LIFESPAN FAMILY HEALTHCARE **CLIENT INFORMATION;** MENTAL HEALTH THERAPY

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
	Gender: M____F____O_____	Ethnicity (optional)	Religious Affiliation
Emergency Contact	Telephone # Relationship		# Years of Education
Insurance company:	Insurance member #:		Primary insurance holder:

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 current struggle)? _____

_____

_____

_____

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 Y / N

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.

_____

_____

_____

Self-Harm:

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

Would you say that you or any other members of your household have a problem with anger? [___] No [___] Yes; 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, pain meds, 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? Briefly describe.

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

___ overeating/loss of appetite ___suicidal thoughts/attempt ___physically abused
___ taking drugs ___headaches ___sexually abused ___addiction problems
___ sleep problems ___ temper outbursts ___ worry about use of alcohol/drugs
___ nervous tics ___ thoughts re: weight __uncontrollable crying ___work too hard
___ worried or anxious ___concentration difficulties ___aggressive behavior
___ procrastination ___ cannot keep a job ___ memory problems __ loss of control
___ unmotivated ___hearing voices ___unmanageable fears ___seeing things
___ feeling unsociable ___gambling

Please check any of the following that describe you in the last two weeks:

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

Thank you for helping me get to know you and your background a little bit. Feel free to write additional comments here before moving on to the next page.

LIFESPAN FAMILY HEALTHCARE

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ **Date:** _____

Over the *last 2 weeks*, how often have you experienced any of the following problems? *(use "√" to indicate your answer)*

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3

If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____

THERAPEUTIC COUNSELING SERVICES AGREEMENT

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. 8:30-1PM; Wed. 8:30AM-1:00PM; Thurs. 8:30-4PM

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) and renewing every two years with required continuing education. Current expiration/ renewal date: 4/30/2023 (LMFT). I am Clinical Fellow of the American Association of Marriage and Family Therapy (AAMFT) and certified by ICEEFT as an EFT therapist and supervisor.

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 paperwork. A therapy session is generally scheduled for one hour (55 min). I will want to get to know you and your concerns, what you would like to be different, and how you have coped. 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. The initial consultation 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 the following:

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 $230 for the initial consultation session. For ongoing therapy thereafter, individual sessions are $170 and couples' sessions are $200 (55 min.). Checks, CC, or cash payment is expected at the time of service. **I do NOT perform court-related assessments**. However, <u>if I am court ordered, court – related paperwork, appearances, and travel are posted and billed at the rate of **$300/hour,** </u>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 <u>beyond 60 minutes</u>. Any extensions to the 55-minutes therapy hour will be self-pay and billed by <u>increments of 15 minutes</u>. 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 *Couples' Sessions or*	***Extended*** *Ind. Therapy Sessions:*
+15 min = $50	+$45
+30 min = $100	+$90
+45 min = $150	+$135
+60 min =$200	+$170

Two-Day EFT Intensive Sessions: Two-day EFT sessions are available for couples. Please contact Rebecca for additional details and to schedule a consult. Standard fee: $2,900.

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 <u>(less than 24 hours prior to appointment)</u> or **missed appointments <u>regardless of the reason</u> (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 $100 charge. * Or alternatively, two no-shows in a row will result in consideration for discharge from practice.

Communication: 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 or Tuesday. The client should leave 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. Please leave non-emergency messages at ext.106.

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 Rebecca Clark *Date* _____

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. □ **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