Lacey Horsman, MFT

Licensed Marriage & Family Therapist

LMFT 46897

1500 W. Shaw Avenue #400   Fresno, CA 93711

559-824-8403

laceyhorsman@gmail.com

www.laceyhorsman.com

This packet contains important forms which must be completed prior to your first session and provides information for you, as a patient, about my professional services and business policies. I understand that asking for help can be difficult and I appreciate your courage to be here today. My goal is to help you make the most of your therapeutic experience and to avoid misunderstandings by explaining the differences between therapy and other healthcare settings. Please feel free to discuss any questions or concerns you may have about the information in this packet or any other aspect of your therapeutic process.

Contents of packet:

1. Information About Therapist and General Guidelines of Psychotherapy
   Please read- this is your copy to keep
2. Office Policies & General Information Agreement for Psychotherapy Services
   Please read- this is your copy to keep
3. Limits of Confidentiality
   Please read
4. The Notice of Privacy Practices (HIPPA) form explaining your
   privacy rights. This is your copy to keep.
5. List of Crisis numbers
   This is your copy to keep
6. Consent of Treatment-**Page 9**
   Please sign, date and return to me
7. Adult Intake Forms
   PLEASE FILL OUT PAGES 10-14 COMPLETELY, PRINT, AND RETURN TO ME

ABOUT THERAPIST:

I am a Licensed Marriage and Family Therapist in the State of California and a current member of the California Association of Marriage and Family Therapists (CAMFT). I am a graduate of CSU Fresno, where I obtained my Bachelor of Sciences degree in Criminology with an option in Victim Services and my Masters of Sciences degree in Counseling with an option in Marriage and Family Therapy. I have worked with adults, children and families in a variety of environments and settings prior to becoming a therapist and have extensive therapeutic experience in the areas of trauma, domestic violence and child abuse. I have received specialized training in play and art therapy techniques when working with children and adolescents and have completed training in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). I also treat issues associated with relationships, life transitions, depression, anxiety and bereavement.

MY APPROACH:

My treatment approach is to provide a safe and supportive environment to help clients resolve current problems and long-standing patterns. I incorporate a blend of psychodynamic, family systems, and cognitive behavioral methodologies, drawing upon a variety of styles and techniques to incorporate what will be most helpful for each client. With sensitivity and compassion, I work with each client to help them build on their strengths, recognize unhealthy patterns, and to identify and achieve their life and relational goals.

GENERAL GUIDELINES:

Psychotherapy can be a powerful, life-changing experience. You have come to therapy because you want to feel better about something or you want to further explore or improve a specific area of your life. While most people who participate in mental health treatment benefit from it, like most kinds of healthcare, your commitment to growth and progress will be the greatest factor of how much you will gain from this experience. This process may also bring up uncomfortable feelings, encouraging you to engage in difficult interactions or face challenging aspects of your life and you may actually feel worse before you begin to feel better. In addition, as with many forms of treatment, there are no guarantees as to the outcome of your psychotherapy and there are no pre-determined number of sessions to attend before you may reach your goals. I am unable to provide custody evaluation recommendation, medication or prescription recommendation, nor legal advice, as these activities do not fall within my scope of practice.

OFFICE POLICIES & GENERAL INFORMATION AGREEMENT FOR PSYCHOTHERAPY SERVICES

CONFIDENTIALITY:
All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law (Please see separate form on "LIMITS OF CONFIDENTIALITY").

CONSULTATION:
I consult regularly with other professionals regarding patient cases and issues, however, I insure that patient identity remains completely anonymous and confidentiality is fully maintained.

FEES/INSURANCE REIMBURSEMENT:
My standard fee for service is $120 per 50 minute session. I accept cash, check, or credit card payments and you will be expected to pay for each session at the time it is held. When paying with cash, please be advised that I do not keep change and when paying with check, please make checks payable to: **Lacey Horsman, MFT.** Please be advised that there will be a $25 service charge for any checks returned by your banking institution. If I am an accepted provider of your insurance and you would like to utilize this option, I will bill your services directly and collect reimbursement, however, you are responsible for any applicable co-payments at the time of your session. You are also responsible for your full session fee in the event that your therapy services are denied reimbursement by your provider. If I am not considered a provider for your insurance company, I can create what is called a "*Super Bill*" for you at the end of each month which details the necessary information for you to submit to your insurance company (Please check with your provider to discuss if this is an acceptable form of billing). If you choose this option, you are required to pay me my full fee at time of service and your insurance company/companies would then issue a reimbursement check to you/ the policy holder. Please be advised, that your insurance company may not reimburse for outpatient psychotherapy from a Licensed Marriage and Family Therapist working in private practice, for a therapist considered "Out of Network", or for certain diagnoses or goals of therapy. If you choose this option, however, I can provide you with a list of questions to ask when contacting your provider to inquire about your psychotherapy coverage.

