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Disclosure Statement & Agreement for Services

Introduction

This document is intended to provide important information to you regarding your therapy. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

Information about Your Therapist

At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation. Your therapist is a Licensed Marriage and Family Therapist, MFC #45067.

Fees and Insurance

The fee for service is $125 per individual therapy session for individuals, couples and families. A sliding scale is available upon request and at the discretion of your therapist. Individual Sessions and conjoint (marital /family) sessions are approximately 50 minutes in length unless arranged otherwise in advance. Fees are payable at the time that services are rendered. Please inform your therapist if you wish to utilize health insurance to pay for services. If your therapist/provider is a contracted provider for your insurance company, your therapist/provider will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist/provider is happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with your therapist.

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment

with you provide their written authorization to release such information. **However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask your therapist about his or her "no secrets" policy and how it may apply to you.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment.

Minors and Confidentiality

Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hrs. in advance of your appointment. If you do not provide your therapist with at least 24 hours notice in advance, you are responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions. You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of

your call. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail. **In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.**

Therapist Communications

Your therapist may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

____My therapist may call me at my home. My home phone number is: ( ) __________ ____
My therapist may call me on my cell phone. My cell phone number is: ( ) __________ ____
My therapist may call me at work. My work phone number is: ( ) __________ ____
My therapist may send mail to me at my home address. ____
My therapist may send mail to me at my work address. ____
My therapist may communicate with me by email.
My email address is: ______________ ____
My therapist may send a fax to me. My fax number is: ( ) ___________

About the Therapy Process

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion. Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

________________________________	________________________________	
Printed Name of Client	Signature of Client	Date

Client Information & History

Today's date: ___________________ Referred by: _________________________________

Your name: ____________________ Date of birth: ___________ Age: ______________

Home phone: ___________________ Cell phone: __________________________________

Address: ____

____

Emergency contact/relationship: ____________________________/____________________

Emergency contact phone: ____

Current Problem

What do you want to address in therapy? ____

____

____

What happened that made you decide to come in at this time? ______________________

____

____

____

What would you like to change about yourself to make your situation better?_____________

____

____

____

Current Family Information

Single___ Married___ Partnered___ Separated ___Divorced ___Widowed ___
Date:___ Date:___ Date: ___ Date:___ Date:___

Name of spouse/significant other: ______________________________ Age ___________

Length of time in current relationship: ____
Do you have any children? Yes □ No □ Have any of your children died? Yes □ No □

Child's Name	Age	Full Custody?	If not, when is child with you?

Others living with you:

Name	Relationship

Education and Work History

Last Grade Completed: Degree:	School: Area of Specialization:
Usual Occupation:	How Long:
Current Employer:	How Long:
Employee's address:	Phone:

Have you ever been unable to work? Yes □ No □
If so, for how long? Dates_______________Reason______________________________________

Have you had long periods of unemployment? Yes □ No □
If so, how often? Dates_______________Reason______________________________________

How many jobs have you held in the past five years?

Do you miss work frequently? Yes □ No □
If yes, what is the most frequent reason?____

Did you serve in the military? Yes   No   If yes, where did you serve? _____________

Medical Information

When was your last physical exam? Date:____________Physician:______________________

Do you have any chronic medical problems?   Yes   No
If yes, please describe medical problem: Date problem started:

____   ____________________
____   ____________________
____   ____________________

Do you have allergies?   Yes   No
If yes, to what are you allergic?____

Are you allergic to any medications?   Yes   No
If yes, to what type of *medications* are you allergic? _______________________________

Are you currently taking any *prescription* medication?   Yes   No

Name of medication	Dosage/frequency	Date first prescribed	Physician
____________________	_____________	_____________	_____________
____________________	_____________	_____________	_____________
____________________	_____________	_____________	_____________

Have you taken any psychiatric medications in the past?   Yes   No

Name of medication	Dosage/frequency	Date first prescribed	Physician
____________________	_____________	_____________	_____________
____________________	_____________	_____________	_____________

Are you currently taking any *non-prescription* medications?   Yes   No
If yes, what type of medication? ____

Psychological History

Have you been in counseling before?   Yes   No

Previous Counselor:	Dates Seen:	Reason:
___________________________	_______________	___________________________________
___________________________	_______________	___________________________________

Have you been hospitalized for psychiatric reasons?   Yes   No

Hospital/Organization:	Year/dates:	Reason:
___________________________	_______________	___________________________________
___________________________	_______________	___________________________________

Please list the non-prescribed substances you currently use or have used in the past, including alcohol, caffeine, tobacco, amphetamines, cocaine, marijuana, heroin and/or others.

