CAROL UMMEL LINDQUIST, PH.D., FACLINP
CLINICAL PSYCHOLOGIST

THE PSYCHOLOGY CENTER
380 GLENNEYRE SUITE D
LAGUNA BEACH, CA 92651
Phone: 949 494 5432
Email: Carol@CarolUmmelLindquist.com

Dear New Client

I am looking forward to meeting with you for your first appointment. I love my work as a psychologist and look forward to helping you with whatever challenges you would like to explore and resolve. Directions to my office are located on my website: www.cullagunabeach.com.

There are some policies and procedures that I may neglect to fully review with you initially because I am most interested in understanding you and your concerns. I felt writing them down would save time and avoid confusion. Please retain this agreement and read it at your leisure and please feel free to discuss any questions or concerns you have about these policies or any other matter at any time. I will gladly discuss any of these with you. As a potential consumer of psychological services you are entitled to be fully informed. Of course, I will bring up with you matters seem to directly affect your particular concerns.

My view of psychotherapy is that you, as a client, are hiring me, as the therapist, to consult with you regarding growth issues or problems that significantly impact your life. Some of my clients view our relationship as coaching them to achieve their goals. One aspect of my practice is executive coaching for healthy people who wish to enhance their performance and communication in their profession or lives.

The goals of therapy and coaching are best set by both client and therapist together, so that our agendas in working together can be clear and most effective. With these goals in mind, a treatment plan will be developed using the latest psychological information available for helping you.

Legal & Ethical Statements

The following statements are to provide you with information concerning therapy, as well as the legal and ethical issues related to services provided by licensed psychologists in California, and federal rules and regulations concerning you.

TYPE OF THERAPY: Many different kinds of psychotherapy are available to the consumer today. Although it is difficult to present a comprehensive statement of my therapy style and theory within the confines of this disclosure statement, I want to share some fundamental ideas that we can discuss any time you wish.

Therapy is essentially a relationship between the client and the therapist. The client may be an individual, a couple or a family. The initial focus of the therapy is on understanding thoughts, emotions and life situations that concern the client. Therapy then offers the support, skills and directions that facilitate the client's desired changes.

As a client you have the ability to understand and implement change; you are responsible for deciding the ultimate course of action. Through a sequence of self-explorations, which include an investigation of your family history and a commitment to change personal behaviors, you learn more about yourself and the external factors that affect the quality of your life. You may find improved skills in the areas of communication, decision making, personal effectiveness, self-control and self-understanding. Formal and informal assessments, readings, structured experiences, journal writing and "homework" are sometimes used to augment the therapy experience. You are in full control of what you want to accomplish in therapy and we decide together what methods to use. It is most helpful, I find, if you are as open and honest as possible about what you choose to share.

If I feel you can best be helped by a therapeutic method different from my own scope of practice, I will discuss a referral with you.

My background statement and a more detailed therapy orientation are available on my website. I hope our work together will add significantly to your experience of wellbeing and achieving your goals.

RISKS AND BENEFITS OF THERAPY AND COACHING: The desired benefits are your improved ability to identify problematic areas, evaluate reasonable options and take action in an honest manner. A good therapy or coaching experience also offers opportunities to learn important things about one's self, to acquire helpful life management skills and to integrate both past and present learning toward higher functioning. The risks include the awareness of negative feelings and situations, some of which may not be changed to your satisfaction. Some awareness may cause emotional disability or disruption to your current life. The possible realization that therapy is helpful and desired, but beyond the limits of your financial resources is also a risk.

You may wonder if there are any guarantees in the light of the benefits and risks presented here. In short, while I expect that therapy will be helpful, there is no guarantee that therapy with me will be the best way to reach your desired goals. Because every therapeutic experience is unique, it varies from individual to individual. Therefore, it is vital that you feel free to discuss any concerns you have about the course of treatment with me at any time. As a client, you also have the right to seek a second opinion from another clinician. I encourage you to do so if you feel it may be beneficial.

