Above All
FAMILY THERAPY

Confidential Client Information

Please complete the following information sheets and bring with you to your first appointment.

*Today's Date*_____

CLIENT'S NAME

(First/Last) _____ DOB _____ Age _____

Sex _____ Ethnicity _____ Social Security #_____

MARITAL STATUS (please circle)

Unmarried Married Separated Divorced Widowed Number of Years _____

Address_____ City_____ State _____ Zip_____

Home Phone (_____) _____-_____ May we leave a message at this number? YES NO

Cell Phone (_____) _____-_____ May we leave a message at this number? YES NO

May we text you messages on your cell #? YES NO

Email Address _____

Employer _____

FAMILY MEMBERS	*AGE*	*OCCUPATION / GRADE*
Spouse _____	_____	_____
Children _____	_____	_____
Children _____	_____	_____
Children _____	_____	_____

CLOSEST FRIEND OR RELATIVE, NOT LIVING AT YOUR HOME, TO CONTACT IN AN EMERGENCY

Name (First/Last)_____ Relationship _____

Address_____ City_____ State _____ Zip_____

Phone (_____)_____-_____ Work Phone (_____)_____-_____

Cell (_____)_____-_____

REFERRAL

Name (First/Last) _____

Organization/Church _____

Life History Questionnaire

Please circle all of the following that apply.

Feelings		Thoughts	
Helpless	Anxious	Confused	Racing
Depressed	Out of Control	Unintelligent	Obsessive
Shameful	Afraid	Worthless	Distracted
Angry	Numb	Unmotivated	Disorganized
Guilty	Relaxed	Unattractive	Paranoid
Hopeless	Happy	Unlovable	Suicidal
Lonely	Excited	Confident	Sensitive
Sad	Hopeful	Worthwhile	Honest
Stressed	Inferiority	Feeling	Homicidal
Unhappy	Mood Shifts		

Other _____ Other _____

Symptoms/Behaviors

Eating Less	Acting Out	Sexually Socializing
Procrastinating	Acting Aggressively	Marital Relationships
Attempting Suicide	Disorganization	Parent/Child Conflicts
Poor Concentration	Impulsivity	Lack of Ambition/Goals
Crying	Recklessness	Poor Peer Relationships
Withdrawing Socially	Irritability	Night Mares
Skipping Classes	Passivity	Worries About Body Image
Binge Drinking	Drug Use	Spiritual Problems
Injuring self	Alcohol Use	Dating Concerns
Compulsivity	Being Good to Yourself	Finances
Career/Major	Choice Sexual	Problems Other _____

Physical Symptoms

Insomnia	Tired	Weight Gain or Loss
Pain	Headaches	Tightness In Chest
Dizziness or Light-headedness		

Please describe any medical conditions you have or medications that you are on:

Numbness or Tingling	Vomiting	Rapid Heart Beat
Dry Mouth	Excessive Sleep	Loss of Memory
Eating Problems	Other _____	

List of medications and dosage:

_____

Please describe what brings you in to our office today: _____

_____

_____

_____

_____

_____

_____

_____ _____

Client Signature Date

Consent for Treatment

COUNSELING SERVICES. Welcome to our practice. This document contains important information about professional services/business policies. Please read it carefully and write down any questions you might have to discuss at our next session. By signing this document, it represents an agreement between us.

I fully abide by the ethical code of the American Counseling Association, American Association of Marriage and Family Therapists and by those of the Florida State Licensure.

RISKS AND BENEFITS OF THERAPY. Therapy can have risks and benefits. Since treatment often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Alternatively, therapy has also been shown to have benefits. Treatment often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees regarding what the experience will be like for you as an individual and your family.

APPOINTMENTS. Individual appointments are generally 50-60 minutes in length. If for any reason you are unable to keep your appointment, it is essential for you to notify me 24 hours in advance of your scheduled appointment. If you do not, you will be charged for the time reserved for you. If you do need to reschedule an appointment, we will cooperate in accommodating your preferences.

Cancellations and rescheduled appointments will be accepted with no additional charge if the request is made at least 24 hours prior to your scheduled appointment. A $50 fee (not covered by your insurance) will be applied for missed appointments, as well as consultations/rescheduled appointments made with less than 24 hours' notice.

RATES & PAYMENTS.
Intake $140
Individual $100
Family $100
Couples $100

INSURANCE. I am a current provider for Cigna, United Health Care, Tricare and selected EAP's. If necessary, I can provide insurance coding on your receipt so that you may file claims with your insurance carrier as needed.

CONTACTING ME. If you have an emergency (thoughts of hurting yourself or someone else) and are unable to contact me, please call 911 or go to the local emergency room. I have a voice mail to leave messages for non-emergency calls.

Consent for Treatment

ELECTRONIC COMMUNICATION. It is important to remember that electronic communication such as e-mail, faxes, cell phone calls, and text messages are not secure. Please keep this in mind when there is communication. If you have any questions about confidentiality, please feel free to discuss them in session.

RECORD KEEPING. All client files are maintained in a secure, confidential environment under multiple locks for added security. Medical records belong to the client and will be kept and maintained for a length of time as prescribed by law and ethical code. Clients may transfer medical records by filing out a ***RELEASE OF INFORMATION FORM.*** All other information belongs to the therapist and will not be released. These records will be destroyed after the prescribed maintenance period as required by law and ethical code. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

MINOR CHILDREN. In accordance with local, state, and federal laws, only a parent or guardian possessing legal rights to do so may register a minor child for counseling services. In instances where a minor child is not in the legal custody of both biological parents, it will be necessary for the parent or guardian to provide documentation that secures legal rights and sign an ***"Authorization to Treat Minor Children"*** form.

