Shainker Behavioral Therapy

(Please Print) Today's Date: _____

CLIENT INFORMATION:

Name: _____ Age: _____ Date of Birth: _____

Sex: Male _____ Female _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May I have permission to send mail to this address? YES ____ NO _____

Where can I contact you? WORK HOME CELL (Please circle)

Employer: _____Occupation: _____

How long have you worked there? _____How long in this occupation? _____

Education: (List highest level of education attained) _____

Marital Status: _____ How long? _____

Primary Physician: _____ Phone: _____

List any significant health problems: _____

_____

List any medications you are taking and the dosage: _____

_____

_____

Have you been in therapy before? YES ___ NO ____

If yes, when, and whom did you see? How was the experience for you?

_____

I am interested in the following type(s) of counseling: (Circle all that apply)

Individual Couples Family Group

How were you referred?_____

Emergency Contact: Name: _____ Relationship: _____

Address: _____ Phone: _____

SPOUSE/PARTNER INFORMATION:

Name: _____ Age: _____ Date of Birth: _____

Sex: Male _____ Female _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Education: (List highest level of education attained) _____

Names of Children Age Living with you?

_____

_____

_____

_____

Please list your siblings (brothers and sisters) in order of their birth, including yourself.

Names of Siblings Age City and State of Residence Describe your relationship (close, estranged, best friends, etc.)

_____

_____

_____

_____

_____

_____

What issues or concerns bring you to this assessment today and when did these issues arise?

_____

_____

_____

_____

_____

_____

Is there any other information that you feel is important for me to know before we begin our work together? _____

_____

_____

FINANCIALLY RESPONSIBLE PERSON'S INFORMATION:

Name: _____ Relationship to Client: _____

Phone (if different from above): _____

Address (if different from above): _____

Social Security Number of Insured: _____

Date of Birth of Insured: _____

Employer: _____

CONFIDENTIALITY:

I abide by and respect the ethical code of confidentiality. This means that I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me, without your written permission. You may give written consent for me to share information with whomever you choose, and you can change your mind and revoke that permission at any time. The following are the legal exceptions to your right to confidentiality. I will inform you if at any time I feel it is necessary to put these into effect.

1) If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also inform the police and ask them to protect that person.
2) If I have good reason to believe that you are someone else is abusing/neglecting a child or vulnerable adult, I must inform CPS or Social Services within 72 hours.
3) If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and contact the police or crisis team. However, whenever possible, I would explore all other options with you before taking this step. In any of these situations, I would reveal only the information necessary to protect you or the person in danger. I would not tell everything you have told me.
4) If you become involved in a court case or proceeding, a judge or court may require that I provide information or testify.
5) I may sometimes consult with another professional about your treatment. All counselors are required by professional ethics to keep your information confidential. These case consultations are helpful to both you and me in determining that I am providing you with the best treatment possible.

FINANCIAL AGREEMENT:

The regular fee for an assessment is $1,000.00. At least half of the fee ($500.00) is payable at the time of service. The assessment report will not be completed until two weeks from the date that the balance is paid in full. I accept credit cards (processing fee applies), cash and checks. I (Choose one and initial)

_____ I agree to pay the fee ($1,000.00) in full at time of service.

_____ I agree to pay half of the fee ($500.00) at time of service, and make payments until the balance is paid off.

****I require two weeks from the date that the balance is paid in full to complete the report.**

FINANCIAL POLICY:

1. You are responsible for full payment of all services.
2. Payment is due at the time of treatment. If you choose to pay by check and your check is returned for insufficient funds, your account will be assessed a $25.00 returned check fee, in addition to the amount of the bounced check.
3. Any fees left unpaid for 30 days will accrue interest of 20% per month.
4. If you require a receipt for services, please indicate below.
   _____ I will need a receipt for services
5. Your appointment time has been set aside for you. You are responsible for coming to your session **on time** and at the time we have scheduled. If you are late for your session, we will still end on time and your regular session fee will apply.

TELEPHONE CALLS, REPORTS AND LEGAL REPRESENTATION:

1. I prefer to see and talk with you in person at our scheduled session time. However, I am aware that telephone calls are necessary at times. If I am unable to answer, please leave a message, including your phone number, and I will return your call as soon as possible.
2. If you request that I write reports to be sent to schools, employers, lawyers, doctors, courts, Child Protective Services, etc., you will be charged for the time it takes me to write these reports. Court appearances will be billed at $150.00/hour.
3. I am not a legal consultant or representative. I do not do custody evaluations or make recommendations regarding child custody. If you do require these services I will be happy to provide you with referrals.

EMERGENCIES:

In the event of a psychological emergency, please call 911. You may also call the Suicide Prevention Hotline of Nevada at 1-877-885-HOPE, Montevista Hospital at 364-1111, Spring Mountain Treatment Center at 873-2400, or Nevada Adult Mental Health at 486-8020.

STATEMENT OF UNDERSTANDING:

I have read the enclosed policies and procedures, asked any questions that I needed to, and understand the terms of this consent. I understand my rights and responsibilities as a client and my therapist's responsibilities to me. I agree to these conditions and consent to assessment and/or treatment.

_____	_____	_____
Client Name (print)	Client Signature	Date
Alyson Shainker, LCSW	_____	_____
Provider/Therapist	Provider/Therapist Signature	Date