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

CLIENT INFORMATION

Date: ____/____/____

| | | | |
|---|---|---|---|
| Client Name | | | Social Security # _____-_____-_____<br>Date of Birth ____/____/____ Age ____ |
| Marital Status:<br>S____M____W____D____O____ | Name of Spouse:<br>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 #<br>Relationship | | # Years of Education |
| Primary Insurance Name | Member ID | | HMO or PPO |

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 |
|---|---|---|
| | | |
| | | |

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 |
|---|---|
| | |
| | |
| | |
| | |

**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:**

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

**Please check any of the following that describe you:**

___ angry ___ guilty ___ unhappy ___ annoyed ___ jealous ___optimistic ___ happy
___ hopeless ___ sad ___ envious ___ energetic ___ restless ___ fearful ___ regretful
___ lonely ___ tense ___ helpless ___ anxious ___ bored ___ content ___ depressed
___ relaxed ___ empty ___ hopeful ___ excited ___ panicky ___ conflicted/confused
___ resourceful ___ resilient ___ other: _____

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

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

**Additional comments:**

# *THERAPEUTIC SERVICES AGREEMENT*

Rebecca E. Clark, M.S., LMFT
Licensed Marriage and Family Therapist (LFMT)
80 River Rd Newcastle, ME 04553 # 207.563.3366
Office Appointment Hours:
Mon. 8:30AM-10:30AM; Tues. 8:45-1PM; Wed. 9AM-6:00PM; Thurs. 8:30-3PM

**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) to 4/30/2021 (LMFT), expiration. I am Clinical Fellow 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 am informed by attachment theory and utilize the evidence-based Emotionally Focused Therapy (EFT) for working with couples and families. From a family systems, attachment, and biopsychosocial-spiritual framework, I look at the role and nature of individuals' primary relationships as a part of their whole health.

**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 clinical consultations.

**Fee Schedule**: The fee for therapy services is $150 for the initial session and $120 per therapy hour (55 min.), thereafter. Checks, CC, or cash payment is expected at the time of service. You may inquire about a discount for uninsured/cash-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 **$300/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 Aetna. Any charge not covered by your insurance will be your responsibility.

**Extended Sessions**: Insurance does not cover beyond 60 minutes. Any extensions to the 55-minutes therapy hour will be self-pay and billed by increments of 15 minutes. Extended sessions will be agreed upon between therapist and client prior to the start of the session. If you are interested in an extended session, please check with the therapist for availability.

Extended Therapy Sessions:

15 min = $30
30 min = $60
45 min = $90
60 min = $120

**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** regardless of the reason (car problems, traffic, an unexpected conflict in schedule etc.) with the exceptions of extremely poor weather conditions that make travel unsafe or sudden illness will be subject to a $60 charge. * 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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Licensed Marriage and Family Therapist

# 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 regard 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