THE CENTER FOR Relational HEALING

Helping Couples Heal

A Workshop for Couples in Recovery from Relational Trauma and Betrayal
Los Angeles, California

Today's Date:_____/_____/_____

Please check off which date you are registering for:
- ☐ November 8-9, 2019 (In San Francisco)
- ☐ December 6-7, 2019
- ☐ January 17-18, 2020

GENERAL INFORMATION

Client #1:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone/cell: _____ Okay to text? ☐ Yes ☐ No
Email: _____
Emergency contact: _____ Contact's phone: _____
Emergency contact's relationship to you: _____

Client #2:

Name: _____
Address: *(if different from above)* _____
City: _____ State: _____ Zip: _____
Phone/cell: _____ Okay to text? ☐ Yes ☐ No
Email: _____
Emergency contact: _____ Contact's phone: _____
Emergency contact's relationship to you: _____

Whom may we thank for referring you? _____

FAMILY & RELATIONSHIP INFORMATION

Present Relationship Status (check all that apply):

- ☐ Married (yrs:___ mos:___)
- ☐ Partnered (yrs:___mos:___)
- ☐ In a new relationship (6 months or less)
- ☐ Other:

If married, partnered or in a primary relationship, do you live with your significant other?

□ Yes □ No

Others living in your household:

NAME	RELATIONSHIP	AGE

MEDICAL INFORMATION

Client #1:

Primary Therapist: Phone:
Psychiatrist: Phone:
Other Specialist: Phone:

Are you in recovery for addiction or compulsion? □ Yes □ No What program(s)?

Are you currently sober? □ Yes □ No How long?

List any medications you are currently taking (including non-prescription or herbal remedies):

Describe any current physical and/or psychiatric concerns that you have:

Client #2:

Primary Therapist: Phone:
Psychiatrist: Phone:
Other Specialist: Phone:

Are you in recovery for addiction or compulsion? □ Yes □ No What program(s)?

Are you currently sober? □ Yes □ No How long?

List any medications you are currently taking (including non-prescription or herbal remedies):

Describe any current physical and/or psychiatric concerns that you have:

Consent for Treatment and Office Policy

This consent is to certify that you agree to participate in the weekend workshop "Helping Couples Heal: A Weekend Workshop for Couples in Recovery from Relational Trauma and Betrayal" and that you give permission to the clinical staff to provide psychoeducation and psychotherapy services. This includes the following clinician staff: Marnie Breecker, LMFT, CSAT and Duane Osterlind, LMFT, CSAT and other therapists to be determined.

CLINICAL ORGANIZATION

The clinical staff works as a treatment team and consults together. As a workshop participant, you authorize the exchange of information between clinicians in order to provide the most effective treatment.

CONFIDENTIALITY

Under most circumstances, all communication between you and your therapist is confidential, unless permission is given by you to convey information to a third party. There are certain exceptions to this:

- When there is a reasonable suspicion of child abuse, dependent-adult or elder abuse.
- When a client threatens violence to an identifiable victim.
- When a client presents a danger of violence to others.
- When a client is likely to harm him/herself unless protective measures are taken.
- When a client states that he or she has downloaded, streamed, or accessed through any electronic or digital media depictions in which a child is engaged in an act of obscene sexual conduct.

Disclosure may also be required in certain legal proceedings. ***If you have concerns about the content of sessions and any legal proceedings in which you are involved or expect to be involved (e.g., divorce, child custody cases), please let your therapist know.***

Before such disclosure is made, every reasonable effort will be made to appropriately resolve these issues or to notify clients.

ALL clients shall maintain the confidentiality of other participants and are not permitted to disclose any personal and/or identifying information about any other participant. This boundary is critical for client safety.

CONTACTING THERAPISTS

Clients may email, text or leave a voicemail for therapists at any time. Please be aware that therapists may not be able to immediately retrieve messages. **If you have a life-threatening emergency, dial 911.**

FEES, BILLING & PAYMENTS

Fees for the workshop are paid in advance, unless other arrangements have been made. The fee for the entire workshop is $2,650 per couple ($2,400 early bird rate applies if you register six weeks prior to the workshop date). There are no additional costs and the fee includes all aspects of the program; additional services, if rendered, may be billed separately (e.g. couples sessions, etc.).
If document preparation is required (e.g. legal proceedings, insurance appeals), clinicians reserve the right to bill for services, plus fees for materials (copies, outside services, etc.). In order to prevent any misunderstandings about payment for services, please be advised of the following:

- All services provided are billed directly to the client unless other arrangements have been made;
- Clients are personally responsible for payment via credit card, cash, check or money order;
- Statements can be provided for you to submit for insurance reimbursement;
- You are responsible for submitting all claims to your insurance provider;
- If payment is not received when services are rendered, payment may be applied to the credit/debit card on file if no other payment arrangements have been made.
- If your credit/debit card is invalid and you have made no other payment arrangements, your past due balance may be sent to an agency for collection.

Payment Guarantee: Clients are responsible for all incurred charges, even if you direct us to bill another person or third party. If you direct charges to be billed to another person or third party, you represent that you are authorized to give such direction. If you have directed charges to be billed to another person or third party who fails to make payment, you will be responsible for payment.

CREDIT CARD AUTHORIZATION

Credit Card Authorization**: I authorize the maintenance of valid credit card information to guarantee my chosen payment option.**

Cardholder Name:_____

Billing Address:_____

City: _____ **Zip:** _____

***Circle Card Type*: Visa MC Discover Amex**

Credit Card #_____ **Expiration date:** ____/____/____

3 digit CVV code: _____

Cardholder/Client Signature: _____ **Date:**____/____/____

A deposit of half the workshop fee is required to hold your space and the balance is due one week prior to the first day of the workshop. **A statement will be provided upon request. Clients are responsible for submitting all claims to their insurance provider.**

I have read, understand and agree to the authorization stated above

Client #1:
Signature:_____ Date:_____

Printed Name: _____

Client #2:
Signature:_____ Date:_____

Printed Name: _____