Thomas Stein, M.S., MFT ❞ *Licensed Marriage & Family Therapist (MFC 48767)* ❞ 805.881-3136 tom@tomstein-therapist.com
Fax: 805-242-9700 1190 Marsh St, San Luis Obispo, CA 93401 ❞ 950 Los Osos Valley Rd, Suite E, Los Osos, CA 93402

CONSENT FOR THERAPY

My signature below indicates that I have read and understand the ***Welcome*** (Informed consent) document. I understand that I do not have to sign this form. I understand I can choose to discuss any questions regarding this consent form with my therapist, **Thomas Stein**, at this time or at any point during the course of my therapy. I understand that after therapy begins I can choose to withdraw my consent to therapy at any time, for any reason. However, if I make this choice, I will make every effort to discuss my concerns with my therapist.

I hereby agree to enter into therapy with **Thomas Stein, LMFT** (or to have my child), as shown by my signature here.

____
Printed Name

______________________________________ __________
Signature Date

______________________________________ __________
Signature of parent or guardian if applicable Date

I consent to participate in family counseling:

Name:________________________________ Date:____________

Name:________________________________ Date:____________

Name:________________________________ Date:____________

Name:________________________________ Date:____________

I, Thomas Stein, LMFT, have met with person(s) named above (and/or his or her parent / guardian or family members) and have informed him or her of the issues and points raised in this consent form. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into therapy with the client, as shown by my signature here.

______________________________________ __________
Signature of therapist Date

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IMPORTANT INFORMATION – CONFIDENTIAL

Date:______________ Name:____________________________ Birthdate:___________ Age:_______

Address:_____________________________________City_______________State:_____Zip:_________

Phone numbers: Home:________________Work:_________________Cell/Other:_______________

Can I contact you at home? Y N Work? Y N Can I leave you messages at home? Y N
Can I mail information to you at the address provided above? Y N
Can I email information to you? Y N Email address:_______________________________________

Note: Occasionally I will text or email reminders, appointment updates, or check in with you. Do you give permission to me to communicate with me via these non-encrypted methods? __Y ___ N

Occupation:___________________________________

Primary Care Physician:_____________________ Phone#:_______________Date of last visit:________
Other health care providers:___________________Phone#:_______________Date of last visit:________
____Phone#:_______________Date of last visit:________
____Phone#:_______________Date of last visit:________

Please list any prescription medications you are taking:

Medication	Dose/Frequency	Reason	Date began	Prescribing physician

Have you been in psychotherapy ?______If yes, with whom:_______________When:_______________
Concerns addressed:____
Was it helpful?____

Referred by:_____________________________________

In case of an emergency, whom would you like notified?
Name_________________________Relationship to you:______________________Phone#:___________
Address:____

List persons living in your home:

Name	Age	Relationship to you	Occupation

In an average week, how often do you use:
Alcohol _________ how much________
Marijuana________ how much________
Other____________ how much________

Other___________ how much________
Other___________ how much________

Does a family member or anyone you are living with have an alcohol or drug problem?______________________________
Is there verbal or physical violence of any kind in your home?____
Are you having any thoughts of hurting yourself or another?____
Have you had any self-harming thoughts, plans, or attempts in the past?___________________When?________________
Have you ever been hospitalized?___________When?____________For what purpose:_____________________________
Have you been court ordered to pursue counseling?____
Are there any issues not covered above which concern your situation?____
____
Why are you seeking therapy at this time?____
____
What do you hope to gain from therapy?____
____
____
____
____

***If client is under the age of 18, please complete the following information:

School:____Grade:____________________

Parent/guardian:_______________________ Birthdate:__________
Address:____City:___________State:______Zip:___________
Home Phone:____________Work Phone:___________Cell Phone:____________Occupation:_____________
Relationship to child:_________________

Parent/guardian:_______________________ Birthdate:__________
Address:____City:___________State:______Zip:___________
Home Phone:____________Work Phone:___________Cell Phone:____________Occupation:_____________
Relationship to child:_________________

Custody Status:_______________________

NOTE: If separated or divorced, I will need a copy of the court document indicating your child's current custody status in order to provide treatment.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have provided for you. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at **(805) 881-3136**.

If you have any questions about my Notice of Privacy Practices, please contact me at:
700 Mar Vista Dr, Los Osos, CA 93402 (805) 881-3136.

I acknowledge receipt of the *Notice of Privacy Practices* of **Thomas Stein, LMFT**.

Signature: ____ Date: __________
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my *Notice of Privacy Practices*, including:

____

____

However, because of

____

____

I was unable to obtain my patient’s acknowledgement.

Signature of Provider: ____________________________________ Date: __________