Bob Fine Ph.D. (c), LPC-S

Licensed Professional Counselor Supervisor
Marriage and Family Therapist

1700 Alma Drive, Suite 305
Plano, TX 75074

1001 Cross Timbers Rd, Suite 2110
Flower Mound, TX 75028

Phone: (214) 499-8755

Name: (**Person/s Seeing Therapist Today**) _____

Age/s: _____ _____

Address: _____ City: _____ State: _____ Zip code: _____

Employer: _____ Current Position: _____ How Long:_____

Parent/Guardian/Insured: _____ Employer:_____

Address: _____ City: _____ State: _____ Zip code: _____

Employer (Insured): _____ Current position:_____

Insured Length of Employment: _____ Annual Household Income_____

Cell phone: ( ) _____ Cell phone Carrier_____ Other phone: ( ) _____

Referred By: _____(or) **How did you hear about me**?_____

Client Birthdate: _____ Gender: _____ Insured Birthdate: _____

Family Information

Number of Marriages Husband _____ Wife_____

List Husband's Spouse(s) name(s)	Years Married	List Wife's Spouse(s) name(s)	Years Married
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please provide your Insurance Card, Drivers License and debit/credit card to the therapist for copies.

Insured Email Address: _____

Client Email Address: _____

I hereby authorize use of my email address listed above, text messages and cell phones for contact with me about services, appointments, payments, insurance and other matters regarding my treatment by Bob Fine PhD(c), LPC-S and I understand that confidentiality cannot be guaranteed with those means of contact.
Client: _____ Insured: _____

Client: _____

Parent(s) or Guardian(s): _____

<u>Individuals</u> complete one the following self assessment <u>Couples</u> each fill out one. The therapist will be able to answer questions that you may have. Name of person completing this self assessment:_____

<u>CURRENT (C)</u> <u>PAST (P) COMPLAINT</u> (MARK ALL THAT APPLY TO YOU):

___ Depression
___ Low energy
___ Low self-esteem
___ Poor concentration
___ Hopelessness
___ Worthlessness
___ Guilt
___ Sleep disturbance (more/less)
___ Appetite disturbance (more/less)
___ Thoughts of hurting yourself
___ Thoughts of hurting someone
___ Isolation/social withdrawal
___ Sadness/loss
___ Stress
___ Anxiety/panic
___ Heart pounding/racing
___ Chest pain
___ Trembling/shaking
___ Sweating
___ Chills/hot flashes
___ Family problems
___ Fear of dying
___ Nausea
___ Obsessions/compulsive behaviors
___ Thoughts racing
___ Can't hold onto an idea
___ Easily angered
___ Excessive behaviors (spending, gambling)
___ Delusions/Hallucinations
___ Feeling that you are not real
___ Feeling that things around you are not real
___ Lose track of time
___ Unpleasant thoughts won't go away
___ Anger/frustration
___ Easily agitated/annoyed
___ Defies rules
___ Blames others
___ Argues
___ Excessive use of drugs, alcohol, or prescription drugs
___ Not thinking clearly/confusion
___ Blackouts
___ Physical abuse issues
___ Sexual abuse issues
___ Partner abuse issues
___ Self harm – "cutting"
___ Parenting issues
___ Tingling/numbness
___ Fear of going crazy
___ Phobias
___ Marital Problems (please describe):

_____

_____

Briefly, what is happening in your life which resulted in this appointment?

_____
_____
_____

What would you like to see accomplished in therapy?_____
_____
_____

My Medical Doctor is _____. I am being treated for the following medical issues.

_____
_____

Have you ever experienced any traumatic events? _____ Yes _____No When?_____
If yes, please describe briefly:_____

_____

Have you seen a psychiatrist before? _____ Yes _____ No When? _____

Name of Psychiatrist(s)_____

What was the diagnosis? _____

What was accomplished? _____

_____

Please list all current prescribed medications _____

_____

_____

Are you compliant with those medications? Yes ____ No _____

Previous psychiatric hospitalization? Yes ____ No ____ Number of hospitalizations _____

Name(s) of Hospital_____

_____

Last medical exam: _____

Alcohol use: Amount_____Frequency_____

Age of first alcohol use:_____

Drug use: What _____ Amount_____ Frequency_____

Have you ever seen a Counselor or Therapist before? Yes _____ No _____

When? _____Name prior of Counselor(s)_____

_____

What was accomplished? _____

_____

_____

Was there anything in particular in those sessions that you liked? _____

_____

_____

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STATEMENT OF UNDERSTANDING, CONSENT FOR TREATMENT and FINANCIAL AGREEMENT

