Ashlee Slattery, M.A.
Licensed Marriage and Family Therapist
LMFT #136870

PATIENT INFORMATION FORM

Patient Name :

Birthdate:

Age:

Contact Information:

Address | City | State | Zipcode

Home phone | Cell phone

Can a message be left : ☐ Yes ☐ No ☐ Special Instructions

Email Address:

May I send email : ☐ Yes ☐ No

What is your current relationship status? For example, in a committed relationship, single, married, widowed, partnered, separated, divorced, etc. _____. If not married, with a significant other? ☐ Yes ☐ No Length of Relationship _____
Pregnancies (if applicable): _____ # of Children _____
Age(s) _____.

Were you adopted? ☐ Yes ☐ No

Religious/Spiritual Preference: _____

How would you describe your ethnicity or race? _____

How would you describe your sexuality? _____

How would you describe your gender identity? (female, nonbinary, trans man or trans female, gender fluid, cis male, etc). _____

What pronouns do you use?_____

Patient Information:

Name of close friend or relative in case of emergency _____

_____

Their phone number:

Have you had previous therapy/counseling? ☐ Yes ☐ No

If yes, with whom? _____ Start date_____ End Date_____

Who may I thank for referring you to me? _____

Please check the problems or concerns that you would like help with in therapy:

- ☐ Academic Concerns
- ☐ Addictions
- ☐ ADHD/learning problems
- ☐ Adjustment to new situation
- ☐ Alcohol or Drug Concerns
- ☐ Anger Management
- ☐ Anxiety, fear, nervousness
- ☐ Bullying/Intimidation
- ☐ Career/job Concerns
- ☐ Caregiver Stress
- ☐ Compulsive Behavior
- ☐ Concentration Difficulties
- ☐ Concern with other's well being
- ☐ Cultural/Multicultural Concerns
- ☐ Cutting or Self Injury
- ☐ Depression, Sadness
- ☐ Divorce/Separation
- ☐ Eating Concerns/Body Image or Weight
- ☐ Emotional/ Psychological Abuse
- ☐ Family Problems
- ☐ Feeling Doomed or Helpless
- ☐ Financial Concerns
- ☐ Flashbacks/Nightmares
- ☐ Identity/sense of self
- ☐ Impulse Control
- ☐ Impulse Control
- ☐ Intimate Relationship Concerns
- ☐ Lack of Motivation
- ☐ Legal Concerns
- ☐ Loneliness/Lack of Support
- ☐ Loss, grief, death
- ☐ Self-esteem
- ☐ Medical or Health Concerns
- ☐ Mood Swings
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Parenting/Parent Child Concerns
- ☐ Phase of Life Problems
- ☐ Phobias/Specific Fears
- ☐ Physical Abuse/Assault
- ☐ Procrastination
- ☐ Relationship Concerns
- ☐ Sexual Abuse or Assault
- ☐ Sexuality Concerns
- ☐ Sexual Dysfunction
- ☐ Sleep Difficulties
- ☐ Spiritual/Religious Concern
- ☐ Stress or Tension
- ☐ Suicidal Thoughts
- ☐ Suicide Attempt
- ☐ Racing/Obsessive Thoughts
- ☐ Trauma
- ☐ Trouble Making Decisions / Getting Things Done

Please list immediate family members, partner(s), children, parent(s), sibling(s), housemate(s), or roommate(s) who reside with you:

Names:	Relationship to you in age:

Contact Information:

Are you currently taking any medication or supplements? ☐ Yes ☐ No

If YES, please list dosage, frequency, and prescribing doctor _____

Are you currently seeing a psychiatrist? ☐ Yes ☐ No

If Yes, Name: _____

Name of Primary Care Physician: _____

City and State: _____

May I coordinate Care? ☐ Yes ☐ No Phone Number: ☐☐☐☐☐☐☐☐

Date of last visit to Physician: _____/_____/_____

Medical Relevant Conditions (please list) :

1. _____ 3. _____

2. _____ 4. _____

Alcohol use (circle)? ☐ Yes ☐ No If YES, frequency? ____/day OR ____/week OR____/month

Cigarette use (circle)? ☐ Yes ☐ No If YES, frequency? ____/day OR ____/week OR____/month

Caffeine use (circle)? ☐ Yes ☐ No If YES, frequency? ____/day OR ____/week OR____/month

Do you exercise? ☐ Yes ☐ No If YES, frequency? ____/day OR ____/week OR____/month

Please circle all drugs you have ever used and indicate date of last use:

