SharingLight Counseling & Psychotherapy Services

Holistic Therapy for Well-being, Growth & Happiness

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GENERAL INFORMATION

NAME ______________________________________ DATE OF BIRTH ____________________

CURRENT AGE _______

ADDRESS _____________________________ CITY ____________________ ZIP _________

HOME PHONE ___________________________ WORK PHONE _________________________

CELL PHONE ____________________________ EMAIL _____________________________

Where may I contact you to leave messages? Home ____ Work ____ Cell____ Email ____

OCCUPATION _______________________________ EMPLOYER _______________________

MARITAL STATUS _____________________ HOW LONG? ______

SPOUSE'S/PARTNER'S NAME ______________________________________ AGE _______

CHILDREN'S NAMES AND AGES ____

FAMILY PHYSICIAN __________________________ PHONE _____________________________

PSYCHIATRIST _____________________________ PHONE _____________________________

CURRENT MEDICATIONS ____

KNOWN HEALTH PROBLEMS ____

RELIGIOUS/ SPIRITUAL ORIENTATION ___________________________________

PRIOR THERAPIST AND TREATMENT DATES ____

CURRENT REASON(S) FOR THERAPY? ____

____

HOW WERE YOU REFERRED TO ME? ____

EMERGENCY CONTACT PERSON & PHONE ______________________________________

Responsible Party / Subscriber, Parent or Spouse

Name: ________________________ Relationship to Patient: ___________________________

SS#________-______-_________ DOB: _______________ Age: ______ Sex: Male Female

Marital Status: Single Married Separated Divorced Widowed Long Term Relationship

Home Address:

____

Home Phone: (____)_______ Occupation: ____

Employer: __________________________________ Work Phone: (_____)_________________

Employer Address:

____

Health Insurance Provider:____________________ Phone Number: ______________________

Policy #:__________________________ Group#:______________________________________

IF CLIENT IS A MINOR COMPLETE THE FOLLOWING INFROMATION:

Name of Parent/Guardian:

____

First Middle Last

Address:

____

Number Street Apt. City Zip Code

Home Telephone: ( ) _______________________ *Work Telephone:* ( ) _________________

Date of Birth ____/____/____ *Marital Status*: __________________

*DL#*____________________________

*Employe*r ____

*Occupation*_______________________________________

Spouse's Name:

____

First Middle Last

Address:

____

Number Street Apt. City Zip Code

SCHOOL INFORMATION (Only if client is a minor or a college student)

Name of school presently attending:

____

Address____

Phone: ( ) ____________________

Name of principal: ___________________________

Principal Teacher: ______________________________

Name of School Counselor/Psychologist: ____

Does your child miss school frequently? _____Yes _____No

Is your child attending special education classes? _____Yes _____No

Has your child had any particular adjustments or learning problems in school? _____Yes _____No

If yes, please indicate grade and describe fully:

____

____

Has your child ever been recommended to be retained in any place? _____Yes _____No

If yes, please indicate grade: ______

Please list name and phone number of the following professionals who might be involved in providing health or mental health services for your child:

Previous Therapists: ____

Present or Previous Psychiatrist: ____

Pediatrician: ____

Your Family Doctor: __________________________________

Do we have your permission to contact any of the above mentioned professionals to provide continuity of care for your child? Yes____ No ____

THERAPEUTIC CONSENT AND THE THERAPEUTIC CONTRACT

Part I: The Therapy Process

Participating in the therapy can result in a number of benefits to you, including the better understanding of your personal goals and values, improved interpersonal relationship, and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part and may result in your experiencing considerable discomfort. Change will sometimes be easy and swift, and more often it will be slow and frustrating. Remembering unpleasant events and resolving them through therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended. My theoretical perspective is an integration of developmental, cognitive-behavioral, humanistic, client centered, solution-focused, transpersonal and positive psychology.

Part II: Client's Rights

You have the right to confidential relationship with me. Within certain legal limits (see #3 below), information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any person without your written permission.

1. You have the right to know the content of your records at any time, and I have the right to provide you with either the complete records or a summary of their content.

2. If you ask me, I can release any part of your records on file with me to any person you specify. I will tell you when you make your request whether or not I think releasing that information to that agency or person might be harmful to you at any time.

3. Under certain legally defined situation, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:

    a. If you reveal information to me about active child abuse or neglect, elder abuse, or dependent adult abuse, I must make a report to protective services. When a perpetrator of child abuse is in contact with minors and

there is a reasonable suspicion that he/she may still be abusing minors, I must also report that information.

b. If you seriously threaten to harm another person, I am required to warn the intended victim and notify the appropriate law enforcement agencies.
c. If you are in therapy or being tested due to an order of a court or lawyer, the results of the treatment or tests ordered must be revealed to that court or lawyer.
d. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena.
e. If you are in a lawsuit where emotional harm is being claimed, the opposing side may subpoena your therapy records.

4. You have the right to ask questions about any of the procedures used in the course of your therapy. If you ask, I will explain my customary approach and methods to you.

5. You have the right to choose NOT to receive therapy from me. If you choose this, I will provide you with names of other qualified professionals whose services you might prefer. You have the right to terminate therapy with me at any time without financial, legal, or moral obligations other than those you've already incurred. I have the right to terminate therapy with you under the following conditions:

6. You have the right to terminate therapy with me at any time without financial, legal, or moral obligations other than those you've already incurred. I have the right to terminate therapy with you under the following conditions:

   a. When I believe that therapy is no longer beneficial to you.
   b. When I believe that you will be better served by another professional, whom I will recommend. If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If you have written consent from you, I will provide that professional with the essential information she or he requires.
   c. When you have not paid for the last two sessions, unless special arrangements have been made with me.
   d. When you have failed to show up for your last two therapy sessions without a 24-hour notice of cancellations.

If any of these situations apply, I will send you a certified letter to your address of record to inform you of my decision, and I will give you the names of several therapists for your future counseling needs.

I, _________________________________, read and understood my rights and the limits of confidentiality.

Signature ____ Date _____________________________

Part III: Fee and Fee Arrangements

My usual and customary fee for service is $120.00 per 50- minute individual session, longer than 50-minutes are charged for the additional time pro rata. Reduced fees are available based on qualification. I reserve the right to periodically adjust this fee. Patient will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with Therapist. **The agreed upon fee is** ______________. From time-to-time, I may engage in telephone contact with you for purposes other than scheduling sessions. You are responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. You are expected to pay for services at the time services are rendered. I accept cash, checks, and major credit cards.

Insurance

Patient is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. Patient is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles.

Cancellation Policy

Patient is also responsible for payment of the agreed upon fee for any session(s) for which Patient failed to give Therapist at least 24 hours notice of cancellation. Cancellation notice should be left on Therapist's voice mail at: (949)533-3335.

Therapist Availability

I have a confidential voice mail system that allows Patient to leave a message at any time. I will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911, or go to the nearest emergency room.

Termination of Therapy

I reserve the right to terminate therapy at my discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, I will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. I will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient.

Acknowledgement

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. You agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with Amirnaz (Ami) Novid, LMFT, CHt, CSMC. Moreover, you agree to hold the therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Patient Name (please print) ____ ______

Signature of Patient(or authorized representative)________________________________ Date ___________

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

Name of Responsible Party (Please print) ____

Signature of Responsible Party ____ Date:____________