INFORMATION AND CONSENT FOR MARTIAL/COUPLES THERAPY

For the best results and for your welfare, it is very important that you take a few minutes to read and understand what it means to be in psychotherapy. This form provides a brief description of what you might expect if you haven't been in therapy before. If you understand the information on this form and choose to begin treatment sign and date this form and return it to your therapist. If you have any questions or concerns about the information on this form, you are urged to discuss them with your therapist.

Psychotherapy is a special kind of health care service. The goals of psychotherapy are to help you find solutions to problems that may be limiting your lifestyle satisfaction, and to help you cope better with the feelings and challenges that you may be encountering in your daily life.

The most common method of psychotherapy involves you talking about your thoughts and feelings, your problems or concerns, and your experiences of the current or past situation(s). Other common methods involve: using your imagination, role-playing, keeping personal records of your experience, and trying new and/or different ways of thinking, acting, or feeling. These methods may be used within treatment sessions or you may be asked to do them at home.

To better understand your experiences, thoughts and feelings, many psychologists use a variety of tests or measures to estimate your current abilities and way of experiencing things. These measures are important in choosing the treatment method that is best suited to you, and they are also helpful in estimating your progress.

The length of treatment often depends on your individual needs and the rate of your progress toward agreed upon goals. Many psychologists use periodic reviews as a means of evaluating your needs, progress and satisfaction.

Most people benefit from psychotherapy. The most common benefits include improvements in self-awareness, self-esteem, self-confidence, hope, feeling understood, relationships with other people, emotional expressiveness, and taking an active and responsible role in one's life. There are also some risks to being in psychotherapy. The most common risks are temporary periods of emotional distress related to changes in your life situation and your relationship with yourself and others (including your therapist). Psychological harm caused by psychotherapy is rare, but you should be aware that it could happen. The most common causes of such harm are poor communication or unethical conduct. If you feel that you are not making reasonable progress or that you are being harmed by your involvement in psychotherapy, you should discuss this with your therapist. If you feel that your therapist has attempted to

violate you in any way – financially, physically, sexually, or otherwise – you should inform the state licensing board.

You always have the right to choose whether or not to continue in psychotherapy. If you feel that you might work better with a different therapist, your current therapist should be able to offer information on possible referrals. Local mental health agencies are listed in the telephone book and they may also offer helpful information. The more common alternatives to psychotherapy are: self-help or support groups, therapeutic reading, and different forms of religious counseling.

Communication is essential to successful psychotherapy. You are urged to ask questions, express concerns, and share information about your personal life with your therapist. This information must be kept private (confidential) by your therapist unless you grant permission to release it to a third party. State laws dictate the ONLY EXCEPTIONS to this protection of your privacy. For example, your therapist is legally obligated to report incidents of child abuse or threats of violence that may place you or another identified person in danger of personal harm. You are urged to discuss this issue and the limits of confidentiality with your therapist.

Your signature below indicates that you have read and understood the above description of psychotherapy and consent to be in psychotherapy with the understanding that you retain the right to review and revise the decision at a later time.

_____ _____

Please print your name Date

_____

Signature

_____ _____

Please print your name Date

_____

Signature

_____ _____

Witness Date

CONSENT FOR SPECIAL CIRCUMSTANCES

COUPLES THERAPY:

The purpose of therapy is for clarification, reconciliation and healing and is at cross-purposes, at times, of legal action that is adversarial by definition. In these cases, **no information** may be released for either party without written consent of both parties because technically, ***the relationship is the client.*** This makes any and all information from the therapy available to both parties of a legal dispute; therefore, I find it in the best interest of the therapeutic process for both parties to agree not to subpoena the therapist for either side in the event of a divorce or custody trial.

Additionally, information received from either party via phone calls, voice mail, and/or written communication will not generally be kept secret as this also impedes the therapeutic process and relationship.

I understand the above information and/or have discussed any questions related to the above information to my satisfaction.

I agree not to subpoena therapy records in the event of a legal proceeding.

