Jill Sterling-Erman, MFT 3427-ATR-BC
3020 Old Ranch Pkway, Ste. 100, Seal Beach, California 90740
(562) 546-6026

OFFICE POLICIES AND GENERAL INFORMATION

Jill Sterling Erman, MFT-ATR-BC

This information has been prepared to answer frequently asked questions about my practice and to inform you of the kind of relations we are entering into.

***CONFIDENTIALITY*:** Let me begin by emphasizing that what you tell me is legally protected and strictly confidential. I will not share any information I know about you to anyone without your prior written permission. There are, however, some exceptions mandates by the courts:

1. In cases where there is a reasonable suspicion you are initiating or are a victim of child abuse, elder abuse, or neglect;
2. If you become a danger to others or to yourself;
3. In cases when you file a personal injury lawsuit and claim mental injury.

Your insurance carrier or HMO/PPO may require I disclose confidential information in order to process the claim. When you sign insurance forms, you authorize release of this information. Most PPO's require Outpatient Treatment Report (OTP) and the 5th visit to obtain authorization for continued care. I will gladly review with you what I wrote. PPO's are increasingly asking for more information about their members (you). I have no control or knowledge over what the insurance company does with the information I submit.

***HOURS OF AVAILABILITY*:**

Wednesday-Friday: 9:00 AM to 5:00 PM

Tuesday-Thursday: 5:00 PM to 7:00PM

Single Session: 50 minutes

Double Session: 90-100 minutes

One therapy "hour" lasts 50 minutes. This is standard for the psychotherapy profession. The clinician spends the remaining 10 minutes of each hour returning phone calls, handling paperwork, or taking a brief break. Sessions are typically arranged once per week. On certain occasions, it may be appropriate to schedule more often, such as being in a crisis or if being treated during a drug dependency. Sometimes extended sessions are needed, such as for family or marital problems. Double sessions are 90-100 minutes in length and are billed accordingly.

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***TELEPHONE AND EMERGENCY PROCEDURES*:** My office voicemail number is 562-546-6026. I return calls promptly. I generally wait to return calls until the end of the treatment session that I am currently attending to. If an emergency session is assessed as needed accommodations will be made accordingly and you will be seen within a 24-hour period. Other emergency references include the 24-hour crisis line at 714-441-1414, or the police (911), or the 24-hour Psychiatric Emergency Line at 800-352-3301 (inpatient hospitalization).

***FEES, PAYMENTS AND INSURANCE REIMBURSEMENT*:** Payment is due at the time of each visit. For fee for service visits: Single sessions are $120 and Double sessions are $200. Extended sessions and telephone conversations that go beyond 10 minutes in length are subject to a $25 per 15-minute charge. There are two separate fee schedules for my services.

Insurance Companies require prior-authorization. In addition, some companies will authorize only short-term therapy. I will be happy to try to assist you in understanding the specifics of your coverage.

***CANCELLATIONS*:** I understand that emergencies arise, and that missed sessions happen from time to time. To be courteous and considerate to all my clients I require a minimum notice of 24-hours before your appointment time to cancel or reschedule your visit. The earlier you call the sooner I can make that appointment available to a client in need, and also reschedule your session. Unfortunately, if you cancel with less that a 24-hour notice before your appointment time, you are responsible for half of your full fee. If you do not call and do not show to your appointment, you will be responsible for the full session fee. I do my best to accommodate all of my clients, however late cancellations or frequent rescheduling becomes mutually disruptive. This cancellation policy is in place to maintain courtesy amongst all clients.

***THE PROCESS OF THERAPY/ EVALUATION*:** Participating in therapy can result in a number of benefits to you, including improving interpersonal relationships, and resolution of the specific concerns that led you seek therapy. Working towards these benefits, however, require effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings or behavior. I will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. During evaluation or therapy, remembering or talking about unpleasant events, feeling, or thoughts can result in your

experiencing considerable discomfort or strong feelings such as anger, sadness, worry, and fear. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in decisions about changing behaviors, employments, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed negatively by another family member. Change will sometimes be swift, but other times may be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

