Sasha Esposito San Román
Marriage and Family Therapist, Inc.
2170 The Alameda, #300, San Jose CA 95126
Email: sashaesposito@gmail.com Website: sashaesposito.com
Cell: 408 348-3896 VM: (408) 378-6510

Licensed Marriage and Family Therapist MFC#37388

Informed Consent for Treatment

I will work to provide the most effective treatment possible. Most clients undergoing psychotherapy experience improvement, however, this cannot be guaranteed. Psychotherapy may involve a variety of different activities. Therapeutic services are designed to resolve or reduce any problems found in initial and ongoing assessments. There may be individual, and/or family sessions. Therapy may focus on feelings, thoughts, relationships, and/or behaviors.

Psychotherapists have professional training and you have the right to inquire fully about my credentials, education and experience. Psychotherapy involves complete confidentiality between family and clinician. However, current laws and ethics require all therapists to make exceptions in the following circumstances to break confidence.

- The client presents a clear and present danger to self or others.
- The client communicates to the therapist a threat of physical violence against a clearly identified or reasonably identifiable victim, or the therapist has a reasonable basis to believe there is a clear and present danger of physical violence against such a victim.
- The client introduces his or her mental condition as a defense in a legal proceeding.
- In child custody or adoption cases, the judge determines that the therapist has information bearing significantly on the client's ability to provide suitable care.
- The client initiates legal action against the therapist.
- The therapist has grounds to believe a child under the age of 18 or an elderly person (over age 60), or a handicapped adult, has been or is at risk of being abused or neglected.
- The therapist has reason to believe a health care professional has engaged in professional misconduct.
- A judge orders the therapist to release client information.

I confirm by my signature on this form that I consent to treatment, and that I understand and consent to the conditions described above.

_____ _____
Signature Date

_____
Please Print Name

Please initial the following to indicate your agreement/consent:

_____ Agreed fee is $150 per 50 minute psychotherapeutic hour (or as otherwise agreed: $_____)
& $185 home visit pr 50 minute psychotherapeutic hour (or as otherwise agreed: $_____)

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Dear Client/Parent or Guardian,

The following are policies that I follow regarding the business aspect of my work. Please read them carefully. If you have any questions or concerns at any point in our work together, I welcome you to talk about them with me during our work together.

Fees:
Your fee for each 50 minute psychotherapeutic hour, payable either immediately before or after each session. Your fee will be established during our first session and reviewed periodically for appropriate changes. You will be given at least one month's notice in the event of a fee increase.

There is a flat fee for group therapy, payable weekly for ongoing groups and prior to the beginning of time-limited groups. Groups are from 1 1/4 to 1 1/2 hours long depending upon the type of group.

Victim Witness clients' fees will be paid for by Victim Witness. Please note that Victim Witness clients are responsible for the Cancellation/Failed Appointment Fee (below) to the extent of the Victim Witness payment.

Your hourly fee will be applied, on a pro-rata basis, to all telephone consultations over 15 minutes.

Your fee may be covered by your insurance company. If you need information from me in order to obtain reimbursement we can discuss the requirements on a case by case basis. Regardless of the insurance coverage, each client is responsible for his or her fees for treatment.

There is a $15. (fifteen dollar) return check charge for all checks returned by the

bank. These charges can add up quickly, if you foresee any complications in payment let's discuss it ahead of time so we can avoid this added charge.

Cancellations and Failed Appointments:
Please keep all appointments. Consistency in our work is a key factor to progress and growth. If something unforeseen prevents you from keeping your appointment please leave a message on my voicemail (408) 378-6510. A 24-hour notice is required to avoid being charged for regular session fees for the missed appointment.

Informed Consent and Confidentiality:
I am a licensed Marriage and Family Therapist (MFC# 37388). Information discussed in our sessions will remain confidential unless…

- **Client consents in writing**
- **Court orders a release of information**
- **Client presents a physical danger to self or others**
- **Child, elder, or dependant adult abuse or neglect is suspected**

Crisis Situations:
Because I work in a private practice setting I am unable to provide 24-hour crisis service. If an emergency should arise requiring immediate attention, the following resources on page 3 of this form are available 24-hours a day. If at all possible, please leave a message on my voicemail informing me of your situation in addition to contacting one or more of the agencies listed on page 3.

I _____ have read and fully understand all information this form.

