Jose' Freeman

Licensed Marriage & Family Therapist
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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 $100 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 □ Date:	Partnered □ Date:	Separated □ Date:	Divorced □ Date:	Widowed □ 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:
Employer'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 what 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___

6. My parents resolved conflict by: _____

_____

_____

7. My greatest hope for our relationship is that: _____

_____

_____

_____

8. One thing I do that gets in the way of my hope for our relationship is _____

_____

_____

_____

9. 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

B.
- □ palpitation
- □ lightheadedness
- □ sweating
- □ trembling
- □ sense of dread
- □ muscle tension
- □ chest pains
- □ frequent urinations
- □ dizziness
- □ panic attacks
- □ shortness of breath
- □ cold, clammy hands
- □ afraid of losing control
- □ avoiding certain situations

C.
- □ nausea, upset stomach, ulcers
- □ headaches
- □ itching
- □ over eating
- □ 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

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
- □ others are inferior to you
- □ others not meeting your needs
- □ other relationship problems