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Client Information

#1 Name _____ **Sex** _____ **Date of Birth** _____
Relationship to insured (if using insurance benefits) _____
Professional referral (physician, therapist) Agency Name _____
Contact_____ **Phone** _____
(Permission to contact them) ☐
☐ **Work Phone** _____ ☐ **Cell Phone** _____
(Please check if we may leave a message)
Email _____ **Address** _____
Employer's/Self – Employed Business _____ **Occupation** _____

#2 Name _____ **Sex** _____ **Date of Birth** _____
Relationship to Insured (if using insurance benefits) _____
Professional referral (physician, therapist) Agency Name _____
Contact_____ **Phone** _____
(Permission to contact them) ☐
☐ **Work Phone** _____ ☐ **Cell Phone** _____
(Please check if we may leave a message)
Email _____ **Address** _____
Employer'/Self - Employed Business _____ **Occupation** _____

Child's Name_____ **Sex** _____ **Date of Birth** _____

Other household member's names and ages _____

Emergency Contact_____ **Phone** _____
Physician _____ **Phone** _____
Insurance **(Please provide both sides of your insurance card plus your Drivers' License to the Front Desk)**
Name of the Insured _____**DOB**_____ **Provider** _____
Policy/Group # _____ **ID** _____

I authorize WBC to send in a claim to my insurance carrier for services provided by WBC and allow the fees to be paid directly to Well Baby Center.
Signature _____ **Date** _____
Signature _____ **Date** _____

For Clinician's Use
Assigned Clinician _____**Today's Date** _____ **Fee** _____
Sessions: Day _____ **Time of Session** _____ **Treatment Unit**_____

For Administrative Dept. – EOB Information
Date provided to submitting clinician _____
Aetna _____ **Blue Shield of CA** _____ **Other** _____
Deductible Amount _____ **Copayment Amount** _____ **# of Sessions** _____

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Consent for Individual, Couples, and Family Treatment

Please read carefully.

1. **About the Therapy Process**

   It is the therapist's intention to provide services that will assist the client(s) in reaching his/her treatment goals. Based upon the information provided by the client and the specifics of the client's situation, the therapist will make treatment recommendations. Therapists and clients are partners in the therapeutic process, therefore, the client has the right to agree or disagree with any recommendations made, and only agrees to attend sessions consistently and to follow the center's payment and cancellation policies as stated in this consent form. Therapist agrees to contribute his/her knowledge, skills, and a willingness to do his/her best. The determination of success, however, will ultimately depend upon the client's commitment to his/her own personal growth. Due to the varying nature and severity of problems and the individuality of each client, the therapist is unable to predict the exact length of therapy or to guarantee a specific outcome or result.

2. **Information about WBC Therapists**

   WBC is a licensed psychology clinic and a clinical training center for Masters level psychotherapy interns, Doctoral candidates, licensed psychotherapists and other infant-family mental health professionals. Interns are under the direct supervision of two clinical supervisors in addition to attending weekly case consultations. Therapists may consult with other mental health professionals within Well Baby Center for the purpose of supervision, education and to maintain best practices.

3. **Training Recordings or Viewings**

   Some therapy sessions may be recorded or viewed for training purposes. Video recordings will be viewed in supervision and then erased. There will be advanced notice of any taping or viewing and it will be with your full and complete awareness.

4. **Confidentiality**

   California law strictly guarantees the client's right to a confidential relationship with his/her therapist. The therapist is legally prohibited from revealing to another person that the client is in therapy with them, nor can the therapist reveal what the client has said in any way that identifies the client without the client's written permission. There are some instances, however, in which the client's right to confidentiality must be set aside as required by law or professional guidelines. These include the following:

   - Instances of suspected abuse or neglect of a child, an elder, or a dependent adult, when a report must be made to the appropriate protective services agency.
   - If the therapist has reason to believe that the client poses an imminent danger of violence to another person, the therapist must take steps to protect whoever may be in danger.
   - If the client reveals a serious intent to harm him/herself, or if the client becomes unable to care for him/herself such that the client becomes a danger to him/herself, the therapist is ethically and legally bound to do whatever he/she can do to help keep the client safe, which may involve notifying others who may be able to help. In all of the above cases, the therapist would release only that information necessary to appropriately carry out his/her responsibilities. Client confidentiality remains an ethical and legal priority.

   There may be circumstances when a therapist may wish to consult with outside professionals such as the client's physician, teacher, or a current, previous, or future therapist regarding client care. In such cases, the therapist will first request the client's written permission to do so. In addition, if the assigned therapist is an intern at WBC and on a time-limited contractual basis, it is possible that the intern could leave WBC before the end of treatment. In this instance, WBC will make every effort to transfer the case to a different therapist.

