Wendy Purcell MA, LMFT, CHt 949-244-7246
25431 Cabot Road Suite #207 Laguna Hills, CA 92653

CHILD FIRST APPOINTMENT CLIENT PACKET

Welcome!

Thank you for choosing me as your child's facilitator in health. I am committed to making your first session as comfortable and productive as possible. To achieve this, I want to walk you through required paperwork, pre-session information gathering and what to expect at your first appointment.

As a reminder, I only see children for 60 minutes. In most cases on the first session Mom and/or Dad will be invited in for the first and end parts of the session. In some circumstances, children prefer a parent present for the entire session.

Pre-session paperwork.
Below you will find your first appointment paperwork to complete. By frontloading me with as much information as possible including a short autobiography and completion of a few forms, we can get started immediately and free up your first session for education and learning new techniques. Please email me back the following completed paperwork:

- Confidential Client Information Sheet
- Informed Consent
- Limits of Confidentiality
- Minor Questionnaire (to be completed by your child)

My office is located inside OC Whole Family Wellness, a holistic practice with a friendly office team. Please help yourself to tea or water near the front door. The restrooms are located outside next to the elevator and the keys are at the front desk.

The practice also offers an IV Nutrition Lounge, pharmaceutical grade supplements and organic skin care products. Please feel free look around and ask questions of the highly trained team, and most importantly, make yourself comfortable.
Sincerely,

Wendy

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Confidential Client Information-Child

Date:_____

Name:_____ DOB:_____

Address:_____

City, State: _____ Zip Code: _____ OK

Phone: Home:_____ OK to leave message Yes No

Child's Cell:_____ OK to leave message Yes __ No__

E-mail:_____ OK to leave email Yes No

Mothers Name:_____ Mom's Cell:_____

Fathers Name:_____ Dad's Cell: _____

Siblings:
Name: _____ Age: _____ Name:_____ Age:_____
Name:_____ Age: _____ Name:_____ Age: _____

School:_____ Grade_____

Medications:_____

If different than a parent listed above please fill out the following.

Emergency Contact:_____ Relationship:_____
Contacts's Home # _____Cell#_____

IF YOU ARE SEPARATED OR DIVORCED FROM YOUR CHILD'S OTHER PARENT:
1) Do you have? Legal Custody: ___ Joint ___ Sole (Parent: _____) Physical Custody: ___ Joint ___ Sole (Parent: _____) 2) Is there a court document (legal agreement) that requires the consent of both parents for mental health services? Yes No 3) Can you provide me with a copy of the document? ___ Yes ___ No

Informed Consent

Everyone participating in therapy is entitled to ***confidentiality*** with certain exceptions. These include situations where a client presents a danger to him/herself, and expressed danger to others, or where the therapist suspects that abuse of a child under the age of 18, and elder over 65 or a dependent adult is occurring or has occurred.

Therapy appointments are made in advance and this reserves my time for you. If you need to cancel a scheduled appointment please do so with ***a minimum of 24 hours notice so I may schedule another client. Please direct all cancellations or reschedules to my voice mail or text at (949) 244-7246.*** I do not accept cancellations through e-mail. ***If you do not give 24 hour notice to cancel, you may be charged full fee for your missed appointment***. _____
Initials

To contact me between sessions, please call or text me at (949) 244-7246. In most cases I will get back to you by the end of the business day Monday through Friday. If you are having a life-threatening emergency please call 911.

Phone sessions are available when pre-arranged or in some emergency situations. Phone sessions are charged at a rate of $90.00 per half hour.

If you wish to use your insurance to pay for therapy, I require payment at the time of service and will provide you with a monthly super bill to submit to your insurance carrier. In accordance with your policy, your carrier will determine coverage and make any reimbursements directly to you.

You will be charged a $25.00 processing fee for any returned checks.

Treatment Agreements:

1. I agree to enter therapy with Wendy Purcell MA, LMFT, CHt
2. I agree to pay $180.00 at the start of each 60-minute session payable by cash, check, Visa, MasterCard, Discover or American Express.
3. I understand that my therapist, Wendy Purcell, is a sole-proprietor and works in her own private practice. Although Wendy's office is located within OC Whole Family Wellness, I understand that none of these professionals are legally connected to or responsible for the professional services she provides.

_____ _____

Signature of Parent or Guardian **Wendy Purcell M.A.,MFT**

_____ _____

Date **Date**

Limits of Confidentiality

Information discussed in the therapy setting is held confidential and not shared without your written permission except under the following circumstances:

1. If the client threatens suicide*
2. If the client threatens to harm another person*
3. If I have reason to suspect that a minor is being abused: including but not limited to physical abuse, sexual abuse, emotional abuse, neglect, unjustifiable cruelty or unreasonable punishment*
4. If I have reason to suspect that an elderly person over 65 years of age or a dependent adult is being abused*
5. If I am ordered by the courts to break confidentiality to comply with legal requirements.
6. If I consult with other marriage & family therapists, social workers or psychologists in order to provide you with the best care and service. In this instance your name and identifying information will be kept confidential.
7. If I have a written release from you, authorizing me to speak with a party you designate such as an insurance company representative, doctor, healthcare provider, attorney, school or family member.

*I am a mandated reporter! State law mandates that mental health professionals are required to report the above situations to the appropriate agency designated to receive such a report.

All other communications between therapist and client will be deemed confidential under the laws of the State of California.

Having read and understood the above, I agree to these limits of confidentiality.

_____
Name of minor

_____ _____
Signature of minor Date

_____
Name of Parent or guardian

_____ _____
Signature of parent or guardian Date

_____ _____
Signature of Clinician Date

Minor Questionnaire:

In a few words describe to me what's NOT working in your life.

Please list 3 goals you have for yourself in regards to the above.

1.

2.

3.

Please list 3 strengths or tools that help you reach your goals:

1.

2.

3.

Please list 3 ways you might sabotage yourself and your goals:

1.

2.

3.

Parent or Guardian Questionnaire:

In a few words describe to me what you believe is NOT working and describe any other information that you feel important for me to know.