Substance:	Current amount/frequency:	Past amount/frequency:
___	___	___
___	___	___
___	___	___

Does anyone else in you house use these substances? Yes No

Childhood and Family History

What is your ethnic, cultural, and religious background?

___

___

Did you parents live together during your childhood? Yes No
If not, what happened, and how old were you?

___

___

List your brothers and sisters from oldest to youngest and their ages:
Name___ Age___ Name ___ Age___
Name___ Age___ Name ___ Age___
Name___ Age___ Name ___ Age___
Name___ Age___ Name ___ Age___
Number of times you moved and at what ages?

___

Grew up in: the city the suburbs the country other ___
Where?___

Special problems in the family:

___disabled child ___serious medical illness ___ death in the family
___hospitalizations ___alcohol and/or drugs ___ parents fought
___parent(s) unemployed ___parent(s) changed jobs a lot ___ legal problems
___other: ___

What were you like as a child?

___

___

Were or did you:__ have problems learning in school __get into trouble at school

__ have problems with the law

Did you have any of these problems with your family?

___felt like you didn't belong
___fought with parents
___isolated yourself from family
___had too much responsibility
___physically abused
___emotionally abused
___sexually abused
___other:________________________________

Please describe in brief your childhood and your relationship with your parents:_________
____
____

Couples' Questionnaire

1. When I argue with my spouse, I often feel (mark one or more as appropriate):

Disregarded___ Criticized___ Shamed___ Aloof___ Fearful___ Angry___

Other____

2. I often have the following thoughts before or after a fight with my spouse ___________
____
____

3. Our most bitter fights are usually about _______________________________________
____
____

4. When I fight with my spouse, I generally tend to: Flee___ Freeze___ Attack___

5. My parents resolved conflict by: ____
____
____

6. My greatest hope for our relationship is that: __________________________________
____
____
____

7. One thing I do that gets in the way of my hope for our relationship is _______________
____
____
____

8. One thing I could do that would contribute to achieving my hope for our relationship is:

____

____

____

____

Current Symptom Checklist

These symptoms may or may not be related to the problem which brings you to see me, however, they may help me plan your treatment.

A. __trouble going to sleep
__restless sleep
__waking up early, unable to return to sleep
__sleeping too much

__feeling guilty
__ depressive feelings, regularly worse in the morning
__thoughts of suicide
__having made suicide attempts
__fatigue of loss of energy
__poor concentration
__decreased sex drive
__significant feelings of restlessness
__loss of pleasure in usual activities
__appetite loss
__feeling worthless
__weight loss
__weight gain
__feelings of sadness or depression
__withdrawing from others

__lower back pain
__vomiting
__hot or cold spells
__numbness or tingling in parts of your body
__allergy problems
__high blood pressure
__menstrual irregularity or distress
__asthma attacks
__hives
__irritable bowls, constipation, diarrhea
__tics
__smoking
__sugar cravings
__eating disturbance
__frequent flu or colds
__minor accidents
__sinus problems
__grinding teeth/jaw tension or pain
__ joint pain
__metabolic dysfunction (thyroid, hypoglycemia, diabetes)
__heart disease
__uncontrollable habits
__other

B. __palpitation
__lightheadedness
__sweating
__trembling
__sense of dread

__muscle tension
__chest pains
__frequent urinations
__dizziness
__panic attacks
__shortness of breath
__afraid of losing control
__avoiding certain situations

C. __nausea, upset stomach, ulcers
__headaches
__ itching
__over eating

D. __arguing with others
__ feeling critical of others
__feeling people dislike you
__feeling shy or uneasy
__wanting to be alone often
__difficulty communicating what you really think
__feeling bored with others
__feeling inadequate, less than others
__others do not understand you
__other relationship problems
__others are inferior to you
__others not meeting your needs