RIGHTS OF CLIENTS: My practice is guided by the Ethical Code of the American Psychological Association. A copy of that code, as well as a statement of clients rights, is available upon request in my office for you to read. Sexual intimacy between client and therapist is never appropriate during or following a therapeutic relationship and here is the California

Board of Behavioral Sciences pamphlet link on the issue: https://www.dca.ca.gov/publications/proftherapy.pdf. The State Board of Psychologists in Sacramento investigates reports of such behavior.

INDEPENDENT PRACTICE: While I am housed with The Psychology Center and enjoy the benefits and the stimulation of interaction with my very skilled peers, we each practice completely independently and are each separately responsible for our own policies and practices.

Therapeutic Policies

TREATMENT SESSIONS: Therapy sessions are usually held once a week for fifty minutes. Sessions are scheduled on a weekly basis until you and I mutually agree that a different time schedule is appropriate. If we decide EMDR therapy for trauma is an appropriate therapy for you, sessions are scheduled differently. After initial orientation session, EMDR therapy is usually scheduled for 90 minute session per week or every other week. Sometimes sessions are separated by non-EMDR session to process changes that that occurring. Goals for therapy are determined within the first few sessions. These are periodically reviewed and refined. Termination occurs when both of us mutually agree that the goals have been satisfactorily addressed or there is some other reason to terminate, such as a required move. You have the right to terminate at any time; I ask that you discuss your concerns with me for at least one session or by telephone before you leave therapy.

THERAPY AND PHYSICAL SYMPTOMS: Physical symptoms are often the result of emotional stress. They can be reduced and even eliminated under certain therapy conditions. It is important, however, that an appropriate medical specialist review your current situation to ascertain the degree to which the symptom has a physical base. A physical exam is therefore required when a physical symptom is a primary concern. If there is a physical problem that affects your therapy, I will work closely with your medical specialist to coordinate treatments and services with your consent. It is important for you to let me know if you have a persistent physical discomfort. I will discuss a referral to another specialist with you.

MEDICATIONS IN PSYCHOLOGICAL THERAPY: Depending on symptoms and problems, medications may or may not be appropriate. As a psychologist I am not licensed to prescribe medication. In the event a consideration for possible medications for psychological distress seems necessary, then I will refer you and assist in obtaining a medical evaluation. It is your responsibility to inform me of any and all prescribed medications and changes in medications as they may significantly affect your mental status and therapy. It is also important that you are compliant with the course of treatment as prescribed by your physician. For some conditions however, therapy has been shown to be more effective than medications. I will inform you if I feel medications will affect or enhance your treatment.

LIMITATIONS AS A THERAPIST: Because I have family responsibilities, I do not do hospital work or severe substance abuse cases. If we feel you require these special services, I will refer you to someone, or a program I trust that specializes in these areas. I will maintain contact with you and support you during that time as permitted by new treatment professional.

CONFIDENTIALITY: The information presented in therapy is personal and confidential. Information is also legally protected. The only circumstances when information could be shared without your prior written and verbal permission are when there is a clear intention to do harm to yourself or to someone else. When your insurance company asks for routine information previously authorized and when a court subpoena is valid. I also have a legal and ethical responsibility to notify appropriate social agencies of any suspicion of emotional, physical or sexual abuse or neglect of a child, a dependent disabled adult or an elderly person. Please note that if you instigate a lawsuit, your mental status and all your records may become subject to court scrutiny. Even when I receive previously signed written authorizations from insurance or regarding legal matters, I will contact you to discuss whether I feel releasing all or some of the information is in your best interest. It is my general policy to forward all information to you, for you to release to your Insurance Company or lawyer as you see fit.

