Sarah Pettengill, M.A. LMFTA
Peninsula Therapy, PLLC

951.384.1770
sarah@murrietachristiancounseling.org

DISCLOSURE STATEMENT

Note: You are responsible for recollection and attestation that this form was read in entirety. Signature required below.

Counselor Training, Counseling Orientation, General Information, and Counseling Fees

Training and Degrees: I'm a Licensed Marriage and Family Therapist Associate with education from Simpson University, working with Mindful Therapy Group. My degree is a Master of Arts in Counseling Psychology. I am credentialed as a Washington state therapist, license number 60406418. Over the past 9 years I have developed experience with adults, adolescents and children. I am a pastor's wife, taught psychology as an adjunct professor at Azusa Pacific University, and run a private practice in California. Experience includes helping others through social work for low income seniors and foster children, teaching foster parenting classes, parent coaching, support groups for anxiety, grief, and foster parent issues. It also includes anger management, premarital counseling, children and adults suffering with ADHD.

Counseling Orientation: Faith is an important part of daily life and relationship to God. To ignore this would be a disservice to the client, so I integrate faith into each session with those who are open. My work consists of anger management, foster parenting and adoption, parenting, ADHD for adults and children, anxiety, depression, and clergy family services. I see women and couples, 16 years of age and up.

Fees: The fee for counseling is $110 per 53-minute session for individuals and $120 per 53-minute session for couples and families who are private pay. Fees are adjusted annually on January 1 and will not increase more than $10 per year, if increased. Payments (cash, or credit) are to be made at the end of each session. **Outstanding balances may be sent to a collection agency.**

Court: If a client would like to do counseling for court purposes, it needs to be discussed at the first session to see if we are a good fit for the court requirement. Any documents that will be needed, time to produce letters or notes, and time in court will be charged at the regular hourly rate.

Missed Appointments and Rescheduling: If you are unable to keep an appointment, please notify me via phone or email a minimum of 24 hours in advance. If you miss your appointment for whatever reason and fail to give me adequate notice, you will be responsible for **half of the session and up to the full fee for the session. Rescheduling two times, if less than a day in advance, results in possible charging, due to not being able to fill a spot with another family due to short notice.** If you are late, I will still stop at our regular ending time to keep my schedule, and you will still be required to pay for the entire session. I can supply you with a receipt for you to submit to your insurance company for out of network insurance. I do not bill insurance. If I have an emergency, I will notify you as soon as possible of my need to reschedule our appointment.

Therapy is online! Teletherapy is the means for which I work with clients, all online through a platform that holds your files. It is a HIPPA compliant platform where you will meet with me on a one on one or couple basis at your appointment time. You can do counseling from anywhere there is internet, and if you have a device with a camera. I will call you on the platform at your appointment

Sarah Pettengill, M.A. LMFTA
Peninsula Therapy, PLLC
951.384.1770
sarah@murrietachristiancounseling.org

time and give you information on how to navigate the platform. Per internet connection issues, you will be called back by me to fix the connection.

Insurance Billing: It is the client's responsibility to verify insurance coverage prior to intake sessions. They are responsible for anything not covered by the insurance plan, including denials. Please call to make sure that your session will be covered, including teletherapy options. Your insurance will be billed by my team per HIPPA standards.

Termination of Treatment: When you wish to terminate treatment, **please give a minimum of one week's notice.** You may terminate treatment at any time without moral, legal, or financial obligation beyond payment of services already rendered. It is expected that we will discuss the prospect of termination so that both parties will be clear about any details that need attention as part of the termination process. If you fail to schedule a future appointment, cancel a scheduled appointment, or fail to keep a scheduled appointment and do not contact me within 30 days of the date of last recorded contact, it will be understood that you have terminated treatment.

Choosing a Counselor and Rights: You have the right to choose a counselor and I recommend calling your counselor before you have your first meeting to ask about specialties and how the therapist will meet your needs. You have the right to refuse treatment and the right to choose a practitioner and treatment modality which best suits your needs.

Mandated Reporting: Any information that I deem relevant in situations where I believe a client or others to be at risk of physical harm, physical or sexual abuse, molestation, or severe neglect will need to be reported. Therapists are mandated reporters and need to help protect others when abuse and neglect is present.

Consultations: I regularly consult with other professionals about how to best help my clients if needed. These consultations are conducted in such a way that confidentiality is maintained.

Unprofessional Conduct: The brochure titled "Professional Therapy Never Includes Sex" mentions ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact the Board of Behavioral Sciences.

