Transformational Healing

CONFIDENTIAL

CLIENT INFORMATION & CONSULTING AGREEMENT

Date: _____/_____/_____

Last Name:_____First Name:_____

Address:_____

City:_____State:_____ Zip:_____

Day Phone:_____Cell:_____

Messages okay? Yes No Messages okay? Yes No

Is it okay to send a text message? Yes No

e-mail address:_____email okay: Yes No

All messages will be discreet, but please indicate any restrictions:_____

Birth date:_____Age:_____

Marital Status:_____If married, how many years?_____

If previously married, please specify how many times and the duration of each marriage?

Sexual Orientation:_____

Do you have children? YES NO

If YES please specify how many ____, age and sex:

Are all your children from your present marriage? YES NO Please summarize briefly.

Current occupation:_____CompanyName:_____

Emergency contact: Name:_____Phone:_____
Relationship:_____Who referred you:_____

What specific problem or issue brings you to this appointment today? Please summarize briefly.

Are you presently under your Doctor's supervision? YES NO

If YES, please specify:

Please list any medications you are currently taking.

Have you been hospitalized or received outpatient treatment any time during the last three years?

Following is a list of common obstacles which often lead people to seek professional assistance. Please check those you feel may apply to you or add any that may have been missed.

__ Anxiety	__ Communication	__ Self Esteem
__ Depression	__ Addictions	__ Eating Problems
__ Insomnia	__ Alcohol	__ Weight Control
__ Stress/Tension	__ Smoking	__ Personal Image
__ Abortion	__ Gambling	__ Grief
__ Work Problems	__ Drugs	__ Emotional Pain
__ Relationships	__ Sexuality	__ Physical Pain
__ Guilt Feelings	__ Panic Attacks	__ Shyness
__ Lack Motivation	__ Emotional Upset	__ Phobias (Please Specify)
__Suicide Attempts	__ Suicidal Thoughts	__ Sexual/Physical Abuse

Other: _____

Do you have a family history of:

__ Alcoholism	__ Depression or other emotional problems
__ Substance abuse or drug addiction	__ History of physical or sexual abuse
__ Suicide or any attempts	__ Psychotic Disorders

f you smoke, how much do you consume on a daily basis?

If you use alcohol, what form and how much do you consume in an average week?

Please describe your eating habits (i.e. preferred foods, and regularity of eating).

If you use illicit drugs, please specify what type, and how much you consume in an average week?

Have you ever received counseling? If yes, how long did you continue with counseling?

Do you feel it helped you?

What are your religious or spiritual beliefs?

What do you expect to achieve through therapy?

How long do you anticipate being in counseling?

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CONSULTING AGREEMENT

All initial intake sessions are billed at $125; sessions are 45-50 minutes.

Marriage, family, and individual therapy sessions are billed at $110; sessions are 45-50 minutes.

Hypnotherapy sessions are billed at $200; sessions are 75 minutes. All sessions exceeding this time will be pro-rated accordingly.

Reports or additional paperwork is $100 minimum and must be paid in advance. Court and/or legal services are billed at $350 per hour with a 4 hour minimum.

Text and email messages are to be used strictly for scheduling or rescheduling appointments.

CANCELLATION/NO-SHOW POLICY

Please be reminded that I have a 24 hr. cancellation policy. I have set aside 45 min of my time especially for you; I promise to respect your time and I ask the same of you.

If I do not receive 24 hrs notice of cancellation, you will be responsible to pay $100 prior to scheduling your next session. _____(initial)

This is not your co-pay or insurance/negotiated rate; insurance does not pay for no-shows. If you have any questions, please ask me!

Payment in full is due at time of each session. Uncollected fees may be turned over to collections.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

Your Rights as a Family Therapy Consumer Are:

1. To receive information concerning the methods of therapy employed, the techniques used, the duration of therapy (if known), and the fee structure for services provided.

2. To seek a second opinion. If needed, I can provide you with names of other qualified professionals.

3. To terminate therapy at any time without any moral, legal, or financial obligations other than those already accrued.

4. To know that in a professional psychotherapeutic relationship sexual intimacy or friendship between therapist and client is never permissible.

5. Your records will remain confidential, and if requested, any part of your records can be released to any person or agency if you sign an authorization.

6. My professional code of ethics as set forth by AAMFT prevents me from disclosing or releasing information gathered from therapy or regarding your use of service to anyone without your express written consent unless mandated by law. Situations mandated by law are as follows: **A)** Where there is clear and imminent danger to yourself or others; **B)** Reasonable suspicion of child or elder abuse or neglect; **C)** I am responding to a court order from a judge to release information; **D)** When a child under 18 years or less is in counseling and I see a clear need to share information with parents, guardian, or authorities. I cannot guarantee confidentiality when there are other participants involved in your therapy process

7. Therapy is a professional relationship. It is extremely important you and I both believe the relationship is the right fit in order to provide you with the greatest benefit possible. Because I value and appreciate your commitment to therapy, if at any time I believe you would greater benefit from seeking the services of another professional, I will inform you immediately and provide referrals.

I understand and accept the terms and conditions of the therapy being offered and voluntarily agree to participate. As a parent or guardian of a minor child, I also give permission for the following child to participate in therapy:

_____
Client Name

_____ _____
Signature Client or Parent/Guardian Date

_____ _____
Signature Client or Parent/Guardian Date

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Patient's Name: _____Date:_____
First MI Last

Patient's Home Address: _____

City: _____ State: _____ Zip: _____

Patient's Home Phone :(___)_____ Cell:(___)_____

Patient's Birth Date: _____ Age:_____

Patient SSN: _____ Email_____

Patient Occupation: _____Employer:_____

Employer's Address: _____Years There: _____

City: _____State:_____ Zip: _____

Complete this section ONLY if someone OTHER than the patient is financially responsible.

Responsible Party:_____Relationship to Patient:_____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: :(___)_____ Cell:(___)_____

Birth Date: _____ Age: _____ SSN: _____

Occupation: _____Employer:_____

Employer's Address: _____Years There: _____

City: _____State:_____ Zip: _____

Name of Spouse: _____

Birth Date: _____ Age: _____ SSN: _____

Occupation: _____Employer:_____

Employer's Address: _____Years There: _____

City: _____State:_____ Zip: _____

Insurance Billing

Transformational Healing will file insurance claims for all services to your primary insurance carrier only. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts. Should your account be sent to collections, you will be responsible for all collection and service charges.

I authorize the release of any and all medical information necessary to process my claim, or continue treatment. I also authorize the use of third party billing services.

Signature of client or responsible party: _____Date:_____

Electronic Communication Waiver

Though I do my best to protect your confidentiality of electronic messages, please note I cannot guarantee confidentiality under circumstances which include use of Internet, cellular phone, or text message. Specifically, I cannot guarantee confidentiality beyond my standard ethical obligations set forth by the American Association of Marriage and Family Therapists.

Electronic communication is only to be used for scheduling and rescheduling appointments, and is not to be used for emergency services or in case of a crisis; please call 911 or go to the nearest hospital.
_____(initial)

Authorize e-mail messages Yes No

Authorize text messages Yes No

Signature of client or responsible party: _____Date:_____

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