In the unlikely event of my sudden inability to conduct my therapy practice, I have a professional will that will be carried out by one of a set of highly competent and trusted professional colleagues. They will use my secure database of clients to contact anyone who has seen me in a professional capacity in the previous 7 years. You will be given a chance to talk about what has happened and will be offered one or more referrals if you desire. By signing this consent, you are agreeing to have your name released to a trusted professional psychologist.

PRIVACY AND VISIBILITY: Laguna Beach is a small town which can present some challenges to maintaining privacy for receiving professional services. While unlikely, it is possible that you will recognize someone or be recognized by someone in the waiting room of the office. If you know someone who sees me and you don't want to cross paths, please let my office manager or I know. I ask all my clients to maintain their privacy and the privacy of others in and out of the office. Of course, I will maintain the confidentiality of all parties at all times. I also live in Laguna Beach, and you may encounter me accidentally or in a planned-expected manner in the community. Unless you tell me otherwise, I will neither acknowledge you in the community first, nor will I acknowledge working with you without your permission. If I act like I don't see you, I probably don't. Please remember I am practically blind at a short distance. Please feel free to discuss any concerns you might have about this with me.

ORIENTATION AND CONFIDENTIALITY IN COUPLE, AND/OR FAMILY THERAPY: My orientation to family and marriage therapy is that children and individuals do better when the family remains intact except in cases of domestic violence or child abuse. When I treat you as part of a couple or family group, no information is released to outside parties without the written consent of <u>all</u> parties present. Minor children will also be asked for their consent. When we meet in individual sessions in the context of family therapy, no information is shared with other members of the family unless the individual (even though he/she may be a minor child) shares it himself/herself or indicates a willingness for me to share or their disclosure suggests they are putting themselves or others in grave danger. Even then I will discuss any disclosure prior to making it, if possible. Again, you are agreeing to this procedure when you sign this document.

REQUESTS FOR INFORMATION: Insurance companies, health maintenance organizations, and preferred provider organizations sometimes require extensive documentation of your diagnosis, treatment plans and progress. While I am happy to comply with such requests, I must charge for my preparation time and routine costs if lengthy reports are required. Fees for report preparation will be billable at $250 per hour and are not included in testimony charges. I will provide you with separate documentation of those fees should the need arise.

Such organizations are not always covered by legal protection of privilege or confidentiality and may have no ethical guidelines. It is my policy to contact you directly when I receive written requests even when the request includes written authorizations to release information. I do this so we can discuss exactly what you wish released and how I might accomplish this. You should be aware that by using third party payment, the releases you sign and/or the processing procedures followed might eliminate your legal protections of privilege and confidentiality. I find many of my clients are unaware of the existence of the Medical Information Bureau that has over 750 insurance companies as members. They share with other health, life and mortgage insurers, if you sign a general or specific release. For these reasons and because of the HIPAA regulations discussed elsewhere, when I am asked by you to release information I mail or give the original in a sealed envelope and a copy to you so that you may forward it as you choose. Often I send you a rough draft by email first if you request it. In the case of a court subpoena I must mail it directly from my office, however.

Legal Matters: Some situations involve legal matters. If you are involved in a legal situation of any kind, you agree to sign the retainer agreement at the beginning of therapy. This is for your protection and mine. See the retainer agreement under forms if this applies to you.

RECORDS: I regularly keep written records of our sessions. These records include date of meeting, who was present, how long we met and brief notes regarding the issues we discussed. I also record quotes and specific details if issues of homicide, suicide, or abuse or neglect or other legal matters are discussed. I document calls to and from other care providers. These records are maintained three years after age of majority and seven years for an adult per California laws and guidelines. After that they are retained in either full or summary form for an additional eight years. Fees for report preparation and review of records will be billable at $250 per hour and not included in testimony charges.

CONSULTATION WITH PEERS: I routinely consult with my therapist peers regarding cases. This is to insure my objectivity and that I do not overlook possible avenues to help you. I do not use my clients' names and try to omit all identifying information unless I have a specific signed consent and you wish me to contact them. Confidential records of these contacts are kept with your records and I inform you of the discussion if I feel it is helpful to you. If you have any questions or discomfort about this, please do not hesitate to discuss this with me.

