Thank you for choosing to work with me. There are many mental health and behavioral health options and I am honored to be part of your journey.

Please read and sign the following forms so we can review my policies together at our first session. ***I require a credit card on file in order to provide services but I do not have to charge it if you prefer to use a different form of payment***.

I will be gathering more information from you when we meet. If the client is a child or adolescent, I generally request some time together with parent/guardian and then time with just the client during the intake session.

If the client is a minor, 10-15 minute complimentary parent sessions will be offered every 8 weeks or so to exchange observations, review progress, and to assess goals. Many parents require a longer session to discuss topics at length and this will need to be scheduled. The session fee will apply to these 50 minute sessions.

If I see clients outside of my office, I do not initiate contact but will be happy to say hello if you do. This is for your privacy as other members of the community may recognize me as a therapist.

If there are any questions or concerns prior to our first appointment, please contact me via text/phone at (732) 439-3385 or email ClintonArtTherapy@Gmail.Com

I look forward to working with you!

Sincerely,
Cathy Rosa, MS, ATR-BC, LPAT, ATCS, RYT-200, EMDR- T

Agreement to Pay for Professional Services

Embodied Art Therapy & Yoga, LLC
Catherine Rosa, LPAT, MS, ATCS, ATR-BC, EMDR- T, RYT-200

I request that the therapist named above provide professional services to me, or to _____, (if client is a minor), and I agree to pay this therapist's fee of $150 per session for these services.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform her that I wish to terminate treatment. I agree to meet with Cathy Rosa in person at least once before stopping therapy, after notification. Notification can be provided in person, via email, or telephone. I agree to pay for services provided for me up until the time I end the relationship. In the case of cancellation of appointments, **I agree to give at least 24 hours notice for cancellations, otherwise I will be charged the full session fee for the missed appointment. I** agree that I am responsible for charges for services provided by this therapist to me (or client, as named above).

Credit card information is required to hold on file and this card will be charged if I cancel with less than 24 hours notice.

Signature of client or responsible party:_____

Date:_____
Client's or Responsible Party's printed name:

Credit Card #:

Expiration Date: CVV Code: Zip Code:

I, the therapist have discussed the above issues of payment with the client or responsible party and the person's behavior and responses give me reason to believe that this person is competent to give consent to treatment for either themselves or for party they are responsible for.

Signature of Therapist:_____
Date:_____

If you would like me to collaborate with another professional (school counselor, psychiatrist, teacher, therapist, etc.) please fill out this optional form. Both professionals must have a copy of this or their own PHI form in order for us to communicate.. This ensures your privacy is respected and maintained.

Authorization for Release of Information

Embodied Art Therapy & Yoga, LLC
Catherine Rosa, MS, LPAT, ATCS, EMDR- T, ATR-BC, RYT-200

I, _____ (DOB)_____ give my permission for Catherine Rosa of Embodied Art Therapy & Yoga to exchange information with the following person/agency for the purpose of coordination of care.

Name: Phone:
Address: Email:

I understand that verbal or written information will be disclosed only for this purpose and that the information will be limited to the following items: Please circle:

Psychiatric Evaluation	Treatment Progress	Intake Records
Medication Records	Psychosocial Data	Psychological Assessment
Discharge Summary	Prognosis/Diagnosis	Sub. Abuse assessment/treatment
Education/Evaluation		

This shall remain in effect until _____ (date or event upon this authorization expires, ie. end of treatment.)
You have the right to revoke this authorization at any time by submitting a request in writing to Catherine Rosa of Embodied Art Therapy & Yoga, LLC. If you do this, it will prevent any releases after the date it is received, but can not change the fact that some information may have been sent or shared before that date. I understand that my treatment is not dependent upon whether or not I sign an authorization form. I understand that I may inspect and have a copy of the health information described in this authorization. I understand if the person or entity that receives the information is not a healthcare care provider covered by federal privacy regulation the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA. I have been offered a copy of this release and do/do not _____ want a copy.

Signature of client or representative: Date:
Printed name: Witness:

OPTIONAL

Art Release

Embodied Art Therapy & Yoga, LLC
Cathy Rosa, MS, LPAT, ATCS, ATR-BC, EMDR-T, RYT-200

I consent to the photographing of any artwork that I, or the child/adolescent/adult that I am guardian/parent of, produce with Catherine Rosa, MS, ATR-BC, RYT-200 at Embodied Art Therapy & Yoga, LLC. I understand that all details as to identity will be kept confidential and the use of such photographs will be for educational purposes only. Catherine Rosa will not share in any public forum artwork created in sessions except for educational purposes with client or guardian's permission.