Signature _____ Date _____

Signature _____ Date _____

FAMILY THERAPY:

In family therapy, the family is the client. No information may be released without the consent of all parties to whom confidentiality belongs. As outlined in the couples' therapy section (above), I find it in the best interest of the therapeutic process for all parties to agree not to subpoena the therapist in the event of a legal proceeding.

Additionally, information received from either party via phone calls, voice mail, and/or written communication will **not** generally be kept secret as this also impedes the therapeutic process and relationship.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

INTAKE INFORMATION

Please print your names **Date:**

Last	First

Last	First

Address or Addresses if not living together

Street		
City	State	Zip

Street		
City	State	Zip

Please provide secure phone lines and emails where a confidential message may be left from this office.

Name:	Name:
Phone:	Phone:
Email:	Email:

DATES OF BIRTH	**AGES**	**Relationship Status**

IN CASE OF EMERGENCY WHO WHOULD I CONTACT?:

Names:
Relationship:
Address:
Phone: (H) (W)

PRIMARY CARE OR FAMILY PHYSICIAN(S)

Name:	Name:
Address:	Address:
Phone:	Phone:
Insurance provider	Insurance provider
Policy #	Policy #

OCCUPATIONS/EMPLOYERS

Name:	Name:
Address:	Address:
Phone:	Phone:

Have either of you ever been in psychotherapy before?

If yes, who saw the therapist? _____
What kind of treatment? _____
How long ago? _____
How long did it last? _____
Name of the therapist _____

Is either of you presently taking medication?

If yes, please list name and the purpose of the prescription.

Patient Name	Medication	Reason	Physician's Name

Please list any other people living in your home, eldest first.

Name	Age	Relationship to you

Place a check next to anyone who may be considered helpful to your therapy.

Please list any dependents that do not live with you for whom you have joint or full custody starting with the oldest.

Name	Age	Relationship to you

Name of the person or agency that referred you to my services?

Name:	Phone:

Each of you, please briefly list the problems that have prompted you to seek counseling at this time in order of importance.

1.
2.
3.
4.
5. Initials

1.
2.
3.
4.
5. Initials

On the scale below, with 0 being low and 10 being high, each of you, please circle the number that best describes how much these concerns are interfering with your life and relationship right now.

__initials

Comments:

___initials

Comments:

INTRAPERSONAL INVENTORY **NAME**_____

Please place a (1 = important) or a (2 = very important) next to each item that is a concern for YOU. You may place a (1) or a (2) by those items at this time.

_____ 1. Not being the kind of person I want to be
_____ 2. Too tired to do anything
_____ 3. Unhappy with my physical appearance
_____ 4. Discouraged about my future
_____ 5. Financial problems
_____ 6. Dissatisfied or bored with everything
_____ 7. Concerned about my physical health
_____ 8. Feeling guilty a lot
_____ 9. Concerned over my living situation
_____ 10. Being ill at ease at social gatherings
_____ 11. Having difficulty making decisions
_____ 12. Eating problems
_____ 13. Sleeping problems
_____ 14. Feeling like others don't like me
_____ 15. Thoughts of suicide
_____ 16. Intend to commit suicide
_____ 17. Thought of hurting someone else
_____ 18. Worrying excessively
_____ 19. Unable to concentrate
_____ 20. Feeling that no one understands me
_____ 21. Nervousness
_____ 22. Relationship problems
_____ 23. Problems with children
_____ 24. Other related family problems
_____ 25. Sexual concerns
_____ 27. Headaches
_____ 28. Lacking love and/or affection
_____ 29. Religious or Spiritual concerns
_____ 30. Pressure from others
_____ 31. Discrimination or oppression from others because of group affiliation
_____ 32. Fearing failure or rejection
_____ 33. Having difficulty trusting others
_____ 34. Getting into too many arguments
_____ 35. Too easily influenced by others
_____ 36. Concerns about alcohol or drug use
_____ 37. Concerns about recovery from alcohol or drug use
_____ 38. Feeling a great sense of loss or grief related to death
_____ 39. Trauma/Abuse recovery
_____ 40. Work/Career/Educational problems
_____ Other specific problems (please specify)

_____

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_____

I

INTERPERSONAL INVENTORY **NAME_____**

Please answer the following questions as they pertain to your relationship. Please be truthful in your assessment and try not to collaborate on your answers.

