Welcome to my practice! I look forward to meeting with you. The following forms will orient you to the basic policies of my office, ask you to provide me with your contact information and some basic information about your current life situation and background. If you have any questions about the forms or policies please let me know when we meet, I’ll be happy to discuss the with you.

Please complete the following:

1. [PSYCHOTHERAPY SERVICES AGREEMENT AND CONSENT](#_PSYCHOTHERAPY_SERVICES_AGREEMENT)

 There are two copies – one for you to keep.

1. [CONSENT TO TREAT A MINOR](#CONSENT)
2. [DEVELOPMENTAL HISTORY](#HISTORY)

Please fill out as much as you are comfortable with. If there are questions that you would rather discuss in person, please mark them with an “X”.

1. [ELECTRONIC PAYMENT COMMUNICATIONS DISCLOSURE](#PAYMENT)

Please fill this form out and sign it if you think that at some point you may be paying for your sessions with credit or debit card.

1. [OFFICE POLICIES](#POLICIES)

General guidelines about how I run my practice.

Please flip the switch for Room 2 when you are finished.

Thank you so much!

Ines Vaniman MA, MFTI

# **PSYCHOTHERAPY SERVICES AGREEMENT AND CONSENT**

**Outpatient Services Contract**:

This document (THE AGREEMENT) contains important information about Bay Area Psychotherapy Training Institute's (BAPTI) professional services and business policies. When you sign this document it will represent an agreement between us which you can revoke at any time unless BAPTI has taken action in reliance on it or your health insurer requires it to substantiate claims in process; or if you have not fulfilled your financial obligations to BAPTI.

**Psychological Services:**

Psychotherapy can be a difficult as well as rewarding process. Since therapy often involves exploring unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand therapy can often lead to better relationships, solutions to specific problems, and a reduction in feelings of distress. Because we will work toward your goals together, it is important that you inform us of any problems or difficulties that may arise for you. BAPTI interns have at least a Masters Degree, are registered with the California Board of Behavioral Services, and are supervised by a licensed clinician.

**Fees:**

Fees are based on a sliding scale and will be negotiated between the therapist and client at the beginning of treatment. You will be expected to pay at each session unless it is agreed otherwise. Full fee is $120 per 45-minute therapy session. In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment installment plan. Therapist reserves the right to periodically adjust fee. Patient will be notified of any fee adjustment in advance. Upon request, invoice statements can be provided.

**Insurance Reimbursement:**

If you have a health insurance policy, it may provide some coverage for your treatment. We will provide you with whatever assistance we can in helping you receive the benefits to which you are entitled, however, you (not the insurance company) are responsible for full payment of session fees. It is very important that you clarify what mental health services your insurance policy covers.  **It should be understood that insurance companies and managed care organizations often require information about your treatment. You should be aware of what confidentiality you may have waived when you enrolled with them.**

**Cancellations:**

A 24-hour advance notification of cancellation is required. For missed appointments or those cancelled less that 24-hours in advance there is a charge for the full session fee. Please note that insurance companies do not provide reimbursement for late cancellations of missed appointments (unless we both agree that you were unable to attend due to circumstances beyond your control).

**Confidentiality:**

The law protects the privacy of all communications between a client and a therapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by state law and/or the Health Insurance Portability and Accountability Act (HIPAA). However there are some situations where we are permitted or required to disclose information without your consent or Authorization. These exceptions include the following:

1. Disclosures required by health insurers or to collect overdue fees
2. If a government agency requests information we may be required to provide it.
3. If a patient files a complaint or lawsuit against us, we may disclose relevant information in order to protect ourselves.
4. If clients poses a serious threat to himself/herself. We may enlist family members or others in an effort to protect a potentially suicidal client.
5. Client threatens to physically harm an identifiable victim.
6. Child abuse (both past and present), elder abuse, or dependent adult abuse is suspected.
7. Per a new law enacted August 2014, viewing child pornography (with child pornography defined as images of any type involving an individual under the age of 18) is also an exception to confidentiality.

In the later three situations we are required by law to inform any potential victims and the appropriate authorities so that protective measures can be taken. Every effort will be made to fulfill this reporting requirement in a manner that is in the best interest of those involved.

**Professional Consultation:**

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Client.

**Availability / Crisis:**

Sessions are by appointment. For phone contact, clients can leave a phone message on the
BAPTI intake line at 925/284-2298, or call the voicemail of their individual therapist. For crisis emergencies requiring immediate assistance, please notify the individual therapist first and then call the Contra Costa Crisis Line at 1-800-833-2900.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , have read, understand, and agree to all of the above information, and give my permission to Bay Area Psychotherapy Training Institute and \_\_\_\_\_\_\_INES VANIMAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (individual therapist) to provide psychotherapy services to;

 Myself\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ My Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print Name)

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If a personal representative of the client signs the authorization, a description of the representative’s authority to act for the patient must be provided below)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the fee has been negotiated, the agreed upon rate is \_\_\_\_\_\_\_\_\_\_\_\_\_\_. Financial need and this rate will be reviewed periodically.

