**CLIENT INFORMATION**

Confidential Use Only

Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Permission to leave message: Yes No

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Permission to leave message: Yes No

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_

Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (For Insurance Purposes Only)

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_ Relationship Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name & Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_

Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Coordinating care with your physician may be necessary. Do I have permission to contact your physician to collaborate for your well-being, should the need arise? Yes No

List any current medications and dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been in therapy or counseling before? Yes No

Name of previous therapist(s), if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What matters would you like to work on in therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Use:

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fee: \_\_\_\_\_\_\_

**Fee Agreement**

**Appointments**

It is a privilege to support you during this time. Therapy is a process that is taken seriously and I will do my best in providing you with the support that you need. Additionally, I will assist you by connecting you to other resources that may contribute to your wellness. As we begin our therapeutic relationship, I will honor our appointment times to the best of my ability by keeping any changes to a minimum. Similarly, I request that I received a minimum of 24 hour notice prior to a cancellation. Missed sessions and cancellations received less than 24 hours prior to our session will be charged the full fee. Please note that a referral may be provided for continued cancellations (3x) or no-shows.

**Fee Policy**

All fees will be determined prior to the start of treatment. Phone consultations will have a prorated fee of $15 per every 15 minutes. Payments may be made using cash or credit card. A fee of $1.50 is applied to credit card charges for every $30 increment. Payments must be made in full and cannot be carried over. The standard fees for session apply as follow:

|  |  |  |
| --- | --- | --- |
| Individual | 55 minute sessions | $120 |
| Couples/premarital | 1 hour 30 minutes | $150 |
| Family Sessions | 1 hour 30 minutes | $175 |

**Client Agreement**

I agree to pay for all services I receive. Payments will be made using cash or credit card. If I use a credit card, I agree to an added fee of $1.50 for each transaction. Should I select to use insurance to an approved carrier, I agree to pay for any amount that is not covered by my health care provider. Additionally, I understand that I will be fully liable for the full fee of any incomplete sessions, missed sessions and sessions cancelled with less than 24 hour notice. I am aware that if I arrive late to a session, the session will conclude based on my original appointment time and I will be financially liable for the full rate of the session.

**Videotaping**

For the safety of the client and the therapist, note that this office and therapy room may be recorded. Videotapes will not be reviewed or used unless a possible crime has been committed.

Client(s) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Evaluation and Treatment**

**The Therapy Process**

Participating in therapy can result in benefits to you by allowing you to better understand yourself and your personal goals, values and sense of self. Therapy may also allow you to better understand your personal relationships and find resolutions related to issues that encouraged you to seek therapy. Working towards these benefits will require effort on your part that may result in your experiencing considerable discomfort. At times, change may be easy and swift and more often it will be slow and frustrating. The process of recalling unpleasant events and resolving them through therapy can bring on feelings of frustration, anger and possible depression or anxiety. When working with a partner or family member, the situation may be further complicated because of the ongoing relationships outside of the session.

**Your Rights**

You have the right to a confidential relationship with me as your therapist. All information discussed in session will be kept confidential and released only after obtaining your written consent outside of the three mandates:

* Suicidal and/or homicidal ideations
* Abuse of a child
* Abuse of an elderly or dependent individual

Additionally, you have the right to know the content of your records at any time and I have the right to provide you with either the complete records or a summary of their content.

Upon request, I can release any part of your records on file with me to any one that you specify. Please note that I will use my clinical judgement in releasing this information especially in cases where it may harm you in any way. Moreover, you have the right to ask questions about the procedures used in the course of therapy. Additionally, you will be informed on my clinical orientation and what to expect during the intake session.

Please notify me if you do not feel that you are benefiting from working with me as your therapist. Be assured that your best interest is always in mind and you will be provided with appropriate referrals to select another therapist. This will be done without any form of retaliation and full compliance in regards to your subsequent therapeutic relationship. Similarly, I reserve the right to refer you if I do not feel that I am able to support you using the therapeutic orientations that I follow. This referral will occur with a thorough discussion of your treatment goals and your current progress.

**Consent for Evaluation and Treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize and request, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to carry out therapeutic interventions, counseling services and referrals for the purpose of my care or the care of my minor child.

The purpose of interventions and treatments will be disclosed to me and are subject to my agreement. I fully understand the therapeutic relationship I am entering with my therapist and the credentials my therapist has to conduct treatment.

Guardian/Client’s Signature to authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Client or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian’s relationship to Client\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

**Attention all Medi-Cal members**

If you will be using Medi-Cal to cover the cost of your sessions, please note that a no-show fee of $65 will be applied if you miss your scheduled appointment. You will be billed the amount and required to pay. Should you need to reschedule an existing appointment, please call at least 24 hours prior to the time of your appointment to reschedule and avoid the penalty. Please note that any appointments canceled less than 24 hours prior to the scheduled time will also be held liable to the entire amount.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_