Sarah Y. Kerem, MFT

Licensed Marriage and Family Therapist MFC 39860
1665 Creekside Drive, Suite 106
Folsom, CA 95630
(916) 529-7002

General Information

Client	Date of Birth	Male / Female
Address	Telephone:	Email:
City	State	Zip

If minor, please list legal guardian / parent

Name	Telephone
Name	Telephone

Spouse/Partner Information

Name	Date of birth	Male/Female
Address	Telephone:	Email:
City	State	Zip

Other Information

Occupation and Employer	Religion

Academic Information

Current School Name	Current or Highest Grade Completed

Marital Status

☐ Never ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er) | Number of Marriages

Family Members

Name	Age	Relationship	In the home
Name	Age	Relationship	In the home
Name	Age	Relationship	In the home
Name	Age	Relationship	In the home
Name	Age	Relationship	In the home

Medical Information

Primary Care Physician	Phone	Date of Last Physical

Medication (prescribed by whom, medication name, dosage)

Medical Conditions and/or Allergies

Alcohol Use (frequency / amount)

Drug Use (non-prescribed street or over the counter)

Therapy Information

What would you like to discuss

How long has this been going on

Have you had previous therapy	By Whom	When
Person to contact in case of an emergency		**Phone**

Referred by:

Can I thank them for the referral? Yes / No

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Thank You for Selecting Me as Your Therapist

Therapy is a process that may lead to problem solving, resolving grief and loss issues, and reaching personal goals. You may experience changes that have benefits and risks, and such changes can effect how you relate to others. Moreover, changes in relationships may occur. Sometimes throughout the process, you may feel worse before you feel better. I trust that you will let me know when you are having unmanageable painful feelings and call 911 or go to the hospital should you be in crisis away from our sessions. I look forward to working with you.

- **Office Address**

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- **Confidentiality Statement**

The law and ethics of psychotherapy protect your right to privacy. Information about you will not be released without your prior permission, except for the following:

1. Suspicion of child, dependent adult, or elder neglect or abuse.
2. Reasonable belief that you are a danger to yourself or others.
3. Insurance company requires a report of your diagnosis, therapy needs, and goals, for authorization of benefits.

If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. I maintain a "no secrets" policy with couples or family therapy. Individual therapy may be an option if a secret needs to be kept for safety reasons.

- **Permission for Treatment**

I, _____, give my permission to Sarah Y. Kerem, MFT, to see my son / daughter, _____, for treatment of counseling. I have the legal right to consent for treatment. This authorization is effective immediately and shall remain in effect until the termination of therapy, unless otherwise revoked by the undersigned.

- **Cancellations**

For cancellations, please call me **24 hours** in advance of your scheduled appointment. Otherwise, you will be charged for the full session fees unless you have an obvious emergency.

- **Fees**

My standard fee is **$165 per 50 minute session, due at time of service**. Phone consultations, including texting or emails, lasting longer than 10 minutes will be charged at a rate of $42 per 15 minute increment. I do not accept insurance. If needed, I will offer referrals so that your counseling needs may be met by another, more affordable professional. You will be responsible for any fees incurred due to returned checks.

"I agree that I am responsible for payment due at time of service. I understand and agree to the above conditions and hereby request psychotherapy services."

Signature of Client	Date	Sarah Y. Kerem, MFT	Date
Signature of Client/Parent	Date	Signature of Parent / Legal Guardian	Date

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Informed Consent for Telemedicine

I _____(client's name) hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as "telemedicine") with my therapist, Sarah Kerem, MFT.

I understand that I have the following rights under this agreement:

I have a right to confidentiality with telemedicine under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to any other entities shall not occur without my written consent.

I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal, and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus I understand that while I may benefit from telemedicine, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to telemedicine, including, but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that telemedicine treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I understand that I have a right to access my medical information and copies of medical records in accordance with applicable California law.

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

I have read and understand the information provided above. I have the right to discuss any and all of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

Signature and title (client, conservator, guardian ,etc.): Signature of psychotherapist:

_____ _____
Sarah Kerem, MFT

Date: _____