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Lynn A. Durand, MD, Medical Director

Dear _____,

I appreciate you asking me to help you. This informed consent is designed to give you information about my practice and our professional relationship. I realize it is long, but sufficient information can help you make informed decisions and give consent for treatment.

CONFIDENTIALITY:

I regard the information you share with me with the greatest respect. I will maintain confidentiality and privacy of your therapy and my records as it is a privilege of yours and is protected by state law and professional ethics in all but a few situations. These situations include: (1) if I suspect you intend to harm yourself, another person or property; (2) when I suspect a child, elder or dependant adult has been or will be abused or neglected. (3) In rare circumstances, therapists can be ordered by a judge to release information (subpoena). In all other circumstances, I will maintain confidentiality unless you give me expressed written authorization to do otherwise. As a collaborative clinic, if you see more than one practitioner at CFIM one chart is kept for each patient. If you prefer to have psychotherapy notes kept separate please inform me.

It is important to understand that once information leaves You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to break-ins and unauthorized access. It has been reported that medical data have been legally accessed by enforcement and other agencies, which also puts you in a vulnerable position. I consult regularly with other professionals regarding clients I work with; however, a client's identity remains completely anonymous and I fully maintain confidentiality.

SCOPE OF PRACTICE AND PROCESS OF THERAPY:

I am a licensed to practice both physical therapy and psychotherapy. I am also a Somatic Experiencing practitioner, consultant and trainer, and a Rosen Method Bodywork practitioner. I may use Somatic Experiencing as part of your therapy. I studied psychotherapy at the California Institute of Integral Studies and physical therapy at Stanford University. My work is influenced by several schools of psychotherapy, physical therapy and somatic practices (bodywork), all of which help people understand

their bodies, injuries, emotional lives, relationships, illnesses and personal dynamics as part of their healing process. My focus is on wellness and my areas of clinical expertise include pain, anxiety disorders and stress related problems, chronic and acute musculoskeletal problems, trauma issues, relationship problems and life transitions.

There are times that integrating psychotherapy and physical therapy might be helpful. You have the choice of working exclusively in physical therapy or exclusively in psychotherapy, or integrating them. Integrating them can take various forms of either alternating treatment sessions, doing a series of one and then a series of the other, or doing both concurrently. Which model and modalities/interventions I employ will depend on your situation and will be done with your informed consent.

Modalities/Interventions can include talk therapy, exercise, manual (hands-on) therapy, Somatic Experiencing, Integrative Bodywork, movement education, electrical modalities (in physical therapy). For clients working in psychotherapy, hands-on bodywork might be an option, but will be added only with your informed consent

All therapeutic work, including hands-on therapy, is strictly at a professional, not a personal level. You have the right to withdraw from therapy at any time. After our initial session I will inform you of my assessment of what I think I can be helpful with and what I may not be able to help with. This will include a treatment plan. If I feel I cannot help you I will tell you that and provide referrals for you when possible.

While it is impossible to predict the exact outcomes of therapy, we will work together toward the goals that we establish. In addition to the work we do together in my office, I may suggest things for you to do between treatment sessions. In psychotherapy it is not uncommon for clients to feel levels of sadness, anxiety, fear as well as joy, happiness and love. Clients healing from physical conditions in physical therapy might feel some level of pain and discomfort while exercising or having certain manual interventions applied. Your feedback is very important.

FEES:

The fee for a 50-55 minute appointment is \$110 for psychotherapy. Physical therapy fees are based on the several procedure codes billed. There may be other costs associated with physical therapy equipment. The frequency of treatment will depend upon your needs and the severity of your troubles. Missed appointments and appointments canceled with less than 24 hours notice may be charged to you and insurance companies may not reimburse for these charges.

INSURANCE:

I am a member of some insurance networks as a psychotherapist. As a physical therapist I am a member of most provider panels. If you cannot use insurance (even with an out-of-network portion) and your income is limited we can discuss a fee based on your ability to pay and what the Center considers equitable. You should call your insurance company to verify your coverage benefits, including out of network benefits, prior to your first appointment. Ultimately, you are responsible to know your health care insurance coverage for all of your health care and are responsible for the charges for your treatment.

Please be aware that once information (clinical or financial) is sent out of the clinic I am unable to guarantee confidentiality of your records. I cannot guarantee that your insurance company will pay for your care or continue to pay for your care after we have begun therapy, although I will do my part in securing reimbursement for your treatment.

EMERGENCIES and VACATION:

Upon occasion an emergency situation arises. In case of an emergency you can call the Center; after hours the answering service will attempt to contact me. In both cases, I will call you back as soon as I can. I do have voicemail for you to leave a confidential message. When I am on vacation or for other reasons the Center or answering service will contact my back up therapist. If you are unable to contact me and it is an emergency call 911 or go to the nearest emergency room.

