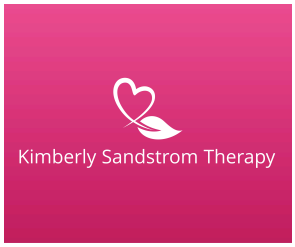

Kimberly Sandstrom, LMFT MFC#80011
10065 Old Grove Road, Su. 102
San Diego, CA 92131
619.333.6382
therapy@kimberlysandstrom.com
www.kimberlysandstrom.com

INFORMED CONSENT

,
Kimberly Sandstrom is a licensed Marriage and Family Therapist MFC80011

Fees and Insurance
The fee for service is $140 per session. You have agreed to pay $_____ per session. Sessions are 50-60 minutes in length. Fees are payable at the end of each session, with either a check, credit card or cash. Please let me know if you are unable to continue paying for your therapy. Scholarships rates are sometimes available, otherwise we will discuss referral options. This practice does not do insurance billing. It is your responsibility to submit claim forms for reimbursement to your own insurance company. If your insurance denies payment of any service, payment of sessions is your responsibility. Currently, I do not accept Health Savings Account credit cards for payment.

Appointment Scheduling and Cancellation Policies If you are unable to attend your scheduled appointment, you must call **at least 24 hours notice in advance, or you will be charged a full session fee.** Please understand that your insurance company will not pay for missed or cancelled sessions.

Returned Checks $25 is required (in addition to the original amount) for any returned checks.

Phone and Skype Sessions Phone and Skype sessions are charged at the same rate as regular sessions.

Confidentiality
All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment.

Exceptions to confidentiality:
a) Therapists are required to report instances of suspected child, dependent adult or elder abuse to the proper authorities.
b) Therapists may be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a client is dangerous to him or herself. This includes cases where the client is gravely disabled and the therapist needs to protect the client from harm. You may not use confidentiality as a way to avoid legal punishment. Your therapist will not aid or abet committing a crime according to the federal law known as The Patriot Act of 2001. This law requires therapists in certain circumstances, to provide FBI agents with books, records, papers and documents and other items. It prohibits the therapist from disclosing to the client that the FBI sought or obtained the items under the Act.
c) Kimberly Sandstrom uses the services of a bookkeeper and shares basic contact & payment information for the purposes of bookkeeping for Kimberly Sandstrom's business. Kimberly Sandstrom's bookkeeper is covered under a non-disclosure agreement and will not release confidential information to anyone other than client at Kimberly Sandstrom's request.

No-secret Policy for Family Therapy and Couple Therapy
If you participate in couple or family therapy, your therapist 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 such information. Secrets within relationships sometimes can be destructive or counter-productive to the goals of therapy. If a client divulges such a secret to the therapist, the therapist will use her discretion about revealing it. Generally, the therapist will ask the client to divulge the secret – if the therapist believes the secret is destructive or counter-productive to the counseling process, she may refuse to continue working with the client until the client reveals the secret. In cases of danger, the therapist may reveal the secret to maintain safety.

Minors
By signing below I am giving Kimberly Sandstrom's consent to conduct therapy sessions with the minor listed below. Communications between therapists and clients who are minors (under the age of 18) are confidential. The holder of the privilege is the minor. I have been informed of the limitations of confidentiality in terms of the treatment of certain topics such as substance use and sexual activity. I accept Kimberly Sandstrom's judgment in regards to releasing information related to the treatment of this minor. I understand that anytime Kimberly Sandstrom' believes this minor is in danger of hurting him or herself, I will be notified immediately.

Therapist Availability/Emergencies
Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions. You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance. If you have an urgent need to speak with your therapist, please indicate that fact in your message.

If you have an emergency, please call 911 or the 24 hour emergency crisis line at 1888 724 7240.

Therapist Communications
Your therapist may need to communicate with you by telephone, mail or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

My therapist may:
____ call me at my home. ____ call me on my cell phone. ____ call me at work. ____ send mail to my work
___ communicate with me by email. ___ send a fax to me. ___ send mail to my home address
Email communication is for non-emergencies only. Email is not a confidential medium of communication and is used only for appointment changes, referrals and non-clinical questions. If you are canceling an appointment with less than 24 hours notice, please call my business number.

Social Media
Kimberly Sandstrom does not accept friend requests from current or former clients on any social networking site (including but not limited to professional social media sites). Adding friends can

compromise client confidentiality, along with blurring boundaries of the therapeutic relationship. Your therapist will not follow clients on any social media interface, nor respond to posts by current/former clients. Messaging Kimberly via any social interface as a way to schedule or communicate is not encouraged. If clients need to contact Kimberly between sessions, the best way to do this is via phone call or email.

About the Therapy Process
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 clients 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. Due to the varying nature and severity of problems and the individuality of each client, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy
You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Litigation Limitation
Kimberly Sandstrom does not do court work. If you need these services, referrals to forensic professionals will be provided for you. My desire is to protect your psychotherapy from the intrusiveness of legal proceedings. By signing this form, you are agreeing that neither you nor your attorney will call me to testify in court or any other legal proceedings, nor will a disclosure of psychotherapy records be requested for legal proceedings.

