SUSAN M. POSADA, PhD, LMHC, LMFT
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COUPLES COUNSELING INTAKE FORMS
(Please EACH fill out a separate pack of forms)

CLIENT NAME:_____DOB:_____ AGE:_____

PARTNER NAME: _____

ADDRESS: _____

CITY: _____STATE:_____ZIP CODE: _____

HOME PHONE: _____ May I contact you at this number? _____

CELL: _____ May I contact you at this number? _____

EMAIL: _____May I Email you at this address? _____

WHO REFERRED YOU? _____FOR WHAT REASON? _____

EMPLOYER: _____YEARS:_____OCCUPATION:_____

HIGHEST GRADE/DEGREE COMPLETED: _____

RELATIONSHIP STATUS: _____YEARS:_____

RELIGIOUS ORIENTATION (if any):_____ACTIVE? _____

MILITARY STATUS_____

I accept full responsibility for any and all fees incurred by myself. Payments of my fee's will be made at the beginning of each visit. I agree to pay a 20.00 service fee on all returned checks. **If I must cancel an appointment, I will notify Susan Posada, Ph.D. at least 24 business day hours in advance BY PHONE(*initial*)** _____. I understand that I must make payment of $75.00 on any missed appointments, which are not cancelled with-in 24 hour business day notice, prior to scheduling my next appointment.

Signature: _____ Date: _____

SUSAN M. POSADA, PH.D., L.M.H.C., L.M.F.T., P.A.
CLIENT CONTRACT

CONFIDENTIALITY: Please be aware that under the provisions of confidentiality between Mental Health Providers and their clients, Susan Posada will not be able to speak to anyone regarding your case without written consent from you. There are, however, specific limitations to client confidentiality. In the event of a suspected case of abuse/neglect of children or the elderly, or the commission of a felony, I am required by law to make a report to the authorities. Furthermore, as required by law, when a client voices suicidal ideations or homicidal ideations, I am required to take the necessary steps towards protecting the client or the target of the homicidal ideations. I am also required by law to honor subpoenas.

_____ _____
Signature Date

CLINICAL RECORDS: As a client you have the right to review your clinical record.

_____ _____
Signature Date

FINANCIAL RESPONSIBILITY: I accept financial responsibility for any and all fees incurred by myself or my family members for services provided by Susan Posada. I agree to have a credit card on file which will be charged for unpaid balances. Should I desire to have phone consultations or require that a third party communicate with Susan Posada, or request written documentation, I agree to pay for all additional fees are incurred. Payment of my portion of fees will be made at the beginning of each visit. If I default on payment, I agree to pay collection costs, and reasonable attorney fees associated with collection of outstanding balance.

_____ _____
Signature Date

CANCELLATION POLICY: If I must cancel an appointment, I will notify the office at least **24 business day** hours in advance (**BY PHONE).** I understand that a missed appointment without providing adequate notice will result in a **$75.00** fee, which will be due prior to my next session and may be charged to my credit card on file.

_____ _____
Signature Date

CLIENT CONSENT TO TREATMENT: I HEREBY AUTHORIZE SUSAN POSADA, Ph.D. TO ADMINISTER TREATMENT. SUSAN POSADA WILL PROVIDE ME WITH THE BEST POSSIBLE CARE. THIS, IN NO WAY CONSTITUTES A WARRANTY THAT MY PRESENT CONDITION WILL BE CURED. I SIGN THIS WILLING AND VOLUNTARILY IN FULL UNDERSTANDING OF THE ABOVE, AND IN DOING SO RELEASE SUSAN POSADA FROM ANY AND ALL LIABILITY WHICH MAY ARISE FROM THIS ACTION, WHETHER OR NOT FORESEEN AT PRESENT.

_____ _____
Signature Date

CREDIT CARD CHARGE AGREEMENT

I authorize Susan Posada, PhD, to keep my signature on file and to charge my credit card for unpaid balances on my account, which may include the following:

- Written documentation, forensic services, and phone consultations.
- $75.00 fee for missing my appointment or for not canceling my appointment 24 business day hours in advance.
- Book, DVD or CD borrowing fee equal to the purchase price of the item (You will be reimbursed you when item is returned) $_____.
- Any returned check amount plus an additional 20.00 bank fee.
- Charge back fee's

I understand that as a courtesy, Dr. Posada will attempt to contact me if a charge needs to be made. However, she may place a charge whether or not she is able to contact me_____(initial) when I have an outstanding balance.

Clients Name: _____

Cardholder Name:_____

Cardholder billing Address:_____

City:_____ State: _____ Zip: _____

Type of card: Visa _____ Master Card _____ Discover _____ Am Ex _____

Charge card number: _____ _____ _____ _____

Expiration date: _____ Security Code (3 digit # on back of card) _____

Cardholder's signature: _____ Date:_____

PERSONAL INFORMATION

Briefly describe your reason(s) for seeking counseling at this time:

_____

_____

List names of significant others who may be involved in your counseling sessions:

NAME AGE RELATIONSHIP

_____

_____

What would you like your partner to change?

_____

What do you believe your partner would like you to change?

_____

Do you believe your sex life has been impacted by couple issues and if so, in what way?

_____

_____

Are there any other issues impacting your sexual relationship?

_____

_____

How will you know when it's time to terminate couples counseling (what will you see happening in your relationship that is different)?

_____

_____

Symptom List

Please rate 0-10 only the following that pertain to you (10 being the highest):

Difficulty with daily routine ____
Letting others take advantage of you ____
Persistent unwanted thoughts ____
Unable to stop certain behavior ____
Physically Abusing Others ____
Sexually hurting others ____
Verbally hurting others ____
Being physically abused ____
Being sexually abused ____

Hyperactivity ____
Nervous/Anxious ____
Anger ____
Lying ____
Depression ____
Stealing ____
Euphoria (feeling high) ____
Stress ____
Irritability ____

Being verbally abused ___
Seeing or hearing things without cause ____
Thoughts of hurting your self ____
Thoughts of hurting others ____
Worry about your health ____
Worry about someone else's health ____
Overly dependant on others ____
Letting others overly depend on you ___
Others complaining about your behavior ___
Acting before thinking ____
Self-esteem ____
Sexual concerns ____
Self control ____
Parenting issues ____
Relationship issues ____
Employment issues ____
Grief or loss _____
Financial Issues ____
Sudden mood changes____
Guilt_____

Please rate 0-10 any of the following behaviors you use to cope:

Shopping ____
Eating ____
Gambling ____
Sexual activity ____
Cleaning ____
Alcohol ____ How much do you drink a week? _____
Drugs ____ What drugs do you use and how much? _____
Cigarettes ____ How much do you smoke? _____
Caffeine ____ Source of caffeine and how much? _____

Please rate 0-10 your physical concerns:

Sleep patters ____
Eating patterns ____
Bladder control ____
Bowel control____
Seizures ____
Weight problem ____
Sexual functioning ____

Please list medical conditions or health issues you have had and indicate which ones affect your life now:

_____

Please list medications you are taking and for what purpose:

_____

Emergency contact name, relationship and phone number:

_____

I will Allow Dr. Posada to contact _____in an emergency situation.

Signature: _____ Date:_____