1. What is wrong with your relationship?

2. How has this affected you?

3. What has caused the pain and problems in the relationship?

4. How have you contributed to the problem?

5. How do you think your partner has contributed to the problem?

6. What do you specifically want to see happen in and/or to your relationship? What must change (starts and stops)?

7. For these changes to happen, tell me what you will need to do differently?

    A. Now tell me what you think your partner must do differently?

    B. Are there some things you must do differently together?

8. What do you know about yourself that will make it difficult for you to make the necessary changes?

    A. What do you believe about your partner that will make it difficult for him/her to make the necessary changes?

    B. Is there anything about the two of you together that will make it difficult to make the necessary changes?

9. When will you know “it’s time to stop our formal therapy?

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Service Agreement

The following statement is designed to clarify the services delivered by the provider, Malcolm E. Anderson, Ph.D., P.C.), the rates assigned for said services, and the expectations of the client/patient and the provider/therapist in this therapeutic agreement. This contract is negotiable and may be changed upon the agreement of the provider/therapist and the client/patient.

Fees for service

Fees for service are due upon delivery of services by cash, check, major credit card or money order. A receipt will be provided for your records. Accounts will be updated and you will be notified of delinquent payments. The standard fees for services are as follows:

- **Individual Psychotherapy**: $200.00 per hourly session
- **Couples and /or Family Sessions**: $250.00 per hourly session
- **Presentations, Consultations and Supervision**: $200.00 per hourly session up to 3 hours, plus administrative/preparation charges.

  A standard, non-refundable advanced fee will be obtained via credit card, online, to hold any Intake Session in advance.
- **Half-day trainings**, workshops and/or presentations: $1000.00
- **Full- day trainings**, workshops and/or presentations: $3,000.00

A full fee will be charged for invalidated or returned checks. In the event that a check is returned for "insufficient funds," the client(s) will be expected to pay for the session *as well as* any service penalty charged to the therapist's account for the invalidated transaction. I reserve the right to utilize third party collectors to ensure proper payment of outstanding debts at the client's expense.

Appointments

Clients in psychotherapy are expected to be on time for appointments. So as to be courteous to other clients awaiting appointments, a ten-minute grace period will be given before rescheduling is considered. If you are expecting to be more than ten minutes late for your appointment, please call to reschedule. If you do not call and arrive late for therapy, you will be expected to render the full payment of the session missed. ***If you are unable to make your scheduled appointment you must give notice of cancellation within 24 hours of the scheduled time. If you fail to give notice within this time, you will be expected to render full payment for the session missed.*** In the event that appointment failure occurs again, twice, the patient will be expected to provide a current credit card to the therapist prior to continuation of services.

Insurance

At this time the provider does not participate on or with any insurance panels and instead collects full fees for services when delivered. Clients with insurance coverage are expected to make full payment for services when rendered and then seek reimbursement on their own with their third party company. The therapist will provide any necessary documentation for the client to expedite this process including a record of client visits and services, an invoice of payments and account balance, a clinical diagnosis, and a summary of treatment interventions as requested from the insurance company for reimbursement.

Therapist/Provider Responsibilities

The therapist/provider will be expected to be on schedule with his appointments and contracted work assignments. A ten-minute grace period will be allowed to accompany paperwork and scheduling conflicts. In the rare event that the therapist finds it necessary to reschedule an appointment, he will try do so within a 24-hour period by phone. As client emergencies may happen there may be occasion when this early notice plan cannot be executed. If for some reason the therapist misses an appointment or fails to notify you of a cancelled appointment you will be refunded for the missed appointment.

I/We have read and understand the above information regarding the services provided by Malcolm E. Anderson, Ph.D., P.C. and agree to the negotiated statement by signing below:

_____ _____

Patient/Client/Representative Name (Please Print) Date

_____

Authorized Signature

_____ _____

Patient/Client/Representative Name (Please Print) Date

_____

Authorized Signature

_____

Witness and Seal