BaoGia (Julia) Le, LMFT #114470
Licensed Marriage & Family Therapist
594 N. Glassell St,
Orange, CA 92867
714.794.9145

Child's Name: _____ **Date:** _____

Child's Address: _____

City, State, & Zip: _____

Child's Phone: _____ **Parent's Phone**: _____

Child's Email: _____ **Parent's Email**: _____

Child's Date of Birth: _____ **Ethnicity**: _____

Child lives with: _____

Currently in School: __ Yes/No (FT/PT) **Highest Completed Grade**: _____

Child's School: _____ **Employed:** __ Yes/No FT/PT

Relationship Status: _____ **How Long**: _____

Check the problem areas that are leading you to seek counseling:

Marital	Emotional	Alcoholism/Drugs
Family	Financial	Personal Relationships
Legal	Employment	Parental Issues
Trauma	Educational	Physical
Sexual	Major Stressor	Other

Please briefly describe the concerns that have brought you/your child here: _____

_____

_____

_____

_____

_____

How long has your child been experiencing the symptoms? _____

Were there any family or lifestyle changes that occurred at the time the problem(s) started? _____

_____

_____

What have you/your child done about this problem? _____

_____

Family History: Indicate if any of the following is true for the child or a family member.

	Child	Mother	Father	Sibling
Depression				
Suicide				
Suicide Attempt (# times)				
Mental/Emotional Problem				
Abuse (physical, sexual, etc.)				
Alcohol Problem				
Drug Problem				
Marijuana				

Medical History: Any serious/chronic illness(es) or surgery: _____

_____

Name, Address & Phone # of Physician: _____

_____

Date of Last Exam _____ General Health _____

List all medications your child is now taking (prescription and non-prescription):

Name of Medication	Dosage/Day	Purpose

Prior Psychotherapy Yes/No

Name	Address	Dates of Service

Has your child ever been hospitalized for psychiatric reasons in the past? Yes/No

Hospital	Address	Dates of Hospitalization

Please provide people we can contact in case of an emergency

Name	Phone Number	Relationship

Symptoms - Please indicate any symptom or behavior that applies to your child, note a 1 for mild, 2 for moderate and 3 for severe.

___ nail biting	___ anger	___ plays with matches or fire
___ bedwetting	___ irritability	___ hurts animals
___ soils underwear	___ shyness	___ disobeys rules
___ specific fears	___ academic issues	___ speech problems
___ anxiety/nervous	___ behavior issues/home	___ suicidal thoughts
___ sadness	___ behavior issues/school	___ suicidal attempts
___ depression	___ truancy	___ medical problems
___ poor concentration	___ peer problems	___ sleeping problems
___ attention problems	___ adult relation issues	___ poor appetite
___ difficulty w/directions	___ disrespects authority	___ physical abuse
___ mood swings	___ lying	___ sexual abuse
___ negativism	___ stealing	___ alcohol use/abuse
___ temper tantrums	___ destroys property	___ drug use/abuse
___ gang involvement	___ cigarette use	___ other _____

Please list any other information that would help us to understand your child _____

_____

_____

Peer Relationships

___ Yes ___ No Does your child want to be friends with others?

___ Yes ___ No Do others want to be friends with your child?

___ Yes ___ No Are your child's friends about the same age as your child?

If no ___ younger ___ older

___ Yes ___ No Does your child prefer to play with others?

Describe any problem(s) your child may have with peers _____

_____

_____

_____

_____

School

Has your child ever had to repeat a grade? Y/N

Present class placement ___ advanced ___ regular ___ special education

Rate your child's school experiences related to academic learning

	Good	Average	Poor
Nursery School	___	___	___
Kindergarten	___	___	___
Current Grade	___	___	___

Rate your child's school experiences related to behavior

	Good	Average	Poor
Nursery School	___	___	___
Kindergarten	___	___	___
Current Grade	___	___	___

Does your child's teacher see any of the following as problems in the classroom?

___ doesn't sit still ___ doesn't cooperate in group activities ___ wanders around the room

___ best one-on-one ___ shouts out ___ doesn't listen ___ doesn't wait for turn

___ other _____

What is your child's best attribute? _____

_____

What do you hope for your child now? _____

_____

What do you hope for your child in the future? _____

_____

Completed by: _____

_____ _____ _____

Signature Relationship Date

Who may I thank for referring you to me? _____

BaoGia (Julia) Le, LMFT #114470
Licensed Marriage & Family Therapist

AGREEMENT FOR SERVICE AND INFORMED CONSENT

Introduction
This Agreement has been created for the purpose of outlining the terms and conditions of services for the minor child(ren) _____ [Client name] (herein referred to as "Client") and is intended to provide _____ [name of parent/legal guardian] (herein referred to as Representative) with important information regarding the practices, policies and procedures of BaoGia (Julia) Le, Licensed Marriage & Family Therapist (herein referred to as the "Therapist"), and to clarify the terms of the professional therapeutic relationship between the Therapist and the Client. Any questions or concerns regarding the contents of this Agreement should be discussed with the Therapist prior to signing it.