I abide by the Codes of Ethics of American Counseling Association and the American Physical Therapy Association. You can find the specifics of each code of ethics at www.counseling.org and www.apta.org, respectfully. My intent is to help you. Please ask me any questions you have as you move through your healing journey.

Thank you for asking me to help you.

Sincerely,



Dave Berger, LCMHC, PT, MA

Client Name (print)

Date

Signature

Somatic Experiencing®

Informed Consent

When appropriate, and according to my clinical judgment, I will use Somatic Experiencing (SE) in our work together. SE is a short-term naturalistic approach to the resolution and healing of trauma developed by Dr. Peter Levine and is supported by research. It is based upon the observation that wild prey animals, though threatened routinely, are rarely traumatized. Animals in the wild utilize innate mechanisms to regulate and discharge the high levels of energy arousal associated with defensive survival behaviors. These mechanisms provide animals with a built-in “immunity” to trauma that enables them to return to normal in the aftermath of highly “charged” life-threatening experiences.

- SE employs awareness of body sensation to help people "renegotiate" and heal rather than re-live or re-enact trauma. □
- SE's guidance of the bodily "felt sense," allows the highly aroused survival energies to be safely experienced and gradually discharged. □
- SE may employ touch in support of the renegotiation process.
- SE “titrates” experience (breaks down into small, incremental steps), rather than evoking catharsis - which can overwhelm the regulatory mechanisms of the organism. □

For more information about SE please note the following references:

Levine, P. and Frederick, A. (1997). *Waking the Tiger: Healing Trauma: The Innate Capacity to Transform Overwhelming Experiences*. Berkeley, CA: North Atlantic Books.

Kline, M. and Levine, P. (2007). *Trauma Through A Child's Eyes: Awakening the Ordinary Miracle of Healing*. Berkeley, CA: North Atlantic Books.

For further references and information online about SE go to <http://www.traumahealing.com>

SE can result in a number of benefits to you, such as relief of traumatic stress symptoms, increased resiliency, and resourcefulness. Like any other treatment it may also have unintended negative “side effects.” It is important that you are aware that there are other forms of body-oriented and somatic psychotherapy. The United States Association of Body Psychotherapy (www.usabp.org) is a good source of information about other modalities. Obviously, there are also many non-somatic focused forms of psychotherapy and counseling that you can choose from. I started my studies in Somatic Experiencing 15 years ago, and I am on faculty teaching the SE training.

As with all therapy, it is your responsibility to tell me when you are uncomfortable with any parts of the treatment. If you have any questions about SE or other treatments, please

ask and I will do my best to answer your questions in full. You have the right to refuse or terminate treatment at all times, or to refuse techniques or interventions I may propose or employ.

I have read the above informed consent, understand, and agree to it.

Client name (print)