_____

Client's Signature

_____

Responsible Party's Signature, if applicable

_____

Client's or Responsible Party's Printed Name

Date

Intake Questions

Embodied Art Therapy & Yoga, LLC
Cathy Rosa, MS, LPAT, ATR-BC, ATCS, EMDR-T, RYT-200

Name & pronoun of client:

Name and phone number of guardian(s):

DOB:

Ethnicity/Culture:

Address:

Phone:

Email: (parent/guardian if under 18):

Emergency Contact (Please Specify relationship):

Client's school (if minor) or Place of Employment:

Optional Release of Records Signed: _____Yes _____No

Did someone refer you? If so, can I thank them?

These questions are meant to provide an overview of what's going on. During sessions, we will discuss in greater detail.

*What brings you to therapy? What do you hope to achieve?

*What is your occupation or grade level?

*How do you currently cope with stress?

*Friends/ Support System:

*What, if anything, has brought you joy/purpose/passion?

*Any hobbies, interests, or creative activities?

*Please describe your living situation.

Are there any significant illnesses or hospitalizations? Recent medical exam? Please list current medications. Continue on the back of the form if needed.

_____

_____

*Are there problematic/unhelpful behaviors at home or school?

*Have you/client been in therapy before? What was the outcome?

*Is there any substance abuse history with yourself or in your family? YES / NO

*Any history of abuse/neglect/toxic stress/any forms of trauma? YES / NO
(If yes, please do not go into detail on this form. In order to keep you as safe and regulated I prefer to discuss this question in person.)

*What else is important or helpful for me to know about you?

RISKS & BENEFITS

It is agreed that the client shall make a good-faith effort at personal growth and engage in the therapy process as an important priority at this time in his/her life. Therapy is designed to assist clients in resolving issues and dealing with difficult challenges. I will make every effort to make therapy successful in this manner. However, you should know that participating in therapy is no guarantee that you will "solve" your problems and that issues will be 100% resolved. Please be aware that through the course of therapy, we may expose unresolved issues that may cause emotional distress. Participation in therapy means that you accept these risks and are willing to deal with the potential emotional upheaval. Suspension, termination, or referral shall be discussed for lack of commitment or for any unresolved conflict or impasse between therapist and client as soon as possible.

Every effort to deal with discrepancies in dealing with treatment or payment should be made first with Cathy Rosa. If no satisfactory mutual agreement is reached after an extended and reasonable period of time, the client may contact the American Art Therapy Credentials Board:

7 Terrace Way, Greensboro, NC, 27403-3660.

(877)-213-2822

Disclosure Statement

Part of providing the best possible treatment and professional development involves my utilization of professional supervision sessions in which I discuss professional practices for the sake of furthering my knowledge base, to improve my clinical skills, and to seek guidance and support from experts/peers in the mental health field. There is a chance I may discuss your case in supervision but I will never use your actual name or any other identifying features.

I understand and agree.

_____

Signature, Date

Social Media Policy and Electronic Communication Policy

Embodied Art Therapy & Yoga, LLC
Catherine Rosa, MS, LPAT, ATR-BC, EMDR-T, RYT-200

Electronic Communications: I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. You are also advised that any email sent to me via computer in a work environment is legally accessible by an employer. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Embodied Art Therapy & Yoga/ Catherine Rosa is ethically and legally obligated to maintain records of each time we meet, talk on the phone, or correspond via electronic communication such as email or text messaging. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. A judge can subpoena your records for a variety of reasons, and if this happens, Embodied Art Therapy & Yoga must comply.

Social Media/Internet Search/Endorsements: While my present or potential clients might conduct online searches about my practice and/or me, I do not search my clients on search engines or social media unless there is a clinical need to do so, as in the case of a crisis or to assure your physical wellbeing. I do not “Friend”, “Connect” or “Follow” clients on any form of social media if I have personal accounts in order to protect your confidentiality. If clients ask me to conduct such searches or review their websites or profiles and I deem that it might be helpful, I will consider it on a case by case basis and only after discussing possible impacts to our professional relationship and your privacy. I also will not endorse client or contractor’s products in any presence whether online or otherwise as that creates a dual relationship.

Signature of Client or Responsible Party

Date

_____

Confidentiality Agreement, Embodied Art Therapy & Yoga, LLC

Embodied Art Therapy & Yoga
Catherine Rosa, MS, LPAT, ATR-BC, EMDR-T, RYT-200

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records, as well as artwork, about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm self or another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health-care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities. Prenatal Exposure to Controlled Substances Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. Minors/Guardianship Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Client Signature (Client's Parent/Guardian if under 18 or due to other condition)

_____

Print Name

_____

Today's Date