Policy Regarding Consent for the Treatment of a Minor Child
The Therapist generally requires the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of the Representative to give consent for psychotherapy, the Therapist will require that the Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services.

Risks and Benefits of Therapy
A minor client will benefit most from psychotherapy when his/her parents, guardians or other caregivers are supportive of the therapeutic process.

Psychotherapy is a process in which the Therapist and Client, and sometimes other family members, discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so the Client can experience his/her life more fully. It provides an opportunity to better and more deeply understand oneself, as well as any problems or difficulties the Client may be experiencing. Psychotherapy is a joint effort between the Client and the Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors.

Participating in therapy may result in a number of benefits to the Client, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of the Client, including an active participation in the therapeutic process, honesty and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which the Therapist will challenge the Client's

perceptions and assumptions, and offer different perspectives. The issues presented by the Client may result in unintended outcomes, including changes in personal relationships. The Client should be aware that any decision on the status of his/her personal relationships is the responsibility of the Client.

During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. The Client should address any concerns he/she has regarding his/her progress in therapy with the Therapist.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice. As such the Therapist regularly participates in clinical, ethical and legal consultation with appropriate professionals. During such consultations, the Therapist will not reveal any personally identifying information regarding the Client.

Records and Record Keeping

The Therapist may take notes during session, and will also produce other notes and records regarding the Client's treatment. These notes constitute the Therapist's clinical and business records, which by law, the Therapist is required to maintain. Such records are the sole property of the Therapist. The Therapist will not alter his/her normal record keeping process at the request of any client. Should the Client request a copy of the Therapist's records, such a request must be made in writing. The Therapist reserves the right, under California law, to provide the Client with a treatment summary in lieu of actual records. The Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. The Therapist will maintain the Client's records for ten years following termination of therapy, or when the Client is 21 years of age, whichever is longer. However, after ten years, the Client's records will be destroyed in a manner that preserves the Client's confidentiality.

Confidentiality

The information disclosed by the Client is generally confidential and will not be released to any third party without written authorization from the Client, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a client is dangerous to him/herself or the person or property of another.

The Representative should be aware that the Therapist is not a conduit of information from the Client. Psychotherapy can only be effective if there is a trusting, confidential relationship between the Therapist and the Client. Although the Representative can expect to be kept up to date as to the Client's progress in therapy, he/she will typically not be privy to detailed discussions between the Therapist and the Client. However, the Representative can expect to be informed in the event of any serious concerns the Therapist might have regarding the safety or well-being of the Client, including suicidality.

Client Litigation

The Therapist will not voluntarily participate in any litigation, or custody dispute in which the Client, and another individual, or entity, are parties. The Therapist has a policy of not communicating with the Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in the Client's legal matter. The Therapist will generally not provide records or testimony unless compelled to do so. Should the Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving the Client, the Client agrees to reimburse the Therapist for any time spent for preparation, travel, or other time in which the Therapist has made him/herself available for such an appearance at the Therapist's usual and customary hourly rate.

Psychotherapist-Patient Privilege

The information disclosed by the Client, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between the Therapist and the Client in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the client is the holder of the psychotherapist-patient privilege. If the Therapist received a subpoena for records, deposition testimony, or testimony in a court of law, the Therapist will assert the psychotherapist-patient privilege on the Client's behalf until instructed in writing to do otherwise by a person with the authority to waive the privilege on the Client's behalf. When the client is a minor child, the holder of the psychotherapist-patient privilege is either the minor, a court appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law. The Client should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. The Client should address any concerns he/she might have regarding the psychotherapist-patient privilege with his/her attorney.

Sessions and Appointments

A standard psychotherapy session runs for forty-five to fifty (45-50) minutes. This allows time for writing progress notes, thinking about the just-completed therapy session, returning phone calls, and taking a short break so that the Therapist is alert and ready for the next client. In the event the Client must cancel or reschedule a session, it is important that the Therapist be informed as soon as possible so that another client can use that time. The Therapist asks that the Client provide 24-hour notice of any cancellation or need to reschedule an appointment for a later date. In the event that the Client does not give 24-hour notice, the usual session fee will be charged. Insurance does not pay for missed sessions. If 24-hour notice is not given by the Client, the Client agrees to pay the full insurance fee or agreed-upon fee as delineated below.

Fees and Fee Arrangements

The agreed-upon fee between the Therapist and the Client is $150 for intake and $120 thereafter. The Therapist reserves the right to periodically adjust the fee. The Representative will be notified of any fee adjustment in advance.

