

*Licensed Marriage & Family Therapist
Specialist*

Certified Addiction

STATEMENT OF SERVICE POLICIES

To My Client: _____
Print Name

In order to prevent any misunderstandings about my Service Policies, I would like to make the following information available to you.

1. Sessions are the standard fifty-minutes long. The remaining 10-minutes are used for case notes and planning.
2. My fees are: \$160 for individual and \$180 for couples. The contracted fee is due each session. You will be provided with a receipt suitable for insurance submission. There is a \$25 returned check fee.
3. The contracted fee will be charged for missed appointments if not cancelled 24 hours in advance. An appointment is considered "missed" if you are more than 15 minutes late and have not called to say you are on your way.

THERE ARE NO EXCEPTIONS TO THIS POLICY !

4. No information regarding the services being rendered to you can be released without your written consent (see #5 for the legal exceptions to this confidentiality).
5. Complete confidentiality will be maintained except in the following circumstances:
 - 1) You consent in writing, 2) The law requires disclosure (i.e. there is risk of harm to self or if you threaten or reveal harm to another's person or property), 3) You are deemed to be gravely disabled and in need of hospitalization, or 4) a court of law issues a legitimate court order.

I have read this Statement of Service Policies, understand and agree to its content.

Client Signature

Date

CONFIDENTIAL INFORMATION AND HISTORY

Date _____ email _____ DOB _____

Name: _____ Ph./ Home _____ Cell _____

Address _____ City _____ Zip _____

Employer _____ How long? _____

Relationship Status: Married: yrs./mos. ____/____ Divorced: yrs./mos. ____/____

Separated: yrs./mos. ____/____ Widowed: yrs./mos. ____/____

Significant relationship: yrs./mos. ____/____ No significant relationship for yrs./mos. ____/____

Partner's Name: _____ Age: _____

Children:	Name	Age	At Home?	Problems?
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Other people in home: _____

Recent/Current medical problems: _____

Medications: _____

Prescribing physician name & phone number: _____

Hospitalizations in last two years, for: _____

Other physician/psychiatrist name/s & phone number/s:

Confidential info. & hist. conti.

1. Do you drink alcoholic beverages? ___yes ___no- proceed to #9
2. If yes, what do you drink? ___Beer ___Wine ___Hard liquor
3. How often? ___Daily ___3-5 times per week ___1-2 times per week ___less
4. How much? ___Bottles of Beer ___glasses of wine ___oz. of liquor

Alcohol

Drug

Yes No Yes

No

5. Have you had times you were unable to remember events while drinking or using? ___ ___ ___ ___
6. Do you sometimes drink/use more than you had planned? ___ ___ ___ ___
7. Have family or friends expressed concern about your drinking/using? ___ ___ ___ ___
8. Have you gotten DUI's ___No ___Yes How many? _____
9. Have you ever been arrested on alcohol/drug related charges? (circle 1 or more) ___ ___ ___ ___
10. Have you ever received treatment for alcohol/drugs: AA, inpatient, outpatient ___ ___ ___ ___
11. Do you currently use any type of drugs other than Dr. prescribed? ___No ___Yes

If yes, what kind and how often? _____

What is your past alcohol, drug and/or medication use? Please indicate type and frequency of use, as well as estimated date of last use: _____

Other current/past addictive/compulsive behavior: _____

Family History of mental/mood disorders, alcohol/drug use/abuse; suicide attempts; affairs: _____

Personal History of Childhood Abuse: _____

Any other family information you consider significant: _____

Issue you are here to address: _____

Thank You For Completing This Confidential Form
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