VOICE MAIL SERVICE: We have a Voice Messaging Service on the 949-494-5432 telephone. If you do not receive a call back within 12 hours of when you leave a message, please call again because I may not have gotten the message. If your call is urgent or is about an appointment in the next 24 hours, please leave a message then press the # then wait to be

prompted to press the number 4, listen for menu then press # and I will be paged. If it is a life threatening emergency and I can't be reached, call your local hospital emergency room.

VACATION POLICY: I will always inform you about my plans to be away from the office on the day(s) we usually meet. When I am not available at times other than our scheduled times, I will usually inform you in advance. In any case, my office will be available to inform you who will be on call. Your signature on this form provides me with permission to share some minimal information about your case with the on-call therapist covering for me. For each vacation, I will inform you what information, if any, I feel it necessary to share and with whom.

TELEPHONE CALLS, TEXTS AND E-MAILS BETWEEN SESSIONS: Routine calls for the purpose of scheduling or billing information are an expected part of my service and not billed. Telephone calls, emails or texts occurring on week-ends that are primarily therapeutic in nature, occur frequently, and/or require more than ten minutes will be prorated and billed at the usual rate. Please do not use texts to communicate therapeutic information. Please know that texts, email correspondence and cellular phone calls cannot be considered completely confidential or secure. If you choose to email, be aware that all emails are retained in the logs of your internet service providers and mine. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record. Also, we do typically respond to calls regarding schedule issues, texts or emails during business hours of Tuesday, Wednesday & Thursday.

I cannot guarantee a timely response on emails so schedule changes and cancellations should always be handled by phone. Please do not text Larna or myself outside of our normal business hours regarding schedule changes.

I can schedule telephone sessions for some clients if it is appropriate to their goals and treatment.

SOCIAL MEDIA AND INTERNET: As a therapist, my concern is to protect your safety, privacy and confidentiality. For these reasons, I do not follow or accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Twitter, Instagram, etc). I do not use search engines (Google, Facebook, etc) to obtain information about current clients except in extremely rare crisis situations where I am concerned about your well-being or when you want to show me something about you.

You may find my practice listed on business review sites such as Yelp, Healthgrades, Bing, etc. These listings are generated by the business review sites independently from me and without my knowledge. Please know that this listing is NOT a request for a testimonial, rating, or endorsement from you as my client. Of course, you have a right to express yourself on any site you wish but I would urge caution when sharing personally identifying information in a public forum. Due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I ask you to take your own privacy as seriously as I take my commitment of confidentiality to you.

FEES FOR SERVICES: The fee for service is $250 for a 50-minute session. It is best to pay at the desk when you arrive for your session as we may discuss challenging material and you may be more comfortable leaving directly when the session is over. Payment can be made with cash, credit card or a personal check. If you have insurance coverage, we will be glad to provide you with a receipt or statement satisfactory for filing your insurance claim at the end of each month. My office will be glad to assist you in determining the extent and limitations of your coverage. Therapy is a significant personal and financial commitment. Please do not hesitate to discuss financial matters with me.

MEDICARE INSURANCE: I do not accept Medicare. If you are over the age of 65 and have Medicare, please inform us so we can have you complete and sign the Medicare Opt Out Form. It is also available on the website for your convenience.

MISSED APPOINTMENTS AND CANCELLATIONS: Sometimes emergencies come up. If I need to cancel or change an appointment time, I will give you 24 hour notice, as I know you will have reserved the time for the appointment. If for any reason I cannot give you 24 hour notice, I will provide our next hour free of charge to you. Likewise, I expect that you will give me 24 hour notice if you must cancel the appointment. If, for any reason, you cannot let me know 24 hours in advance you will be charged the regular fee for the time reserved.

