Carol J Timmons, LMFT

Psychotherapy for Individuals, Couples, Families, Women's Groups

INTAKE

NAME_____Date_____

Address_____

City_____
Cell phone_____Message OK? YES _____ NO_____
Work phone_____Message OK? YES _____ NO_____
Email_____
Date of Birth_____Minor?_____
Marital Status_____
Occupation_____ Employer_____

Emergency Contact_____
_____phone_____
Relationship to Client_____

Billing Information (if different from above or patient is a minor)

Name_____

Address_____
_____
Relationship to client_____
Email_____

A Super-bill/Receipt will be provided for you to submit to your insurance for your own reimbursement.

I understand that I am responsible for payment at time of services rendered.

_____ _____
Signature Date

Client Information

Current relationship status_____
How long?_____
Name of partner_____
Children: Names and Ages_____
_____

Referred by _____

List any medical conditions:_____

Medications:

_____
Prescribing Physician_____
Phone and Contact info._____
Describe Alcohol, Nicotine, and Drug use:_____

Average sleep /night_____
Sleep difficulties?_____
Frequency of exercise?_____Type_____
Hobbies, Interests, Activities?_____
_____

Difficulties with appetite/eating patterns?_____

Is your work stressful?_____
_____

Do you consider yourself to be spiritual or religious?_____
If yes, describe your faith_____
Have you previously received any mental health services such as psychotherapy or counseling?_____
Previous therapist/Practitioner? _____

How would you describe your current physical health?_____

Are you currently experiencing?.....(Check any that apply)

- Sadness, grief , depression
- Chronic pain
- Anxiety or Panic attacks
- Phobias
- Domestic Violence

What significant life changes have you experienced lately?_____

What do you consider to be some of your strengths?_____

What do you consider to be some of your weaknesses?_____

What concerns would you like to address in therapy?_____

What would you like to accomplish out of your time in therapy?

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CONFIDENTIALITY

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law.

When Disclosure is Required by Law: Some of the circumstances where disclosure is required by the law:

- When there is reasonable suspicion of child, dependent or elder abuse or neglect
- When a patient presents a danger to self, to others, or is gravely disabled
- FBI requests information under certain specified circumstances

When Disclosure May be Required: Disclosure may be required pursuant to a legal proceeding:

- In a legal proceeding initiated by the client, the defendant may have the right to obtain Psychotherapy Records and or the testimony of your therapist
- In marital or family therapy, the therapist will NOT disclose confidential information about your treatment unless all adult persons who participated in the treatment provide written authorization to release such information

However, it is important to know that this therapist utilizes a 'No Secrets Policy' when conducting family or marital/couple therapy. This means that this therapist is permitted to use information obtained in an individual session when working with other members of the family.
(Please feel free to ask for clarification if necessary.)

Minors and Confidentiality: Communications between therapists and clients who are minors (under 18) are confidential. However, this therapist may discuss the treatment *progress* of a minor client with a parent, caretaker, or Guardian. (Please discuss questions or concerns on this topic with the therapist.)

Health Insurance and Records: If you are submitting a 'super-bill' for services to your health insurance carrier or other third party carrier, disclosure of some confidential information may be required. Only the minimum necessary information will be communicated, and unless authorized by you explicitly, the Psychotherapy Notes will not be disclosed to your insurance carrier. However, the therapist does not have control or knowledge about what insurance companies do with submitted information.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a highly sensitive and confidential nature, it is agreed that should there be legal proceedings (such as divorce and custody disputes, injuries, lawsuits, etc.), neither the client, nor their attorneys, nor anyone else acting on your behalf will call your therapist to testify at any proceeding, nor will a disclosure of the Psychotherapy Records be requested.

I agree to the above limits of confidentiality and understand the meanings and ramifications.

_____ _____

Client Signature (Client Parent/Guardian if under 18) Date

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OFFICE POLICIES

Payment: Payment is due at the beginning of each session unless other arrangements are made. Please notify me if any problem arises during the course of therapy regarding your ability to make timely payment.

Individual and couple sessions are about 50 minutes in length. Current charges are:

$140 per individual session
$150 per couple or family session
$45 per group therapy session

Insurance: Clients who utilize insurance for any part of payment should realize that professional services are rendered and charged to the client and not to the insurance company. It is therefore your responsibility to collect moneys due you from your insurance carrier. I will provide you with a 'super-bill' for your own records and for submission to your insurance company for reimbursement.
If you are unsure about your insurance coverage (and you have a PPO, not an HMO) you may contact your insurance company and ask this question:
"*What will you reimburse for an out-of-network Provider (me) for individual therapy …or couple therapy?*

Consultation: For the best possible care, your therapist may consult with other professionals during the course of your therapy. However, client names and identifying information are never mentioned or disclosed in order to protect confidentiality.

Contact Methods: Please use my private cell-phone VM to leave a confidential message for me. Texting is fine for appointment setting, but I cannot respond therapeutically to content via text.
If you are experiencing extreme discomfort between sessions, you may contact me by leaving a confidential VM and also texting me, and I will return your call as soon as possible.
If you require more than 10 minutes on the phone, your current fee will be pro-rated. At your request, I will set up an appointment time with you in the next 24 – 48 hours.

In case of medical emergency, immediate danger, or potential for harm, please call 911.

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CONSENT TO THERAPY

It is my sincere intention to provide services that will help you manage your life circumstances in the healthiest possible way. Believing that we are partners in the therapeutic process, I will provide recommendations regarding your treatment, but you have the right to agree or disagree with these suggestions.

Benefits: The benefits of psychotherapy may be that you will:

- Be better able to handle or cope with family and social relationships
- Have a better understanding of personal boundaries and goals
- Be able to let go of troubling past experiences

Risks: Psychotherapy may also involve risks as well, such as:

- Remembering unpleasant events
- Arousing powerful emotions and intense feelings
- Uncovering buried or forgotten information from the past

Goal: Our mutual goal will always be to heal from the difficult past, cope effectively with present realities, and discern needed points of growth for future success and well-being.
Please understand that I am not a physician and cannot prescribe or provide any medication for you.

Length: The length of your treatment and timing of eventual termination will depend on the specifics of your situation and the progress you achieve. You may discontinue treatment at any time, but preferably this would be a collaborative discussion between client and therapist.

Cancellation: The scheduling of an appointment involves the reservation of time specifically for us. To avoid being charged my full fee for a missed session, please inform me of your cancellation at least 24 hours in advance. Thank you!

I have read the above Informed Consent for Psychotherapy Services and Office Policies carefully; I understand them and agree to comply with them.

_____
Signature

_____Date_____
Print Name