

Family or Couples Therapy Intake Packet
Tyana Alexander, LPC Gateway to Wellness

Client Name: _____ Gender ____ Age ____ DOB ____/____/____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Ok to send mail? Y/N?

Please list any medications prescribed

Psychiatrist _____ Date last seen _____

List any head injuries, past or present major illnesses or allergies

Client Name: _____ Gender ____ Age ____ DOB ____/____/____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone _____ Ok to send mail? Y/N?

Please list any medications prescribed

Psychiatrist _____ Date last seen _____

List any head injuries, past or present major illnesses or allergies

Insurance Information:

Client's relationship to Primary Insurance Holder : self spouse child other _____

Insurance Company: _____ ID #: _____

Group/Plan #: _____ Employer Name: _____

Primary Insured Name (Please identify name of the primary insurance holder):

_____ Primary Insured DOB: ____/____/____

Emergency Contact:

Name _____ Relationship _____ Phone _____

How did you hear about me? _____

Therapeutic Contract

Probable Length of Services: Although some clients elect to pursue long-term in depth treatment, many issues can be resolved within 12-24 sessions. Of course, the success of any treatment depends on the motivation, willingness and dedication of the person being treated. For this reason, I can make no guarantees about treatment length or success.

Risk of Services: As with any change in your life, you should be aware that outcomes of therapy can be unpredictable. However, it has been my experience that the overwhelming majority of willing clients improve their situations through therapy. Treatment is intended to induce change in your life, and when this change occurs it may disrupt your accustomed manner of living and your relationships with others. You should also know that positive change takes work and you may be asked to try things that are difficult for you. Some people reach their goals fairly quickly and without much discomfort, while others need more time and feel more stress through the process. The experience of each individual is impossible to predict as each person has their own unique strengths and problems. Therapy can also provoke feelings of affection and/or anger toward the therapist which will be addressed in session.

My Therapeutic Approach: I believe the therapeutic process is both cooperative and collaborative. I am a process consultant. Because I see the client as the expert, we identify and develop the treatment goals together. I utilize the following therapeutic approaches;

1. Emotionally Focused Therapy, which is process oriented approach that focuses on present process, how inner and relational realities are constructed and confirmed in the present. We will focus on evoking and deepening emotions to create a new experience or second order change rather than symptom modification. The goals of EFT are: to expand and reorganize key emotional responses, to create a shift in partner's interactional patterns with one another and to foster the creation of a secure bond between partners.

2. Family Systems, which focuses on patterns and communication styles present in your current and past relationships, as well as the roles you play within those relationships. We will also review how one person's growth can effect change in the entire system, even when the others are not participating in the treatment. This is why, not all members of a system need to be present to address relationship issues.

Your Rights: Treatment is entirely voluntary, and you have the right to terminate treatment at any time. I have the right to terminate therapy with you under the following conditions:

1. If I believe that therapy is no longer beneficial to you.
2. If you fail to follow recommended treatment repeatedly.
3. If I believe that you will be better served by another professional.
4. If you have not paid for at least two sessions, unless special arrangements have been made.
5. When you have failed to show up for your last two therapy sessions without a 24-hour notice.
6. If you fail to comply with the 24 hour clean and sober policy for more than two sessions.
7. You are seeing another therapist, and participating in treatment with me would jeopardize our relationship and work with that therapist. (If you are seeing another therapist I will require that you sign a consent form to release information so I can communicate with the other therapist).

If for any reason our services terminate, I will provide you with the names of three other qualified professionals.

Limits of Confidentiality: All information that you disclose to me within our sessions is confidential and will not be revealed to anyone without your written permission (or your parents' permission if you are under 18), except for the following reasons:

1. Where there is a reasonable suspicion of child abuse, dependent adult abuse or elder adult abuse.
2. Where there is a reasonable suspicion that you may present a danger of violence to others.
3. Where there is a reasonable suspicion that you are likely to harm yourself.

In all of the above cases, the psychotherapist is either allowed or required by law to break confidentiality in order to protect you, or someone you might endanger from harm.

4. I can release all or portions of your records to any person or entity you specify. I will inform you whether or not I think releasing that information to that agency or person might be harmful to you.

