Catherine D. Cundy, M.A..

Licensed Marriage and Family Therapist

1732 Tehama Street • Redding, CA 96001 • (530) 515-7946

Adult Client Information Form

If someone other than the client is completing this form provide name and relationship:			
Client Name:			
Physical Address:			
City:	State:	Zip:	
Mailing Address (if different):			
City:	State:	Zip	
Email Address:	Date of Birth:	Age:	
Phone Numbers Home:		Work	Cell:
Emergency Contact:		Phone Number:	
Referred by:			
If applicable please complete information for (circle one): Spouse/Partner /Parent /Guardian/Social Worker /other_____			
Name:			
Physical Address (if different):			
City:	State:	Zip:	
Mailing Address (if different):			
City:	State:	Zip:	
Email Address:	Date of Birth:	Age:	
Phone Numbers Home:		Work	Cell:

Insurance Information (if applicable)

Name of primary insured:	Primary insured date of birth:
Insurance Company:	
Address:	
Insured ID Number:	Group Number:

Others living in home:

Name	Relationship	Age

Significant relationship status (check those that apply)

	Single		Engaged		Married How long?
	Separated How long?		Divorced How along?		Remarried How long?
	Committed Relationship How long?		Widowed How long?		

Name and age of your children (if, applicable)

Name	Age	Name	Age

Primary Concern (reasons for seeking therapy):
How long has this been a concern:
What have you tried so far?
Have you sought counseling in the past? YES or NO If yes, whom did you see?
What was the outcome of therapy?

Medical History
Name of primary care physician:
List of current physical concerns:
Current or past major illnesses or operations:
Date of last physical examination:

Current Medications:

Medication	Dosage	Purpose	Prescribing Physician

Symptoms (please check all that apply):

	Headaches		Nightmares		Frequently worried
	Dizziness		Unusual thoughts		Can't make friends
	Stomach problems		Ready to explode		Weight change
	Panicky feelings		Can't keep friends		Bowel problems
	Sexual problems		Muscle Aches		Financial problems
	Feel like crying		Fear of things		Feeling worthless
	Blurred vision		Drugs use		Alcohol Use
	Unable to make decisions		Frequently tired		Loss of appetite
	Strong dislike of criticism		Trouble falling asleep		Trouble staying asleep
	Trouble waking up		Memory problems		Tremors or tics
	Choking feeling		Trouble concentrating		Tense feelings
	Nervous around strangers		Family Conflict		Thoughts of Suicide
	Fear of losing control		Panic Attacks		Unable to get interested
	Lack motivation		Feeling lonely		Feeling sad
	Excessive Alcohol use		Feel hopeless		Hallucinations
	Frequently sick		Phobias/fears		Mood swings
	Other (please list)				
	Did you have any of the following occur during your childhood?				
	Night terrors		Bedwetting		Sleepwalking
	Nail biting		Stammering/stuttering		Happy childhood
	Observed domestic violence		Unhappy childhood		Victim of sexual abuse
	Victim of child abuse		Victim of child neglect		Foster care
	Parental separation		Parental Divorce		Suicide Attempt
	Medical Issues		Felt loved and respected by parents		Alcohol/Drug Addicted Parent
	Other (please list)				
Previous suicide attempts: YES or NO					
If yes, approximate date(s)					

Role of religion and/or spirituality in your life?
Current religious preference:
Family History of Mental Illness (If applicable, please describe)
Is there any additional information that you would like me to know about at this time?

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MFC 51063

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Informed Consent and Therapeutic Contract

CONFIDENTILITY: All information shared in our therapy sessions will be kept strictly confidential. The only exceptions to this rule are:

- Threats to harm yourself or others.
- Suspected child or elder abuse or neglect.
- I was appointed by the Court to evaluate you.
- You waive your right to privilege and give consent to limited disclosure of information allowing release of information to a specific designated person within a specified time frame.
- Your insurance company paying for your service has the right to review all records.

