

REGISTRATION FORM

PATIENT'S NAME _____ Today's Date _____

Social Security # _____ Birthdate _____ Marital Status (circle) M D S W

Address _____ City _____ Zip _____

Home phone _____ Work Phone _____ Cell Phone _____

Reason for appointment? _____

Medical doctor who referred you? _____

How else were you referred? _____ May we thank them? Y N

INSURANCE INFORMATION

Name of Insured _____ Social Security # _____

Employer _____ Birthdate _____

Insurance Company _____ Group # _____

Billing Address _____ City _____ Zip _____

SPOUSE / PARTNER INFORMATION, FOR COUPLES OR FAMILY THERAPY

Name _____ Social Security # _____

Address _____ City _____

Zip _____ Home phone _____ Birthdate _____

Employer _____ Work phone _____

Insurance Company _____ Group # _____

Billing Address _____ City _____ Zip _____

OTHERS LIVING IN THE HOME, AND ALL CHILDREN:

Name _____ Birthdate _____ Name _____ Birthdate _____

Name _____ Birthdate _____ Name _____ Birthdate _____

Name _____ Birthdate _____ Name _____ Birthdate _____

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY, OTHER THAN FAMILY

Name _____ Phone _____ Relationship _____

Agreement for Psychotherapy Services

Because therapy often begins in a situation of considerable emotional difficulty, I have prepared these notes so that you will have an understanding of our basic agreement

Therapist Name: _____

Patient Name: _____

Families Counseling Center is owned by Deborah Tucker, M.A., M.F.T. (Lic #MI 17142). Each therapist's practice is separate, and each is solely and entirely responsible for any liabilities resulting from that practice.

The Process of Therapy

Risks and Benefits: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty and openness in order to change your thoughts, feelings, and/or behavior. Your therapist will ask for your feedback and views on your therapy, its progress and other aspects of the therapy, and will expect you to respond openly and honestly.

During therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc ... or experiencing anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions or perceptions, or propose different ways of looking at, thinking about, or handling situations that can cause you to feel upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, your therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and their assessment of what will best benefit you. Their approaches may include but are not limited to behavioral, cognitive, psychodynamic, system/family, development, or psycho-educational techniques.

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, your therapist will discuss with you their working understanding of the problem, treatment plan, therapeutic objectives and their view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, your therapist's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that your therapist does not provide, your therapist has an ethical obligation to assist you in obtaining these treatments.

Terminating Treatment: You always have the option to terminate treatment at any time, for any reason. It is customary to discuss this with your therapist in session, so that any concerns either you or your therapist have

may be adequately addressed. If your therapist feels that therapy is not benefiting you, your therapist will also discuss this with you.

Telephone and Emergency Procedures: If you need to contact your therapist between sessions, please leave a message on their regular voicemail and your call will be returned as quickly as possible. If an emergency arises, please indicate it clearly in your message, and page your therapist as well. Please make a note of your therapist's emergency number. **If you need to talk to someone right away, or if there is a life-threatening emergency, please call 911 and/or the Psychiatric Emergency Assessment Team at 805-371-8375 first.**

Financial Terms and Insurance Coverage

Fees: The fee for your psychotherapy is: _____

Cancellation and Missed Appointment Policy. Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled with less than 24 hours notice, you may be billed according to the scheduled fee and instructions of your benefit plan. Your insurance company will not be billed for fees associated with missed or canceled appointments; therefore you may be responsible for the entire fee if appointments are cancelled without appropriate notice. **Exceptions are if you are sick or have an unavoidable emergency; please discuss this with your therapist.** Initial here: _____

Delinquent Accounts. You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless other arrangements have been made in advance. Should your account become delinquent, you agree to pay interest at 1.5% per month, and if it becomes necessary for the account to be referred for collection action, you shall pay the actual balance due plus any collection expenses for 30-50% of any balance owing and any attorney's fees.

You are responsible for obtaining prior authorization for treatment from your insurance carrier. Your therapist will bill your insurance, however, you are responsible for co-payment amounts and deductibles as set by your benefit plan. Missed appointments are not covered by your insurance and the charges associated with them are your responsibility. If at any time during treatment you become ineligible for insurance coverage, you will be notify the therapist and understand you will become responsible for 100% of the bill.

Contact information and permissions

Occasionally mailings are sent announcing workshops or classes that are offered. Would you like to be included in these mailings?

If yes, please include your email address _____ **Yes** ___ **No** ___ **Initial here** _____

If there are specific phone numbers you **WOULD** like us to use to contact you, please note, and give us directions as to what we may and may not say, directly or in a message:

If there is a specific address, other than your home, that you **WOULD** like statements sent to, please state:

If there are phone numbers and/or addresses on the intake form that you **WOULD NOT** like us to use, please state: _____

Therapist's confidentiality policies – Please acknowledge by initialing here _____

Confidentiality. The information disclosed by you is generally confidential and will not be released to any third party without written authorization from you, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

Psychotherapist-Patient Privilege. The information disclosed by you, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege on your behalf until instructed, in writing, to do otherwise by you or your representative. You should be aware that you might be waiving the psychotherapist-patient privilege if you make your mental or emotional state an issue in a legal proceeding. You should address any concerns you might have regarding the psychotherapist-patient privilege with your attorney.

Patient Litigation. I will not voluntarily participate in any litigation, or custody dispute in which you and another individual, or entity, are parties. I have a policy of not communicating with clients' attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in any legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate for such services of \$200 per hour, billed in half-day increments

Patient's permissions

Release of Information

I authorize the release of information for claims, certifications/case management/quality improvement, and other purposes related to benefits of me Health Plan. I authorize my Health Plan to pay my therapist directly for treatment.

Please sign here, or write "not authorized" if you do not want your insurance billed:

Consent for Treatment

I authorize and request my therapist to carry out psychological and/or psychiatric exams, treatment and/or diagnostic procedures that now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request, and are outlined above in this document, and that they are subject to my agreement.

Patient signature

Date

Spouse/partner signature
(if couples or family therapy)

Date

General Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the therapist/group to deliver mental health care services to the patient. You also understand that all policies described in this statement apply to the patient you represent. Please be aware that under California's Family Code, a parent without custody may still be entitled to information about his or her child's treatment.

Patient Name

Date

Signature of Legal Guardian/Representative

Relationship to Patient