

# **José Freeman**

**Licensed Marriage & Family Therapist**

**MFC #45067**

**2716 X Street, Sacramento, CA 95818**

**(916) 505-0355**

## **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 \$110 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 <input type="checkbox"/>	Married <input type="checkbox"/>	Partnered <input type="checkbox"/>	Separated <input type="checkbox"/>	Divorced <input type="checkbox"/>	Widowed <input type="checkbox"/>
	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:
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?

- |  |   |
|--|---|
| <input type="checkbox"/> felt like you didn't belong   | <input type="checkbox"/> physically abused  |
| <input type="checkbox"/> fought with parents           | <input type="checkbox"/> emotionally abused |
| <input type="checkbox"/> isolated yourself from family | <input type="checkbox"/> sexually abused    |
| <input type="checkbox"/> had too much responsibility   | <input type="checkbox"/> other _____        |

Please describe in brief your childhood and your relationship with your parents: \_\_\_\_\_

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### **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 \_\_\_\_\_

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3. Our most bitter fights are usually about \_\_\_\_\_

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

- Flee\_\_\_
- Freeze\_\_\_
- Attack\_\_\_



6. My parents resolved conflict by: \_\_\_\_\_

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7. My greatest hope for our relationship is that: \_\_\_\_\_

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

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

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## 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. | <input type="checkbox"/> trouble going to sleep                              | <input type="checkbox"/> lower back pain   |
|    | <input type="checkbox"/> restless sleep                                      | <input type="checkbox"/> vomiting  |
|    | <input type="checkbox"/> waking up early, unable to return to sleep          | <input type="checkbox"/> hot or cold spells                                      |
|    | <input type="checkbox"/> sleeping too much                                   | <input type="checkbox"/> numbness or tingling in parts of your body              |
|    | <input type="checkbox"/> feeling guilty                                      | <input type="checkbox"/> allergy problems  |
|    | <input type="checkbox"/> depressive feelings, regularly worse in the morning | <input type="checkbox"/> high blood pressure                                     |
|    | <input type="checkbox"/> thoughts of suicide                                 | <input type="checkbox"/> menstrual irregularity or distress                      |
|    | <input type="checkbox"/> having made suicide attempts                        | <input type="checkbox"/> asthma attacks  |
|    | <input type="checkbox"/> fatigue or loss of energy                           | <input type="checkbox"/> hives   |
|    | <input type="checkbox"/> poor concentration                                  | <input type="checkbox"/> irritable bowels, constipation, diarrhea                |
|    | <input type="checkbox"/> decreased sex drive                                 | <input type="checkbox"/> tics  |
|    | <input type="checkbox"/> significant feelings of restlessness                | <input type="checkbox"/> smoking   |
|    | <input type="checkbox"/> loss of pleasure in usual activities                | <input type="checkbox"/> sugar cravings  |
|    | <input type="checkbox"/> appetite loss                                       | <input type="checkbox"/> eating disturbance                                      |
|    | <input type="checkbox"/> feeling worthless                                   | <input type="checkbox"/> frequent flu or colds                                   |
|    | <input type="checkbox"/> weight loss   | <input type="checkbox"/> minor accidents   |
|    | <input type="checkbox"/> weight gain   | <input type="checkbox"/> sinus problems  |
|    | <input type="checkbox"/> feelings of sadness or depression                   | <input type="checkbox"/> grinding teeth/jaw tension or pain                      |
|    | <input type="checkbox"/> withdrawing from others                             | <input type="checkbox"/> joint pain  |
|    |  | <input type="checkbox"/> metabolic dysfunction (thyroid, hypoglycemia, diabetes) |
|    |  | <input type="checkbox"/> heart disease   |
|    |  | <input type="checkbox"/> uncontrollable habits                                   |
|    |  | <input type="checkbox"/> other   |
| B. | <input type="checkbox"/> palpitation   |  |
|    | <input type="checkbox"/> lightheadedness                                     |  |
|    | <input type="checkbox"/> sweating  |  |
|    | <input type="checkbox"/> trembling   |  |
|    | <input type="checkbox"/> sense of dread                                      |  |
|    | <input type="checkbox"/> muscle tension                                      |  |
|    | <input type="checkbox"/> chest pains   |  |
|    | <input type="checkbox"/> frequent urinations                                 |  |
|    | <input type="checkbox"/> dizziness   |  |
|    | <input type="checkbox"/> panic attacks                                       |  |
|    | <input type="checkbox"/> shortness of breath                                 |  |
|    | <input type="checkbox"/> cold, clammy hands                                  |  |
|    | <input type="checkbox"/> afraid of losing control                            |  |
|    | <input type="checkbox"/> avoiding certain situations                         |  |
| C. | <input type="checkbox"/> nausea, upset stomach, ulcers                       |  |
|    | <input type="checkbox"/> headaches   |  |
|    | <input type="checkbox"/> itching   |  |
|    | <input type="checkbox"/> over eating   |  |
|    |  | D.   |
|    |  | <input type="checkbox"/> arguing with others                                     |
|    |  | <input type="checkbox"/> feeling critical of others                              |
|    |  | <input type="checkbox"/> feeling people dislike you                              |
|    |  | <input type="checkbox"/> feeling shy or uneasy                                   |
|    |  | <input type="checkbox"/> wanting to be alone often                               |
|    |  | <input type="checkbox"/> difficulty communicating what you really think          |
|    |  | <input type="checkbox"/> feeling bored with others                               |
|    |  | <input type="checkbox"/> feeling inadequate, less than others                    |
|    |  | <input type="checkbox"/> others do not understand you                            |
|    |  | <input type="checkbox"/> others are inferior to you                              |
|    |  | <input type="checkbox"/> others not meeting your needs                           |
|    |  | <input type="checkbox"/> other relationship problems                             |