Date

Client Signature

Rev. 3/08

Name _____

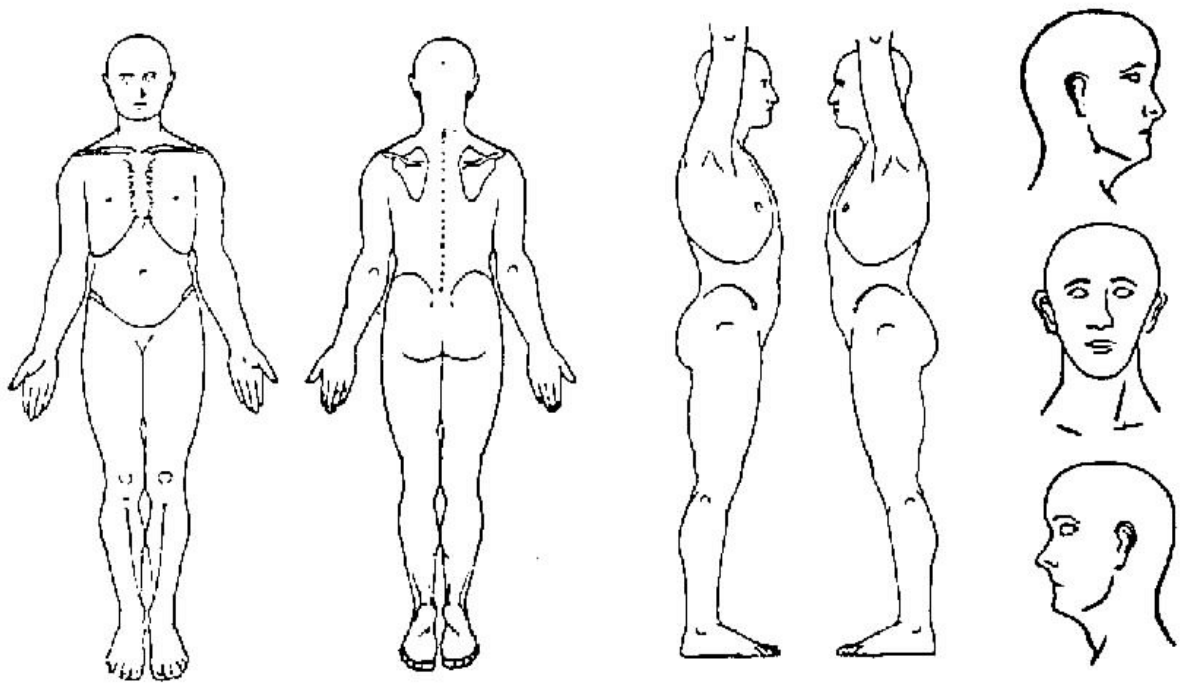
Date _____

Sharing information about yourself is will help me understand why you are here. Please answer the following questions before your first appointment. Thank you.

Name: _____ Date of Birth _____ Age _____

1. What are the main concerns you have for seeking help at this time? Please include your symptoms, pain, illness, injuries, onset, upsets, losses, functional problems, fears, worries, etc.

2. Please describe what you feel in your body and mark on the chart where you feel your symptoms.



Name _____

Date _____

3. What would you like to achieve from therapy (what are your goals)? Include Functional Goals.

1. _____

2. _____

3. _____

4. _____

4. List the medications, supplements, remedies and herbs you take.

_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Do you have any allergies? Yes___ No___

6. Past Medical History (include dates)

Include major illnesses, surgeries, hospitalizations, accidents, injuries and traumas.

7. Primary Care Provider _____ Phone _____

8. Do you exercise Yes___ No___

What do you do, how often and how much? _____

9. Do you have a spiritual practice? Yes___ No___

What is it? _____

Name_____

Date_____

10-. Do you smoke tobacco? Yes____ No____ Cigarette, Cigar, Pipe

How many per day_____

Did you ever smoke tobacco? Yes____ No____

When did you quite_____ How much did you smoke_____

11. How much alcohol do you drink, if any? None____

____beers/day

____glasses of wine/day

____drinks/day

12. Do you use recreational drugs? Yes____ No____

If yes, what do you use?_____

How often?_____

13. What are you eating habits like?

Typical breakfast_____

Typical Lunch_____

Typical Dinner_____

Typical Snacks_____

14. Have you every had a problem with eating or an eating disorder?

Yes____ No____ Anorexia, Bulimia, Binging, Overeating

15. How is your sleep?_____

16. Do you remember your dreams? Yes____ No____

Has there been a theme to them recently? What is it?_____

17a. What are the stressors in your life right now?_____

Name_____

Date_____

17b. How do you reduce your stress?_____

18. Have you experienced any anxiety or depression lately?

Anxiety____ Depression____ Mixed____

Please describe:_____

19. Have you recently or in the past thought about suicide? Yes____ When____ No____

Have you ever attempted suicide? Yes____ No____

If your answer is yes to either of these questions, please describe what treatment have had:_____

20. What do you do that makes you feel good?_____

21. Have you ever been, or are you presently in counseling or psychotherapy?

Yes____ No____ Other therapeutic work____

Describe why you went and your experience:_____

22. Have you been treated for musculoskeletal problems or ongoing medical problems?

Yes____ No____ Please Describe:_____

23. What is your occupation?_____

Do you enjoy your work? Yes____ No____

Describe why or why not:_____

Name_____

Date_____

24. What kind of support system do you have?

Family____ Friends____ Relative____ Other_____

25. Marital status:

Single____ Married____ Spouses Name_____

Divorced____ Remarried____ Committed Relationship ____

If divorced, when did you get divorced?_____

How was the process?_____

If remarried, when did you get remarried?_____

Do you have a blended family? Yes____ No____

How many children? Yours____ Spouses____ Together____

26. Your children:

Names	Ages	Living Where?
_____	_____	_____
_____	_____	_____
_____	_____	_____

27. Family History

Name	Age	Age @ Death	Illnesses (med/psych)
Mother	_____	_____	_____

Father_____

Sisters_____

Brothers_____

Name_____

Date_____

28. Briefly describe your childhood, particularly in relationship to your family of origin

29. Sexual Orientation: Straight____ Gay____ Lesbian____ Bisexual____

30. Briefly describe your present living situation:_____

31. What is you level of education?_____

32. What do you enjoy doing in your life?_____

Is there anything else you would like me to know right now?

Thank you for taking the time to reflect on aspects of your life and completing this form.

Dave Berger, LCMHC, PT, MA