* * * * * *

SIGNATURES: By signing below, you agree as follows:

- *I have read the materials presented in this disclosure statement.*
- *My signature indicates that I understand the information, and agree with the conditions of therapy that are either stated or implied here, and I commit myself to compliance with them.*
- *I understand that once therapy begins, I retain the right to withdraw consent to participate in therapy at any time that seems appropriate.*
- *I will make every effort to discuss my concerns about the progress of therapy with you before I terminate.*

_____

Client's Signature Date

_____

Client's Signature Date

_____

Carol Ummel Lindquist, Ph.D. ABPP Date

Revised 5/23/2019

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(949)494-5432
EMAIL: CAROL@CAROLUMMELLINDQUIST.COM

Client Information

Full Name: _____
first middle last

Address: _____
Street city state zip

Cell Phone:( )_____Work Phone: ( )_____ Home Phone: ( )_____

As a courtesy, we notify you of next days appointment. Please check preferred notice ☐ Text ☐ Email
Please check here if you do not want to be reminded: ☐

Birthdate: _____ Age: _____ Social Security #:XXX-XX-( )

Occupation/Job Title: _____ Employer: _____

Employment Address: _____

Length of time on job: _____ Email Address: _____

Spouse/Partner Information

Name:_____ Time Together: _____

Birthdate: _____ Age: _____

Occupation/Job Title:_____ Employer: _____

Name of Referral_____

(May we contact them to thank them?) ☐ Yes ☐ No If yes, Phone #:_____

Person to Notify in Case of Emergency (Other Than Spouse/Partner)

Name: _____Relationship to You: _____

Address: _____ Phone: ( )_____

Current Symptoms/Problem and Background Information

Briefly describe reason for seeking help: _____

_____

_____

Approximate date these problems/symptoms first appeared: _____

Have you ever had these problems/symptoms before? ☐ Yes ☐ No If yes, when? _____

Approximate date of last physical examination/visit to your Physician? _____

Physician Name_____ For what reason(s)? _____

List any current health problems: _____

_____

List names and telephone numbers of Physicians concurrently treating you and indicate if we may contact them should the need arise: _____

_____

_____

_____

Have you seen a Chiropractor, Physical Therapist, or Alternative Healer? ☐ Yes ☐ No

Name & how recently seen_____ _____

List the members of your family and all others living with you at this time:

Name	Age	Relationship	Occupation

List parents, step-parents, siblings and any children of yours and/or your spouse who do not live with you:

Name	Age	Relationship	Occupation

Prior History of Psychological/Psychiatric Treatment or Treatment for Alcohol or Drug Problems

Problem Dates Response Name of MD/Therapist (Phone if known)

If you drink alcoholic beverages, please indicate which kind and how often:

If you use drugs of any kind, including prescription medications and/or street drugs, please indicate which kind, for what purpose, the dosage/amount and frequency:

Drugs (prescription, marijuana, cocaine, Ecstasy) Purpose Dosage/Frequency

Names and relationship to you of family members in which there has been a drinking or drug problem (include grandparents, aunts or uncles):

Have you or has anyone in your family had an eating problem (e.g. overeating, anorexia, bulimia)?

☐ Yes ☐ No If yes, who?

Have you been a victim of physical, sexual or emotional abuse, neglect or other trauma? ☐ Yes ☐ No
If yes, by whom and in what situation or relationship?

Do you currently have any legal problems? ☐ Yes ☐ No If yes, please describe:

Symptom Checklist

Please circle any of the following problems that apply to you:
Number the most important in order (1 is first priority)

Nervousness	Depression	Fears	Shyness
Sexual Problems	Suicidal Thoughts	Separation	Divorce
Finances	Drug Use	Alcohol Use	Friends
Anger	Self Control	Unhappiness	Sleep
Stress	Work	Relaxation	Headaches
Tiredness	Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions	Loneliness
Concentration	Health Problems	School	Career Choices
Marriage Problems	Temper	Nightmares	Appetite
Stomach Trouble	Bowel Troubles	Being a Parent	My thoughts
Children	Inferiority Feelings	My parents	Education
Self Confidence	Anxiety	Aging	Guilt
Menopause Issues			

Considering your issues, what is the goal you would like to most achieve first in therapy?

