

José Freeman

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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?

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

Others living with you:

Name Relationship

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

___ physically abused

___ fought with parents

___ emotionally abused

___ isolated yourself from family

___ sexually abused

___ had too much responsibility

___ 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 or 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 bowels, 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