APPOINTMENTS: I will make an effort to set appointments that are mutually convenient on Mondays, Tues, Wednesdays and Thursdays. Emergency appointments are available and will be assessed on an individual basis, but will be charged at a higher rate (see fees below).

CANCELLATION POLICY: ***APPOINTMENTS THAT ARE NOT CANCELLED 24 HOURS IN ADVANCE WILL BE CHARGED FOR THE AMOUNT OF TIME RESERVED, AND THAT FEE RATE, FOR THAT SESSION.*** If you give less than 24 hours notice, every effort will be made to fill your time, however there is no guarantee that will be able to happen. You are responsible for "no shows" and "last minute cancels" (less than 24 hours notice), no matter what the reason. Please note that insurance companies and Victim/Witness will not reimburse you for broken appointments. You will be responsible for these charges.

PAYMENT:

- Payment is expected by cash or check at the beginning of each session, unless other arrangements are made. If your check is ready when you arrive, there will be a minimum of time spent on receipt writing, leaving more time for your session. I do this at the beginning of the session rather than the end so that you can leave therapy focused on your work and not on the finances.
- Check should be made payable Catherine Cundy.
- There will be a $25.00 service charge on all returned checks.
- In the event that your account goes to collections or small claims court, a 20% collections fee will be added to your balance.

ARRIVAL AT THE OFFICE: I will usually be in session when you arrive at the office. Have a seat in the waiting room (first room on the right). If you are with a child, please do your best to keep voices down as there are therapy sessions going on in the building. Young children may not be left unattended in the waiting room. The bathroom in located down the hall on the right.

LATE ARRIVAL: If you are late for your session, look at my door.. If it is open, I've probably

already been out to the waiting room looking for you so come on in. If it is closed, I'm probably still in the session prior to yours so have a seat in the waiting room and I'll come out to get you as soon as I'm done. If for some unforeseen reason I am going to be more than 10 minutes past your starting time, I will come and let you know what to expect. If you are late in arriving, we will end the session at the normal time scheduled for your session. If I am late (sometimes emergencies happen and the session before you could go overtime - although I do my best to run on time), you **will** still receive your 50-minutes from the time we start.

INSURANCE BILING: I authorize Catherine Cundy to release information to my insurance company that is deemed necessary for claim submission and reimbursement. I authorize direct payment to be made by my insurance company to Catherine Cundy. I understand that it is my responsibility to contact my insurance and ascertain my insurance coverage. Catherine Cundy is a not a preferred provider but bills a clients insurance company as a convenience to the client. It is the clients responsibility to pay any deductable amounts, co-pay, co-insurance amount or any other balance not paid by my insurance on the day and time services is provided.

FEES:

Individual Therapy	50 minute session	$110.00
EMDR Therapy Session	75 minutes session	$150.00
Couples and Family Therapy	50 minutes session	$125.00
Emergency Session	50 minute session	$150.00
Group Therapy	100 minutes	$50.00
Brief Telephone Call	To set appoints	No charge
Extensive information or crisis calls		$10.00/10 minutes
Report Writing		$150.00/hour
Court Testimony		$450.00/half day $900.00/full day

If you have any questions or concerns regarding these guidelines, let's talk about them. Therapy is an excellent place to practice new communication skills.

Sincerely,

Catherine Cundy, MA MFC 51063
Licensed Marriage, Family Therapist

**********KEEP ABOVE TWO PAGES AND DETACH HERE**********

I, (print name) _____, have read and understand the guidelines for confidentiality and payment given to me by Catherine Cundy, LMFT. and I agree to follow them. I understand that I am responsible for payment, regardless of what my insurance does or does not cover or if Victim/Witness denies or terminates my claim. I also understand that I will be expected to pay for any "no-show" or "last-minute-cancel" sessions (24-hour notice required).

_____ _____
SIGNATURE DATE