PSYCHOTHERAPY INFORMATION AND CONSENT FORM

Risks and Benefits: Psychotherapy can have both risks and benefits. The therapy process may include discussions of your personal challenges and difficulties, which can elicit uncomfortable feelings such as sadness, guilt, anger, and frustration. However, therapy has been shown to have many benefits. It can often lead to better interpersonal relationships and family dynamics, improved work/academic performance, solutions to specific problems, and an increased capacity to manage intense feelings. But there is no assurance of these benefits. Therapy requires your very active involvement in order to work towards growth. I will be committed to this process and work hard for you, and I will ask you to do the same.

Confidentiality: In keeping with ethical standards of the National Association of Social Workers and state and federal law, all services I provide are kept confidential, except as noted below. At times I may consult as needed with supervisors or colleagues about the best way to provide the assistance that you might need. As required by social work practice guidelines and current standards of care, I keep records of your therapy. Neither the fact that you seek therapy nor any information disclosed in the therapy sessions will be disclosed except as requested by you and as noted in the exceptions below.

I have a legal responsibility to disclose patient information without prior consent when a patient is likely to harm himself/herself or others, unless protective measures are taken, when there is reasonable suspicion of abuse of children, dependent adults or the elderly, when the client lacks the capacity to care for him or herself and when there is a valid court order for the disclosure of client files. Fortunately, these situations are infrequent. By signing this form you also give me permission to communicate with the emergency contact that you have designated if I believe that you are at risk. Please consult with me if you have any questions about confidentiality.

Cancellation policy: Consistency is essential for effective therapy and together we will agree upon the frequency of treatment. You are responsible for your regularly scheduled, standing appointment and will be charged for the time reserved. If you need to cancel I ask for **48 hours notice** to avoid charge. If you do not provide adequate notice or do not arrive for your session you are responsible for the full session fee. I will try to be as flexible as possible in rescheduling. I also provide the option of conducting session by phone or Skype/FaceTime if you cannot come to my office.

Fees: All fees are due at the time of session, unless we make alternative arrangements. I accept payment by check, cash and credit card. Checks should be made payable to Mind Body and Beyond Center. The maintenance of a valid credit card on file is required to ensure a smooth billing process. If you do not make a timely payment your card will be charged the full-session fee(s) plus a late-fee of $25. Your card will never be charge without your being notified. All phone contact, other than scheduling, will be billed at the hourly rate after the first 15 minutes. In general, your fee will be assessed annually, though conditions may warrant more frequent assessment.

Please sign below to indicate that you understand and agree to participate in therapy in accord with the above policies.

Print Name:_____ Date:_____

Signature:_____

PATIENT INFORMATION

Name _____

Age: _____ Date of Birth: _____

Local Address:_____

Billing Address :_____

Phone number: _____

Email: _____

Emergency Contact Name: _____

Emergency Contact's Phone number:_____

Relationship to Emergency Contact: _____

REFERRED BY: _____

COLLATERAL CONTACT

Do you currently see a psychiatrist? Yes _____ No_____

Psychiatrist's Name: _____

Address:_____

Contact phone:_____

Do I have your consent to contact the psychiatrist? Yes _____ No_____

Your signature of consent to contact your psychiatrist:

Sign: _____ Date: _____

Do you currently see a Nutritionist? Yes _____ No_____

Nutritionist's Name: _____

Address:_____

Contact phone: _____

Do I have your consent to contact the nutritionist? Yes _____ No_____

Your signature of consent to contact your nutritionist:

Sign: _____ Date: _____

Do you currently see a Medical Doctor? Yes _____ No_____

MD's Name: _____

Address:_____

Contact phone: _____

Do I have your consent to contact the MD? Yes _____ No_____

Your signature of consent to contact your MD:

Sign: _____ Date: _____

Personal History

Where were you born?

_____

Do you work at the present time?

_____No

_____Yes, Full or part time? _____

_____Student, Full or part time?_____

_____Homemaker
_____ Retired

_____Supported by savings, family, etc...

If you are employed, where do you work?

_____
_____
_____

What is the nature of your work?

_____
_____
_____

What were your previous jobs?

_____
_____
_____
_____

How long have you been at your present job? _____

What is the highest grade of school you completed?

_____

If you are a student, where do you attend school?