☐ Marijuana _____ ☐ Mushrooms _____ ☐ PCP _____

☐ LSD/Acid _____ ☐ Ecstasy _____ ☐ Heroin/Opium _____

☐ Cocaine (coke, crack) _____ ☐ Amphetamines (meth, speed) _____ ☐ Inhalants/Solvents/Other _____

Family History (Check Appropriate Boxes)

	Mother	Father	Siblings	Aunt/ Uncle	Grandparents
Depression					
Alcohol/ Substance Abuse					
Anxiety					
Suicide Attempt Or Completion					
ADHD					
Marital Issues					
Significant Physical Disability					
Survivor or perpetrator of physical/sexual Abuse					

What are the areas of your life for which you are seeking assistance? _____

How long has this been a concern? _____

Insurance Information

Insurance Company_____ Policy #_____

InsuranceAddress_____

Insurance Phone Number (____)_____ Group #_____

Social Security Number (patient)_____ (insured)_____

Occupation_____ Employed by_____

Insured's Address, Date of Birth, Phone, and Employer (if different):

_____

_____

Are you involved in any legal proceedings currently, or do you anticipate being involved with any lawsuits? Yes No If yes, please explain: _____

_____

_____

CONSENT FOR TREATMENT NOTICE OF BUSINESS POLICIES AND PRIVACY PRACTICES

Please read these documents carefully as they contain important information related to my professional services and business policies. When you sign this document, it will represent an agreement between us. Questions related to this agreement can be discussed at any time.

The information provided regarding my policies for protecting the privacy of your confidential medical information is required by law. I want you to know that I am a Licensed Marriage and Family Therapist, employed by Dr. Brittany Chidley/Trails Therapy, APC. I may coordinate care and consult with Dr. Brittany Chidley and employees of Trails Therapy, APC to discuss your treatment and to make sure I am providing the best services possible.

Psychological Services

The psychotherapy I provide varies depending on your characteristics and the particular concerns you bring forward. Psychotherapy is not like other forms of treatment in that it calls for an active effort on your part. In order for psychotherapy to be as successful as possible, you will need to consider the things we talk about both during and between our sessions, and consider making changes in some of your habits and in the way you think about certain things.

Psychotherapy has benefits and risks. Since psychotherapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, extensive research indicates that psychotherapy often offers benefits, including improved mood, better relationships, solutions to specific problems, and significant reductions in feelings of distress. In short, while psychotherapy is often helpful, there are no guarantees of what you will experience in psychotherapy.

Psychotherapy involves an initial evaluation, which typically takes one or two sessions to complete. By the end of the evaluation period, I will offer you some initial impressions of how our work together might be helpful should you decide to continue with treatment. You should evaluate this information along with your own impressions of whether you feel comfortable working with me. Psychotherapy involves a significant investment of time, money, and energy, so you should think carefully about making this commitment. If you have questions or concerns about our work together, we can discuss them when they arise.

It is important that we discuss your concerns and attempt to address them directly. If you decide at any time that our work together is not meeting your needs, I would be happy to help you determine the best course of action, such as beginning treatment with another mental health professional or disengaging in treatment altogether.

Sessions
During the initial evaluation, we can both decide if I am well positioned to provide the services that you need. If we decide to work together in psychotherapy, I will typically schedule one 40-50 minute session per week, or as frequent as necessary at a time we agree upon. *Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24-hours advance notice of cancellation.*

Professional Fees

My fee for our initial evaluation is $135. Follow-up appointments for individuals are scheduled for 40-50 minute increments at the rate of $120 each. Follow-up appointments for couples and families are scheduled for 60-minute sessions at a rate of $135.00.

Fee agreed upon if different from above: _____

In addition to regular appointments, I charge this amount for other professional services you may need, but I will break down the hourly cost if I work for periods of less than one hour. Other services may include report writing, extended telephone conversations, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

Billing and Payment for Services
Unless otherwise agreed upon, payment is expected at the time of service. I accept checks, cash, credit card and payment via PayPal as forms of payment. You may authorize us to bill the card on file to avoid receiving any statements or accruing any balance on your account.

Dr. Brittany Chidley and her billing advisor, Julie Hulstine oversee and sometimes manage my accounting and invoices. They will have access to limited information about you and my work with you—for example, they will know your name, address, diagnosis, and other similar information, and will also know about the services I've provided for you.

Insurance Reimbursement
Given that ***I am an employee of Dr. Brittany Chidley/Trails Therapy, APC.***, it is dependent on the insurance company whether they cover for my services. If you have health insurance it will usually provide some coverage for mental health treatment. You should carefully review the details of your insurance coverage for mental health services. If you have questions about the coverage, please call your plan administrator.