_____ _____

Signature **Date**

CRISIS & RESOURCE PHONE NUMBERS

- **Suicide and Crisis Service…….……(408) 279-3312**
- **Gateway (alcohol & drug treatment referrals)…...1 (800) 488-9919**
- **AA (Main number)…….……(408) 374-8511**
- **Alanon (Main number)…….……..(408) 379-9375**
- **Support Network for Battered Women……..…….(800) 572-2782**
- **Next Door (domestic violence)……....…(408) 279-2962**
- **Bay Area Impact (formerly BAMM).……..……..(408) 928-3860**
- **Adult Protective Services……..……..(408) 928-3860**
- **Child Protective Services…….……...(408) 299-2071**
- **Contact Hotline (for teens and also for parents)…..(408) 279-0303**
- **Red Cross Runaway Hotline……...1 (800) 231-6946**
- **The Bridge (rape crisis)……..…(408) 779-2115**
- **Valley Medical Psychological Services…….…(408) 885-6100**
- **Emergency calls for police, fire & ambulance..……911**
- **Educational Consultant Sue Strand……...…….(408) 927-8894**
- **Gay & Lesbian National Hotline……....1 (888) THE-GLNH**

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

By signing this form below, I hereby give my consent for release of information between:

Sasha Esposito San Roman, M.A., MFT (MFC# 37388)
2170 The Alameda, #300, San Jose CA 95126
Phone (408) 378-6510

and

_____
_____
_____
_____,

in regards to:

Name: _____

Social Security #: _____

Date of Birth: _____

My signature below also indicates that I understand all communication between the first two above mentioned parties may include, but is not limited to: diagnosis; legal status; results of psychological and vocational tests; pertinent summary of psychosocial and psychiatric history; treatment summary; and, medical information/test results.

I extend this authorization with the knowledge that such contact discloses the fact that I am receiving and/or have received mental health services. This authorization shall remain in effect until such time as I withdraw it by written notification to all parties named herein.

_____ _____
Signature **Date**

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Consent for Emergency Contact

By signing this form in the space provided below, I give my consent to allow contact by whomever Sasha Esposito has deemed appropriate and safe should any situation arise where Sasha would be unable to meet or continue treatment due to unexpected circumstances such as illness, injury or death. I have been informed that Sasha has established a trusted team of colleagues to handle such an event, and I give my consent for them to access my contact information in order to get in touch with me.

Client's full name:_____

Date of birth:_____ Grade:_____ Gender: M F Age:_____

Mailing Address:_____

Parent/Legal Guardian name(s):_____

Address:_____

Home phone:_____ Work phone:_____ Cell/pager:_____

_____ It is OK to leave message

Occupation:_____

Emergency contact: _____ Phone: _____

Primary language spoken in home:_____

_____ _____

Signature **Date**

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Initial Intake Form

Initial contact date: _____ Termination date:_____

Referred by:_____

Client's full name:_____

Date of birth:_____ Grade:_____ Gender: M F Age:_____

School:_____ Teacher name:_____

Parent/Legal Guardian name(s):_____

Address:_____

Home phone:_____ Work phone:_____

Cell phone/pager:_____

Occupation:_____

Emergency contact: _____ Phone: _____

Primary language spoken in home:_____

Ethnicity(ies):_____

If client lives in more than one location or in a special circumstance, please describe:_____

_____

_____

Please list all persons living in home:

Name _____ Relationship Occupation/School __ D.O.B. _____

_____

_____

_____

_____

_____

_____

Is there a past or current therapist for this client? ☐ Yes ☐ No

If yes, name:_____

Phone:_____

☐ Release signed permitting communication

Is there a past or current social worker for this client? ☐ Yes ☐ No

If yes, name:_____

Phone:_____

☐ Release signed permitting communication

Family doctor name: _____

Phone:_____

☐ Release signed permitting communication

Is the client currently taking any medication? ☐Yes ☐ No

If yes, please describe:_____

_____

Family history:_____

_____

_____

_____

_____

_____

_____

School/employment history:_____

_____

_____

_____

_____

_____

History of presenting problem(s):_____

_____

_____

_____

_____

_____

What has been done to address presenting problem(s) to date:_____

_____

_____

_____

_____

_____

Does the client have any physical disabilities? ☐ Yes ☐ No If yes, please describe:_____

_____

_____

What are the clients strengths, abilities or interests?_____
_____
_____
_____
_____
_____

Please describe special resources/referrals needed for this case_____
_____
_____
_____
_____

Termination Summary:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____