

Couple's Intake

Date	Referred By		
Name	/ / Birthdate	Age	- - SS#
Name	/ / Birthdate	Age	- - SS#
Street Address	City	Zip	
Mailing Address (if different)	City	Zip	
() Home Phone			

If I contact you at home, may I say who I am? Yes No

Employer	Employer Address
If needed, may I contact you at work? Yes No () Work Phone	

How long have you been Married Engaged Separated

Spouse's Employer	Spouse's Employer Address
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Children's Names (include step) & Relationships

Name	/ / Birthdate	Age	- - SS#	Comments re: relationship
Name	/ / Birthdate	Age	- - SS#	Comments re: relationship
Name	/ / Birthdate	Age	- - SS#	Comments re: relationship
Name	/ / Birthdate	Age	- - SS#	Comments re: relationship
Name	/ / Birthdate	Age	- - SS#	Comments re: relationship
Name	/ / Birthdate	Age	- - SS#	Comments re: relationship

Marital History Husband

Marital History Wife

Additional Comments on Children or Marital History:

<hr/>	<hr/>	<hr/>
Church affiliation (if any)	City	Pastor
Are either of you currently under medical treatment? Yes No If yes, name of		
doctor:		

Any medication currently taking? Yes No If yes, please list:

Please describe any current or chronic diagnosed medical conditions:

Are you currently involved in any legal matters, including custody disputes or insurance settlements? If so, describe:

Previous counseling experiences:

<hr/>	<hr/>	<hr/>
Counselor/Location	Dates/Length of counseling	Issues addressed
<hr/>	<hr/>	<hr/>
Counselor/Location	Dates/Length of counseling	Issues addressed

Husband's Reason for currently seeking counseling: (describe presenting problem, including length & precipitation event, if applicable)

Wife's Reason for currently seeking counseling: (describe presenting problem, including length & precipitation event, if applicable)

Goals for counseling:

Please circle any appropriate answers: "H" for Husband, "W" for wife, or no indication for both.

- | | | |
|---|-------------------------|--|
| Current or previous alcohol or drug abuse | Eating Disorder | Family/spouse current or previous alcohol/drug abuse |
| Anger difficulty | History of sexual abuse | History of physical abuse |
| Financial stress | Marital distress | Parenting difficulties |
| Job difficulties | Anxiety difficulties | Recent loss of a loved one |
| | | Changes in sleep |
| | | Changes in level of energy |

Have either of you ever had suicidal thoughts? If yes, please explain:

Give a brief history of relationships with:

Husband w/ Father

Husband w/ Mother -

Husband w/ Siblings -

Wife w/ Father

Wife w/ Mother

Wife w/ Siblings-

Children

Friends

Are there any additional comments you would like to tell me about yourself?

Fees, Insurance and Confidentiality

THE STANDARD FEE for a psychotherapy session is \$95.00 per fifty-minute session. For those who do not have the resources to pay this fee, a sliding scale will be provided. Group therapy sessions have rates that vary with the type of group. Phone sessions will be billed at your normal psychotherapy rate. Mediation and court appearances will be billed at the rate of \$150.00 per hour, regardless of your established fee for psychotherapy. Letters will be billed at your psychotherapy fee for hour(s) spent in preparation. Court reports, psychological evaluation reports, and legal reports will be billed at the rate of \$95.00 per hour spent in preparation, regardless of your established fee for psychotherapy, with a minimum charge of at least \$250.00.

FEE PAYMENTS are presented ahead of the session, unless prior arrangements are made with the therapist. Also, there are additional charges for psychological testing and for copying of records.

REGARDING INSURANCE: For those individuals with HMO's, the CO-payment will be made before the start of each session. For all other insurance plans, payment will be made in full before each appointment and a submittal form will be given to you so you may bill your insurance company for reimbursement, unless other arrangements are made.

YOUR APPOINTMENT TIME reserves a psychotherapist's time for you. Missed sessions will be billed at your full fee unless the appointment has been canceled 24 hours in advance of the scheduled time. A missed session will not be rescheduled automatically. You must call to reinstate appointments, or mention during canceling that you wish another appointment.

OUR PURPOSE is to provide excellence of service to each of our clients. Still, the success of therapy does not just depend on the skill of the therapist. Many other factors, such as the client's openness to working with difficult material, help to determine the outcome of therapy. If you have any questions regarding your progress in therapy at any point during therapy, please communicate this with your therapist.

CONFIDENTIALITY is a basic policy. Information and records regarding clients are kept confidential unless a signed, written consent form is obtained to release records. The court and legislature have determined that confidentiality cannot override the obligation of a therapist to report child abuse, elder abuse, or threats to harm oneself or others.

I UNDERSTAND AND AGREE TO THE ABOVE. MY FEE IS _____. IT IS MY RESPONSIBILITY TO NOTIFY SELAH COUNSELING SERVICES AT LEAST 24 HOURS PRIOR TO MISSING A SCHEDULED APPOINTMENT. I AGREE TO PAY THE FULL FEE FOR EACH MISSED SESSION I CANCEL WITHOUT GIVING PROPER NOTICE.

SIGNED

DATE



CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____ and me/us _____ . When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written that name here _____ .

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others to arrange payment for your treatment, or for other business or government functions.

By signing this form you are agreeing to let me use your information here and share it with the others as mentioned above. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our Privacy Officer, Kate Pieper, LMFT, or by calling her at (530) 268-1355.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it in writing. We will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

Signature of client (or personal representative) Date

Printed name of client (or personal representative) Relationship to client

Description of personal representative's authority

Signature of authorized representative of this office or practice

Date of NPP Copyright 2004 _____

Copy given to the client/parent/personal representative Page 6