Sessions Counseling Group

Agreement for Services

Client Questionnaire

Name _____Age _____Date of birth_____

Marital status _____Educational level _____Occupation _____

Referred by _____

Areas of Concern

What issues/concerns causes you to seek treatment? Please describe.

_____

_____

_____

_____

Do you have any specific goals with regard to your treatment?

_____

_____

Do you have any particular concerns/fears with regard to treatment?

_____

_____

Medical History*

Do you have any medical conditions that may affect your mental health treatment?

_____

What is the date of your last physical? Please describe your overall health today.

_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress related condition? Please describe.

_____

_____

Do you smoke? How much? For how long?

_____

Do you drink alcohol? _____On average, how much alcohol do you consume in a week? _____

Have you ever been in a 12-step program? _____

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Family of Origin History

Mother's name, age, living/deceased, client's age at the time of mother's death:

_____

Father's name, age, living/deceased, client's age at the time of father's death:

_____

Names and ages of siblings:

_____

Names and ages of children:

_____

Are there any significant events from your past that you believe contribute to your current feelings?

_____

_____

_____

Psychological History*

Have you ever received mental health treatment before? When and for how long?

_____

Have you ever been hospitalized for mental or emotional problems? When and for how long?

_____

Are you currently taking any prescription medications? How long have you been on the medications?

_____

Have you ever taken any medications for a mental or emotional condition? When and for how long?

_____

Have you ever attempted suicide? When? Describe the circumstances that led to that attempt.

_____

_____

_____

_____

Are you currently having any suicidal thoughts? Please describe _____

_____

_____

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Other Information

Please describe your spiritual identity/orientation. _____

Please describe your interests/hobbies _____

_____

_____

Are you now or have you ever been involved in a lawsuit? Please describe.

_____

_____

Have you ever been a victim of a violent crime? Please describe

_____

_____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested.

_____

_____

_____

*Authorization for release of confidential information will be needed from the client in order to contact any individual other than the client.

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Disclosure Statement & Agreement for Services

At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

Your therapist is (Name, BBS registration type and number)

___Marriage and Family Therapist Registered Associate

___Associate Clinical Social Worker

and this practice is conducted under the supervision of a licensed mental health professional.

The clinical supervisor's names, license type and licensure are Gary D. Pearle, MFC 30246 and R.Brian Carlson, LMFT 50436

Information about This Practice

The name of this practice is Sessions Counseling Group, Inc. This practice is a Licensed Marriage and Family Therapist Professional Corporation and the individual therapist(s) who operate this practice are R.Brian Carlson, LMFT 50436 and Gary D. Pearle, MFC 30246.

Session Fees

• Individual therapy session is $_____ per. Individual Sessions are ____ minutes in length.
• Marital /Family therapy session is $_____.
Conjoint sessions will be a minimum of ____ minutes in length and may be extended to _____ minutes in length upon your therapist's discretion.

Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure. Cash and check are accepted for payment. Please make checks payable to Sessions Counseling Group..

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time. Please discuss any questions or concerns that you may have about this with your therapist.

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Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, your therapist will not disclose information communicated privately to him or her by one family member, to any other family member without written permission.)
There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a client is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the client that the FBI sought or obtained the items under the Act.

No Secrets Policy
All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment.
If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask your therapist about his or her "no secrets" policy and how it may apply to you.

INFORMED CONSENT

Minors and Confidentiality
Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor client with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Appointment Scheduling and Cancellation Policies
Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance of your appointment. If you do not provide your therapist with at least 24 hours notice in advance, you are responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

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Therapist Availability/Emergencies
You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call.
Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions. Prorated fees will apply to telephone consultations.
Nonurgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail.

Therapists Limited Availability
The therapist's limited availability, i.e. travel, illness, or personal commitment, will be communicated directly to the client or communicated through the therapist's outgoing voicemail message. You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Due to the nature of the therapist's absence return call times may vary. The therapist will provide an alternative therapist's contact information for nonurgent situations.
If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail message.

In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Therapist Communications
Your therapist may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.
____My therapist may call me at my home.
My **home phone** number is: _____
____My therapist may call/text me on my cell phone.
My **cell phone** number is: _____
____My therapist may call me at work.
My **work phone** number is: _____
____My therapist may send mail to me at my home address.
My **Home Address** is:_____
____My therapist may send mail to me at my work address.
My **Work Address** is: _____
____My therapist may communicate with me by email.
My **email address** is: _____
____**In case of an emergency, my therapist may contact**:

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About the Therapy Process

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each client, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

SIGNATURE PAGE

Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask your therapist to address any questions or concerns that you have about this information before you sign.

_____

Client Name (Print)/Signature/Date

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