Therapist \_\_\_\_INES VANIMAN\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervised by\_\_\_\_\_COLETTE BISCHER-CHOATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Psychotherapy Services Agreement and Consent (CLIENT COPY)**

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I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , have read, understand, and agree to all of the above information, and give my permission to Bay Area Psychotherapy Training Institute and \_\_\_\_\_\_\_INES VANIMAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (individual therapist) to provide psychotherapy services to;

 Myself\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ My Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print Name)

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If a personal representative of the client signs the authorization, a description of the representative’s authority to act for the patient must be provided below)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the fee has been negotiated, the agreed upon rate is \_\_\_\_\_\_\_\_\_\_\_\_\_\_. Financial need and this rate will be reviewed periodically.

Therapist \_\_\_\_INES VANIMAN\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervised by\_\_\_\_\_COLETTE BISCHER-CHOATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSENT TO TREAT A MINOR

I state that I am allowed by California law to consent to the mental health treatment of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor, age \_\_\_\_\_\_\_\_\_.

My relationship to the patient is:

(Please check appropriate box)

\_\_\_\_\_ Biological mother or biological father, and the marriage is intact.

\_\_\_\_\_ Biological mother or biological father and I am divorced or legally separated.

 I have sole legal custody.

 I have joint legal custody.

 (Please circle which applies) I have provided/will provide a copy of the

Custody Order authorizing me to make mental health treatment decisions for the minor.

\_\_\_\_\_ Stepparent

* I have legally adopted the minor.
* I am an Authorized Caregiver pursuant to Section 6550 of the Family Code.
* (Please Circle which applies) I have provided/will provide a copy of the “Caregiver’s Authorization”.

\_\_\_\_\_ Adoptive Parent

\_\_\_\_\_ Unmarried Parent

 There is no dispute as to paternity. (If there is a dispute, only the biological mother can consent.)

\_\_\_\_\_ Legal Guardian

\_\_\_\_\_ A “Qualified Relative”, including, but not limited to, a brother, a sister, an uncle, . an aunt, a grandmother, or a grandfather

* (Please circle which applies) I have provided/will provide a copy of the “Caregiver’s Authorization”.

\_\_\_\_\_ I have received a copy of the Consent to Treatment of a Minor.

My signature represents my consent to treatment of this minor.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name of consenting adult Signature of consenting adult Date

 Ines Vaniman \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print name of therapist Signature of therapist Date

**DEVELOPMENTAL HISTORY**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Grade \_\_\_\_\_\_\_\_\_\_\_\_

School of Attendance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Early Developmental History

Any problems with child during pregnancy? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s age at birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s age at birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How was your child delivered? Vaginal Delivery \_\_\_\_\_\_\_\_\_\_ Cesarean-Section \_\_\_\_\_\_\_\_\_

Any problems with the child’s birth or immediately after birth? Yes \_\_\_\_\_ No \_\_\_\_\_\_

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please briefly describe your child before the age of 2 (i.e., calm, active, difficult, fearful, sad, happy, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was it an easy or difficult attachment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate the approximate ages of the following developmental milestones:

Sitting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Playing with others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crawling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sleeping through the night \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Walking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Good eating habits \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Talking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Counting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Toilet training \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Writing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Talk in sentences \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reading \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If needed, please explain any of the above .\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Composition

Who lives in the home with the child?

Name Age Describe their relationship to the child?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Siblings:

Name Age Relationship to child (i.e. full, half, step

 adopted?)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Parental Relationship:

Married \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Separated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Divorced \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Never Married \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Together? Yes \_\_\_\_\_ No \_\_\_\_\_

Mother Re-Married \_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father Re-Married \_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly describe the parental relationship (i.e., loving, co-operative, strained, turbulent, estranged) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Behavioral History

Please describe your child’s strengths \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please describe your child between the ages of 2-5 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please describe your child between the ages of 6-9 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please describe your child between the ages of 10-13 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please describe your child between the ages of 14-18 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does your child have behavioral problems at school? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does your child have behavioral problems at home? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does your child have any academic problems? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does your child receive Special Education Services? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does your child receive any other counseling? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, with whom? . \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many friends does your child have at school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much time do they play together per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many friends does your child have at home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much time do they play together per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History

Pediatrician’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of child’s last medical exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child on any medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child wear glasses? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your child ever been hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child ever had a fever over 104 degrees? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child ever had any accidents or serious injuries? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Family History

Does your child’s family have any history of medical problems? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does your child’s family have any history of emotional or psychological problems?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does any member of your child’s family have any current medical problems? \

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does any member of your child’s family have any current emotional or psychological problems?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are any members of your child’s family currently using alcohol and/or drugs?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Additional Information

Any major stressors that have occurred in your child’s lifetime (i.e. death, illness, divorce, domestic violence, abuse, moving, addiction) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List the three biggest stressors in your child’s life currently\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Any additional information about your child that you would like to share \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ELECTRONIC PAYMENT COMMUNICATIONS DISCLOSURE**

If you wish, you may pay fees electronically – through funds transfer or using a payment card -- using any of the following services:

* Square

**Please Be Aware of the Following:**

We have a duty to uphold your confidentiality, and thus we wish to make sure that your use of the above payment services is done as securely and privately as possible.

