**Karen Wolfe Therapy**

Karen Wolfe, MA, Marriage and Family Therapist #53878
3150 18th St, mailbox # 207, suite 255, San Francisco, CA 94110
Karen@SFBayPlayTherapy.com
415-420-9459

## GENERAL INFORMATION AND POLICIES

PARENT(S) NAME(S) _____

CHILD'S NAME: _____

DATE OF BIRTH: _____

ADDRESS:_____

PHONE NUMBERS:
CELL_____ HOME_____

EMERGENCY CONTACT:_____

**TERMS**

_____**Initials** Karen Wolfe, Marriage and Family Therapist will be engaging in therapy with my child (ren). I understand and agree to the potential of Karen Wolfe working with my child, or other family members as needed or requested during the course of therapy.

_____ **Initials** I understand that I may end therapy at any time. However to honor the importance of closure I agree to have a closure session prior to ending.

**OUTCOMES OF THERAPY**

_____**Initials** I understand that the effectiveness of therapy depends on many things, including client participation and readiness, and fit between therapist and client and that engaging in therapy does not mean a guaranteed cure.

_____ **Initials** Feedback has been shown to improve the outcomes of therapy. Each week prior to my child's appointment or after my appointment I can fill out a brief feedback form by accessing www.SFPlayTherapy.com, go to the "Just for Clients" page and click the "Effective Therapy Feedback" tab. Send reminder emails to _____

**CONFIDENTIALITY**

_____**Initials** I understand that in order to protect the therapeutic container and privacy, the content of sessions is confidential. Themes of play and other important developments to support my child's progress will be shared. Exceptions to this rule are if abuse or potential danger to my child are indicated.

_____**Initials** Clinical Consultation: I understand Karen Wolfe, MFT may discuss my case in a confidential environment with other clinicians to support treatment. Details are always protected.

## GENERAL INFORMATION AND POLICIES, CONT.

### CANCELLATION AND SICK POLICIES

_____**Initials** I understand that I must cancel a session within **48 hours** to avoid being charged. I understand that the only exception to this is illness or emergency in which case I may cancel with less than 48 hours with no charge, up to 4 times per year (after which a late cancellation fee will be charged).

_____**Initials** If my child is contagious, has had a fever or vomited within the last 24 hours I agree that I will not bring my child to session and that I will inform Karen Wolfe that the session will be missed as soon as possible. I understand this falls under the illness policy and the session will not be charged.

_____ **Initials** If my child is enrolled in a social skills group, I understand that there are no refunds for missed or cancelled group sessions, even with notice

### FEES and PAYMENT

_____**Initials** Payment is due at the time of service. After the first month of treatment sessions may be billed monthly at the end of the month. Camps and groups are paid monthly in advance. Other payment arrangements (if applicable): _____

_____**Initials** 50-minute parenting or individual therapy session is $150
45-minute child or family play therapy session is $150
90-minute parent group is $75 per session, or $120 for 2 parents/caregivers
90-minute social skills group is $120 per session
Summer camp is $200 per day
Sliding Scale or Other fee arrangements (if applicable): _____

____ **Initials** I consent to having invoices emailed to me, with full understanding that email is not secure and personal information may be at risk. *Leave Blank if you do not consent.

email address to send invoices, if applicable:_____

### CONTACT OUTSIDE OF SESSION

_____**Initials** Occasional brief phone conversations and simple email exchanges are included free of charge as part of therapy. Written reports, meetings, extensive emailing, phone calls over 10 minutes, and travel will be charged at the regular session rate.

_____**Initials** I understand that I can expect a response to email within 24 hours. If I need a faster response or have something more detailed to discuss I agree to call Karen Wolfe at 415-420-9459.

Name:_____ Signature:_____

Name:_____ Signature:_____

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# RELEASE OF INFORMATION

Fill this form out if you would like me to discuss your child's case with his/her teachers, other specialists, etc. Fill out your child's name and the names or titles of persons you'd like me to speak with (e.g. "Peter, 2nd grade teacher" or "the staff at SF Elementary").

I give Karen Wolfe, Marriage and Family Therapist permission to exchange information concerning the treatment of myself or my child (_____), to the following people or organizations:

Person or Organization:_____

Title/role:_____

Contact Information:_____

Person or Organization:_____

Title/role:_____

Contact Information:_____

Person or Organization:_____

Title/role:_____

Contact Information:_____

Signed:_____ Date:_____

Signed:_____ Date:_____