Since I am an Art Therapist, we may use art to help you expose your feelings. During the course of therapy, I will likely draw on various psychological approaches according to the problem that is being treated and my assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, existential, system/family, development (adult, family, child), or psycho-educational. If you have any unanswered questions about any of the procedures used in the course of your therapy, their risks, my expertise in employing the, or about your treatment plan, please ask, and you will be answered fully. You also have the right to ask about other treatments that I do not provide, I have an ethical obligation to assist you in obtaining those treatments. I consult regularly with other professionals regarding my clients; however, clients remain completely anonymous, and confidentiality is fully maintained

***CUSTOMER PROTECTION*:** Therapy never involves sexual or business relationships, nor any dual relationships. If at any time you feel you are being harmed by your experience, I would hope that you would discuss the matter frankly in our sessions. If you are dissatisfied with the response you receive you have the right to report to the Board of Behavioral Science Examiners, the agency charged with regulating the practice of Marriage and Family Therapists in this state. Information about this agency is posted in my office. You have the right to terminate therapy at any time. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you may prefer. If at any point during our psychotherapy I assess that I am not effective in helping you reach your therapeutic goals, I am obligated to discuss it with you, and if appropriate, to terminate treatment. In such a case, I will give you a number of referrals, which may be of help to you.

NOTICE TO CLIENTS: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage

and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

The above notice is required to be shared with all clients. Thank you for your attention to these policies and information. Should you have any questions please contact me. I look forward to working with you in I am looking forward to working with you in a collaborative effort to reach the goals you bring to therapy.

***AGREEMENT*:**

I hereby acknowledge that I have read the above office procedures carefully. I understand them and agree to comply with them:

Client Name (print) Date Signature

Client Name (print) Date Signature

Jill Sterling-Erman, MFT-ATR-BC Date Signature

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RELEASE OF INFORMATION AUTHORIZATION

CLIENT NAME: _____

DATE OF BIRTH: _____

I give my permission to schools, community agencies, court personnel and _____to release information to Jill Sterling-Erman.

I also give my permission to Jill Sterling-Erman to release information to the above-mentioned individuals/ organizations to better serve the needs of the _____ client/family.

_____ _____

Signature Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers

- Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that I restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide to such restrictions.

PATIENT NAME _____

RELATIONSHIP TO PATIENT _____

SIGNATURE _____

DATE _____

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CONSENT FOR TREATMENT FORM

CLIENT NAME: _____

DATE OF BIRTH: _____

I give permission to Jill Sterling-Erman, Marriage and Family Therapist, Clinical Art Therapist to provide counseling and psychotherapy to me.

I understand that all communications between the therapist and me is both privileged and confidential.

This means the therapist cannot discuss my case orally or in writing without my express written permission.

The California courts hold that if an individual intends to take harmful or dangerous action against another individual, it is the therapist's duty to warn the person and/or the family of the person who is likely to suffer the result of the harmful behavior. By law, therapist must also report suspicion of child, adult dependent, or elder abuse to the appropriate protective agency.

Similar actions will be taken with clients who have suicidal thoughts or intents. Every effort will be made to prevent an attempted suicide or a dangerous action against another person.

Every effort will be made to resolve these issues, with the least invasive means being taken, before such a violation of confidentiality takes place.

_____ _____

CLIENT SIGNATURE DATE

_____ _____

THERAPIST SIGNATURE DATE

_____ _____

PARENT OR GUARDIAN SIGNATURE IF MINOR DATE

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INITIAL INTERVIEW FORM

CLIENT INFORMATION:

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

PHONE: _____ ☐ HOME ☐ CELL ☐ WORK

Is it okay to leave messages at this number? ☐ YES ☐ NO

SEX: _____ DATE OF BIRTH: _____ AGE: _____

MARITAL STAUS: (Please circle one)

MARRIED SINGLE DIVORCED WIDOWED SEPARATED

EMPLOYER: _____ POSITION: _____

HOW LONG HAVE YOU WORKED THERE: _____

MEDICAL INFORMATION & HISTORY:

PRIMARY PHYSICIAN: _____ PHONE: _____

LIST ANY SIGNIFICANT HEALTH PROBLEMS: _____

_____

_____

LIST ANY CURRENT MEDICATIONS & DOSAGE: _____

_____

_____

HAVE YOU HAD ANY PSYCHIATRIC HOSPITALIZATIONS? _____

IF YES, WHEN, HOW LONG, AND WHY? _____

_____

DO YOU FEEL SUICIDAL? _____ DO YOU FEEL HOMICIDAL? _____

HAVE YOU BEEN IN THERAPY BEFORE? _____ IF YES, WHEN _____

NAME OF THERAPIST: _____

HOW DID YOU HEAR ABOUT US? _____

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NEAREST RELATIVE/ FRIEND, OTHER THAN SPOUSE:_____

PHONE:_____RELATIONSHIP TO YOU:_____

REASON FOR SEEKING THERAPY AT THIS TIME:_____

_____

CONFIDENTIALITY STATEMENT:

All information shared in session is confidential, except in circumstances governed by the laws including mandatory reporting of alleged harm to self or harm to others, particularly in the case of children, disabled persons or dependent/elder abuse.

FINANCIAL AGREEMENT:

Your fee per session is $_____.

Co-payment or session payment is due in full at the time of each session. Fees are re-evaluated and subject to change every six months. Fees may be paid either by cash, checks, or Zelle at the beginning of each session. If a check is returned by the bank for non-sufficient funds, a fee of $25.00 will be charged to you. In addition to that fee, you may be required to pay subsequent visits in cash.

Sessions are 50 minutes in length, unless otherwise agreed upon. A 24-hour notice prior to your scheduled appointment time is required for any cancellations or rescheduling. If you cancel with less than a 24-hour notice before your appointment time, you are responsible for half of your full fee. If you do not call and do not show to your appointment, you will be responsible for the full session fee.

It is understood that charges will apply for professional services rendered by your therapist (i.e. phone contacts over 10 minutes, preparation of special forms, reports, letters, court time, etc.). The fee for these services is _____ and is not covered by insurance.

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STATEMENT OF UNDERSTANDING

My therapist has reviewed this client-therapist agreement with me.

Client Name (print)	Date	Signature
Client Name (print)	Date	Signature
Parent or Guardian Name (print)	Date	Signature
Jill Sterling-Erman, MFT-ATR-BC	Date	Signature

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The purpose of this questionnaire is to obtain a comprehensive picture of your circumstances and of your background. Please answer these questions as thoroughly as you can, so as to help facilitate your evaluation and explore concerns with greater depth.

CURRENT PSYCHOLOGICAL SYMPTOMS:

Which of these characteristics best describe you?

☐ Excitable	☐ Confused	☐ Anxious
☐ Helpless	☐ Can't Sleep	☐ Sleep too Much
☐ Depressed	☐ In Pain	☐ Shy
☐ Selfish	☐ Bad Temper	☐ Few Friends
☐ Sad	☐ Stubborn	☐ Guilty
☐ Impulsive	☐ Bothersome thoughts	☐ Many Secrets
☐ Easily Tired	☐ Increased Appetite	☐ Decreased Appetite
☐ Unable to Concentrate	☐ Forgetful	☐ Insightful
☐ Avoiding People	☐ Crying Spells	

PRESENTING PROBLEM

What is the main complaint or problem that brings you here?

_____
_____
_____
_____
_____
_____
_____
_____

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MEDICAL FACTORS

List any medical problems you have:_____

_____

_____

_____

Are you taking any prescription medications? ☐ YES ☐ NO

Name of Prescribing Doctor:_____

Name of Medication	Reason for Taking	Dose	Start Date

List the name of all your prior psychiatrists, physiologists, and psychotherapists.
List the dates you saw them, the reason, and outcome: _____

_____

_____

_____

_____

Do you have any allergies or drug interactions? ☐ YES ☐ NO

If yes, explain:_____

_____

_____

_____

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When did this problem begin?What have you tried so far to solve this problem?

Why are you seeking treatment now? Did something recently happen?

What do you hope to achieve from therapy? What are your goals?

POTENTIAL HARM TO SELF OR OTHERS

Do you have suicidal thoughts? ☐ YES ☐ NO

Have you ever attempted suicide in the past? ☐ YES ☐ NO

If yes, when and how?

Do you have thoughts of harming someone else? ☐ YES ☐ NO

Have you ever injured anyone? ☐ YES ☐ NO

If yes, when and how?

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Please check the column that best describes your functioning during the past month.