Signature_____ Signature_____

Date: _____ Date: _____

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INITIAL CONTACT INFORMATION

Name of person initiating therapy: _____
Birthdate: _____ Age: _____ Email: _____
Home Phone: _____ Cell: _____ Work Phone: _____
Address: _____City_____State___Zip_____
Employer: _____
Name(s) of others who may be attending sessions:
#2: Name: _____
Birthdate: _____ Age: _____ Email: _____
Home Phone: _____ Cell: _____ Work Phone: _____
Address (if different from above): _____City_____State___Zip_____
#3: Name: _____
Birthdate: _____ Age: _____ Email: _____
Home Phone: _____ Cell: _____ Work Phone: _____
Address (if different from above): _____City_____State___Zip_____
Who currently lives in your home? _____

_____
Your medical doctor and / or psychiatrist:
#1: Name: _____ Phone: _____
#2: Name: _____ Phone: _____
Who were you referred by?
_____May I thank them? _____
Briefly summarize your reason for beginning therapy: _____

_____
Person to notify in case of an emergency: _____
Phone: _____ Relationship to you: _____

Have you ever received psychological or psychiatric or counseling services before?
Yes___No___If yes, please indicate:
When? From whom? For what? Results?

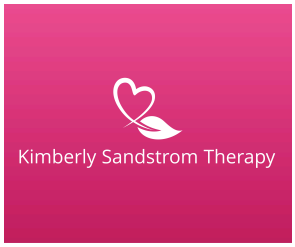
_____ _____ _____ _____
_____ _____ _____ _____

Have you ever taken medications for psychiatric or emotional problems?
Yes___No___If yes, please indicate:
When? From whom? Medication For what? Results?

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Family History
Have any of your BLOOD RELATIVES ever had any of the following:
WHO?
Alcoholism Yes No _____ _____
Depression Yes No _____ _____
Mental Illness Yes No _____ _____
Epilepsy Yes No _____ _____
Neurological Disorder Yes No _____ _____
Suicide Attempts Yes No _____ _____
Hallucinations Yes No _____ _____
Drug Problems Yes No _____ _____
Psychiatric Treatment Yes No _____ _____

Education/Employer(or for child, parent's current employer)
Highest grade/degree completed? _____ College/Graduate
Major(s):_____
Employer: _____ Occupation:_____
Address: _____ Phone: _____
If student, school attending_____



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HIPAA Patient Notice of Privacy Practices

Due to the "Privacy Rule" established by the Department of Health and Human Services, any personal healthcare information is protected and kept confidential for your privacy. The Privacy Rule establishes a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information in order to carry out treatment, payment, or healthcare operations.

We respect the privacy of your personal medical records. We will take precautions to secure and protect that privacy. When appropriate we will provide only the minimal information necessary in order to provide health care that is in your best interest. Please carefully read our "Office Policies and Procedures" for more details.

With your consent, disclosure of your personal health information may be shared for purposes of treatment, payment, or health care operations with hospitals, pharmacies, health plans, co-treaters, and laboratories.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, if you refuse to disclose your Personal Health Information (PHI), we have the right to refuse to treat you. If you choose to give your consent, at some future time you may request to refuse to disclose all or part of your PHI. You may not revoke actions that have already been taken which relied on a previously signed consent. You have the right to receive accounting of any disclosures we have made.

You have the right to receive a copy of your PHI at this counseling center, but your request must be submitted in writing. In certain situations your therapist may deny your request. If so, you will be told in writing the reasons for denial and your right to have the denial reviewed. If you request copies of your PHI, you will be charged no more than $.25 each page. Your therapist may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

You have the right to have your therapist amend your PHI. If we deny your request, you may file a disagreement with us and prepare a rebuttal, which will be added to your PHI.

All of our therapists and employees undergo training to understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA), with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

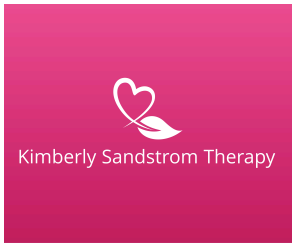
We have implemented a Compliance Program that we believe will help us prevent any inappropriate use of your PHI. We welcome your input regarding any service problem so that we may remedy the situation promptly.

If you have any questions, please ask to speak with Aloma DeVaux, HIPAA Compliance Officer, at 619 298-8722x110. You may also file a complaint to the Secretary of Health and Human Services if you believe we have violated your privacy rights.

I acknowledge receipt of this notice.

Client Signature _____ Date _____

Client Signature _____ Date _____



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Consent for Videotaping of Sessions

In order to provide the best possible therapy for you, Kimberly Sandstrom, LMFT MFC#80011, tapes her sessions to meet with supervisor consults or training groups on a regular basis. At some point you may also be asked to participate in a therapy session which will be observed live by a consultant or training group. In this case, you will know in advance.

With your consent, Kimberly Sandstrom will present your case via video tape to therapists/supervisors she consults with. In addition, a summary of the presenting problem will also be included in this presentation. Absolutely no identifying information is presented to the consultation group or training group. All consultant or training groups follow the same confidentiality guidelines as Kimberly Sandstrom. If by chance someone in the group was to know you or a member of your family, they will be asked to immediately leave the group and will not be permitted to participate in the portion of the meeting involving your case.

____ I am willing to be recorded by video to be reviewed with a consultation and/or training group.
____ I am willing to participate in a live consultation and/or training group with minimal background - relationship and individual clinical history revealed.

Authorization for Taping of Counseling Sessions

I, _____, hereby give permission for my Therapist, Kimberly Sandstrom to videotape my counseling sessions. I understand that the purpose for this taping is for my therapist to consult with his/her supervisor consultants to ensure the best possible treatment planning for my case.

I also understand that all therapy is bound by the laws of confidentiality, and that neither my counselor nor the consultant or training group will disclose any information about my identity or the details of my treatment outside of their consultation.

I know that I can revoke this release in writing at any time I choose to.

_____ _____
Client(s) Signature Date

_____ _____
Counselor's Signature Date