_____

List any major physical illness, hospitalizations, accidents that you have had and at what age they occurred:

_____
_____
_____
_____

Have you had past psychiatric hospitalizations? _____Yes _____No

If yes, please state where and reason for hospitalization

What prescribed medications do you take regularly, if any?

What recreational substances do you use / have you used in past, if any (please include alcohol and cigarettes)?

How often do you use these substances (if not currently using, how often in past)?

Do you consider any of your substance use to be a problem?

_____ Yes _____ No

If yes, please describe:

_____
_____
_____

Are you having any problems with your sleep habits?

_____ Yes _____ No (If yes, circle where applicable)

Sleeping too little

Sleeping too much

Poor sleep

Disturbing dreams

Other

Use this space to describe sleep issues:

_____
_____
_____

How many times a week do you exercise? _____
For about how long each time? _____
What type of exercise do you do ?

_____
_____

Do you consider your relationship to exercise to be a problem?
_____Yes _____No

If yes, please describe:

_____

Are you having any difficult with appetite or eating habits?

_____ Yes _____ No (If yes, circle where applicable)

Eating less

Eating more

Binging

Restricting

Significant weight change

Do you have any problems or worries about sexual functioning? _____ Yes _____ No (If yes, circle where applicable)

Lack of desire

Performance Problems

Sexual Impulsiveness

Difficulties maintaining arousal

Other

What activities do you enjoy doing in your free time?

_____
_____
_____

Which of the following applies to you?

I am _ Single _ Married __ Partnered _ Divorced _ Widowed _ Other

_____ I am in a serious relationship and we live together

_____ I am in a serious relationship and we do not live together

Please list previous marriages and/or serious relationships.

_____
_____
_____

Please answer the following if you are with your partner now:

What is your partner's name?

_____

What is your partner's occupation?

_____

FAMILY BACKGROUND QUESTIONNAIRE

Please list the names and ages of your children, if any, including step-children. Please note if your children are biological or adopted. If adopted, please note age adopted. If any of them are deceased, please list date they died:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list the members of your current family, including ages and occupations. Please be sure to state if family members are biological, adoptive, or other

_____
_____
_____
_____
_____

Please circle and describe any past or impending issues that apply to your family:

Alcohol abuse

Drug abuse

Emotional problems

Psychiatric Hospitalization

Anxiety

Depression

Other mental illness

Ulcers or colitis

Asthma

Serious physical illness

Weight/eating problems

Anorexia

Bulimia

Insomnia

Attempted/Completed Suicide

Epilepsy

Physical Abuse

Sexual Abuse

Disabilities

Childhood illness

Frequent relocations

Learning problems

Deaths

Divorce

Unemployment

Legal problems

Other

Are your parents married or divorced?

_____

If Divorced, are either of they re-married?

_____

How much is your immediate family a source of emotional support for you? (Circle one):

None

Little

Somewhat

Substantial

Very

Strong

Besides family members who do you count on right now for friendship or emotional support? (please name and note relationship to you)

_____
_____
_____

Please state in detail your present issues, how long they have persisted, and your reason for seeking treatment at this time. Feel free to use as much or as a little space as you like.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

GUARANTEE OF PAYMENT AND

CREDIT CARD AUTHORIZATION

I _____ understand that my credit card is securely being held on file for use in the event of a late payment. A payment is considered late 14 business days after the day of issued invoice. I understand that my credit card will only be charged if I do not make timely payments by cash or check. I agree to provide notification of any changes made to card information. I understand that these policies are in place to ensure smooth billing processes. My signature below indicates understanding and acceptance of aforementioned payment policies and hereby authorizes Mind Body and Beyond Center to charge the credit card below as needed.

If you would like your credit card used as your primary method of payment and charged after each session please initial the following:

I authorize Mind Body and Beyond Center to charge my credit card after each session [_____]

Individual responsible for payment: _____

Credit Card Number: _____

Expiration: _____

Address of Card Holder: _____

_____

Verification Code: _____

Email of Card Holder: _____

Phone number of Card Holder: _____

I (we) have read, understand, and agree with the provisions of the Financial Policy and procedures/policies of Mind Body and Beyond Center. In the event, someone other than the Patient has agreed or will agree to pay the fees, charges and expenses on behalf of patient, such third party shall sign below and thereby agree to be bound by and adhere to the terms and policies set forth herein.

SIGNATURE: _____

DATE: _____