CHILDCARE. We do not provide childcare and cannot assume responsibility for any child left unsupervised.

CONFIDENTIALITY. Your therapy records are the property of your counselor and shall be treated as confidential. To comply with state and federal laws your records will not be released without properly executed written consent. Everything about your care will be held in strictest confidence (with the exception of those situations which we are required by law to report). If you choose to have your counselor keep a third party informed of your progress, it is necessary to complete a ***"Release of Information Form"*** that will be kept on file.

The following circumstances are an exception to keeping confidentiality and are required by law to report:

A. When a client communicates threat of bodily injury to self another person or is suicidal.

B. When there is reasonable suspicion of abuse to a child or a dependent adult which has occurred or will occur.

C. When information is required by law or is ordered by the court.

D. Counselor Team. Counselors typically work as a team and reserve the right to consult and discuss pertinent information, without identifying information, with other counselors and supervisors within the counseling team.

Consent for Treatment

_____ / _____ I have read and understood the above information regarding confidentiality. I agree to disclose personal information with these exceptions in mind.

_____ / _____ I, the undersigned, acknowledge that I have received and read this counseling agreement & understand the above information, and agree to voluntarily receive and participate in the counseling process on that basis. I fully understand the responsibility of this agreement.

_____ / _____ I, the undersigned, hereby will be paying for services at the close of each session.

_____ / _____ I, the undersigned, understand that if a payment plan has not been established and when charges have not been paid within 30 days of the due date, I agree that I will subject to a late charge of 1.5% per month on the unpaid balance. I agree to pay for any charges for each returned check. The charge for a returned check is $25.

_____ / _____ I, the undersigned, understand that all CANCELLATIONS MUST BE MADE 24 HOURS IN ADVANCE OTHERWISE A $CHA50RGE WILL BE MADE. I will be fully responsible for such charges.

_____ / _____ I, the undersigned the rate we will be paying per session is $_____.

_____	_____	_____
Client (Parent/Guardian) Printed Name	Client (Parent/Guardian) Signature	Date
_____	_____	_____
Client (Parent/Guardian) Printed Name	Client (Parent/Guardian) Signature	Date
_____	_____	_____
Therapist Printed Name	Therapist Signature	Date

CLIENT'S BILL OF RIGHTS

Client's rights include:

 The right to be treated with dignity and respect.

 The right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.

 The right to have their treatment and other member information kept private. Only in an emergency, or if required by law, can records be released without member permission.

 The right to information from providers in a language they can understand.

 The right to have an easy to understand explanation of their condition and treatment.

 The right to know all about their treatment choices. This would mean no matter of cost or insurance coverage.

 The right to get information about the managed care company's services and role in the treatment process.

 The right to information about providers.

 The right to know the clinical guidelines used in providing and/or managing their care.

 The right to know about the complaint, grievance and appeal process.

 The right to know about State and Federal laws that relates to their rights and responsibilities.

 The right to know of their rights and responsibilities in the treatment process.

 The right to share in the formation of their plan of care.

Clients have a responsibility to:

 Give providers information they need. This is so they can deliver the best possible care.

 Let their provider know when the treatment plan no longer works for them.

 Follow their medication plan. They must tell their provider about medication changes, including medications given to them by other providers.

 Treat those giving them care with dignity and respect.

 Not take actions that could harm the lives of the managed care provider, or other clients.

 Keep their appointments. Clients should call their providers as soon as possible if they need to cancel visits.

 Ask their provider questions about their care. This is so they can understand their care and their role in that care.

 Let their provider know about problems with paying fees.

 Follow the plans and instructions for their care. The care is to be agreed upon by the member and the provider.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

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FAMILY THERAPY

ELECTRONIC MESSAGE CONSENT

Maintaining client confidentiality is the cornerstone to a therapeutic relationship between a client and a therapist. However, due to the nature of electronic communications (e-mail, cell phone, text message, and fax), therapists are unable to reasonably assure their client(s) that communications using these means will be reliably confidential.

Clients agree to limited use of electronic communications as set forth in this agreement.

TEXT MESSAGE USE

Client agrees to send and receive text messages for initiating, confirming, canceling, or rescheduling of appointments only. _____

E-MAIL

Client agrees to the use of e-mail messaging for initiating, confirming, canceling, or rescheduling of appointments only. _____

E-mail: _____

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date

CANCELLATION POLICY

Scheduled appointment times represent an agreement between you and your mental health care provider. This time has been set aside and reserved for you. Appointments that are not kept, but have not been cancelled cannot be used for another client.

In accordance with the Consent For Treatment agreement (***Appointments*** section), Above All Family Therapy, LLC charges clients a $50.00 Missed Appointment Fee when the client does not attend and does not cancel their scheduled sessions at least 24-hours prior to their appointment time. We realize that illnesses and emergencies arise. Please contact your mental health care provider as soon as possible if you experience an illness or emergency.

Thank you for your consideration regarding this important matter.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Date

_____

Therapist Signature

_____

Date