	Increased	Decreased	N/A
Appetite	☐	☐	☐
Weight	☐	☐	☐
Sleep	☐	☐	☐
Sexual Interest	☐	☐	☐
Energy Level	☐	☐	☐
Interest in Unusual Activities	☐	☐	☐
Anxiety, Nervousness, Restlessness	☐	☐	☐
Tension and Inability to Relax	☐	☐	☐
Shaking, Trembling	☐	☐	☐
Chest Pain	☐	☐	☐
Unexpected Anxiety/ Panic Attacks	☐	☐	☐
Skipping or Racing Heart	☐	☐	☐

SUBSTANCE ABUSE

Check all that apply to you. Explain next to the item if necessary.

- ☐ I never drink alcohol.
- ☐ I drink only on special occasions.
- ☐ I drink socially, but rarely get drunk.
- ☐ I drink socially and get intoxicated at least once a month.
- ☐ I drink socially and get intoxicated almost every weekend.
- ☐ I drink several times a week, averaging 2-3 drinks at a time.
- ☐ I drink nearly every day and get intoxicated.
- ☐ I don't drink now, but used to drink alcoholically.
- ☐ I attend a 12-step program to help me remain sober.

I currently or have had a history of the use of street drugs

- ☐ Amphetamines When, how long, how often _____
- ☐ Marijuana When, how long, how often _____

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☐ Cocaine When, how long, how often _____
☐ Heroin When, how long, how often _____
☐ Other _____ When, how long, how often _____

I have abused prescription medications such as anti-anxiety or pain pills.

☐ YES ☐ NO

If yes, which drug, how long, how often

_____
_____
_____

Cigarette Use: I smoke _____ cigarettes per day

I have smoked for _____ years.

☐ I do not smoke cigarettes.

Please rate the importance or frequency of the following:

	Not At All	Sometimes	Most of the Time
I am bothered by my weight	☐	☐	☐
When I eat, I am bothered by feeling of guilt after	☐	☐	☐
I prefer to eat by myself	☐	☐	☐
I alternate between dieting and overeating	☐	☐	☐
I use laxatives to make myself vomit, to lose weight	☐	☐	☐
I feel that my eating is out of control	☐	☐	☐
I am afraid of becoming fat	☐	☐	☐
I severely restrict my food intake	☐	☐	☐
I feel fat even though other people tell me I am thin	☐	☐	☐
I have been told that I am obese	☐	☐	☐
If I don't exercise, I have an intense fear of gaining weight.	☐	☐	☐

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If you have children, please list their names and ages.

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently experiencing any issues of behavioral problems with your children? Please describe._____
_____
_____
_____
_____
_____

Have you previously been married or in a long-term relationship?

☐ YES ☐ NO

If yes, how many times/ duration_____
_____
_____
_____

Reasons for divorce(s)/ termination of the relationship_____
_____
_____
_____
_____

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FAMILY HISTORY

Mother: Age:_____ Occupation:_____

Step-mother: Age:_____ Occupation:_____

Describe your mother's personality and how you got along with her as a child___

Describe your step-mother's personality and how you got along with her as a child_____

Relationship now

Mother:_____

Step-Mother:_____

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Father: Age:_____ Occupation:_____

Step-father: Age:_____ Occupation:_____

Describe your father's personality and how you got along with him as a child____

Describe your step-father's personality and how you got along with him as a child_____

Relationship now

Father:_____

Step-Father:_____

Describe your parent's marriage_____

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Identify significant family events (separation, divorce, death, etc.)_____

Are you an adopted child?_____

How many siblings do you have?

_____Brothers _____Sisters

_____Step-Brothers _____Step-Sisters

_____Half-Brothers _____Half-Sisters

How did you get along?_____

Name/ Relation	Age	Then	Now

email: jill@yournextstepinlife.com t: 562.546.6026 www.yournextstepinlife.com

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Has anyone in your family been abused? Indicate who was abused, by whom and the type of abuse.

Name of Abused	By Whom	Emotional	Verbal	Physical	Sexual
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

When you were growing up, were there others living in the house besides your parents, brothers, and sisters? If yes, who and what is their relationship to you?

_____
_____
_____
_____
_____
_____

My childhood was (please mark):

☐ Very Happy ☐ Happy ☐ Typical ☐ Unhappy ☐ Very Unhappy

How were you disciplined as a child? By who were you disciplined?_____

_____
_____
_____
_____
_____
_____
_____

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