CAROL ROSE ADKISSON
Licensed Marriage Family Therapist

IMMIGRATION CLIENT INFORMATION SHEET

Please complete all items. Information is held as strictly confidential.

Client Name_____Birthdate_____Age_____ M___ F___

If client is a minor, Parent's name_____Birthdate_____ Age_____ M___ F___

Address_____City_____Zip_____

Home Phone_____Cell Phone_____Wk. Phone_____

Email Address: _____

Single_____ Married_____ Separated_____ Co-Habitating_____ Divorced_____ Widowed_____ Engaged_____

Employer _____ No. Years_____

Address_____City_____Zip_____

Occupation_____Education_____Religion_____

Spouse Name _____ Birthdate _____Age_____ M ___ F___

Address_____City_____Zip_____

Home Phone_____Cell Phone_____Wk. Phone_____

Employer_____ No. Years_____

Address_____City_____Zip_____

Occupation_____Education_____Religion_____

Emergency Contact Name_____

Relationship_____

Address_____City_____Zip_____Ph_____

Employer Name_____Ph_____

Other Children Living at Home:

Name_____Birthdate_____ Age_____M___F___

Name_____Birthdate_____ Age_____M___F___

Name_____Birthdate_____Age_____ M___F___

Name_____Birthdate_____Age_____ M___F___

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CLIENT INFORMATION SHEET

Please read the information below and sign your name in the spaces provided. Should you have any questions, please feel free to discuss any of these issues with the receptionist or your therapist before signing.

Client's Rights and Responsibilities:

As a client, you have certain rights:

- You have the right to know our assessment of the problem, the recommended treatment plan, and resources available to help improve this problem.
- You have the right to refuse treatment. Even though your counselor may strongly suggest you seek help, you may choose to not follow the counselor's advice. Should you choose to refuse treatment, you will be advised of the consequences that may result from your refusal. Alternative forms of treatment or help may be available.

Along with these rights go certain responsibilities. These are:

- To be honest, open and willing to share your concerns with your counselor
- To ask questions when you do not understand or need clarification
- To discuss any reservations you have about your treatment plan with your counselor
- To follow the agreed-upon treatment plan
- To report changes or unexpected events as related to your problem with your counselor

Fees: Standard fees are $120.00 for each individual session (45-50 minutes). In cases of financial difficulty, you may qualify for a courtesy discount. **Please feel free to discuss this arrangement with your therapist**.

Cancellations and Missed Appointments: As the time reserved for your appointment is your time, please give **48-hour notification** if it is necessary to cancel an appointment. There will be a **one full session charge** for any missed or late cancelled appointment.

Payment: Payment is due at the time of your appointment and it is requested that you keep up with your co-payment on a weekly basis or make arrangements with your therapist. You are responsible for any charges incurred by your bank for returned checks.

Confidentiality: Information shared with your therapist is confidential unless you have signed a release. According to the law, the following may be shared without a signed consent: observed or suspected **child abuse, elder abuse,** prevention of **bodily harm** to yourself or to another person, any information **subpoenaed by court** or otherwise necessary to the administration of justice, filing an **insurance claim, breach of contract** (small claims court), if a client is a **minor,** or the client experiences an **emergency** requiring information from the client's record to be given to another health care provider or for other reasons which can be explained by the therapist. Further as we are a group practice, support staff may be aware of limited clinical information to aid in therapist's functioning. We, as a staff will maintain your confidentiality.

Consent for Treatment: I have completely read this form and certify that I am the client, or the client's parent or guardian. I authorize my therapist to administer and perform treatment and diagnostic procedures that may now or during the course of treatment be deemed advisable or necessary.

_____

Signature of client (Parent or Guardian if under 18 years of age) Date

Authorization to Release Information: A treating doctor or therapist/counselor referred me and I have no objection to having my therapist communicate with the referring professional regarding my care.

_____ S

Signature of Responsible Party

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Confidentiality Policy

Confidentiality and privileged communication remain the rights of all clients of professional counselors according to the law. However, there are limits to such communication, some of which are mandated by state law. It is very important that you and those seeking counseling with carefully read and understand the following limits of confidentiality.

Duty to Warn

Some courts have held that if an individual intends to take harmful, dangerous, or criminal action against another human being, or against himself or herself, it is the counselor's duty to warn appropriate individuals of such intentions. Those warned may include a variety of persons such as:
1. The person or the family of the person who is likely to suffer the results of the harmful behavior
2. The family of the client who intends to harm him/herself or someone else. 3. Associates or friends of those threatened or making threats. 4. Law enforcement and medical emergency officials.

Child Abuse

California state law mandates the reporting of incidence or *suspected* incidence of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional, and psychological abuse. All actual or suspects acts of child abuse will need to be reported to the appropriate agencies (Article 2.5 Penal Code 11165 and 11166)

"Dependent Adult" and Elderly Abuse

California law requires the incidence of "dependent adult" or elderly physical abuse reported to your counselor must also be reported to California authorities (Welfare and Institution Code, Sec. 15630).

Therapeutic Criminal Involvement

The State Law in the Evidence Code 1018 reads that "There is no privilege (confidentiality) under this article if the services of the psychotherapist were sought or obtained to enable or aid anyone to commit or plan to commit a crime a tort to escape detection or apprehension after the commission of a crime or a tort." (Evidence Code 1024, 1965. Chp 299)

Family and Couple Therapy

Family members and couple may be seen at times individually or conjointly. Information shared during these sessions or in related settings (e.g. telephone calls) is considered part of the overall family or couple therapy process and inot confidential from the other participating family members or partners. Your therapist will use his or her discretion in handling these matters. This is simply our "no secrets policy." It is important that you understand this policy before treatment begins. It supports our belief that healthy relationships are built on openness and truth.

Case Evaluation

In order to ensure the best treatment possible for each client, our therapists do consult with each other regarding cases. There are certain situations in which support staff will also be made aware of limited clinical information to support the therapists functioning. If you have any concerns regard this practice, please notify your therapist.

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Neglect of Outstanding Debt

In the event that a client fails to honor, after reasonable efforts to collect, his/her debt, your therapist may place the account in the hands of an agency or attorney for collection or legal factionalisms will necessitate the release of pertinent demographic information as well as accounting information. **NO THERAPEUTIC INFORMATION WILL BE RELEASED.**

Please be sure that you have read the above very carefully. If you are not sure that you fully understand any of the above areas of confidentiality limitations, please ask your therapist before you sign below.

I/We the undersigned, have read and fully understand the limits of my/our confidentiality. I/We further agree to abide by the policy set out above. I/We have had a chance to ask my/our therapist for additional clarification regarding the limits of confidentiality.

_____ _____

Client Signature Date

_____ _____

Client Signature Date