

Lifespan Family Healthcare
 Rebecca E. Clark, M.S.
 LMFT (Marriage & Family Therapist)

CLIENT INFORMATION

Date: ___/___/___

Client Name		Social Security # ____-____-____ Date of Birth ___/___/___ Age ____	
Marital Status: S ___ M ___ W ___ D ___ O ___	Name of Spouse: Date of Current Marriage:		
Street Address		City & State	Zip Code
If Minor, parent's name(s)		Email	
Who referred you here:	Home Phone	Work Phone	Cell Phone
	Insurance	Ethnicity (optional)	Religious Affiliation
Emergency Contact	Telephone # Relationship	# Years of Education	

REASON FOR THERAPY: Please explain briefly why you have come to therapy.

Why now?

What would you like to be different as a result of therapy?

What would you say (or others say) are your personal strengths (especially those strengths that may help you overcome your problem)?

PLEASE LIST INDIVIDUALS CURRENTLY IN YOUR RESIDENCE:

Name	Age	Relationship

CHILDREN OR OTHER SIGNIFICANT FAMILY MEMBERS NOT AT HOME

Name	Age	Relationship

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HISTORY OF MEDICAL / MENTAL HEALTH:

Do you or anyone in your family have any known medical problems, either current or past?

Name / Relationship	Medical Problem	Current or Past	Treating Physician	Date of last visit	Medication(s)	Hospitalized Yes / No

Please continue on back or form if necessary.

Have you or anyone in your family received any previous psychological help? If so, describe briefly, including names of previous therapists, length of therapy, and issues that caused you to seek help. Include any medication and / or hospitalizations.

Have you ever attempted suicide or purposefully attempted to harm yourself? No Yes
 Are you thinking about suicide or purposefully attempting to harm yourself now? No Yes

Would you say that you or any other members or your household have a problem with anger? Please describe if applicable.

To what extent do the following in your household (**F**requently **S**ometimes **N**ever):

Yelling ___ hitting ___ throwing things ___ making threats of physical harm ___ name calling ___

Other: (explain)

Have you been concerned for your safety? (explain)

SUBSTANCE USE:

Are you aware of or concerned about the ways you or anyone in your family use alcohol or other substance? (Marijuana, speed/Amphetamine, Downer/Barbiturates, Opiate/Heroin, LSD, PCP, Inhalants, Prescriptions, Cocaine, etc?)

Name / Age of first use	Substance / Drug

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LEGAL:

Have you been involved or do you expect to be involved in litigations or legal issues?

Comments:

ACADEMIC:

Do you or anyone else in your family struggle with learning difficulties?

Please check any of the following that apply to you over the past two weeks:

- | | | |
|---|--|--|
| <input type="checkbox"/> overeating/loss of appetite | <input type="checkbox"/> suicidal thoughts/attempt | <input type="checkbox"/> physical abused |
| <input type="checkbox"/> taking drugs | <input type="checkbox"/> headaches | <input type="checkbox"/> sexually abused |
| <input type="checkbox"/> addiction problems | <input type="checkbox"/> sleep problems | <input type="checkbox"/> temper outbursts |
| <input type="checkbox"/> worry about use of alcohol/drugs | <input type="checkbox"/> nervous tics | <input type="checkbox"/> thoughts re: weight |
| <input type="checkbox"/> uncontrollable crying | <input type="checkbox"/> work too hard | <input type="checkbox"/> worried or anxious |
| <input type="checkbox"/> concentration difficulties | <input type="checkbox"/> aggressive behavior | <input type="checkbox"/> procrastination |
| <input type="checkbox"/> cannot keep a job | <input type="checkbox"/> memory problems | <input type="checkbox"/> loss of control |
| <input type="checkbox"/> unmotivated | <input type="checkbox"/> hearing voices | <input type="checkbox"/> unmanageable fears |
| <input type="checkbox"/> seeing things | <input type="checkbox"/> feeling unsociable | <input type="checkbox"/> gambling |

Please check any of the following that describe you:

- | | | | | | | |
|--------------------------------------|------------------------------------|-----------------------------------|------------------------------------|-----------------------------------|--|------------------------------------|
| <input type="checkbox"/> angry | <input type="checkbox"/> guilty | <input type="checkbox"/> unhappy | <input type="checkbox"/> annoyed | <input type="checkbox"/> jealous | <input type="checkbox"/> optimistic | <input type="checkbox"/> happy |
| <input type="checkbox"/> hopeless | <input type="checkbox"/> sad | <input type="checkbox"/> envious | <input type="checkbox"/> energetic | <input type="checkbox"/> restless | <input type="checkbox"/> fearful | <input type="checkbox"/> regretful |
| <input type="checkbox"/> lonely | <input type="checkbox"/> tense | <input type="checkbox"/> helpless | <input type="checkbox"/> anxious | <input type="checkbox"/> bored | <input type="checkbox"/> content | <input type="checkbox"/> depressed |
| <input type="checkbox"/> relaxed | <input type="checkbox"/> empty | <input type="checkbox"/> hopeful | <input type="checkbox"/> excited | <input type="checkbox"/> panicky | <input type="checkbox"/> conflicted/confused | |
| <input type="checkbox"/> resourceful | <input type="checkbox"/> resilient | <input type="checkbox"/> other: | _____ | | | |

Please check any of the following that have happened to you or an immediate family members in the past two years:

- | | |
|--|---|
| <input type="checkbox"/> death/suicide of spouse/partner | <input type="checkbox"/> divorce/change in relationship |
| <input type="checkbox"/> death of a pet | <input type="checkbox"/> reconciliation with spouse/partner |
| <input type="checkbox"/> retirement from work | <input type="checkbox"/> death/suicide of family members |
| <input type="checkbox"/> marital separation | <input type="checkbox"/> major change in health |
| <input type="checkbox"/> skipped a grade in school | <input type="checkbox"/> detention in jail or other institution |
| <input type="checkbox"/> pregnancy | <input type="checkbox"/> school failure |
| <input type="checkbox"/> victim of a crime | <input type="checkbox"/> death/suicide of close friend |
| <input type="checkbox"/> marriage | <input type="checkbox"/> birth/adoption of child(ren) |
| <input type="checkbox"/> change of employment /re-employment | <input type="checkbox"/> re-marriage forming stepfamily |
| <input type="checkbox"/> being fired from a job | <input type="checkbox"/> promotion |
| <input type="checkbox"/> being terminated from job due company | <input type="checkbox"/> relocation or change in school |
| <input type="checkbox"/> problem of the economy | <input type="checkbox"/> disclosure of a secret |
| <input type="checkbox"/> other | |

Additional comments:

LIFESPAN FAMILY HEALTHCARE , LLC

Rebecca E. Clark, M.S., LMFT

Licensed Marriage and Family Therapist (LMFT)

80 River Rd Newcastle, ME 04553 # 207.563.3366

Office Appointment Hours: Mon. 3Pm-6:30PM; Tues. 8:45-1PM; Wed. 9AM-5:30PM;

Thurs. 8:30-3PM.; Fri. 8:30-10AM *subject to change*

Degree: I hold a Master's of Science degree in Marriage and Family Therapy/ Human Development. I earned this at Virginia Tech, No.VA in 2003.

License: LMFT. #MF4478. Issue/Expiration Date: first issue, 07/05 (LMFT-C) to 4/30/2017 (LMFT), expiration. I am an Associate Member of the American Association of Marriage and Family Therapy (AAMFT).

Areas of Competence: I am trained to work with individuals of all ages, couples, and families to address relational and mental health concerns such as marital distress, family life transitions, anxiety/depression, trauma, parent/child relationships, and psychosocial issues relating to medical concerns using a variety of modalities tailored to fit the needs of each individual client. I provide solution-focused family therapy from a family system and biopsychosocial-spiritual framework meaning I look at the role and nature of individuals' primary relationships as a part of their whole health. I am informed by attachment theory and utilize the evidence-based Emotionally Focused Therapy (EFT) for working with couples.

Course of Treatment: In the first interview, we will have the opportunity to meet each other, evaluate your needs, and go over any insurance paperwork. A therapy session is generally scheduled for one hour (50 min). I will want to get to know you and your concerns, what you would like to be different, and how you think I could be of help to you. We will then discuss the frequency of counseling recommended (i.e. once a week, etc) and begin setting therapy goals. This will help us both have a clear understanding of how you would like to use this therapy and when you have achieved your goals. At times the first session will run 55-65 minutes.