From time-to-time, the Therapist may engage in telephone contact with the Client for purposes other than scheduling sessions. The Representative is responsible for payment of the agreed-

upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, the Therapist may engage in telephone contact with third parties at the Client's, or the Representative's, request and with advance written authorization. The Representative is responsible for payment of the agreed-upon fee (on a pro rata basis) for any telephone calls longer than ten minutes.

Representatives are expected to pay the full amount of the fee at the end of each session, or as agreed to by the parties involved (e.g., insurance). The Therapist operates on a strict cash, check, or credit card basis paid at each session, with a written receipt given for each payment made. If the Representative's check is returned for non-sufficient funds, the Representative will be responsible for the session fee, plus a $15 non-sufficient funds charge. This payment must be made in cash, credit card, or money order. Therapist accepts payment by major credit cards.

Therapist Availability

The Therapist's office is equipped with a confidential voice mail system that allows the Client to leave a message at any time. The Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. The Therapist is unable to provide 24-hour crisis service. In the event that Client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

Email and text messaging is a service that is available for clients to use for scheduling purposes only (i.e., scheduling, changing, or canceling appointments). Texts should not contain the following: Information pertaining to health concerns or emergencies, confidential information or sensitive therapeutic subjects, or concerns of danger to self or others. Any concerns of danger to self (self-harm or suicide) communicated through text could result in the breaking of confidentiality. Any therapeutic subjects and confidential information shall be handled while in session with the Therapist. During therapy session, the Therapist will help the Client set up a safety plan that includes the use of outside support.

Termination of Therapy

The Therapist reserves the right to terminate therapy at her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Client needs are outside of Therapist's scope of competence or practice, or the Client is not making adequate progress in therapy. The Client also has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, the Therapist will generally recommend that the Client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. The Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to the Client.

Acknowledgement

By signing below, the Client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. The Client has discussed such terms and conditions with the Therapist, and has had any questions with regard to its terms and conditions answered to the

Client's satisfaction. The Client agrees to abide by the terms and conditions of this Agreement and consents to allow the Client to participate in psychotherapy with the Therapist. Moreover, the Client agrees to hold the Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

By signing below, the Representative also acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. The Representative has discussed such terms and conditions with the Therapist, and has had any questions with regard to its terms and conditions answered to the Representative's satisfaction. The Representative agrees to abide by the terms and conditions of this Agreement and consents to allow the Client to participate in psychotherapy with the Therapist. Moreover, the Representative agrees to hold the Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____

Client Name (Please Print)

_____ _____

Signature of Client (if 12+ years of age) Date

_____ _____

Signature of Representative (and relationship to Client) Date

_____ _____

Signature of Representative (and relationship to Client) Date

Julia (BaoGia) Le, LMFT #114470
Licensed Marriage & Family Therapist

Client-Informed Consent for Online Counseling Services

I _____ (guardian's name) hereby consent _____ (Client's name) to engage in online counseling/teletherapy services for my child with Julia (BaoGia) Le, LMFT. I understand that online counseling/teletherapy includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that online counseling/teletherapy also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to online counseling/teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to online counseling/teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are limits and exceptions to confidentiality with teletherapy, just as there are with in-person therapy. I am in agreement with these limits/exceptions, and understand that my therapist will explain these to me in detail if I wish.

3. I understand that there are risks and consequences from online counseling/teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Julia (BaoGia) Le, LMFT, that: the transmission of my information could be disrupted or distorted by technical failures.**

** I understand that if the teletherapy session does get disconnected, Julia (BaoGia) Le, LMFT, will call me back by phone, to complete our session.

4. In addition, I understand that online counseling/teletherapy based services and care may not be as complete as face-to-face services. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not be improve, and in some cases may even get worse.

5. I understand that I may benefit from online counseling/teletherapy, but that results cannot be guaranteed or assured.

6. I accept that online counseling/teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911; or proceed to the nearest hospital emergency room for help; or call my primary care physician or psychiatrist. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. I can also call the Orange County 24/7 Crisis Hotline at (800) 273-8255. From their website: “Crisis Prevention Hotline provides toll-free, 24-hour, immediate, confidential, culturally and linguistically appropriate, over-the-phone suicide prevention services to anyone, who is in crisis or experiencing suicidal thoughts”

7. I understand that I am responsible for (a) providing the necessary computer, telecommunications equipment and internet access for my online counseling/teletherapy sessions, (b) using www.doxy.me and/or www.zoom.us and (c) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my online counseling/teletherapy session.

8. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

I have read, understand and agree to the information provided above.

_____ _____

Guardian Printed Name Date

_____

Guardian Signature

_____ _____

Client Printed Name Date

_____

Client Signature