Of course, I will provide you with whatever information I can and will be happy to help you in understanding the information you receive from your insurance company.
Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end treatment. Note that you always have the right to pay for my services yourself if you don't want to use your insurance or if your insurance is limited. You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries. This information will become part of the insurance company files and will probably be stored in a computer. I will provide your insurance company with only the information required in order to meet their administrative needs.

By signing this consent form, you authorize me to provide information to your insurance company as needed for payment for services. It is important to understand that there are certain situations where insurance will not pay for mental health services: Insurance will not pay for missed sessions or sessions that are cancelled less than 24 hours in advance. Insurance also does not pay for missed EAP appointments, court-ordered treatment outside the scope of routine outpatient care, legal matters, or any time you elect not to use your insurance for services. By signing this form, you acknowledge and accept the limitations of what your insurance company will pay for and what you would be responsible for yourself.

Professional Records and Confidentiality

The laws of California and the standards of my profession require that I keep treatment records. Since I am an employee of Brittany Chidley, Psy.D./Trails Therapy, APC., Dr. Brittany Chidley along with her billing team may need to access the records in your file. The information in your medical record is utilized in a number of ways. I use it to plan your treatment and keep a record of the significant issues that we address in treatment. I also use the information to coordinate your treatment with other professionals or to provide information to significant others or family members; information is only provided to those that you have given me permission in writing to communicate with regarding your treatment. I will maintain treatment records for a minimum of seven years following termination of treatment. After seven years treatment records will be destroyed in a manner that preserves confidentiality.

Exceptions to Confidentiality

There are some exceptions to confidentiality and I will provide information from your record when required to do so by local, state or federal law. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, however, a judge may order my testimony if she or he determines that the issues demand it. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, a person over age 65, or a disabled person is being abused or mistreated, I am required to file a report with the appropriate state agency that can investigate that matter. If I believe that a client poses a serious risk to someone else, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm her or himself, and I am not able to resolve the situation in treatment, I may seek hospitalization for the client or contact family members or others who can help provide protection. I am also obligated under the law to report to the appropriate authorities any instance where a client discloses that s/he has accessed, streamed, or downloaded material where a child is engaged in an obscene sexual act. I must also report electronic images of children that depict obscene sexual conduct. Professional consultation is an important component of psychological practice, and I may occasionally find it helpful to consult other professionals regarding clinical, ethical, and/or legal issues. During a consultation, I make every effort to avoid revealing the identity of my client and/or my client's family members or caregivers. If a situation occurs that requires that I share information without your written permission, I will make every effort to fully discuss it with you before taking any action.

In most situations, in order to release any information to another party, I will ask that you sign an Authorization to Release Information. You may revoke your authorization at any time. In the event of my incapacitation, disability or death, I have authorized my employer, Brittany Chidley, Psy.D./Trails Therapy, APC**.** to have access to my client files and my appointment book. As a psychologist, she is bound by confidentiality as well.

Minors & Parents

Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement is also essential, it is usually my policy to request an agreement with minors [over age 12] and their parents about access to client information. This agreement provides that during treatment, I will provide parents with only general information about the progress of the treatment, feedback as to actions that may be helpful to the client's treatment, and the client's attendance at scheduled sessions. Any other communication will require the child's Authorization unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any specific information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Clients under 18 years of age who are not emancipated can consent to psychological services subject to the involvement of their parents or guardian unless the psychologist determines that their involvement would be inappropriate. A client over age 12 may consent to psychological services if he or she is mature enough to participate intelligently in such services, and the minor client either would present a danger of serious physical or mental harm to him or herself or others, or is the alleged victim of incest or child abuse. In addition, clients over age 12 may consent to alcohol and drug treatment in some circumstances. However, unemancipated clients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records unless I determine that access would have a detrimental effect on my professional relationship with the client, or to his/her physical safety or psychological well-being.

Litigation

I will not voluntarily participate in any litigation or custody dispute involving a client. I have a policy of no communication with a client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in a legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed or ordered by a court of law to appear as a witness in a legal matter involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at an hourly rate of $300.

Complaints

The California Board of Behavioral Sciences and California Department of Consumer Affairs' Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. You may contact the Board of Behavioral Sciences 1625 North Market Blvd., Suite S200, Sacramento, CA 95834 or by calling (916) 574-7830. You may contact the Board of Psychology by calling 1-866-503-3221, at www.psychboard.ca.gov, or by writing to the Board of Psychology, 1625 N Market Blvd Ste N-215, Sacramento, CA 95834.

