Jean L. Mirando, M.A., MFT

Licensed Marriage & Family Therapist

INTAKE FORM & INFORMED CONSENT

CLIENT INFORMATION

Full Name: _____ **Marital Status** (Please Circle): S M D SEP W

Date of Birth: _____ **Age**: _____ **Sex**: M F **Social Security Number** (REQUIRED): _____

Occupation: _____ **Employer**: _____

Home Address: _____

City: _____ **State**: _____ **Zip**: _____ **Email**: _____

Home Phone: Ok to leave messages? Yes No

Cell Phone: Ok to leave messages? Yes No

Work Phone: Ok to leave messages? Yes No

Substance Use

Are you currently using alcohol, nicotine or other legal or illegal drugs? Yes No

Have you ever felt worried or guilty about your substance use? Yes No

Have you ever felt you ought to cut down on your substance use? Yes No

Prescription Medications (List all currently taking or have taken within past 6 months):

_____

Other/Elicit/Illegal Substances (List whether usage is current or past):

FAMILY BACKGROUND

	Age	Name	Deceased (Y/N)	Relationship Satisfaction (How close/happy are you with each)		
Spouse/Partner:	_____	_____	_____	Not At All	Somewhat	Very
Parent:	_____	_____	_____	Not At All	Somewhat	Very
Parent:	_____	_____	_____	Not At All	Somewhat	Very
Step-Parent:	_____	_____	_____	Not At All	Somewhat	Very
Step-Parent:	_____	_____	_____	Not At All	Somewhat	Very
Sibling:	_____	_____	_____	Not At All	Somewhat	Very
	_____	_____	_____	Not At All	Somewhat	Very
	_____	_____	_____	Not At All	Somewhat	Very
Children:	_____	_____	_____	Not At All	Somewhat	Very
	_____	_____	_____	Not At All	Somewhat	Very
	_____	_____	_____	Not At All	Somewhat	Very

Are your parents divorced? Yes _____ No _____ **Remarried**? M _____ F _____

FAMILY BACKGROUND

Have you experienced any abuse in your family or relationships? (Circle)	None	Emotional	Physical	Sexual
In general, how happy were you growing up?	None	Somewhat	Mostly	Extremely
How much is your family of origin a source of support for you?	None	Somewhat	Very	Extremely
How much conflict in values do you experience with your parents?	None	Somewhat	Substantial	

Have you personally experienced legal problems? No Yes (Describe): _____

Have you ever been in counseling before? No Yes (Approx dates): _____

Please identify below if there is a family history of: (If yes, indicate the relationship in the space provided, father, sister, uncle, etc): (Please Circle)

History Of: **List Family Member'(s) Relationship to You**

Alcohol/Substance Abuse: yes no

Anxiety/Depression: yes no

Criminal Behavior/Incarceration: yes no

Domestic Violence/Abuse: yes no

Eating Disorders: yes no

Extreme Mood Swings: yes no

Obesity: yes no

Obsessive Compulsive Behavior: yes no

Trauma: yes no

Suicide Attempts: yes no

INTAKE FORM & INFORMED CONSENT

Confidentiality & Exceptions _____ (Initials on Line)

Therapy is best experienced in an atmosphere of trust. Thus, all therapy services are strictly confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law.

Legal exceptions to confidentiality are in place to protect your safety and the safety of others. This includes: when there is reasonable suspicion of child or elder abuse/neglect; and where a client presents a danger to self, to others, or to property.

I practice a no-secrets policy when conducting marital/couples therapy, which means that confidentiality does not apply between the couple or among family members when one requests an individual session. The couple or the family is considered the client. Any information given in the individual sessions will not be held in confidence in couples or family sessions, unless all members mutually agree, or upon under rare circumstances involving personal safety.

Notice of Privacy Practices _____ (Initials on Line)

Federal privacy regulations known as the Health Insurance Portability and Accountability Act (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide. I collect information about you that may include your date of birth, address, identification numbers (like social security numbers), and other personal information. It also may include billing/financial information. Unless you give me permission in writing, I will only disclose your information for the purposes of treatment, payment, healthcare operations, or when I am required by law to do so.

I must release information when required by law to do so. Examples of such releases would be for law enforcement or national security purposes, subpoenas or other court orders, communicable disease reporting, disaster relief, review of our activities by government agencies, public health authorities, to avert a serious threat to your health or safety, or in other kinds of emergencies. To obtain payment for treatment from your insurance company or health plan.

Your rights regarding your health information:

- Restrictions: You can request a restriction in the use or disclosure of your health information for treatment, payment, or health care operations, as well as the right to restrict disclosure of your health information to only certain individuals involved in your care or payment for your care, such as family members and friends.
- Receiving a copy of your health records: You can inspect and receive a copy of your health information that may be used to make decisions about your care, including medical records and billing records, but not including psychotherapy notes. You must submit your request in writing. I hold records for seven (7) years after termination of treatment.
- You are entitled to receive a copy of this Notice of Privacy Practices. You may ask for a copy at any time.
- If you believe that your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint about your privacy rights.
- I reserve the right to change this Notice in the future, and before any important changes to my policies are made, I will promptly change this Notice and offer you a new copy of the policy.

