



familyconcerncounseling

· 918 Sierra Drive · Modesto, CA 95351
· 209.522.9568 · confidential fax 209.593.5808 ·

Client's Rights and Information

Dear Client, Parent or Guardian:

Our desire as counselors is to help you as best as we are able. Since counseling can raise different expectations it is best to give you information up-front, to set some clear guidelines for the counseling relationship and to let you know you have certain specific rights.

Background/Orientation: As counselors, we seek to integrate sound Psychological principles. We believe that effective changes in counseling come from dealing with the whole person: physical, mental, emotional, and spiritual.

You are entitled to receive information before and during therapy regarding the methods of treatment we will use, our theoretical background, and the practical techniques we may use. We do not claim to have all of the answers. At times it may be necessary to refer you to another professional who may have specific training or specialize in alternative treatments. You have the right to know what other treatment options are available and the possible effectiveness of those alternatives. Also, you as a client always have a right to seek a second opinion or to terminate counseling at any time and for any reason.

Confidentiality/Supervision: As Registered Marriage and Family Therapist Interns and unlicensed psychotherapists we are required to be supervised by a qualified supervisor. Our supervisor is Curt Willems, MA, MS, a licensed Marriage and Family Therapist (MFT #31419). We will be consulting with him about your treatment plan and progress. Information regarding clients and treatment may be shared between Family Concern counselors, interns and trainees during supervision and as deemed necessary by the therapist for the client's best interest. You may contact Curt Willems if you have questions or concerns. His telephone number is (209) 848-0880.

Other than noted above, we will not inform anyone that you are receiving counseling, nor will we discuss the content of your counseling sessions, unless you sign a written release requesting us to do so. However, there are certain legal and ethical exceptions to your right for confidentiality. Professional ethics and California law mandate that we must report if one or more of the following conditions apply:

1. If you pose a serious physical danger to yourself or another person.
2. If you disclose that you or another person has physically or sexually abused or molested a child, an elderly person, or an incompetent or disabled person.
3. If you disclose that you (if under age 18) or a child, or an elderly, incompetent or disabled person has been abused or is suffering because of neglect.

If abuse or neglect is disclosed under the conditions above, the State of California law requires us to report such information to an appropriate agency.

Aside from the specific instances outlined above your confidentiality will be strictly guarded. Information in your records can be released only with your written authorization or with the parents or legal guardian authorization when the patient is less than 18 years of age. However, the child, unless very young, must also agree to the disclosure. The authorization will designate to whom the information will be released and the termination date of the authorization.

Duration/Fees:

The normal fee for a 50 minute session is \$100.00. Since Family Concern is supported in part by Youth for Christ – Central Valley and its donors, we are able to offer lower-cost counseling. All fees will be applied toward the operating costs for YFC/Family Concern. If the normal fee will be a hardship, you may apply for a reduced fee based on a sliding scale which is based on your annual household income, size of family, as well as available funding. If you wish to apply for a reduced fee, you may request an application from the Family Concern administrative assistant.

Counseling may vary in duration from just a few sessions to an extended time over a year, depending upon the specific needs of the client and their goals of therapy.

Clients should understand that all professional services furnished are charged directly to the patient. Payments are to be made at each visit unless prior arrangement has been made with the counselor. We regret that at this time YFC Family Concern cannot bill your insurance company; however, we are willing to provide whatever documentation possible that you may need to obtain a reimbursement from your insurance company.

Cancellation Policy: If an appointment is missed or if you cancel less than 24 hours in advance, you will be billed for the full fee for the missed session. This is necessary because we have other clients that we may need to schedule at the time we are holding for you. If a third party provider normally pays your fee, you are still required to pay the cancellation fee.

Authorization for Treatment and Financial Agreement:

I have read the above information, and I understand my rights and limitations as a client receiving counseling from a trainee, intern or licensed therapist at Family Concern Counseling. I agree to abide by the terms and conditions set out in this Informed Consent document. A signed copy of this Informed Consent has been given to me for my records. I consent to therapy, including evaluation, treatment, and/or referral.

I authorize treatment of the person named below and I agree to pay all charges incurred for me and for members of my family for which I am responsible promptly upon presentment thereof, unless protested in writing within thirty days of date of services. In the event legal action should become necessary to collect an unpaid balance due for services rendered to my family, or me I agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

In consultation with the therapist I agree to the following fee: \$ 100.00

I have signed and completed application for reduced fee (if so, check box)

I also agree to pay the full fee of \$100.00, as contracted, if I do not show for an appointment or if I cancel less than twenty-four hours in advance. _____ (Initial here)

Signature: _____ Date: _____
Person(s) Responsible (Parent or Legal Guardian)

Client Signature: _____ Date: _____
If different from person responsible

Therapist's Signature: _____ Date: _____

Beginning Date of Therapy: _____ Termination Date: _____

Client Intake Information

Name of Client _____ Birth Date ____/____/____ Age _____

Address _____ City _____ Zip _____

Home Phone _____ Cell or Work Phone _____

Occupation _____ Employed by _____

Religion _____ Race _____

Highest level of education _____

Marital Status: Single _____ Married _____ Divorced _____ Separated _____

Widowed _____ Coupled (living together) _____

Spouse's Name _____ Birth Date ____/____/____ Age _____

Address _____ City _____ Zip _____

Occupation _____ Employed by _____

Religion _____ Race _____

Highest level of education _____

Please list all children and specify their ages. Note if they are adopted, foster or biological children.

Please list all others presently living in the home _____

If client is a minor, what is the name of the responsible adult? _____

Emergency Contact _____ Phone _____

Initial reason for coming _____

Have you had previous therapy/counseling? Yes _____ No _____

If yes, where? _____ Dates _____ Therapist's name _____

Please describe your previous counseling experience: _____

Would you be willing to sign a release in order for our counselor to obtain your previous records?

Yes _____ No _____

Family Concern Counseling / Life History

Note to Parent: If client is a child, parent should assist in completion of this form.

- List any known abnormal conditions surrounding your birth:

- State your general mood as a child (fearful, angry, moody, etc.):

- What kind of relationship did your parents have with each other?

- What kind of relationship did you have with your
 - Father:

 - Mother:

 - Step Parents (if applicable):

 - How many brothers and sisters do you have? _____
 - What birth order are you? _____

- How often did you move?

- Was there alcoholism, drug abuse, physical abuse, verbal abuse, sexual abuse, or unfaithfulness in your childhood home?

- List any medical problems that have a repeated pattern in your life:

- Are you currently taking any medication?

- Do you have any active prescriptions?

- List ways that you most often react to stress (sleeplessness, rage, withdrawal, etc.)
- List your most common stress-reducer (eating, alcohol, exercise, etc.)
- Do you have any of the following?
 - ___ Sleep Problems
 - ___ Frequent feelings of sadness or depression
 - ___ Appetite loss
 - ___ Fatigue or loss of energy
 - ___ Loss of pleasure in usual activities
 - ___ Thoughts of suicide
- Are there any other conditions or events that have had a significant impact on your life?
- Have you ever attempted suicide in the past? ___ Yes ___ No
- Have other family members or friends ever attempted or committed suicide?
___ Yes ___ No If yes, who?
- Describe your closest friend...
- List three things that you enjoy doing...
- If you could change one thing about your life right now, what would that be?
- How do you picture God?
- Is there anything else that would be helpful to know about you?
- Who referred you to this counseling center?

- May we say who we are if we call you at home? ____ Yes ____ No , at work? ? ____ Yes ____ No