Matthew Lehman, MA LMFT
LMFT#98173
23151 Moulton Parkway, Suite 108
Laguna Hills, CA 92653
Phone: (714) 473-4603
Fax: (714) 752-5842
mattlehmanmft@gmail.com

Client Name ____

Address ___________________________________ City _______________________ Zip _____________

Home Phone (___)_______________ Mobile Phone (___)_______________ Work Phone (___)_______________

Okay to leave message? Please Circle (Home) (Mobile) (Work)

Email ________________________ Sex _________ Age___ DOB _________ Martial Status_____________

Employer/School _____________________ Occupation ____

Work/School Address ____

Referred by? __________________________ Highest Education (degree/years in school) ______________

Notify in Case of Emergency _________________ Phone _____________ Relationship to Client _________

Names, ages and relationships of other persons living with you ______________________________________

____

Primary Care Physician ____________________ Address ____

Phone (___)_______________ Date of most recent visit ___________ Date of most recent physical__________

Describe any health problems ____

List all current medications, dosage, length of time taking it ______________________________________

____

Allergies to food or medication? ____

Please list any previous mental health professionals you have seen, city where located, when and for what reason(s) ____

____

____

Please describe the reason you are seeking counseling services ______________________________________

____

____

Matthew Lehman, MA LMFT
LMFT#98173
23151 Moulton Parkway, Suite 108
Laguna Hills, CA 92653
(714) 473-4603
mattlehmanmft@gmail.com

Welcome. Thank you for choosing me as your psychotherapist: I look forward to working with you! This document contains important information regarding office policies and confidentiality, in addition to your rights and responsibilities. Please read it carefully and feel free to ask me any questions you have regarding these policies.

Appointments and Availability. Sessions are typically 50 minutes in length, scheduled by appointment only. Clients are generally seen weekly, although frequency can vary depending upon need. I am available and check messages during normal business hours, and you can contact me at (714) 473-4603. If there is an emergency, and you are unable to reach me directly, call 911, go to your nearest emergency room, or contact the Orange County, Centralized Assessment Team (C.A.T) at 714-517-6353 or 1-866-830-6011.

Fees. The fee per 50-minute session is $125 payable at the beginning of each session, unless we make other arrangements. Sessions longer than 50 minutes and services provided outside of scheduled appointments (e.g., telephone conversations, email, correspondence, etc.) will be billed at the same hourly rate on a prorated basis. There is a $25 service fee for returned checks. A limited number of sliding-scale fee openings are available.

Insurance Reimbursement. Client is responsible for verifying and understanding the limits of coverage, as well as co-payments and deductibles. If I am a contracted provider with your insurance plan I will bill your insurance. If I am not contracted with your insurance plan, I will provide a, "superbill" for each therapeutic encounter that may be submitted to your insurance plan (by client) for partial reimbursement as an out of network provider. Please contact your insurance carrier or managed care plan for additional information.

Cancellations and Missed Appointments. If you must cancel an appointment, please contact me as soon as possible: you are responsible for up to the full session fee of $125 if you cancel fewer than 24 hours in advance of or our scheduled appointment, regardless of the circumstances. Your insurance will not cover an appointment for which you were not present, so it will be your responsibility to pay up to the full fee for late cancellations. You agree that your credit card will be charged for any missed sessions for which you fail to provide 24 hours' notice (Medi-Cal exempt).

Risks and Benefits of Therapy. It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion. Your therapist will work with you to develop an effective treatment plan. Over the course of therapy, your therapist will attempt to evaluate whether the therapy provided is beneficial to you. Your feedback and input is an important part of this process. It is the goal of your therapist to assist you in effectively addressing your problems and concerns. However, due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the

length of your therapy or to guarantee a specific outcome or result.

Families and Couples in Therapy. If I am seeing your family for therapy, I reserve the right to use my own discretion and clinical judgment in disclosing information family members choose to share with me individually. I will use my best judgment as to whether, when, and to what extent I will make disclosures and will also, if appropriate, first give the individual the opportunity to make the disclosure himself or herself. This no secrets policy also applies if I am seeing you in couples therapy.

Child Custody. I am not a child custody evaluator, therefore I cannot make conclusions or recommendations to the court regarding custody. I do not make court appearances.

Services Beyond Psychotherapy. My rate for extra services (e.g., writing letters, attending meetings) is $125 per hour (prorated as necessary).

Records and Record Keeping. Therapist may take notes during session, and will also produce other notes and records regarding Client's treatment. These notes constitute Therapist's clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any client. Should Client request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Client with a treatment summary in lieu of actual records. 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. Therapist will maintain Client's records for ten years following termination of therapy. However, after ten years, Client's records will be destroyed in a manner that preserves Client's confidentiality.

Confidentiality. The information disclosed by Client is generally confidential and will not be released to any third party without written authorization from 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 client 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.

Termination of Therapy. Therapist reserves the right to terminate therapy at his/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 Client is not making adequate progress in therapy. Client has the right to terminate therapy at his/her discretion.

Ethical Standards. As a Licensed Marriage and Family Therapist, I am bound by ethical standards to "advance the welfare of families and individuals, respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately." (California Association of Marriage and Family Therapists, Ethical Standards, Part I). I do not discriminate on the basis of race, gender, religion, national origin, age, sexual orientation, and disability, socioeconomic or marital status. I will not exploit the trust you place in me as your therapist.

Complaints. You have the right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, please inform me immediately so that we can discuss and resolve the situation. If you feel that I have breached an ethical or legal standard, you may contact the licensing board, the Board of Behavioral Sciences, 400 R Street, Sacramento, CA 95814.

Acknowledgment. By signing below, Client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Client's satisfaction. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Client agrees to hold 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.

Consent for an Adult or Couple:

____ _________________________

Signature of Client Date

____ _________________________

Signature of Client Date

____ _________________________

Matthew Lehman, LMFT Date

Consent to Treat a Minor

I, ____, as the parent/legal guardian of minor_______________________________ (DOB: _______________) give permission to Matthew Lehman, LMFT to provide treatment, which may include individual and/or family therapy for the minor. I also understand that I will be informed of the child's progress or of any new issues which arise during treatment.

____ _________________________

Parent/Guardian Signature Date

____ _________________________

Signature of Minor Date

____ _________________________

Matthew Lehman, LMFT Date

Late Cancel/No Show Fee Credit Card Information (Medi-Cal exempt):

Name on Card:____

Credit Card Number:____

Expiration Date:____

Security Code:____

Zip Code:____