responsible for the session that you missed.

Telephone Contact and Emergency Procedures

If you need to contact me between sessions, please leave a message on my confidential voicemail at 323-896-2693, and your call will be returned as soon as possible. If you are in an emergency situation, call 911 or proceed to your nearest emergency room for immediate care.

Confidentiality

The information you share in therapy is confidential and will not be disclosed without your written permission. There are some exceptions to confidentiality including: (1) If you are at imminent risk to harm yourself or another person, the law requires me to try to protect you and/or the other person by informing appropriate individuals to maintain safety; (2) If you disclose information pertaining to child or elder abuse, the law requires me to report this to authorities: and (3) If I receive a court-order for your clinical record or to testify. If such rare situation(s) occurs, I will make every effort to fully discuss it with you before taking action.

I certify by my signature that I have read, fully understand, and agree to abide by the terms of this Outpatient Services Contract.

_____ _____

Client Signature Date

_____ _____

Tzippy Kohen, MS, LCPC, NCC Date

Tzippy Kohen, MS, LCPC, NCC

323-896-2693

Consent to Treatment

I acknowledge that I have received, read, and understand the Outpatient Services Contract.

I do hereby seek and consent to participate in treatment by this therapist.

I am aware that the formulation of a treatment plan and review of progress are in my best interest and I agree to actively take part in this process.

I am aware that the information I share in a therapy session is confidential and will not be disclosed to anyone without my written permission except when disclosure is necessary to protect myself or someone else from imminent harm, or when such disclosure is required by law.

I am aware that the prediction of effects of psychotherapy/counseling is not exact. I acknowledge that no guarantees have been made to me regarding the results of services provided by this therapist.

I am aware of the fee schedule, payment methods, and cancellation/missed session policies.

I am aware that I may terminate at any time without consequence, but I will still be held responsible for payment of services rendered. Likewise, nonpayment of fess will result in termination of professional services and fee collection for fee services rendered.

I have received a copy of Notice of Privacy Practices describing disclosure of protected health information (PHI).

I certify by my signature below that I have read, fully understand and agree with the content of this Consent to Treatment.

_____ _____

Client Signature Date

_____ _____

Tzippy Kohen, MS, LCPC, NCC Date

Tzippy Kohen, MS, LCPC, NCC
323-896-2693

Consent to Treatment
CLIENT COPY

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Signature of Client Date

_____ _____
Tzippy Kohen, MS, LCPC, NCC Date

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Preliminary Information Forms

A. Identifying Information

Name: _____ Date: _____

Birth date: _____ Age: _____ Social Security #:_____

Address: _____
(Street) (City) (State) (Zip Code)

Gender: _____ Male _____ Female

Relationship Status: _____ Committed Relationship ____ Single ____ Married

____Separated/Divorced ____Domestic Partnership _____Widowed

Ethnic/Racial Identity: ____African American ____Asian American (please specify): _____

____ Caucasian ____Biracial (please specify): _____

____Latina/Latino ____ Native American

____ Other

To (re) schedule an appointment, where may I contact you?

____ Home phone: _____ _____Cell/Work: _____

May I leave a message on the answering machine? ____ Yes ____No (Please check one)

May I leave a message with someone at this number? ____ Yes _____No (Please check one)

Who may I contact in case of an emergency?

Name: _____ Phone: _____

Address: _____
(Street) (City) (State) (Zip Code)

Relationship to you: _____

Did someone refer you?

_____ Yes If "yes", who? _____

_____ No

B. Clinical Information

Have you ever had previous counseling or psychotherapy? _____ Yes _____No

If "yes," by whom, when, and for what? _____

Have you ever been psychiatrically hospitalized? ____ Yes _____ No

Have you ever made a suicide attempt/gesture? _____ Yes _____ No

Please list current or chronic health problems:

_____

Please list current medications (prescribed & OTC):

_____

In the space below, please briefly describe your reason(s) for seeking services:

_____

_____

_____

PLEASE USE THE SCALE BELOW TO INDICATE YOUR CURRENT LEVEL OF DISTRESS ON THE FOLLOWING ITEMS:

	No concern	Minimal		Moderate		Urgent
Academic/Occupational concerns	0	1	2	3	4	5
Perfectionism	0	1	2	3	4	5
Financial Concerns	0	1	2	3	4	5
Relationship with family or friends	0	1	2	3	4	5
Relationship with romantic partner	0	1	2	3	4	5
Sexual orientation concerns	0	1	2	3	4	5
Racial/cultural issues or conflict	0	1	2	3	4	5
Recent loss or death	0	1	2	3	4	5

Loneliness	0	1	2	3	4	5
Low self-esteem, self-confidence	0	1	2	3	4	5
Depression	0	1	2	3	4	5
Anxiety, fears, worries	0	1	2	3	4	5
Irritability, anger	0	1	2	3	4	5
Sleep problems	0	1	2	3	4	5
Eating problems	0	1	2	3	4	5
Body image concerns	0	1	2	3	4	5
Sexual concerns	0	1	2	3	4	5
Concerns regarding sexually transmitted diseases	0	1	2	3	4	5
Survivor of abuse (Emotional, physical or sexual)	0	1	2	3	4	5
Post-partum concerns	0	1	2	3	4	5
Problems with alcohol or drugs	0	1	2	3	4	5
Other addictive concerns	0	1	2	3	4	5
Cutting/Self-injurious behavior	0	1	2	3	4	5
Suicidal thoughts/behaviors	0	1	2	3	4	5
Fear of endangering others	0	1	2	3	4	5

Please indicate how often you use the following substances

	DAILY	WEEKLY	MONTHLY	RARELY	NEVER
Alcohol					
Nicotine					
Marijuana					
Ecstasy or other hallucinogens					
Cocaine and/or other stimulants					
Opioids (heroin, morphine)					
Sedatives, hypnotics, tranquilizers					

Thank you for completing the paperwork. Data is solely used for the purpose of understanding treatment concerns and will be held strictly confidential.

Tzippy Kohen, MS, LCPC, NCC

323-896-2693

FINANCIAL CONTRACT

This contract outlines my financial and business policies. My fee is $140 per therapy session (50 minutes). If other professional services are required, such as report writing, consultations longer than 20 minutes, or preparation of treatment records, you will be charged my hourly fee of $140 (prorated if necessary). Payment is expected at the end of each session in the form of cash or check.

If you think you may have trouble paying your bill on time, please discuss this with me so we can make an agreeable plan. If your account has not been paid for more than 60 days and arrangements have not been made, services will be suspended.

Payment method: _____CC _____Chase QuickPay _____ Cash _____Check

PLEASE INITIAL

_____ *Financial Relationship*

I agree that a financial relationship with this therapist will continue as long as the therapist provides services to me. I agree to pay for services provided through the termination of services.

_____ *Accepting Financial Responsibility*

I understand that I am ultimately responsible for the services provided by this therapist to me; however, other persons or insurance companies may make payments on my account.

_____ *Authorization for Release of Information for Billing Purposes*

I hereby authorize the release of any information necessary for third-party submission and/or payment for services. I authorize payment of third-party benefits to Tzippy Kohen, MS, LCPC, NCC for mental health services described herein.

____ *Cancellation Policy*

Any cancellations of appointment must be made at least 24 hours in advance of the scheduled session. If I do not call to cancel and/or fail to show, I will be charged for that appointment.

_____	_____	_____	_____
Signature of Client	Date	Tzippy Kohen, MS, LCPC, NCC	Date

Tzippy Kohen, MS, LCPC, NCC

323-896-2693

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