SUSAN J. RAY, LMFT
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Name: _____ Date of Birth:_____ Sex: _____

Spouse/Partner: _____ Date of Birth:_____ Sex: _____

_____
(Address) (Apt.#) (City) (State) (Zip Code)

Phone:_____
(Personal) (Spouse/Significant other if here as a couple)

Insurance Company:_____ Card Number:_____

Spouse Insurance Company: _____Card Number: _____

Policy Holder if not self _____ Birth date of Policy Holder _____Phone:_____

HIPPA All the information that you share with me, verbally or in writing is put into your record under lock. No one may look at your record beyond insurance quality assurance reviewers who are bound by the same laws of confidentiality as a therapist. You may look at your record at any time and you also may add any comments you wish. There are rare occasions when a therapist must disclose information about you or your case without your consent. This is known as "Duty to Warn" issues, which include the following: 1. The law requires us to report any known or suspected child abuse, neglect or exploitation. 2. If the court subpoenas your record I must release it. 3. If you threaten or are planning to hurt yourself or others I will share that information with to make sure you get the extra support and help you need. 4. Domestic Abuse including spouse abuse, child abuse and elder abuse. 5. In cases of serious medical emergency-- I may release information if requested by a medical personnel to secure your safety and well being only if no family is available to do so, and only in very urgent matters such as life and death. Except for these few instances I will guard your privacy extremely carefully as mandated by law.

Client/Therapist Agreement *My contact information is located above. If I am not immediately available to you, & you are feeling like hurting yourself or others,* ***call the crisis line at 832-3100, or ask for the crisis team after calling 911.*** *If I am on vacation, you will be notified. My associate Dr. Alfred Sison will be my back up while I am on leave. His number is (808) 393-0320.*

Co-payments and Tax *This is your financial responsibility after your initial insurance coverage)* ***are due at each session.*** *It is your responsibility to contact your insurance carrier & find out what your co-pay is and & the number of authorized visits. Co-payments typically range between 12.00 & 50.00. The norm falls around $12 & $15 per visit. Tax is 4.725% of the full price of services, not just your co-pay. Lately many plans have added a deductible which you are responsible for.*

Appointment Attendance *Since I usually have clients scheduled after you, arriving on time is important. If you need to reschedule or cancel an appointment, I require at least 24 hours' notice. If you do not cancel the appointment at least 24 hours in advance, there is a $50.00 no show cost. I am usually fully booked so if you are a no-show-- someone else would have taken your spot, so rescheduling ASAP would be greatly appreciated.*

Personal Confidentiality *If I see you in public, (or you, I)-please know that your confidentiality will be my upmost concern, and I will not acknowledge you, unless you initiate contact first. People vary on their comfort level with this sort of thing. If I don't acknowledge you, please know it is because I am respecting your confidentiality. I am happy to chat in most settings, just please initiate conversation, so I know it is ok with you. By signing below; I understand the policies described above, and have asked if I have any questions.*

Other *Any add on's (PEMF, EMDR,,or Happy Light) discussed in therapy are optional services and techniques and are voluntary. I will always advocate you to do your own research before you decide to use them. All decisions are up to you, including cognitive exercises, referrals for med assessments, supplements or homework assignments and readings shared with you.*

Print name of Client Signature (client/guardian if minor) Today's Date

_____ _____ _____

Print name of Client Signature (spouse/ family member) Today's Date

_____ _____ _____