Shir Shanun Psy.D.
PSY25481
(626)5102652
174 West Las Flores Ave
Arcadia CA, 91007
shirshanunpsyd.com

SHIR SHANUN PSY.D.
Psychotherapy for individuals and couples

Intake form- Biographical information

Age:_____ Date of Birth:_____ Place of Birth:_____

Name: _____ Pronouns: _____ Gender:_____

How do you identify culturally/racially: _____

Address: _____

Phone number:_____ Email:_____

Emergency contact name:_____ Phone#:_____

Relationship to you:_____

How did you hear about me:_____

Relationship status:_____

Who do you live with:_____

Children names and ages: _____

_____

_____

Occupation:_____

Medical Doctor and/or Psychiatrist:_____

Phone number:_____ Medications:_____

_____

Past/Present Psychotherapy:_____

_____

Past Hospitalization and when:_____

What brings you to therapy today and how can I help:_____

_____

_____

Print your Name:_____

Sign:_____ Date:_____

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Informed Consent for Psychotherapy

Welcome to my practice. This form will provide you with information about my therapy practice, office policies and procedures and both of our rights and responsibilities. Please read the entire statement carefully and sign the last page to indicate that you have reviewed and understand all the information and agree to these terms in our work together.

PSYCHOTHERAPY: can have both risks and benefits. Because therapy often involves exploring and discussing unpleasant or difficult aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, loneliness, and frustration. Often, things feel worse before they feel better. However, it has been shown that people often experience significant benefits from psychotherapy, whether that is in better relationships, increased ability to cope, reduction in symptoms or greater satisfaction in life. Ultimately, there are no guarantees of how you will experience psychotherapy and for this reason, it is important for you both to be an active participant and to be honest in providing me with feedback about how therapy is feeling for you so we can determine how best to proceed. Therapy can involve a significant commitment of time, money, and energy, so you should select a therapist carefully. I encourage you to discuss any doubts, dissatisfactions, concerns, or discomfort regarding your treatment with me at any time. If you have any questions about my procedures or policies, please discuss them with me as soon as they arise. If your doubts persist or if I believe another provider would better serve you, I will discuss this with you and assist you in a referral to another therapist.

SESSION LENGTH & FREQUENCY: Psychotherapy sessions last 45 minutes, usually at a minimum of once weekly; the duration and frequency will vary depending on your needs and concerns. If I am not able to start our session on time, I will make every effort to extend your session when possible to the full 45 minutes. If you are not on time to your appointment, our session will be shortened by the amount of time you are late, without any reduction in fee.

CANCELLATIONS, MISSED SESSIONS AND FEE: Psychodynamic psychotherapy is a treatment that benefits from consistent and regular sessions. As part of your treatment, I offer regularly scheduled appointments. Frequent cancellations and schedule changes can result in disrupting our work or interfering with therapeutic progress. I understand that cancellations are sometimes necessary and ask that you provide 48-hour notice for cancellation of a session. Cancellations made under 48 hours will result in charging for the full fee of the session. Exceptions to the late cancellation fee will be made on a case-by-case basis at my discretion, particularly in situations involving unavoidable circumstances. If I have not seen you in 30 days and we do not have an agreed upon plan in place regarding your treatment, you will be considered discharged from my care and no longer a current client.

My full fee is 200$ a session that you are responsible to pay at each session. If you become involved in legal proceedings that require my participation, you will be responsible for charges for my professional time, including preparation and transportation time, even if I am called to testify by another party. Because of the complexity of legal involvement, I charge $600 per hour for preparation and attendance of any legal proceeding. Telephone conversations, site visits, writing and reading of reports, consultation

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with other professionals, release of information, reading records or emails, longer sessions, travel time, etc. will be charged at the session rate, unless indicated and agreed upon otherwise. Please notify me if any problems arise during the course of therapy regarding your ability to make timely payments. I am a private pay therapist and if you choose to submit reimbursement to your insurance I will provide you with a copy of your superbill on a monthly basis, please be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality.

CONTACT: You are welcome to call me if you need to reach me between appointments to discuss questions or concerns that cannot wait until our next appointment. You may leave a confidential voicemail at any time of the day; my phone number is (626)510-2652. I am often not immediately available by phone, but I will do my best to return your call as soon as I am able. I welcome email for purposes of scheduling appointments and logistical matters, but recommend all other concerns be discussed by phone or in person. Please be aware that if you choose to use email or text, that it is not a completely secure form of communication. servers or communication companies may have unlimited and direct access to all emails and text that go through them. Please notify me if you decide to avoid or limit, in any way, the use of email, texts, cell phones calls or phone messages. If you communicate confidential or private information via email or text we will honor your desire to communicate on such matters. Please do not use texts, email or voice mail for emergencies. In a life-threatening emergency, you should call 911 or go to your nearest emergency department.

EMERGENCY**:** If there is an emergency during therapy, or in the future after termination, where I becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided as emergency contact.

PRIVACY: Your privacy is very important to me. All protected health information will be kept confidential, unless I have your written consent to release information. However, by current federal and state law, I am required to disclose information in the following circumstances:

- I am required to report to appropriate agencies all cases of physical and sexual abuse or neglect of minors (children under the age of 18), the disabled and the elderly.
- If I believe that you present a clear, imminent risk of serious physical harm or death to yourself, I may be required to disclose information to appropriate agencies or parties in order to take protective actions.
- If you have made a specific threat of violence to an identifiable other or if I believe that you present a clear and imminent risk of serious physical harm to an identifiable other, I may be required to disclose information to appropriate agencies or parties in order to take protective actions.
- When authorized by you, to support health insurance claims and authorized payment of benefits.

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- In response to court subpoena of information concerning your treatment.

CONSULTATION: I may engage in consultation with other professionals in a consultation group setting, or with senior clinicians in order to advance therapeutic knowledge and skills. Such discussions will always be handled to maintain and protect your confidentiality and those with whom I consult are also legally bound to maintain any material discussed confidential.

HEALTH RECORDS: The laws and standards for mental health professionals require that I keep Protected Health Information about you in your clinical record. I am required to retain your records for 7 years after my last contact with you. If I must discontinue our relationship because of illness, disability or other unforeseen circumstances, I ask you to agree to my transferring your records to another clinician who will ensure their confidentiality, preservation and appropriate access.

INFORMED CONSENT: I have read and understand the above office practice and financial policy information. I have had an opportunity to ask questions about the terms described and I agree to them without exception and willingly consent to treatment with Shir Shanun, PsyD.

Printed Name: _____

Signature: _____Date:_____