LAURA PAULSON, M.A., LMFT
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Informed Consent for Treatment

Date: _____

Name: _____ Date of Birth: _____

Address: _____

_____

Home telephone: _____ Mobile/Other: _____
☐ OK to leave message? ☐ OK to leave message?

Referral:

Name: _____ Phone: _____

Address: _____

Medical Information:

Primary Care Physician: _____ Phone: _____

Address: _____

Date of last physical exam: _____

Psychiatrist: _____ Phone: _____

Address: _____

Date of last visit: _____

Are you experiencing any health problems or taking any medications? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Emergency Contact:

Name: _____ Phone: _____

Address: _____

Relationship: _____

This "Informed Consent for Treatment" document contains information regarding the rules and regulations of the state of California as well as guidelines of the Board of Behavioral Sciences mandate, which we provide you. One of the overall goals of providing you with this information is that you become a well-informed consumer of our services. If any of the information presented here is unclear, please ask us to clarify before signing the last page. Please continue to the next page.

Patient's Rights and Benefits/Risks:
Most people find the therapeutic experience to be one of growth, support, and positive personal change. However, psychotherapy usually involves discussing sensitive, emotional, and personal information. Discussing such material may cause a client to experience intense emotions, including but not limited to, anxiety, anger, frustration, and sadness. In some cases the client may feel worse before feeling better. This is common and the client should be informed of the possibility of such an experience before giving consent to treatment.

Limits of Confidentiality:
Psychotherapy sessions between the client and our staff are strictly confidential, except under certain legally defined situations involving threats of self-harm or harm to another, and in cases of child abuse, elder abuse, or abuse of otherwise dependent individuals. In the case of danger to others, we are required by law to notify the police and to inform any intended victim(s). In the case of self-harm, we are ethically bound to inform the nearest relative, significant other, or to otherwise enlist methods to prevent self-harm or suicide. In instances of child abuse, elder abuse, or dependent abuse, we must notify the proper authorities.

Payment and Fees:
The client will be informed of the fee for services no later than the end of the first appointment. The client agrees to provide payment for services, in the form of cash, credit card, or personal check, at the end of each session, and to reimburse us for any and all bank fees for returned checks. Please make all checks payable to the Los Angeles Body Dysmorphic Disorder Clinic.

Telephone Accessibility:
For all urgent matters or clinical emergencies, the client can reach me by calling (310) 502-5497. Please note, however, that no voicemail system is 100% foolproof, and technical glitches may occur. In the event an emergency voicemail is not returned in a timely fashion, the client agrees to leave another voicemail for their individual therapist/psychiatrist. In the unlikely event that the client is experiencing a clinical emergency and we are not available, the client agrees to call 911.

E-mail Accessibility:
In regards to e-mails, we request that the client only send e-mails regarding non-urgent matters since several days may pass before the e-mail is retrieved and since some e-mails are returned undeliverable. In addition, the client is informed that he/she should never send via e-mail any information that he/she would like to be kept confidential. As is true of any e-mail, confidentiality can never be guaranteed. **For all urgent or emergency matters and for any communication of confidential information, the client agrees to use only telephone and voicemail.**

Appointment and Cancellation Policy:
Appointments are typically scheduled a week in advance. If the client needs to cancel or reschedule an upcoming appointment, he/she agrees to provide us with at least 48 hours notice. If the client provides less than 48 hours notice, the client agrees to pay the full fee for the missed session. The client acknowledges that insurance companies do not cover any fees for missed appointments and that if the client needs to pay the fee for a missed appointment, the client agrees to pay for this out of pocket.

Acknowledgment and Signature:
Please do not sign if you have any questions regarding the contents of this informed consent for treatment or if any of the information is unclear.

By signing below, I acknowledge that I have read and understand the information presented in this "Informed Consent for Treatment" document and that I give my consent for treatment to the Los Angeles Body Dysmorphic Disorder Clinic. This consent shall remain in effect for the duration of my therapy or until I provide written revocation.

_____ _____

Signature of patient 18 years of age or older Date

_____ _____ _____

Signature of person authorized in lieu of patient Relationship Date

Name: _____ Date: _____

Intake Questionnaire

Please circle the symptom(s) you are currently experiencing:

Symptom	Mild	Moderate	Severe	For how long?
Depressed mood	1	2	3	
Hopelessness	1	2	3	
Suicidal thoughts	1	2	3	
Appetite changes	1	2	3	
Weight changes	1	2	3	
Sleep problems	1	2	3	
Poor concentration	1	2	3	
Obsessive thoughts	1	2	3	
Daily rituals	1	2	3	
Strange, unusual thoughts	1	2	3	
Tension/Anxiety	1	2	3	
Panic attacks	1	2	3	
Memory problems	1	2	3	
Compulsive behavior	1	2	3	
Hostility or anger	1	2	3	
Violent acts	1	2	3	
Social isolation, loneliness	1	2	3	
Sexual problems	1	2	3	
Relationship problems	1	2	3	
Substance abuse	1	2	3	

Any other concerns or issues:

- ❑ _____
- ❑ _____

Please circle the number (#) which best describes how well you are doing on your job:

0	1	2	3	4	5	6	7	8	9
Not working	Cannot function				Moderate problems			Mild problems	

Please circle the # which best describes how well you are doing in your marital/significant other relationship:

0	1	2	3	4	5	6	7	8	9
N/A	Cannot function				Moderate problems			Mild problems	

Please circle the # which best describes how well you are doing in your family relationships:

0	1	2	3	4	5	6	7	8	9
N/A	Cannot function				Moderate problems			Mild problems	

Please circle the # which best describes how well you are doing in relationships with people outside your family:

0	1	2	3	4	5	6	7	8	9
N/A	Cannot function				Moderate problems			Mild problems	

Please circle the # which best describes your current physical health:

0	1	2	3	4	5	6	7	8	9
N/A	Cannot function				Moderate problems			Mild problems	

Please circle the # which best describes your general happiness and well-being:

0	1	2	3	4	5	6	7	8	9
N/A	Cannot function				Moderate problems			Mild problems	

Substance Use Assessment (Please circle):

Alcohol use:

Never 1-4 times per month 2-3 times per week Daily

Level of consumption:

1-2 drinks per sitting 3-4 drinks per sitting 5+ drinks per sitting

Intoxication frequency:

Never 1-4 times per month 2-3 times per week Daily

Substances used:

None Marijuana Sedatives Stimulants Cocaine Opiates Hallucinogens

Frequency of use:

Never 1-4 times per month 2-3 times per week Daily

Have you ever been in psychotherapy before? ☐ Yes ☐ No

If yes, for how long? _____

_____

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, please describe: _____

_____

Please list all medications (including non-prescription) that you currently are taking: _____

_____

_____

Is there a family history of substance abuse and/or mental illness? ☐ Yes ☐ No

If yes, please describe: _____

_____