

McDermott Counseling, LLC

1220 W. Center Avenue, Visalia, CA 93291

Client's name: _____ SSN: _____-_____-_____ DOB: ____/____/____

Age _____ Gender: Male Female Address: _____

Apt. # _____ City: _____ State: _____ Zip: _____

Phone: home # (_____) _____-_____ cell # (_____) _____-_____ work # (_____) _____-_____

How did you hear about our office? _____

Insurance Company Name: _____ ID #: _____ Group #: _____

Answer the following regarding PRIMARY INSURED: Name: _____ DOB: ____/____/____

Address: _____

SSN: _____-_____-_____ Telephone # (_____) _____-_____ Employer: _____

Person to contact in case of Emergency: _____

Relationship: _____ Phone: home # (_____) _____-_____ cell # (_____) _____-_____

Primary reason(s) for seeking services: _____

FAMILY INFORMATION

Relationship	Name	Age	Living		Living with you		Your Relationship?		
			Yes	No	Yes	No	Good	Fair	Poor
Mother	_____	_____	<input type="checkbox"/>						
Father	_____	_____	<input type="checkbox"/>						
Spouse / S.O.	_____	_____	<input type="checkbox"/>						
Children	_____	_____	<input type="checkbox"/>						
	_____	_____	<input type="checkbox"/>						
	_____	_____	<input type="checkbox"/>						
(Other):	_____	_____	<input type="checkbox"/>						
_____	_____	_____	<input type="checkbox"/>						
_____	_____	_____	<input type="checkbox"/>						

MARITAL STATUS: Single Married Divorced Separated How Long? _____ Total number of marriages: _____

PARENTAL INFORMATION: Parents still married and together Parents Separated Parents Divorced

Father remarried _____ number of times Mother remarried _____ number of times

Have either of your parents or anyone in your family ever suffered from a mental illness (i.e. depression, anxiety, schizophrenia)?

Yes No If yes, please describe: _____

DEVELOPMENTAL HISTORY

Are there special, unusual, or traumatic circumstances that affected your development? Yes No Describe: _____

Has there been history of child abuse? Yes No If Yes, which type(s)? Sexual Physical Verbal / Emotional

Describe: _____

Other childhood issues: _____

SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply) Affectionate Angry Aggressive Shy
 Withdrawn Outgoing Passive Friendly Other (specify): _____

Sexual orientation: _____ Sexual dysfunctions? Yes No If yes describe: _____

CULTURAL/ETHNIC

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? Yes No If yes describe: _____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? Not at all Little Moderate Very Much Not Currently Practicing

Are you affiliated with a spiritual or religious group? Yes No Name and Type: _____

Were you raised within a spiritual or religious group? Yes No Name and Type: _____

LEGAL

Are you involved in any active cases (traffic, civil, criminal)? Yes No If yes describe: _____

Have you ever been arrested (i.e. DUI)? Yes No If yes describe: _____

EDUCATION & EMPLOYMENT

Years of Education: _____ Current Occupation: _____ Employer: _____

MEDICAL

List any health concerns: _____

List any surgeries (including cosmetic procedures): _____

List all medications presently taking (Rx and over the counter): _____

CHEMICAL USE HISTORY

	<u>Age of First use</u>	<u>Age of last use</u>	<u>amount used</u>	<u>Used in past (circle)</u>	<u>30 days</u>	<u>48 hours</u>
Alcohol	_____	_____	_____		Yes No	Yes No
Amphetamines	_____	_____	_____		Yes No	Yes No
Cocaine/Crack	_____	_____	_____		Yes No	Yes No
Opiates	_____	_____	_____		Yes No	Yes No
Marijuana	_____	_____	_____		Yes No	Yes No
Caffeine	_____	_____	_____		Yes No	Yes No
Nicotine	_____	_____	_____		Yes No	Yes No
Prescription drugs	_____	_____	_____		Yes No	Yes No

Does/Has someone in your family present/past have/had a problem with drugs or alcohol? Yes No If Yes, describe: _____

Have you ever received treatment for substance abuse issues? Yes No If yes, where: _____

COUNSELING/PRIOR TREATMENT HISTORY

Have you ever been to counseling / therapy / or seen a psychiatrist for any reason? Yes No If Yes, Name of Provider and dates of service: _____

Have you ever had suicidal thoughts/attempts? Yes No If Yes, When: _____

Have you ever been Hospitalized? Yes No If Yes, Where & When: _____

CONSENT FOR TREATMENT & PATIENT AGREEMENT

Welcome to McDermott Counseling, LLC. Your therapy is an important joint venture in which you and your therapist will work together to understand the problems that you are having and to explore your options and obstacles in resolving those problems. This document contains information about our professional services and business policies. Should you have any questions about these at any time, we will be happy to answer them.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on many factors, including the personalities of the patient and therapist, your early experiences, your life stage, and your goals. There are several different approaches that can be used. Psychotherapy requires an active effort on your part and a working relationship with your therapist in which you work together to identify the issues you would like to resolve.

