Psychotherapy In-take Form
Confidential

*****Please print and fill out to bring to your first appointment.**

Name_____DOB: _____Age:_____

Address_____City/Zip_____

Home Ph. #: _____May we leave a message? _____

Cell Ph. #: _____May we leave a message? _____

Email Address: _____May we email you? _____

SSN#:_____Marital Status/Relationship?_____

Length of relationship? _____

Names/Ages of children:_____ Living With You?_____

Occupation/Place of employment: _____How long?_____

Referred by? _____

Personal Physician(s)/Psychiatrist: _____

Current medications/reasons: _____

Have you previously been prescribed psychiatric medication? _____

Physical problems/health concerns:_____

Family Health History: _____

Have you been in previous counseling/treatment? With Whom? For how long? _____
_____

Are you currently involved in legal matters? _____

What do you consider your strengths? _____
_____

What are your goals for therapy? What changes do you hope to accomplish by coming to FSR?
_____

_____

Confidentiality and Limits of Confidentiality:
Full Spectrum Recovery offers psychotherapeutic services in accordance with California State Law. All information disclosed within sessions and the written records pertaining to those sessions are confidential, and may not be revealed to anyone without your written permission except where disclosure is required by law. Some of the circumstances in which disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents as a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to Full Spectrum Recovery that the client presents a danger to others. If there is an emergency during therapy, or in the future after termination, where Full Spectrum Recovery becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, s/he will do whatever s/he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. Full Spectrum Recovery consults regularly with other professionals regarding clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained. _____ (Initial)

General Office Policies

Appointments: Services are rendered by appointment only. You are responsible for making and keeping appointments. Should you fail to show up, cancel or postpone your appointment **without 24 hours** notification, you will be charged for a full session. If an emergency arises and you cannot keep your appointment please call immediately so a possible rescheduling can be discussed. Monday appointments must be canceled before the end of the workday on Friday. _____(Initial)

Termination: You have the right to terminate therapy and communication at any time. It is helpful to discuss termination fully with your therapist in an appointment specifically for that purpose. If appropriate and/or necessary, your therapist may provide you with 3 referrals that may be of help to you. _____(Initial)

Telephone & Emergencies: If you need to contact your therapist or FSR between sessions, please attempt to leave a message on your therapist's direct phone or with our answering service at (805)-966-5100 and your call will be returned as soon as possible. We check our messages regularly during regular business hours. If an emergency situation arises, indicate it clearly in your message and if you need more immediate assistance please call the police at 911. Please do not use email or fax for emergencies. _____(Initial)

Fee Statement: Clients are expected to pay the standard fee of _____ per 50-minute therapy session and _____ per 80-minute therapy session at the end of each session. Telephone conversations, writing and reading reports, consultations' with other professionals, release of information, reading records, longer sessions, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify FSR immediately if any problems arise during the course of therapy regarding your ability to make timely payments. We cannot render services on the assumption that our charge will be paid by an insurance company. We will assist in preparing necessary forms to expedite your claim. _____(Initial)

I agree to pay the stated fee at the time of each session. _____(Initial)
I will typically be paying with cash _____, check _____, M/C or Visa _____
Credit Card # _____Expires on_____
Verification Code:_____ Billing Zip Code_____

My signature below shows that I understand and agree with the confidentiality and limits to confidentiality as well as the general office policies.

Client's Name (print): _____

Signature: _____

Date: _____

Therapist Signature:_____

Date: _____