_____

_____

_____

_____

Thank you for your time and attention in completing this information form. Rev. 5/19

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NOTICE OF PRIVACY PRACTICES

This notice describes how information about you as a patient of this practice may be used and disclosed, and how to access your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).
My patient medical records are kept confidential, secure, and out of reach by unauthorized persons. All reports, consultations and correspondence are reviewed by me prior to being filed in the medical records. A written release signed and dated by the patient/guardian must be obtained prior to the release of medical record information. My practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

The following circums tances may require us to us e or disclose your health information:

To provide treatment: We will use your health information within my office to provide you with the best health care possible. This may include administrative and clinical office procedures to schedule and coordinate care between doctors, and business office staff. In addition, we may share your health information with referring physicians, specialists, clinical laboratories, pharmacies or other health care personnel providing your treatment. It may be necessary to release your test results to authorized health care providers treating patients even when the provider requesting the results did not originally order the tests.

To obtain payment: We may include your health information with an invoice used to collect payment for treatment you received in my office. We may do this with insurance forms sent to you in the mail or sent electronically. We will make every attempt to work only with companies with similar commitment to the security of your health information.

To conduct health care operations: Your health information may be used during performance evaluations of my staff, during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

Communications: Because we believe regular follow up is very important to your health, we may remind you of a scheduled appointment or that it is time for you to contact me to make an appointment. These communications may include postcards, letters, and telephone reminders. I may share your health information with those you tell us will be helping you with any auxiliary treatments, medications, or payment. You can request that my practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may request that we contact you at home, rather than work. We will try to accommodate reasonable requests.

Required by law: We may disclose your health information to public health authorities and health oversight agencies that are authorized by law to collect information, when required to do so by a law enforcement official, lawsuits and similar proceeding in response to a court or administrative order, when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, for Workers' Compensation and similar programs.

You are entitled to receive a copy of the Notice of Privacy Practices
I,_____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities, and health care operations and laboratory testing.

Signature:_____ **Date:**_____
(parent/guardian if patient is a minor)

Carol Ummel Lindquist, Ph.D., FAClinP
CLINICAL PSYCHOLOGIST

THE PSYCHOLOGY CENTER
380 GLENNEYRE, SUITE D
LAGUNA BEACH, CA 92651-2303

Permission to Release Confidential Records to/From Outside Sources

To: _____
(The person who has information)

Address: _____

Phone Number: _____

Re: _____
(Yourself and/or your child)

Date of Birth: _____

Permission is hereby granted to Carol Ummel Lindquist to obtain/release and information about the above named person to/from the above named person/agency regarding

_____
(self or child)

Limitations: _____

_____
(Things you don't want me to discuss)

Signed: _____

Date: _____ Expiration Date: _____

I routinely gather information from other professionals who have worked with you unless you would prefer I did not. If you have some one you have previously seen in therapy, or another professional such as an M.D. that you would like me to communicate with or get records from, please sign and return to my office. If you want me to talk to them before our first session you may fax this release to me at the above number. Otherwise, bring this form with you and we will discuss whether there is anyone additional it would be helpful to contact. You may make extra copies of this form or get them from me.

Revised 4/00.

TELEPHONE 949-494-5432 • FACSIMILE 949-497-0913 • E-MAIL clindquist@fullerton.edu

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Retainer Agreement for Professional Appearances (Court/Deposition/Hearing/Mediation)

Expert witness fees for an appearance are $ 1,500 per half day or $ 2,500 for the full day. This will not be prorated. When placed on call for testimony a minimum $ 2,000 retainer for that purpose must be received 10 days prior to being on call in the form of a cashier's check or money order. The retainer covers minimum preparation time and half day court costs. A minimum $ 800 fee for preparation* for that day will be charged if the case is settled and Dr. Lindquist's services will not be needed in court. The remaining funds will be returned, less any fees outstanding for reports requested and generated.

