



LICENSED MARRIAGE & FAMILY THERAPIST

Counseling Information and Consent for Treatment

In order to better serve you, I would like to provide you with some information about counseling and the therapeutic relationship. This information will be discussed during your first appointment. If you have any questions, please let me know.

What is Counseling? During the therapeutic relationship, I will ask about many areas of your life, the focus of therapy will be on working toward your specific goals. In order for counseling to be effective, it is necessary for you to take an active role. Participation involves discussing your concerns openly, completing assignments, and providing feedback to your counselor.

Your First Appointment: During your first visit, called the *Intake* session, you will discuss your concerns and goals for treatment. This session will help both you and I decide how you can best be helped. These services may consist of individual, couples or group counseling or possibly a referral that may be more appropriate to your needs.

Fee: Counseling sessions are 50 minutes for individual, couple, or family sessions. The fee is \$150.00 per session. Payment is due when the services are rendered. Checks or money orders must be written to “**Brynne Lum, LMFT**”. Credit cards can be used in for single payments or ongoing per session. There is a \$25.00 fee for any returned checks.

Insurance Providers (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries. You are responsible for all charges whether or not paid by insurance and unpaid charges may be applied toward your credit card.

Cancellations and No-Shows: Your appointment time has been reserved for you. **Therefore, you are responsible for payment for any sessions that you are unable to give at least 24 hours’ notice of cancellation or that you miss.** You can leave a cancellation message on voicemail or text (949.391.7272) at any time, day or night, and it will record the date and time. If you will be late, please provide notice by phone call or text. If you are later than 15 minutes late, in order to stay within therapeutic bounds, the appointment will need to be rescheduled and you will be responsible for the full fee of the session.

Voicemail and Emergencies: You may leave a text or voicemail message at any time, and I will make every effort to return your call by the next business day. These telephone contacts are for arranging and changing appointments times and for emergencies only. All other information should be discussed in session, not via email or phone. In the event that you are feeling unsafe or require immediate medical or psychiatric assistance, you should call 911 or go to the nearest emergency room.

Confidentiality and Records: Counseling often involves sharing sensitive, personal, and private information. Recognizing this, laws and ethical guidelines require that all interactions in the therapeutic relationship, including content of your sessions, your records, scheduling of or attendance at

23282 MILL CREEK DR., SUITE 205
LAGUNA HILLS, CA 92653



LICENSED MARRIAGE & FAMILY THERAPIST

appointments, and progress in counseling are confidential. Your information will not be released to anyone without your written permission.

Exceptions to Confidentiality: For the vast majority of clients, no exceptions to confidentiality are made; however, there are some exceptions to confidentiality, which you should know about before you begin counseling. A therapist is legally required to disclose information to:

- a. protect you or someone else from imminent danger
- b. report suspected abuse of children, the elderly, or the disabled
- c. respond to a court subpoena
- d. report physical violence or threatened violence toward your therapist, counseling center staff and/or anyone else in the office.

In any of these situations, I would reveal only the information needed to resolve this immediate crisis or risk of danger. If you are in danger of hurting yourself or others, a therapist may contact people in a position to prevent harm. This includes but is not limited to the person listed as your emergency contact, family members, close friends, and appropriate medical, school, and legal authorities.

Risks of Counseling: In therapy, you risk learning things about yourself or your relationships that you don't like. Often growth cannot occur until you confront issues that cause you to feel sadness, sorrow, anxiety or pain. A therapist is there to support you as you accept the responsibility for making the choices and changes that are required to achieve your goals. There is also the risk that therapy may not resolve your problem or that therapy alone may not be sufficient. Should this be the case, we will explore alternative plans.

ACKNOWLEDGMENT/CONSENT FOR TREATMENT:

I acknowledge that I have read and understand the information described above, and I authorize the Brynne Lum, LMFT to provide for my care. I understand that I may withdraw this consent and terminate treatment at any time.

Print Name _____

Signature _____ Date _____

Parent/Legal Guardian (if applicable):

Print Name _____

Signature _____ Date _____

Therapist Signature _____ Date _____

PLEASE RETAIN SECOND COPY OF THIS CONSENT FOR YOUR PERSONAL RECORDS

23282 MILL CREEK DR., SUITE 205
LAGUNA HILLS, CA 92653



LICENSED MARRIAGE & FAMILY THERAPIST

Intake Form

Please provide the following information and answer the questions below.
Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____

Name of parent/guardian (if under 18 years): _____

Birth Date: ____/____/____ Age: _____ Gender: m/f

Marital Status: single married divorced widowed other

Spouse/Partner's name if applicable _____

Please list any children/age: _____

Address: _____

Home Phone: () _____ Cell/Other Phone: () _____

Leave a message? yes/no

Leave a message? yes/no

E-mail: _____ May we email you? yes/no

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? yes/no

Are you currently taking any prescription medication? yes/no

Please list: _____

Have you ever been prescribed psychiatric medication? yes/no

Please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

23282 MILL CREEK DR., SUITE 205

LAGUNA HILLS, CA 92653



LICENSED MARRIAGE & FAMILY THERAPIST

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

How many times per week do you generally exercise? _____ What types of exercise to you participate in? _____

Please list any difficulties you experience with your appetite or eating patterns:

Are you currently experiencing overwhelming sadness, grief, or depression? yes/no

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? yes/no

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain? yes/no

If yes, please describe: _____

How often do you drink alcohol?

___ Daily ___ Weekly ___ Monthly ___ Infrequently ___ Never

How often do you engage recreational drug use?

___ Daily ___ Weekly ___ Monthly ___ Infrequently ___ Never

Are you currently in a romantic relationship? yes/no

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently:

23282 MILL CREEK DR., SUITE 205

LAGUNA HILLS, CA 92653



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PERSONAL/FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a history of any of the following. If yes, please indicate “self” or the family member’s relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle & List Self or Family Member

Alcohol/Substance	yes/no	_____
Anxiety	yes/no	_____
Compulsive Behavior	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____
Emotional Abuse	yes/no	_____
Obesity	yes/no	_____
Obsessive Behavior	yes/no	_____
Physical Abuse	yes/no	_____
Sexual Abuse	yes/no	_____
Sexual Assault	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____
Trauma	yes/no	_____

ADDITIONAL INFORMATION:

Are you currently employed? yes/no

If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

Do you consider yourself to be spiritual or religious? yes/no

If yes, describe your faith or belief:

What do you consider to be some of your strengths?

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What do you consider to be some of your weaknesses?

What would you like to accomplish out of your time in therapy?

EMERGENCY CONTACT

Name _____

Phone _____ Relationship _____

Name _____

Phone _____ Relationship _____

Signature _____

Date _____



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Credit Card Authorization

I authorize, **Brynne Lum, LMFT** to charge my credit card as follows (please check one):

- Ongoing for each counseling session:
- One time charge

Name of Client _____

Name (as it appears on the card): _____

Billing Address w/zip code:

Phone: _____

Type of Card (select one): Visa MasterCard American Express

Card Number: _____

Expiration Date: _____ 3 (or 4)-Digit Security Code: _____

Amount to be charged (total or per session): _____

I understand that if I fail to cancel an appointment with 24 hours' notice or, if I not show up for a scheduled appointment that my card will be charged.

Signature: _____

Date: _____

For this document to be valid it must be signed and dated.

- Receipts: Please text receipt to: _____
- Please email receipt to: _____
- No receipt

You may mail this document to the address above or scan and email to BrynneMFT@gmail.com.