APPOINTMENTS/CANCELLATION POLICY:
Sessions are 45-50 minutes in length and typically scheduled once per week. If necessary, we may meet more or less frequently depending on you or your child's needs and progress of treatment.

Unlike other healthcare settings, time set aside for you or your child's scheduled appointment is reserved for you/their use alone. In addition, in order for therapy to be most effective, it needs to occur on a consistent basis. If you need to cancel or change you or your child's appointment, please contact me at (559) 824-8403- **a 24-hour notice is required**. If you fail to provide a 24-hour notice of cancellation or appointment change, you will be charged a $50.00 fee for your missed appointment. Your insurance company or other third party payer will not pay for missed sessions, therefore you will be solely responsible for this expense and be required to address your balance before further sessions are scheduled.

If I need to reschedule or cancel your appointment, I too will give at least a 24-hour notice except in the case of an emergency or acute medical illness.

TREATMENT PLANS:
Within a reasonable period of time after the initiation of treatment, I will discuss with you my understanding of the issue that brought you to therapy, your treatment plan and therapeutic objectives and possible outcomes of your treatment. If you have any unanswered questions about any of the procedures used in the course of your/your child's therapy, their possible risks, my expertise in employing them, or about the treatment plan, please feel free to address them with me at any time.

NO/OPEN SECRETS POLICY:
Sometimes when treating couples or families, an individual will disclose a secret to me and ask that the other/s not be told. Generally, the holding of secrets from other members of the therapeutic relationship is not advised. Of course, there are exceptions so please bring these matters to my attention as soon as possible so that we can work through them.

CONTACTING THERAPIST /EMERGENCY PROCEDURES:
If you need to contact me, I have 24-hour voicemail. You may leave a message or text on my cell phone at (559) 842-8403 and I will make every effort to return your call/text within 24 hours with the exception of weekends, holidays, or when I am on vacation. It is my policy not to address any therapeutic issues via phone, email or text and I ask that you address any and all concerns at the time of your next appointment. If an emergency arises, please go to the nearest hospital emergency room, dial 911, contact Community Behavioral Health (559) 449-8000 or go in person to 7171 N. Cedar Avenue where consultation is available 24 hours a day. If I am concerned that your personal safety is in jeopardy, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. If necessary, I may also contact the person whose name you have provided on the Intake form to ensure your safety.

VACATION POLICY:
In the event that I will be out of the office for vacation, I will give you reasonable notice. When on vacation, I will make arrangements with another therapist to be on call for emergencies. If you feel that you will need continuing treatment during this time, I will help you make arrangements ahead of time with another therapist.

E-MAILS, CELL PHONE, COMPUTERS AND FAXES:
It is very important to be aware that computers and e-mail communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Faxes can easily be sent erroneously to the wrong number. E-mails, in particular, are vulnerable to unauthorized access due the fact that Internet servers have unlimited and direct access to all e-mails that go through them. Additionally, my e-mails are not encrypted. My computer is equipped with a firewall, a virus protection and a password and I back up all confidential information from my computer on a regular basis. Please notify me if you decide to avoid or limit in any way the use of any or all communication devices, such as e-mail, cell phone or faxes. If you communicate confidential or private information via e-mail, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and I will honor your desire to communicate on such matters via e-mail.
PLEASE DO NOT USE E-MAIL OR FAXES FOR EMERGENCIES.
***Please note that I may be contacted for brief questions or concerns but for phone calls that go beyond 10 minutes, you will be charged based on my hourly rate.**

SOCIAL MEDIA POLICY:
It is my policy not to accept friend or contact requests from current or former patients on any social networking site (Facebook, LinkedIn, etc). I believe that adding patients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

LITIGATION LIMITATION:
Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, disability etc.), **neither you nor your attorney, nor anyone else acting on your behalf will call me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.**

COURT SUBPOENAS AND REQUEST OF RECORDS:
In the event that I am subpoenaed by the court on your behalf, you will be billed at the rate of $120 per hour with a 2-hour minimum plus travel time and mileage reimbursement. If court-ordered to provide records of services that you have received with me on your behalf, you will be billed at the rate of $120 per hour with a one-hour minimum. Advance notice of one week is requested for this service and please note that you are responsible for this fee-it is not covered by third party providers.