5. If a court of law issues an order, I am required by law to comply.

Records: Your clinical file will consist of (a) legal forms such as this document, (b) a record of visits and payments, and (c) clinical progress notes (these progress notes will contain enough information about your treatment to justify it, should such justification ever become an issue).

*You have the right to view your records at any time. I have the right to provide you with the complete records or a summary of their content.

Office Policies

Insurance: As a courtesy, I will bill your insurance company, but ultimately you will be held liable for any costs that the insurance company does not pay (up to either the amount I am contracted with them or my fee of \$150.00 if I am not contracted with them). Please call your insurance company ahead of time (before your scheduled appointment) to see how your policy pays for Behavioral Health, In-Network, and also for Out-of-Network therapy. Also find out what your co-pay is for Behavioral Health sessions and/or if you have a deductible. Please know that if you are using your insurance to pay for sessions, they assume the right to know your diagnosis, determine how many sessions you can have as well as the right to request additional information from the therapist to justify continued payment for your treatment. This information is given in a brief summary form as your confidentiality is important to me.

Cancellation or late arrival: Since an appointment reserves time specifically for you, 24-hour notice is required for rescheduling or canceling of an appointment. Outside of an agreed upon emergency or accident, you will be charged a fee of \$50.00. Most insurance companies do not reimburse for missed sessions so you will be responsible for the bill. Additionally, if you are late, we will meet for whatever amount of your time remains and you will be charged for the full session.

Telephone calls: You are welcome to leave messages at any time on my phone. If you need to speak with me regarding a therapeutic issue, I will call you back within 24 hours if it is an emergency and within 48 hours if it is not (please leave message briefly stating nature of call). Remember that, in general, telephone calls are not meant to take the place of an office visit; if you require extended time (15 minutes +) on the phone I will bill you for my time. Most insurance companies do not cover telephone counseling so you will be charged a fee equal to your regular session fee.

In case of an emergency or you are at risk of harming yourself or others please contact the 24-Hour Crisis Lifeline at 988 , or call 911 immediately.

24-Hour Clean and Sober Policy: Therapy can only be effective with a willing and able client. Clients are expected to be sober during our sessions. I assert the right to terminate any session if I believe that a client is under the influence or has used substances within the past 24 hours that impairs his/her ability to participate in treatment. If a session is terminated due to substance use, this is considered a no-show and the client will be charged a fee equal to your regular session fee.

E-mail: I discourage the use of e-mail with established clients because of the risk it poses to confidentiality. If you choose to email, please understand the potential risk.

Payment for Service: Sessions are \$150.00 for an intake, and \$120.00 per session, or a fee that I have contracted with your private insurance, per therapeutic hour (53 minutes). You are expected to pay for services (full fee or co-pay) at the time they are rendered unless other arrangements have been made. Please notify me ahead of time if any problem arises regarding your ability to make timely payment.

I accept cash, or credit card as a form of payment.

I, _____ agree to be legally responsible for any charges that said persons listed below may incur during * (please print name of responsible party) psychotherapy with Tyana Alexander, LPC. _____ (initial here)

“No Secrets” Policy for Family Therapy and Couples Therapy

This written policy is intended to inform you, the participants in family therapy or couple therapy, that when I agree to work with a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (the treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since these sessions can and should be considered a part of the family or couple therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party. However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit — that is, the family or the couple, if I am to effectively serve the unit being treated.

I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the patient (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the couple/family or other unit being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Tyana Alexander, LPC, and that we enter into couples counseling and/or family therapy in agreement with this policy.

Name of Client (please sign)

Date: ___/___/___

Name of Client (please sign)

Date: ___/___/___

Gateway to Wellness Tyana Alexander, LPC

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, I cannot use this time for another client and you will be charged \$45.00 due to your missed appointment.

The cancellation/no show fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

I require a credit card number be kept on file in the event that you same day cancel or no show for your scheduled visit.

Thank you for your consideration regarding this important matter.

Name on Card: _____

Credit card number: _____

Exp. Date: _____ ***Verification code:*** _____

Type of Card: *Visa* *Mastercard* *Discover* *American Express*

By signing below, I authorize Tyana Alexander, LPC to charge the above credit card in the event of a missed appointment.

Client Signature

Date