Consent for Individual, Couples, and Family Treatment

Couples or Family Therapy

- If the client participates in couples or family therapy, the therapist will not disclose confidential information about the treatment to external parties unless all persons who participated in the treatment provided their written authorization to release such information.
- Well Baby Center utilizes a "no secrets" policy when conducting couples and family therapy. This means that the therapist is permitted to use any information obtained in concurrent individual or dyadic session(s) when working with the other members of the treatment unit.

Well Baby Center cannot guarantee confidentiality with the use of electronic communications such as cell phones or email. Although we make every effort to maintain your confidentiality, if the client agrees to contact using these methods of communication, he/she agrees to these limitations on confidentiality. The client's signature below will indicate consent to be contacted via cell phone and email.

4. Client Litigation/Custody Disputes

- **WBC therapists are not trained custody evaluators and, therefore, will not voluntarily participate in any way in litigation or custody disputes.** Being both a client's therapist and his/her custody evaluator is a dual relationship and is therefore not permitted by our code of ethics. In addition, the therapist has a policy of not communicating with a client's attorney and will generally not write or sign letters, reports, declarations, or affidavits for a client's legal matter. The therapist will generally not provide records or testimony unless legally compelled to do so.
- Should a therapist be compelled to appear as a witness in an action involving a client, or to provide written documentation, the client agrees to reimburse the therapist for time spent in preparation, travel, or for other matters pertaining to the requirement to participate. Any therapist's time or administrative involvement in a court setting is billed to the client at the rate of $125/hour. Clients should be aware that they would be waiving the psychotherapist-client privilege if the client's mental or emotional state were brought up as part of the legal proceeding. The client should address any concerns he/she might have regarding the psychotherapist-client privilege with their attorney before involving the therapist.

5. Fees, Appointments & Cancellation Policies

- Sessions take place at least once a week, unless otherwise arranged, for a 50-minute clinical hour. **If a client is unable to attend his/her session, the client must cancel no later than 24 hours before the time of session or there will be a full fee charged.** Therapy could be discontinued, postponed, or the appointment time lost if client makes over three consecutive cancellations.
- During the initial intake, a session fee will be determined based on income, otherwise clinical fees are $100/hr. For sliding scale fees, we require proof of income. As a client courtesy, we will invoice insurance companies.
- **Payment is due before each session.** We do not invoice clients unless there is a past due balance or for insurance reimbursement**.** Uncollected fees may result in an interruption in therapy until the balance is paid. Any longstanding unpaid balances may be referred to a collection agency. If this should become necessary, the client will be notified in writing beforehand. There is a $14 service fee for any returned checks.
- There is a charge for telephone calls over 10 minutes in duration. The fee is prorated according to the client's usual fee.
- Clients may be charged at their regular rate for administrative paperwork the client has asked his/her therapist to complete. Such paperwork may include, letters to insurance companies, state disability agencies, or to obtain reimbursement of treatment costs. We will bill the insurance company if client's insurance covers such administrative tasks.

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Consent for Individual, Couples, and Family Treatment

6. Client Rights and Responsibilities

In addition to a client's right to confidentiality, a client has the right to end therapy at any time, for whatever reason, without any obligation except for fees already incurred. Clients also have the right to question any aspect of their treatment with their therapist, and if they choose to end treatment, to expect that their therapist will work with them to meet their needs for alternative treatment. Clients also have the right to expect that their therapist will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with them, all of which would greatly compromise the client and therapist's work together.

Acknowledgement

By signing below, the client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. The client has discussed the terms and conditions of this Agreement with his/her therapist, and has had any questions with regard to its terms and conditions answered to the client's satisfaction. The client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with the therapist. In addition, the client agrees to hold the therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____	_____
Print Name of Client #1	Print Name of Client #2
_____	_____
Signature of Client #1	Signature of Client #2
_____	_____
Date	Date

This is to certify that I give permission to Well Baby Center (WBC) for my family or child's participation in therapy. The names of the family members in therapy are listed below.

Name of Child: _____ DOB: _____ Age: _____

Name of Child: _____ DOB: _____ Age: _____

Name of Child: _____ DOB: _____ Age: _____

Mother, Father, or Legal Guardian's Name: _____ DOB: _____ Age: _____

Mother, Father, or Legal Guardian's Name: _____ DOB: _____ Age: _____

Therapist's Name: _____ Therapist's Title: _____

All Marriage and Family Registered Interns will be supervised by David Brooks, Ph.D.