Information In Your Medical Record Including the Right to Inspect and Copy
You are entitled to receive a copy of your medical record unless I believe that receiving that information would be emotionally damaging. Because these are professional records, they can be misinterpreted or upsetting to untrained readers. If you wish to see your records or receive a copy of your records, I require written notice to that effect, and I would expect to discuss your request with you in person.

I typically provide a treatment summary when there is a request for records. If I deny you access to your records, you can request to speak with an independent mental health professional about the situation. Your request for independent review of your original request for records should also be made in writing. If you are provided with a copy of your medical record information, I may charge a fee for any costs associated with that request. If you believe that the information I have about you is incorrect or incomplete, you may ask me to amend that information. It is my practice to accept this sort of request in writing, and that any information you may wish to add to your record also be provided to me in written form. You have the right to request an Accounting of Disclosures. This is a list of the disclosures I have made of medical record information. That information is listed on the Authorization To Release Information, and will be provided to you at your written request. You have the right to request a restriction or limitation on the health information I disclose about you for treatment, payment, or health care operations. As noted above, I will not release your confidential information without your written permission. Any restrictions to your Authorization To Release Information should be specified on the Authorization. You have the right to request that I communicate with you only in certain ways. For example, you can ask that I not leave a telephone message for you, or that I only contact you at work or by mail.

Complaints Regarding Privacy Rights
If you believe your privacy rights have been violated, you may file a written complaint with me, or with an independent mental health professional, or with the U.S. Department of Health and Human Services, 50 United Nations Plaza, Room 322, San Francisco, CA, 94102. You will not be penalized for filing a complaint. You have the right to a paper copy of this document, and you will be offered one when you sign the original for your treatment record. I reserve the right to change my policies as outlined in this document--if they change you will be informed of that change and will be provided with a copy of the updated form.

Termination of Treatment
I reserve the right to terminate treatment at my discretion. Reasons for termination include, but are not limited to, cessation of my practice, untimely payment of fees, conflicts of interest, failure to participate in treatment or to make adequate progress in treatment, or treatment needs that are outside the scope of my practice or expertise. You also have the right to terminate treatment at your discretion. Should either of us decide to end treatment, I will generally recommend that you participate in a final session so that we can reflect on the work that was completed and discuss any ongoing treatment needs. When indicated, I will also offer referrals and attempt to ensure a smooth transition for any recommended ongoing treatment.

Contacting Me
I am often not immediately available by telephone. In addition to my role within a private practice, I have other clinical responsibilities at other locations. When I am unavailable, my telephone will roll over to a voicemail system that I check frequently. I will make every effort to return your call in a timely fashion, and typically within a business day or two after you leave me a message.

I am unable to provide 24-hour crisis service. In emergencies, you can attempt to reach me at my office number and leave a message. If I will be unavailable for an extended time, the voicemail greeting will provide you with the name of a colleague to contact, if necessary. If you feel that you can't wait for a return call, you can contact the San Diego Access and Crisis Line (1-888-724-7240) or go to the nearest hospital emergency room and ask for help. If you are experiencing a medical emergency, call 911. If you simply want someone to talk to for support, the County of San Diego operates the WARM Line, available everyday during afternoons and evenings, at 1-800-930-9276. Finally, the Suicide & Crisis Lifeline offers support by phone or chat at https://988lifeline.org (or call 9-8-8). If I am on vacation and you have an emergency, you may call my voicemail and the outgoing message will have the name and contact information of a colleague who is on-call on my behalf.

Acknowledgment

- Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.
- By signing below, you acknowledge that you have reviewed and fully understand the terms and conditions of this agreement and consent. Moreover, you agree to hold me free and harmless for any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from treatment.
- You also understand that you are financially responsible for all charges for services provided, including unpaid charges by your insurance company or other 3rd party payor.
- You understand that I am a Licensed Marriage and Family Therapist employed by Brittany Chidley, Psy.D./Trails Therapy, A Psychological Corporation
- If you have discussed using your insurance, you allow Brittany Chidley, Psy.D./Trails Therapy, Inc. to file on your behalf for payment of services with your insurance company if they accept claims and receive payment for these services directly. You agree that Brittany Chidley, Psy.D./Trails Therapy, Inc. may release any and all records to my insurance company or payor as requested for the process.