Emergencies: I do not offer crisis coverage. If you are experiencing emergencies or a threat to yourself or others, please call 911 or go to the nearest hospital emergency room.

Contacting Me by Phone: You may leave me a voice message at 951.384.1770. I check this message periodically and will typically return your call within 24 hours. If you are comfortable with texting, you may do so upon reasonable hours 8-6pm. If you are not comfortable with texting, please let your therapist know.

*I have read and understand the information present in this form.

Date: Patient Signatures _____ _____

Sarah Pettengill, M.A. LMFTA
Peninsula Therapy, PLLC

951.384.1770
sarah@murrietachristiancounseling.org

CREDIT CARD PAYMENT AUTHORIZATION

Sign and complete this form to authorize Peninsula Therapy, PLLC to debit your credit card, debit card, or HSA account as listed below. By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for therapeutic treatment fees and documents requested by the client, accrued while in treatment and does not provide authorization for any additional unrelated debits or credits to your account. **Credit/debit cards will also be debited if you fail to give adequate notice by phone of missing an appointment.** No more than two consecutive missed appointments will be billed. A receipt of credit card processing will be sent to the email or phone umber provided below. Please complete the information below:

I, _____authorize Peninsula Therapy, PLLC to charge my credit card account indicated below (your card may also be copied for our records). Fees accrued for missed appointments or failure to provide payment at the time of service will be processed via credit card at a rate of $110 per 53-minute session for individuals and $120 per 53-minute session for couples.

Billing zip:_____

Card Number_____ exp._____ code_____

Phone number for receipts:_____

Date:_____

Signature:_____

Sarah Pettengill, M.A. LMFTA
Peninsula Therapy, PLLC

951.384.1770
sarah@murrietachristiancounseling.org

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Please fill out this form if you have a diagnosed disorder from another professional and/or are taking medications for a disorder such as depression, sleep issues, anxiety. This form cannot be used for the re-release of confidential information provided to the Murrieta Christian Counseling by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize Murrieta Christian Counseling to:

_____ release to:
_____ obtain from:
_____ exchange with:

_____
_____
_____
_____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ **Social Security #:**_____
Signature of Client **Date** **OR**
Date of Birth:_____

_____
Signature of Witness **Date**

Sarah Pettengill, M.A. LMFTA
Peninsula Therapy, PLLC

951.384.1770
sarah@murrietachristiancounseling.org

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Please fill out this form if you have a diagnosed disorder from another professional and/or are taking medications for a disorder such as depression, sleep issues, anxiety. This form cannot be used for the re-release of confidential information provided to the Murrieta Christian Counseling by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize Murrieta Christian Counseling to:

_____ release to:
_____ obtain from:
_____ exchange with:

_____
_____
_____
_____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ **Social Security #:**_____
Signature of Client **Date** **OR**
Date of Birth:_____

_____
Signature of Witness **Date**

Sarah Pettengill, M.A. LMFTA
Peninsula Therapy, PLLC

951.384.1770
sarah@murrietachristiancounseling.org

Adult Intake Form-Couples

Today's Date: _____

Client Name :_____ Partner Name: :_____

Address:_____

Phone: Home:_____ Cell:_____
Phone: Home:_____ Cell:_____

Date of Birth_____ Date of Birth_____

Email address _____ Email address _____
Would you like to have email contact?_____

Family Information:
Years Married or together: _____

Previous Marriages/Divorces? _____ Previous Marriages/Divorces?_____
Religious Status_____

Children and Grandchildren/names and ages? current location?
_____

Current Issues:_____

_____

Goals for Therapy: _____

Is there any abuse or addiction in your home by you or your partner? _____

Are you or your partner having any **suicidal,** emotional or physical symptoms (i.e. depressed, anxious, trouble sleeping or eating)
_____

Have you or your Partner been diagnosed with any emotional/mental disorders or had any issues of concern?_____

Previous Diagnosis/Treatment/Dates:_____

Current Medication/History/Dates: _____

Sarah Pettengill, M.A. LMFTA
Peninsula Therapy, PLLC

951.384.1770
sarah@murrietachristiancounseling.org

No Secrets Policy

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient.

If you are being seen as a couple or family, please do not text or call during the week to indicate you have information to share with me, that you wish me not to share with the other patient. I am not at liberty to keep secrets, as it harms the relationship and growth in sessions.

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party. However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated.

I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the _____(couple/family or other unit) being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with **Sarah Pettengill, LMFTA** and that we enter couple/family therapy in agreement with this policy.

Signatures_____ Dated:_____