Counseling helps you and/or your family members deal with personal or family problems. I offer assessments, short term counseling, referrals, and follow-up services. Counseling sessions are for 50 minutes, assessments and EMDR sessions may require additional time (usually 90 minutes) and will be billed accordingly at $125.00 per therapy hour with payment due upon provision of services unless agreement has been reached to file for insurance reimbursement. The client(s) agree to provide authorization for filing of insurance claims and payment of insurance benefits to be made directly to Bob Fine and/or Fine Marriage and Family Therapy. The client(s) agree to pay insurance required copayments, co-insurance and deductibles, and understand that they are financially responsible for all charges whether or not the charges are covered by insurance. The client(s) further agrees that a photocopy of this agreement shall be as valid as the original.

MENTAL HEALTH SERVICES

I will help you to assess your problem and develop a plan of action which may include short-term counseling (therapy), long term counseling or referral to other services that meet your needs. All assessment and referral services are provided at a specified cost to you or your family members. If an outside referral is made, the financial responsibility for payment to the referral source is yours. Although I endeavor to provide you with high quality referrals, I do not assume any responsibility for the services that may ultimately be provided by those resources.

While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation, feelings and/or system and move toward resolving the issues or difficulties that are interfering with your quality of live. The therapist, using his knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may be encouraged bring your partner or other family members to therapy sessions based on the belief that change occurs in the family system as much as it does in an individual. You may also be asked to complete homework assignments.

CONFIDENTIALITY AND EXCEPTIONS TO CONFIDENTIALITY

The information exchanged during sessions is <u>confidential</u>. I will not release information to anyone, including your employer or family members, without your written consent. Some information, however, cannot remain confidential and are exceptions to confidentiality requirements**:** when the therapist has a credible belief that an individual intends to harm themselves or another person the therapist is required to break confidentiality to assure the health and safety of all concerned. In addition, counselors are mandated by law to report to the appropriate authorities' information documenting child abuse, abuse of an elderly or disabled person. I may be required to submit documents to a competent court of law if subpoenaed or if a lawsuit is filed against me by you or somebody representing you. I am also required to report any suspicion of your having been in a sexual relationship with another therapist.

COURT TESTIMONY

Any requirement or request to participate in legal issues in any capacity on your behalf or that of your family will be billed to you at the rate of $250.00 per hour for the time spent (i.e. court appearances for custody/divorce cases, writing letters/recommendations to courts or attorneys, writing reports or summaries of treatment for the courts or other legal purposes, issues concerning employer-employee, or on bargaining agency-union issues) no matter what attorney issues a subpoena.

AUTHORIZATION FOR CLINICAL SERVICES

I, the undersigned, request treatment from Bob Fine, LPC-Supervisor, for outpatient mental health services and hereby authorize the clinical staff to administer such treatment as is deemed necessary. I also certify that no guarantee or assurance has been made as to the results or outcomes that may be obtained. Treatment includes the risk of emotional discomfort related to issues discussed during the therapy process. I understand that I am free to discontinue therapy at any time. I am aware that the clinician is not an emergency or 24 hour service provider. After hours if I am unable to contact the clinician I understand that I may contact my physician, call 911 or go to a hospital Emergency Room for emergency services. Fine Marriage and Family Therapy and Bob Fine, LPC-Supervisor is an independent private practice.

CANCELLATION POLICY

Clients who find themselves unable to keep a scheduled appointment are expected to call and cancel or reschedule the appointment 24 hours in advance to avoid having the cancelled appointment billed for the time scheduled. Cancellation may be completed by a voice mail or text message to (214) 499-8755 or an email to bobfine@verizon.net to avoid charges to a client for a missed session.

CONSENT FOR USE OF MEDIA CONTACT

I acknowledge that contact utilizing a cell phone voice, text, or voicemail and utilizing social media via the internet cannot be guaranteed as confidential means of communication and hereby consent and authorize Bob Fine to contact me and/or utilize any of the aforementioned means of electronic communication.

SIGNATURE

I certify that the information I have provided on the intake forms is true and accurate. I have read and I understand the above rights, authorizations and responsibilities and have signed below to indicate my agreement with these terms. I have received a copy of the *Notice of Privacy Practices* and have signed below to indicate my agreement with its terms.

Client/s: _____ _____

Guardian/s:_____

Therapist: _____ Date: _____

Revised October 2016