CONFIDENTIAL

CLIENT INFORMATION & CONSULTING AGREEMENT

Date: / /

Last Name: First Name:

Address:

City:

State: Zip:

Day Phone: Cell: Evening Phone:
Messages okay? Yes No Messages okay? Yes No Messages okay? Yes No

Do you receive text messages? Yes No

Birth date: Age:

Marital Status:

If married, how many years?

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

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?
Company Name?

Emergency contact: Name: Phone: Relationship:

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

If 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?

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 $125; sessions are 75 minutes. All sessions exceeding this time will be pro-rated accordingly.

All missed appointments will be billed with payment due within ten days, and prior to next visit.

Twenty-four hour notice is required for cancelled appointments.

Payment in full is due at time of each session.

______________________________ _______________________
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. If you request, 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 other participants are involved in your therapy process.

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

transformational healing

Psychotherapy

INDIVIDUALS • COUPLES • FAMILIES

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: __________________________ Driver's License #_____________________

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: _____________________

Name of person/company who referred you:__________________________________

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.

Signature of client or responsible party: ________________________Date:_______

I authorize the release of any medical information necessary to process my claim.

Signature:________________________Date:___________
(Client or Responsible Party)

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