**Deborah L. Klinger, M.A., LMFT, PC**

1415 Broad St.

Durham, NC 27705

919-990-1143 www.deborahklinger.com

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

Phone#: Main \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Part time \_\_\_\_\_\_ Full time \_\_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_ Living w/partner \_\_\_\_ Divorced/separated \_\_\_\_\_ Other \_\_\_\_

How/where did you hear about me? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medication? Y/N If yes, please specify the medication(s) and the reason you are taking it/them:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the doctor who prescribes your medication:

\_\_\_\_\_\_\_I give Jennifer Raum permission to contact this person for the purposes of coordination of my care.

Medical conditions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Intake, p.2

Name of the doctor who treats you for these conditions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_I give Jennifer Raum permission to contact this person for the purposes of coordination of my care.

Have you seen a therapist before Y / N ?

If yes, please give the name of the therapist, a brief description of the problem and degree of resolution:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_I give Jennifer Raum permission to contact this person for the purposes of coordination of my care.

What brings you in to therapy at this time?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there anything else you feel would be helpful for me to know about you?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, contact (name/phone#/relationship to you):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_I give Jennifer Raum permission to contact this person in case of emergency. Jennifer will also notify Deborah Klinger in the event of any emergency.

\_\_\_\_\_\_\_ I understand that Jennifer Raum is a student in a Master’s degree program in Marriage and Family Therapy, seeing clients at Deborah L. Klinger, M.A., LMFT, PC for her internship, under Deborah Klinger’s supervision.

Deborah L. Klinger, M.A., LMFT, PC

1415 Broad St. Durham, NC 27705

# (919) 990-1143 [www.deborahklinger.com](http://www.deborahklinger.com)

This document is a summary of the policies that apply to work with a student intern in this psychotherapy practice. It is intended to assist in clarifying the questions that commonly arise in a therapeutic situation as well as items specific to seeing a student therapist.

* **Length of Sessions**: Sessions are 45-50 minutes long, unless otherwise specified.
* **Cancellations**: excepting emergencies, sessions must be cancelled **24 hours in advance**, or the full fee for the session will be charged. If you need to cancel within 24 hours of a scheduled session for any reason, call or text my cell phone.
* **Confidentiality:** The normal confidential relationship between client and therapist does not cover disclosures of child or elder abuse or neglect, or intent to harm another or oneself. You may give me written permission to speak to significant others and/or other professionals involved in your care. I may consult with other professionals about you without your explicit permission so long as I do not give details that would reveal your identity. I may contact your designated emergency contact person in case of emergency, including situations in which I am unable to reach you and have justifiable concerns about your wellbeing. I will be discussing my work with you with Deborah Klinger in supervision. I will be videotaping sessions with you as part of my learning as a graduate student.
* **Phone calls**: The telephone number above is voice mail only. I don’t have access to this voicemail, so any messages left there will be retrieved by Deborah and passed on to me. I check my voice mail regularly and will return any messages as soon as possible. If you want to reach me immediately, call my cell number. Any telephone conversations and/or voice mail messages exceeding 7 minutes will be considered a therapy session and charged pro-rated based on our agreed fee.
* **Texting**: If you’d like to reach me by text, please download the free, HIPAA-compliant app, Signal. Regular texting apps do not meet federal HIPAA privacy requirements.
* **Payment and Insurance**: As a student, I am not able to accept insurance for my services. Payment must be made in cash or check; I’m not set up to accept card or other forms of payment.
* **Email:** I cannot guarantee that email correspondence will be confidential. My email account is password-protected, in accordance with privacy requirements but the nature of the Internet make it impossible for me to control what happens to information as it flows between computers. Any email correspondence requiring more than 7 minutes of my time will be charged as a session.

I understand and acknowledge the above:

Printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Consent for Video Recording of Therapy Sessions**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that sessions with

(printed name)

Jennifer Raum will be video recorded as part of her training and learning processes while an intern at Deborah L. Klinger, M.A., LMFT, PC.

These video recordings will be shown only to Deborah Klinger, LMFT, and other supervisees during supervision sessions if other supervisees are present and will be destroyed after they are shown.

I give consent for the video recording of our sessions and the displaying of these recordings in supervision at Deborah L. Klinger, M.A., LMFT, PC. This consent will expire upon termination of therapy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature date