

**Kathryn Maxwell, Ph.D.**  
**Licensed Marriage Family Therapist #44114**  
**P.O. Box 4462**  
**Santa Rosa, CA 95402**  
**707-237-8900**

Welcome to my practice. I appreciate you giving me the opportunity to be of help to you and I look forward to serving you in a courteous, prompt and professional manner. To help me better serve you I need the following information.

Client Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Additional Client Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip code

Telephones \_\_\_\_\_  
Home Work Cell

Employer (indicate branch, if any): \_\_\_\_\_

SSA # (if billing Ins.) \_\_\_\_\_

If minor, Parent or Guardian: \_\_\_\_\_  
Name Relationship

Who is paying for services? Self \_\_\_\_\_ Other \_\_\_\_\_ Relationship (if other) \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ SSA# \_\_\_\_\_

Name of Insurer \_\_\_\_\_ Member ID # \_\_\_\_\_

Group # or name \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
Name Telephone Relationship

Whom may I thank for referring you to me? \_\_\_\_\_

Policies and Procedures: For the benefit of all my clients, I wish to share my office policies and procedures.

Payment for Services: Clients are expected to pay for services at the time they are rendered unless other arrangements have been made. Please discuss your ability to make timely payments.

If you have insurance, which provides coverage for mental health counseling, I would like to help you receive your maximum allowable benefits. I do not participate in all managed care insurance plans (HMO's). I have found that the extraordinary amount of paperwork required takes away from patient care. I will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize the following:

1. Your insurance is a contract between you, your employer and the insurance company. I am not a party to that contract.
2. My fees are generally considered to fall within the reasonable range by most companies called "Usual, Customary and Reasonable" (UCR). Some companies pay a percentage of the UCR in a given area. However, some companies reimburse on an arbitrary schedule of fees, which bears no relationship to the current standard and the cost of care in the area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will NOT cover.
4. If your company requests any additional reports from me, aside from billing forms, in order to process your claim, I will need to receive my normal hourly fee from you for this service, if it takes more than a few minutes.
5. It is your responsibility to contact your insurance company regarding the above to find out about your reimbursement policies.

Cancellations: Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or canceling an appointment. The FULL FEE will be charged for missed sessions without this notification. Most insurance companies will not pay for missed sessions, and in this case you will be charged.

Emergency Procedures: If you need to contact me between sessions, you may leave a message and your call will be returned. If an emergency situation arises, indicate that your message is urgent, and I will respond in a timely manner. In a life-threatening situation, call 911 or go to your nearest emergency room.

Privacy Policies: Effective April 14, 2003, a national law affecting health care providers came into effect (HIPAA). Due to the length of the law, this is a summary of the information. The California Explanation Form is available upon request and provides more details. Please be aware that your confidentiality is always a priority, both under state laws and in our individual professional codes of ethics.

Uses and Disclosures:

1. Your protected healthcare information is accessed and used for healthcare related purposes only.
2. Your protected healthcare information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
3. Your protected healthcare information can be disclosed to third party entities without your written authorization for the purpose of treatment, to obtain payment for treatment and for healthcare operations.
4. Your protected healthcare information can be disclosed without your written authorization in certain limited circumstances:
  - a. In situations required by law (e.g. danger to self or others, to report elder or child abuse).
  - b. Medical emergencies.

I have been given the opportunity to review or request a copy of the privacy policies according to HIPAA Regulations. I have read and understood the office policies and procedures.

I also understand I am fully responsible for all charges, regardless of insurance coverage.

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Parent's Signature, if minor \_\_\_\_\_

Minor client's name

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**CONSENT TO TREATMENT**

I acknowledge that I have received, have read (or have had read to me), and understand the “Mandated Disclosure of Information to Clients” brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment. My signature below shows that I understand and agree with all of these statements.

Signature of client(s) or person acting for client(s)

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

I, the therapist have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_  
Signature of therapist  
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\_\_\_\_\_  
Date

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**MANDATORY DISCLOSURE OF INFORMATION TO CLIENTS**

With nearly 30 years experience in counseling clients of all ages, I have a pragmatic outlook and the skills to communicate effectively. I received both my B.A. and M.A. in Psychology from Sonoma State University and my Ph.D. from University for Humanistic Study where I studied Neuro-Linguistic Programming and Erickson Hypnosis. I also taught Self-Hypnosis at Grossmont College in San Diego.

In 2008, following extensive training in Trauma Response, I became a member of the California Association of Marriage & Family Therapist's Trauma Response Network. In 2009 I joined Trauma Outreach Associates, Inc.

My early work experience in the 1970s as a counselor at a family counseling facility enabled me to develop interventions and counseling skills with families in crisis. I continued developing my therapeutic skills as the director of the facility through 1976 and then in 1977 I became a licensed Marriage & Family Therapist and entered private practice. In addition to my counseling practice, I later spent several years designing and building homes which gave me an intimate understanding of the business world and the employer experience. In the past couple of years I have enjoyed working more with the elderly population, addressing the problems of adjustments to changing life issues. My training in Elder Mediation and continuing education in brain/neurological research has given me additional tools in assisting older clients.

The basic premise of my approach is that each person has the ability to heal themselves and may benefit from the assistance of a trained and neutral therapist to accelerate the healing/change process. Through caring support a client can gain the confidence and strength to explore painful areas of their lives and to challenge ineffective belief and behavior patterns. My goal is to form a real relationship with you, my client, to see you, hear you and assist you in experiencing yourself in a larger context so you can solve problems and make choices that work for you. I utilize various techniques (as appropriate) derived from the following therapeutic orientations:

Cognitive Behavioral Therapy  
Rational Emotive Therapy  
Neuro-Linguistic Programming (NLP)

Jungian Therapy  
Ericksonian Hypnosis  
Psych K