RECORDS AND YOUR RIGHT TO REVIEW THEM:
Both the law and the standards of my profession require that treatment records be kept for at least 10 years. Unless otherwise agreed necessary, I retain clinical records only as long as mandated by California law. If you have concerns regarding your treatment records, please discuss them with me. As a patient or parent(s) of a patient, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I determine that releasing such information might be harmful in any way. In such a case, I will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, upon your request, I will release information to any agency/person you specify unless I determine that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only when all of the adults involved in treatment have signed authorization paperwork.

MEDIATION & ARBITRATION:
All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of myself and you/all patients involved. The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Fresno County, CA in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum as and for attorney fees. In the case of arbitration, the arbitrator will determine that sum.

TERMINATION:
You or your child's therapeutic relationship with me continues as long as I am providing professional services or until you inform me, in person or in writing that you wish to terminate therapy or I notify you that therapy is being terminated. It is customary that the patient agrees to meet with the therapist at least once before stopping therapy, however, you have the right to end therapy at anytime.

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the patient or the patient’s legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a patient discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the patient discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the patient.

Abuse of Children and Vulnerable Adults
If a patient states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to patients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

HIPAA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.
Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies; I will immediately change this Notice. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.
I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.
A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:
1. For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.
2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.
B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:
1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
4. If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.
5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.
6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
7. If disclosure is mandated by the California Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.
8. If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as intelligence operations.
13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
14. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.

15. Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.
16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that may be of interest to you.
18. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
19. If disclosure is otherwise specifically required by law.
C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.
1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.
D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI
These are your rights with respect to your PHI:
A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.
B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.
C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.
D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i. e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel. Disclosure records will be held for six years.
I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.
E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.
F. The Right to Get This Notice by Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES
If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI; you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR
TO COMPLAIN ABOUT MY PRIVACY PRACTICES
If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Lacey Horsman, MFT P.O. Box 27697, Fresno CA 93729 or call me at (559) 824-8403 or e-mail me at laceyhorsman@gmail.com

VII. EFFECTIVE DATE OF THIS NOIICE
This notice takes effect as of April 14, 2003.

IMPORTANT CRISIS NUMBERS

Fresno County Mental Health Crisis Services: 1-800-654-3937

Community Behavioral Health Center: 449-8000

RCS Resource Center for Survivors of
Sexual Assault and Family Violence: 497 -2900

RCS Crisis Line: 222-7273

Marjoree Mason Center Crisis Services: 233-HELP

National Domestic Violence Hotline: **1−800−799−SAFE (7233)**

Suicide Prevention Resource Center: 1-877-438-7772

National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

Fresno Alcoholics Anonymous: 221-6907

Fresno Narcotics Anonymous: 224-4280

Fresno Al-Anon/ Alateen: 265-3560

Fresno County Child Protective Services Hotline: **255-8320**

Fresno County Adult Protective Services Hotline: 1 (800) 418-1426 or 255-3383

Lacey Horsman, MFT

Licensed Marriage & Family Therapist

CONSENT FOR TREATMENT OF MINORS

Name of Minor____

Date of Birth____

I give my permission to Lacey Horsman, MS, Licensed Marriage and Family Therapist, for treatment of the above listed minor. This treatment may include individual or group psychotherapy.

This treatment may include consultations with other associates, including but not limited to other Mental Health Professionals, Educational Personnel, Psychiatrists, Psychologists, or Pediatricians. If any of the above is a necessary adjunct to provide optimum treatment for your child, this option will be discussed with you.

I have been notified that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of privilege (parent/guardian). I have also been informed of the limitations of confidentiality in the Office Policies paperwork, which I have read and signed.

In the case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs or sex. I will accept Lacey Horsman's judgment in regard to releasing or sharing information obtained during the course of psychotherapy with my child that may endanger or jeopardize their well being.