Cancellations _____ (Initial on Line)

My business line is answered by a confidential voice mail that I monitor frequently. I make every effort to return calls within 1 day. If you are unable to reach me, and feel that you cannot wait for me to return your call, please contact the nearest emergency room, 9-1-1 emergency, or crisis center. I understand that occasionally circumstances beyond your control may arise which would prevent you from keeping your appointment. The message number for cancellations is (925) 494-0964. Cancellation procedures and fees are as follows:

Short-Notice Cancellation: Appointment cancellations must be made **72 hours prior** to your scheduled appointment, or you will be charged the full fee for the session. This charge may be waived if we can move your appointment to another time in the same week.

No-Show: If you do not show up for a scheduled appointment (that you had not already called to cancel), you will be charged the full fee for the session.

Group Therapy: This section applies to individuals joining one of my counseling support groups only. Payments are made prior to the start of your first session. Once joining the group, cancellations must be made one week prior to the start of your first session date to receive a refund. Refunds are not given for missed sessions, and members may not attend a substitute session, unless we make a special arrangement. This is due to limited space in each group, and to maintain the confidentiality of group members, as well as professional boundaries.

Appointments _____(Initial on Line)

I will usually be in a session when you arrive at the office. Have a seat in the waiting room, and I will be with you soon. Unless I have an emergency, I will start our appointment on time and end it on time, even if you arrive late, unless we make special arrangements.

If the office is locked when you arrive, it typically means that I will be right back, or you are my first appointment and I will arrive soon. If there is a mix up in appointment time, or an emergency, and I was unable to contact you, please leave a message on my voice mail and I will call you as soon as I am able.

Explanation of Dual Relationships _____ (Initial on Line)

Your relationship with your therapist must be strictly professional in nature. A therapist is not allowed to invite you into a business venture, ask you for personal favors, maintain a social relationship with you, etc. These examples are called, “dual relationships” and are unethical. Although our sessions may deal with your personal information, psychologically, it is important to acknowledge that you are engaging in a professional relationship only. In the rare occasion that I see a client outside of the office, I am discreet and will maintain your confidentiality. I typically follow your lead, and, thus, it is your choice to acknowledge the encounter or not.

Payments - Insurance Reimbursement - Credit Cards _____ (Initial on Line)

Standard sessions are 45 or 60 minutes in length, 60 minutes for a group session. Longer sessions are available by request at a prorated rate. There is a $10.00 service charge if full payment is not received at each session, unless special arrangements have been made, and a $20.00 fee if a check is returned with insufficient funds.

Your fee for each 45 or 60 minute session (prorated for longer sessions) will be $_____for the first session (client fills in the fee), and $_____for each 45 minute session or $_____for each 60 minute session thereafter, based on the fee discussed in your first consultation phone call with me, payable via cash or check or credit card. Credit card payments will assess a processing fee charged by the billing company, which may be between 3-4% of the total cost of each session. You are expected to pay your session fee at the start of each session, unless other arrangements have been made. Please notify me if any difficulties arise during the course of therapy regarding your ability to make timely payments. This agreement supersedes any previous financial agreements with me, and is effective as of the date signed.

Please note that professional services are rendered and charged to the client and not to the insurance company. However, I will provide you with a billing statement upon request. I can provide you with a monthly statement of services, which you can then submit to your insurance company for reimbursement if you so choose. Not all issues/conditions/problems dealt with in psychotherapy are reimbursed by insurance companies, however. It is your responsibility to verify the specifics of your coverage.

Please Note: Appointment cancellations must be made **72 hours prior** to your scheduled appointment, or you will be charged the full fee for the session. This charge may be waived if we can move your appointment to another time in the same week.

Credit Card Authorization Information

Clients are required to maintain a credit card on file which can be used for billing in the event of a late cancellation or no show. The full session fee will be charged to the credit card listed in the section below unless we are able to reschedule the appointment within the same week.

Per the terms of this Financial Agreement document, in the event of a late cancellation **(less than 72 hours notice)** or missed session, you will be charged the full session fee. Unless other cash/check arrangements are made for that, this will be charged to the credit card account provided below.

I, _____, authorize Jean L. Mirando to charge the session fee of $_____ (client fills in the amount) to the credit card indicated below, in the event that I do not attend a scheduled therapy appointment, without giving a minimum of **72 hours notice,** or making a mutually agreed upon payment arrangement.

Card Type (circle one): Visa MasterCard American Express Discover

Card #: _____ Expiration Date: _____

CV Code (3 digits, back of card):_____

Name as Printed on Card: _____ Billing Zip Code: _____

- Authorized Cardholder Signature: _____ Date:_____

SIGNATURE

- **I have thoroughly read, and fully understand, the Informed Consent pages of this document.**
- **I have read the Fee Agreement, and understand that I am financially responsible for charges**
- **incurred.**
- **I authorize Jean L. Mirando, MFT to provide psychotherapeutic treatment.**

Client/Guardian Signature: **Date:**