After using any of the above services to pay your fees, that service may send you receipts for payment by email or text message. These receipts will include our business name, and would indicate that you have paid for a therapy session.

It is possible the receipt may be sent automatically, without first asking if you wish to receive the receipt. We are unable to control this in many cases, and we may not be able to control which email address or phone number your receipt is sent to.

So before using one of the above services to pay for your session(s), please think about these questions:

* At which email address or phone numbers have I received these kinds of receipts before?
* Are any of those addresses or phone numbers provided by your employer or school? If so, the employer or school will most likely be able to view the receipts that are sent to you.
* Are there any other parties with access to these addresses or phone numbers that should not be seeing these receipts? Would there be any danger to you if such a person discovered them?

**Health Savings Accounts and Flexible Spending Accounts**

If you are using a Health Savings Account (HSA) or Flexible Spending Account (FSA) payment card, please be aware that even if your payment goes through and is authorized at the time that we run your card, there is a possibility that your payment could later be denied. In the event of this happening, you are responsible for ensuring that full payment is made by other means.

|  |  |
| --- | --- |
| Client Printed Name: |  |
| Client Signature: |  | Date: |  |

**OFFICE POLICIES**

I believe in mutual respect, communication, flexibility and commitment, values, which guide my work as your therapist including my scheduling and billing policies.

Regularity - I accept a limited number of clients in my practice. Once we establish an appointment time, I commit to holding that space for you/your child in my practice. I ask that you also commit to attending regularly so that we can achieve your goals and so I can continue to hold your scheduled timeslot for you. At the same time, life calls for flexibility, so with notice, I am happy to reschedule appointments if possible.

Cancellations - Sessions cancelled less than 24 workday hours prior to your appointment will be billed at your regular rate. Monday and Tuesday sessions must be cancelled by Friday of the week before. Often people will know more than 48 hours in advance that they will need to reschedule due to travel or other scheduling changes. I very much appreciate being notified as soon as you know that you will miss a session so I can arrange my schedule accordingly.

If you are not able to cancel a session with more than 24 hours notice and we are able to reschedule the session during the same calendar week you will not be charged for the session. If a true emergency arises – serious illness, a death in the family or car accident, you will not be charged for your session. If an obstacle to transportation arises – your car isn’t running, your child-care fell through, etc. – you will be offered a phone session as an option during your scheduled appointment time.

Payment - Payment is due at or before the start of each session unless otherwise agreed. Some people find it convenient to pay for a series of sessions with the understanding that unused sessions will be refunded in full. I accept check, credit card or cash payments. Checks are made out to “BAPTI”.

I have found it best to address any scheduling and payment topics at the start of the session so there is time, if needed, to talk about them.

Sliding Scale – I dedicate a portion of my practice to providing affordable care to those who cannot afford my regular fee. If you are receiving a sliding scale fee, I will periodically check in with you about the affordability of your care. Career, money management and financial health is one aspect of overall well-being which I offer help with in the course of therapy. As your life evolves, together, we will re-evaluate the need for a reduced rate.

Collaboration – Therapy can be a personally challenging process at times. It is not uncommon to have times when you have mixed feelings about coming. I welcome feedback and encourage you to discuss these feelings with me. It is important that you feel that you are benefiting from our meetings together. If at any time you are unsure of the goals or purposes of treatment, or you are unhappy with any aspect of my work, I encourage you to express your concerns so we can address them. If a change in your care is desired, it has been my experience that discussing it and coming up with a plan together feels much better than cancelling a session or ending treatment without the opportunity for closure. In my experience, while it can be a challenge to communicate unhappiness, doing so in the context of this supportive relationship in itself can be therapeutic and almost always leads to a richer and more satisfying experience of therapy.

Phone Calls – I am usually able to respond to messages left during the week on the same day I receive them, and on Monday for messages left on the weekend. I am available by email for scheduling questions. For your privacy, it is best to limit communications by email to scheduling questions. In case of technological glitch, if you have not heard back from me within 24 hours, please leave another message. If you are in a crisis, please call the 24 hour crisis line at 1800-833-2900 or call 911.