_________________________________ ________________ _________________________ __________

Name (Print) Relationship Signature Date

_________________________________ ________________ _________________________ __________

Name (Print) Relationship Signature Date

____ _______
Witness Date

Lacey Horsman, MFT

Licensed Marriage & Family Therapist

PSYCHOTHERAPY AGREEMENT

I have read the above *Information About Therapist & General Guidelines, Office Policies & General Information Agreement for Psychotherapy Services, Limits of Confidentiality, Notification of Privacy Practices*, and *Consent for Treatment of Minors* (total 7 pages) carefully, understand them and agree to comply with them:

____
Parent/Legal Guardian name (print)

____
Date

____
Signature

____
Parent/Legal Guardian name (print)-if applicable

____
Date

____
Signature

Child/Adolescent Intake Packet

Child's Name ____

Child's Date of Birth__________ Age______ Ethnicity____________________

Child's School________________ Grade____________________

Your Name ________________________ Date of Birth______________

Relationship to Child _________________ Marital Status: Single Married Divorced Widowed Separated

Address ____

City State Zip

Home Phone ___________ Work Phone __________ Cell Phone _________

Other Parent's Name ___________________ Date of Birth______________

Address (if different from above) ________________________________

Phone (if different) ____________________

Insurance: If applicable, do you wish to utilize insurance for your therapy services? Yes or No

Name of Policy Holder______________________ Date of Birth__________

Employer:_________________ Employer Address:_________________

Primary Insurance Co:____

Address:____

City:____________ Zip:_________ Subscriber #:________________

Group #:________________ Have you met your deductible? Yes No Unknown

If EAP-EAP Authorization#_____________________________________

Child's Siblings Names & Dates of Birth ____

____

Pediatrician or Family Doctor ____

Approximate Date of Child's Last Doctor Visit ____

Reason for Visit ____

List any illnesses or hospitalizations of your child: ____

____

List any complications or difficulties during any of the following:

Pregnancy w/child ____

Delivery ____

Infancy ____

Please check any of the following that apply to your child:

_____death in the family

_____illness in the family

_____divorce

_____separation

_____serious illness or physical injury

_____frequent relocations

_____traumas, such as car accident or house fire

_____homelessness

_____violence in the family

_____sexual abuse

_____physical abuse

_____drug/alcohol abuse by parents

_____drug/alcohol abuse by child

_____depression in family member

_____other mental illness in family member

Please check any of the following items that apply to your child:

EMOTIONAL DIFFICULTIES

______frequent tearfulness or crying

______cowers or withdraws from adults

______resists physical or verbal confrontations (passive behaviors)

______often expresses frustration

______exhibits difficulty with transitions either verbally or non-verbally

______reports frequent nightmares

______easily distracted in the classroom

______frequent temper outbursts

______frequently appears to be daydreaming

______low self-esteem

______reports fears that appear in excess to situation, list fears______________________________

DIFFICULTY WITH PEER RELATIONSHIPS

______fighting (physical)

______frequent verbal conflicts

______name-calling, teasing or provoking conflict with peers

______frequently alone at recess or in social situations

______selects only younger peers as playmates

______complains of having no friends

______passive responses when teased, hit or provoked by peers

BEHAVIORAL ACTING OUT

______overt misbehavior or disruption in public

______difficulty sitting still

______vandalism

______stealing

______classroom roaming

______disregard for other persons or property

SCHOOL FEARS

______resistance to school attendance

______difficulty with separation (clinging, crying or physical acting-out)

______physical complaints, such as headaches, stomach aches, arm or leg aches

______complaints about teacher or peer relationships

PHYSICAL SYMPTOMS OF DISTRESS

______soiling or wetting pants

______nervous facial ticks

______pulling out hair, eyebrows or lashes

______eating or sleep disturbances, type____

______persistent thumb sucking or nail biting

______eating or twisting hair

______cutting, head-banging or other self-inflicted injury

______sucking or chewing of clothes or other objects

SEXUALIZED BEHAVIORS

______frequent masturbation

______frequent bladder infections

______sexual drawings

______sexual acting out

______pervasive talk about sexual issues

Please list other concerns you may have about your child:

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Pertinent information about any other family member which affects your child:

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Physical illnesses or problems:

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Please list any medications that your child is currently taking and the purpose of medication:

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____

Learning disabilities suspected or diagnosed:

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Please list any other information that you would like your child's therapist to know:

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