Adult/Parent Questionnaire

To be completed by the client:

Name_____Date_____

1. Please describe what brings you here at this time, and any symptoms that you are currently experiencing:

_____

_____

_____

_____

_____

2. How long have your symptoms been occurring?

_____

_____

3. Are you currently receiving any treatment for these symptoms? *Yes* __ *No* __ If yes, please explain:_____

_____

_____

Therapist/Physician: _____ Phone: _____

4. Have there been any major changes at work or at home lately, or any other precipitating factors? *Yes* __ *No* __ If yes, please explain:

_____

_____

_____

5. Have you received treatment or counseling in the past? *Yes* __ *No* __ If yes, what were the reasons?

_____

_____

_____

Therapist/Physician: _____ Phone: _____ Dates seen: _____

Therapist/Physician: _____ Phone: _____ Dates seen: _____

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Adult/Parent Questionnaire

6. Please list any current medical conditions. Any medication you are currently prescribed?

Current Doses?

1. _____2. _____3. _____

Physician: _____ Phone: _____ Last visit: _____

7. Have you had any medical hospitalizations or procedures in the past? *Yes* __ *No* __

If yes, please describe:

_____

_____

8. Have you had any psychiatric hospitalizations in the past? *Yes* __ *No* __ If yes, please describe:

_____

_____

9. Are you currently experiencing any thoughts of self-harm or suicide? *Yes* __ *No* __

If yes, please describe:

_____

_____

10. Are you currently experiencing any thoughts of harming others? *Yes* __ *No* __

If yes, please explain:

_____

_____

_____

11. Do you have a history of alcohol use? *Yes* __ *No* __ If yes, please describe:

_____

How much? (currently) _____/day; (and in the past) _____/day

12. Do you have a history of recreational drug use? *Yes* __ *No* __ If yes, please describe

_____

_____

How much? (currently) _____/day; (and in the past) _____/day

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Adult/Parent Questionnaire

13. Do you have a history of arrest, probation or incarceration? *Yes* __ *No* __ If yes, please explain:

_____

_____

14. Are you currently experiencing any of the following?

Unusual Fears	***Yes*** __ ***No*** __	Change in Mood	***Yes*** __ ***No*** __
Sexual Acting Out	***Yes*** __ ***No*** __	Frequent Anger Outbursts	***Yes*** __ ***No*** __
Worries	***Yes*** __ ***No*** __	Hearing Voices	***Yes*** __ ***No*** __
Lying	***Yes*** __ ***No*** __	Stomach Problems	***Yes*** __ ***No*** __

15. Please check the one that best describes the following:

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Sadness/Depression	__	__	__	__	Memory Problems	__	__	__	__
Sleep Problems	__	__	__	__	Feelings of Hostility	__	__	__	__
Change in Appetite	__	__	__	__	Acts of Violence	__	__	__	__
Weight Change	__	__	__	__	Social Isolation	__	__	__	__
Can't Concentrate	__	__	__	__	Strange Thoughts	__	__	__	__
Obsessive Thoughts	__	__	__	__	Sexual Problems	__	__	__	__
Tension/Anxiety	__	__	__	__	Panic Attacks	__	__	__	__
Nightmares	__	__	__	__	Compulsivity	__	__	__	__

16. Please check the one which best describes how you are doing in your relationship with your child:

0 ____	1 ____	2 ____	3 ____	4 ____	5 ____	6 ____	7 ____	8 ____	9 ____	10 ____
NA	No Problems		Mild Problems		Moderate Problems			Serious Problems		Cannot Function

17. Please check the one which best describes how you are doing in your marital/significant other relationship:

0 ____	1 ____	2 ____	3 ____	4 ____	5 ____	6 ____	7 ____	8 ____	9 ____	10 ____
NA	No Problems		Mild Problems		Moderate Problems			Serious Problems		Cannot Function

18. Please check the one which best describes how you are doing in relationships with people outside your family:

0 ____	1 ____	2 ____	3 ____	4 ____	5 ____	6 ____	7 ____	8 ____	9 ____	10 ____
NA	No Problems		Mild Problems		Moderate Problems			Serious Problems		Cannot Function

Adult/Parent Questionnaire

19. Please check the one which best describes how you are doing in your job or at school:

0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10 ____

NA No Problems Mild Problems Moderate Problems Serious Problems Cannot Function

20. Please check the one which best describes your current physical health:

0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10 ____

Excellent Very Poor

21. Please check the one which best describes your general happiness and well-being:

0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10 ____

Excellent Very Poor

22. Trauma History: Have you ever experienced any of the following events? If yes, please indicate your AGE at the time of the event, and any other details you wish to provide. Please feel free to use back of paper if needed. Indicate N/A next to each item that does not apply to you in any way.

Childhood neglect		Being bullied	
Childhood physical abuse		Natural disaster	
Childhood sexual abuse		Death of a loved one	
Childhood loss of a parent either by death or divorce		Witnessed another's suicide or murder	
Rape/sexual assault		Experienced a suicide attempt	
Physical assault		Military combat	
Domestic violence		Have/or have had a life-threatening illness	
Community violence		Transportation accident	