Deposition Charges will be a minimum of one hour with an hour preparation time plus any travel time at $250 per hour. This time must be reserved and paid for 10 days in advance of Deposition.

I understand that a half court day appearance will cost $ 1,500 and a full day $ 2,500 and this will not be prorated. I understand that a half-day is morning to the lunch hour or from the time court comes to order in the afternoon until closing.

I, _____, request that Carol Ummel Lindquist, Ph.D. appear at court/deposition/Hearing on the following date/s _____ for _____ (half or full) day. I have read, understand, and agree to the above.

_____ _____
Client's signature Date

_____ _____
Expert Witness' signature Date

* Preparation time will be billed at the hourly rate of $250/hour. A minimum preparation time of 2 hours will be billed for each court appearance. Fees for report preparation will be billable at $250 per hour and not included in testimony charges and/or Deposition charges.

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Informed Consent for Eye Movement Desensitization and Reprocessing Therapy

I have been informed that Eye Movement Desensitization and Reprocessing (EMDR) therapy is supported with 25 years of research showing that EMDR has produced promising results in reducing anxiety and in reducing post-traumatic stress symptoms, such as intrusive thoughts, nightmares, and flashbacks. The World Health Organization, American Psychiatric Association and the US Department of Veterans Affairs and Department of Defense recognize and recommend it as an effective treatment for trauma. I can request a summary of some of this research. It has also produced promising results treating anxiety and depression and substance abuse, although the research is not as extensive.

I have also been specifically advised of the following:

(a) Distressing, unresolved memories may surface through the use of the EMDR procedure.
(b) Some clients have experienced reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including a high level of emotion or physical sensations.
(c) Subsequent to the treatment session, the processing of incidents/material may continue, and other dreams, memories, flashbacks, feelings, may surface.
(d) If I am involved in a lawsuit, the relief from the EMDR procedures may negatively impact my ability to recall details of the trauma necessary to testify clearly or convincingly.

My clinician has explained to me the reasons why the use of EMDR therapy is recommended for me or my child and that there are other options available to me should I decide not to use EMDR therapy and not to give my informed consent. My clinician has provided me with an explanation about the nature of EMDR and my questions about EMDR have been answered. I also know that I may always discontinue EMDR at any time. Before commencing EMDR therapy, I have considered all of the above and I have obtained whatever additional input and/or professional advice I deemed necessary or appropriate to having EMDR therapy for myself or my child. My signature on this acknowledgement and consent form is free from pressure or influence from any person or entity.

By my signature below, I hereby consent to participating in EMDR treatment for myself or my child.

Client Signature: _____ Date: _____

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From 405 or 5 Freeways: Take 133 South (Laguna Freeway). Go south on Laguna Canyon to Laguna Beach. Turn left on Forest. Follow Forest past ocean around the curve, turning to the right at stop sign. You will be on the main shopping street in Laguna. At Glenneyre the second stop, turn left. My office, 380 Glenneyre, Suite D is between Mermaid and Park streets on your left. Make a left turn through breezeway into the parking lot 380 building.

From Pacific Coast Highway: Go north on Forest Ave away from the ocean. (That will be a right turn on Forest coming from the south and a left turn coming on PCH from Newport). Then turn right on Glenneyre. Make a left turn into 380 building.

Parking: Find the three parking spaces labeled "the Center." You may park in any open "Center" space. If full, there is metered parking on the adjacent streets. There is metered a metered parking lot next door across Mermaid on Glenneyre and another 2 story lot one block past the office on Glenneyre on the right as you go up the hill.

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MAP