Catherine D. Cundy, M.A..

Licensed Marriage and Family Therapist

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

Child Information Form

If someone other than the client is completing this form provide name and relationship:			
Childs Name:			
Physical Address:			
City:	State:	Zip:	
Mothers Name			
Address (if different from child):			
City:	State:	Zip	
Email Address:	Date of Birth:	Age:	
Phone Numbers	Mothers Home:	Mothers Work	Mothers Cell:
Father Name:			
Address (if different from child):			
City:	State:	Zip	
Email Address: :	Date of Birth	Age:	
Phone Numbers	Fathers Home:	Fathers Work	Fathers Cell
Emergency Contact:	Phone Number:		
Referred by:			
Name of Person Responsible for payment			
Mailing Address (if not listed above):			
City:	State:	Zip:	
Email Address:	Date of Birth:	Age:	
Phone Numbers	Home:	Work	Cell:

Insurance Information (if applicable)

Name of primary insured:	
Insurance Company:	

Address:	
Insured ID Number:	Group Number:

Others living in home:

Name	Relationship	Age

Childs Living Arrangements

	Mother		Father		Other

Does child attend daycare? YES NO
If yes, please describe current daycare arrangements.

Please complete the following if the child lives between two households.

Describe Custody Arrangements (if applicable)

How long has child maintained current custody arrangements?

Describe any problems the child has with current custody arrangements?

Describe any changes you would like to see in the custody arrangements?

Name and age of all siblings (step and biological) (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/Complaints (please check all that apply):

	Very unhappy		Impulsive		Fire setting
	Irritable		Stubborn		Stealing
	Temper outbursts		Disobedient		Lying
	Withdrawn		Infantile		Sexual trouble
	Daydreaming		Mean to others		School performance
	Fearful		Destructive		Truancy
	Clumsy		Trouble with the law		Bed wetting
	Overactive		Running away		Soiled pants
	Slow		Self-mutilating		Eating problems
	Short Attention Span		Head banging		Sleep problems

	Distractible		Rocking		Sickly
	Lacks initiative		Shy		Drug use
	Undependable		Strange behavior		Alcohol use
	Peer conflict		Strange thoughts		Suicide talk
	Phobic		Nail biting		Stuttering
	Learning disabilities		Victim of sexual abuse		Victim of child abuse
	Other				

Previous suicide attempts: YES or NO

If yes, approximate date(s)

Role of religion and/or spirituality in child's 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?

Catherine D. Cundy, M.A.

Licensed Marriage, Family Therapist

MFC 51063

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

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