Confidentiality: Our conversations will remain confidential. I believe this is essential for creating an environment of safety and trust. Furthermore, ethical and legal codes (included in a separate attachment) prevent me from revealing your Private Health Information (PHI) without your written permission. Whether I meet with one adult or more than one (i.e. couple or family), I must obtain a written release from each adult before sharing any information. The only exceptions to this confidentiality are below:

1. Threat of serious harm to self or others (i.e. physical violence; suicide)
2. Reasonable suspicion of abuse of child, or neglect of a child, or abuse, neglect or exploitation of an incapacitated or dependent adult;
3. A court order;
4. Voluntary release signed by client or guardian; and
5. During supervisory consultations.

Fee Schedule: The fee for therapy services is \$125 for the initial session and \$100 per therapy hour (55 min.), thereafter. Check, credit card or cash payment is expected at the time of service. *Please inquire about a discount for uninsured/ self-pay.* **I do not perform court-related assessments.** However, if I am court ordered, court – related paperwork, appearances, and travel are posted and billed at the rate of \$150/hour, or increments thereof and related payments are due within ten (10) days of service(s) rendered

Insurance: I currently accept Anthem BCBS, MCHO, Harvard Pilgrim, and MaineCare. I currently bill your insurances as an affiliate of Cornerstone Behavioral Healthcare. Any charge not covered by your insurance will be your responsibility.

Appointments: Please call (207) 563-3366. While Lifespan Family Healthcare is opened Mon – Fri., my hours are by appointment only. I look forward to meeting with you.

Cancellations: *Mutual respect for client'(s) and practitioner's time is extremely important. The time of each client's scheduled appointment is held specifically for that client/family. Client(s) agree(s) to provide *48-hours in advance notice of a cancellation*. Notice of cancellation may be either by direct contact or by voice mail at (207) 563-3366. **Late cancellations (less than 24 hours prior to appointment) or missed appointments will be subject to a \$50 charge. (No Charge for the first occurrence).*** Or alternatively, two no-shows in a row will result in consideration for discharge from practice.

Response to Client Calls: Every reasonable effort will be made to return client(s) calls in a timely manner. Clients can expect a return call within one business day. Please note this means a message left on a Friday may not be returned until the following Monday. The client should leave her/his name and at least one telephone number on the voice mail message. Clients should not leave pager numbers. The practitioner will inform clients in advance of any expected absence.

Emergencies: This practice does not provide 24 hour coverage for mental health emergencies. Should the client experience a mental health emergency, s/he should call the crisis hotline (1-888-568-1112), the closest hospital Emergency Room, or dial 911. Please call this therapist, Rebecca Clark, LMFT, within one day after such an emergency.

Accountability: The practice of counseling is regulated by the Board of Counseling Professionals Licensure. The board is authorized by law to discipline counselors who violate the board's law or rules. To learn about the complaint process, or to file a complaint against a counselor, contact:
Complaint Coordinator; Office of Professional and Occupational Regulation,
35 State House Station, Augusta, ME 04333 (207) 624-8660. Or on the Web at www.maine.gov/professionallicensing

I/We have read and agree to the terms of this therapeutic services agreement.

Client's Signature _____ Date _____

Client's Signature _____ Date _____

_____ Date _____

If a minor, Signature of Parent or Legal Guardian

Provider's Signature _____ Date _____

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Lifespan Family Healthcare, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Lifespan Family Healthcare, LLC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Lifespan Family Healthcare, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office Manager, 80 River Road, Newcastle, ME 04553.

I have the right to request that Lifespan Family Healthcare, LLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent, Lifespan Family Healthcare, LLC **may call my home** or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. **yes** **no**

With this consent, Lifespan Family Healthcare, LLC **may mail to my home** or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential." **yes** **no**

With this consent, Lifespan Family Healthcare, LLC **may e-mail to my home** or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
 yes **no**

The following person(s) may contact Lifespan Family Healthcare, LLC inquiring in regards to my health information. You have my permission to release information to them.

Name _____ Relationship _____

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Lifespan Family Healthcare, LLC may decline to provide treatment to me.

Signature of Patient

Print Name

Date