Psychotherapy can have both benefits and risks. Since therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings and changes in your behaviors/thoughts. This is a normal part of the therapeutic process. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful. It often leads to a significant reduction of feelings of distress, better relationships, and resolutions of specific problems.

Your first sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what your work will include and a treatment plan/goals if you decide to continue.

You have the right to stop treatment at any time. The process of termination is generally one of the most important times in therapy. It is highly recommended that you spend at least two to four sessions to work through this process of termination.

CONFIDENTIALITY

With certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. We cannot and will not tell anyone else what you have told us, or even that you are in therapy with us, without your prior written permission. The following are legal exceptions to your right to confidentiality. Should one of these situations occur, we will make every effort to discuss it with you fully before taking any action.

- If we reasonably suspect that a person under 18 or over 65, or a disabled person, is being abused or has been abused, we must file a report with the appropriate state agency.
- If a patient threatens to harm him/herself, we may be obligated to seek hospitalization for the patient, or to contact family members or others who can help provide protection.
- If a patient communicates a serious threat of physical violence against an identifiable victim, we must take protective actions, including notifying the potential victim and contacting the police. We may also seek hospitalization of the patient, or contact others who can assist in protecting the victim.
- We may find it helpful to consult with professional colleagues about our work from time to time. In these consultations, we make every effort to avoid revealing the identity of our patient. The consultant is also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together.
- If you are involved in a court proceeding and a request is made for information about the services that we have provided you and/or the records of them, such information is protected by therapist-patient privilege law. We cannot provide any information without your written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where we do not have grounds for objecting under state law (or you have instructed us not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

APPOINTMENTS

Psychotherapy appointments are usually scheduled once a week for 45 minutes per session. We agree to meet here and to be on time. **Sessions are scheduled on the hour and end 15 minutes before the next hour.** If we are ever unable to start on time, We ask for your understanding, and assure you that you will receive the full time agreed to. If you are late, we will probably be unable to meet for the full time.

CANCELLATION POLICY

Because the scheduling of an appointment involves the reservation of a large amount of time set aside specifically for you, a minimum of **24 hours notice is required for rescheduling or canceling an appointment.** **Insurance companies do not pay for missed appointments; therefore, you are responsible for the full session fee of \$100, if you cancel without such notification.**

PROFESSIONAL FEES

The fee per 45 minute psychotherapy session is \$100. The fee for a 60 minute session is \$133. We accept cash only. Bills are to be paid at the time of each visit. We charge this amount for other professional services you may need, though, will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations (lasting longer than 5 minutes), attending meetings or consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. When fees are not paid for services rendered, a collection agency may be used and given appropriate billing and financial information, (non-clinical information).

If you become involved in legal proceedings that require our participation, you will be charged for of our professional time, including preparation and travel time, even if we are called to testify by another party. Because of the difficulty of legal involvement, the fee is \$300 per hour for preparation for, travel to and from, and attendance at any legal proceeding.

CONTACTING US

We are often not immediately available by telephone. When we are unavailable, our telephones are answered by voicemail, which we monitor frequently. We will make every effort to return your call on the same day you make it, with the exception of calls on weekends and holidays. Also, We do not return telephone calls between 9:00 p.m. and 8:00 a.m. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach us and feel that you can't wait for us to return your call, you can contact your family physician, the Mental Health Info line at (800)321-1616, National Crisis Hotline (800)784-2433, Tulare County Crisis Line (559) 733-6877, or the emergency/police dispatcher at 911. If We are unavailable for an extended time, We will provide you with the name of a colleague whom you can contact if necessary.

Please sign below to acknowledge your informed consent to this agreement.

I have read the above information and have had an opportunity to ask questions which clarify the conditions under which I consent to treatment. I give permission McDermott Counseling, LLC, to provide evaluation and psychotherapy. I am aware that Amy Durst, MFTI and Tracy Slack, MFTI are Marriage and Family Therapy Interns, working toward licensure. They have completed their education, Masters' of Science in Marriage and Family Therapy, and are conducting their 3,000 hours of psychotherapy supervised by Rachel McDermott, LMFT

Name of patient

Signature of patient

Date

(A copy of this agreement is available upon request)