Patient Signature:_____ **Date**:_____

SUPPLEMENTAL TELETHERAPY INFORMED CONSENT FORM (TO BE COMPLETED IN THE EVENT TELEHEALTH IS NECESSARY)

Definition of Services: I,_____, hereby consent to engage in teletherapy with Ashlee Slattery, M.A., LMFT. Teletherapy is a form of psychological service provided via secure internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually. Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted face-to-face. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-toface treatment sessions. I understand that I have the following rights with respect to teletherapy: Client's Rights, Risks, and Responsibilities:

1. I, the client, need to be a resident of California. (This is a legal requirement for psychologists practicing in this state under a CA license.)
2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general Consent for Treatment form I received at the start of psychotherapy treatment.
4. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
5. There is a risk that services could be disrupted or distorted by unforeseen technical problems.
6. In addition, I understand that teletherapy-based services and care may not be as complete as face-to-face services. I also understand that if Dr. Brittany Chidley believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area.
7. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychologist, my condition may not be improve, and in some cases may even get worse.
8. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for Telepsychology services. If this is the case or becomes the case in future, more appropriate services will be recommended.

9. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychological treatment provider to do the same on their end.

10.I understand that dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

11.I understand that I have a right to access my medical information and copies of medical records in accordance with California law. Please do not record sessions.

I have read, understand and agree to the information provided above regarding telehealth:

Client's Signature: _____ Date_____

Therapist's Signature: _____ Date_____

Social Media Policy

This document outlines my office policies related to the use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional, and how you can expect me to respond to various interactions that may occur between us on the Internet. If you have any questions about anything written within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy. Friending: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.) I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

If you have any questions about this, please bring them up when we meet and we can talk about it more. Following: I do not follow current or former clients on blogs or Twitter. My reasoning is that I believe casual viewing of clients' online content outside of the therapy hour can create confusion regarding whether it's being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicitly arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.

Texting or Messaging:

My office number may be used for texting about scheduling-related issues or concerns. However, please do not use SMS (mobile phone text message) to contact me for anything other than a schedule change. Text messages are sometimes unreliable, so I may not receive the text you sent. I may not read the text in a timely fashion so the best way to contact me in an urgent situation is by phone. You should also be aware that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

Email:

I prefer using email only to send a form or scheduling issues. I will email you using my encrypted email server through GSuite. This is the only secure way for us to email. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. Also, email can get lost in cyberspace. I prefer to have a conversation with you in session or over the phone. If you choose to send me an email outside of the encrypted email server at Therapyappointment.com, be aware that all emails are retained in the logs of your and my Internet Service Providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet Service Provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

Location-Based Services:

f you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various geosocial networking sites such as Foursquare. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally “checking in,” from my office or if you have a passive LBS (location-based services) app enabled on your phone.

Use of Search Engines

It is not a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone), there may be an instance in which using a search engine (to find you, to find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

Business Review Sites:

You may find my psychology practice on sites such as Google, Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials: “Psychologists do not solicit testimonials from current therapy clients/patients or other persons who, because of their particular circumstances are vulnerable to undue influence.” Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it.

While you have the right to tell anyone you with that I am your therapist or how you feel about the treatment I provided you, I ask that you consider not submitting online reviews, because this has the potential to undermine your own confidentiality as well as the integrity of our work together. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own protection and privacy. If you feel I have done something harmful or unethical and you do not feel comfortable discussing it with me, you can always contact the Board of Behavioral Sciences, which oversees licensing, and they will review the services that I have provided. Board of Behavioral Sciences **1625 N Market Blvd Ste S200 Sacramento, CA 95834 (916) 574-7830**

Conclusion: Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, please bring them to my attention so that we can discuss them.

I have read and consent to the social media policy:

_____ _____

Clients Signature Date Date

Ashlee Slattery, M.A.
Licensed Marriage and Family Therapist
LMFT #136870

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I have received the attached notice of privacy practices, which is written in plain language. I understand the information and uses and disclosures of my protected health information that may be made by this practice.

_____ _____

Patient's signature Date

_____

Patient's name (please print)

Ashlee Slattery, M.A.
Licensed Marriage and Family Therapist
LMFT #136870

Credit/Debit Card Payment Consent Form

Patient Name :

Name on Card (if different than above):

I authorize Brittany Chidley, Psy.D./Trails Therapy, APC and her associates, to charge my card for professional services as follows:
• I agree to pay the agreed-upon amount per session. I also agree to pay each session I cancel prior to 24 hours or no-show.

• I agree to pay my insurance co-pay (if using insurance).
• I agree to pay for the balance of all fees not paid by my insurance company within 90 days, or otherwise agreed upon

Type of Card: ☐ VISA ☐ MasterCard ☐ Discover ☐ AMEX

Expiration Date:

Card Number:

CVV Number (3 digit number from back of card)

Address | City | State | Zipcode

Home phone | Cell phone

Card Holder Signature: _____ Date: _____

My signature shows that I understand and agree to comply with the credit card policy.