Bonnie Dooms, Licensed Marriage and Family Psychotherapist #95035
225 E. Carrillo Street, Suite 203 Santa Barbara, CA 93101
(925) 642-2052. Fax 888-920-2109. bonniedooms@gmail.com
www.bonniedoomslmft.com

New Client Intake Form

Please provider the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out completely and bring to you first session.

Name:____
(last) **(First)** **(Middle Initial)**
Name of parent/guardian (if under 18 years):______________________________
(Last) **(First)**
Birthdate:_________/__________/__________ **Age:**__________ **Gender:**__________
Address:____ **Contact Phone#:**_____________
(Number & Street Name) **(City)** **(State)** **(Zip)**
Martial Status: ___Never Married ___Domestic Partnership ___Married ___Separated ___Divorced ___Widowed
Name of Spouse:______________________________
Please list any children/age:____
Home Phone:_________________________ **May I leave a message? ___Y ____N**
Cell/Other Phone:____________________ **May I leave a message? ___Y ____N**
Email:_______________________________ **May I email you? ___Y ___N**
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Have you previously received any type of mental health services (psychotherapy, psychiatric services)? ___Y ___N
Previous therapist/practitioner name:____
Are you currently taking any prescribed medication? ___Y ___N
Please list all medications you are currently taking:_________________________________
Have you ever been prescribed psychiatric medication? ___Y ___N
Please list:____

General Health and Mental Health Information

How would you rate your current physical health? (circle) Poor Unsatisfactory Good Very Good
Please list any specific health problems that you are currently experiencing: _____________
____
How would you rate your sleeping habits? (circle) Poor Unsatisfactory Good Very Good
Please list any specific sleep problems you are experiencing:______________________________
How many times per week do you generally exercise?________________________________
Please list any difficulties you experience with you appetite or eating patterns:___________
____
Are you currently experiencing any overwhelming sadness, grief, or depression?___Y ___N

If yes, please explain:____

If yes, for approximately how long?**____**

Are you currently experiencing anxiety, panic attacks or have any phobias? ___Y ___N

If yes, when did you begin experiencing this?_______________________________________

Are you currently experiencing Depression? ___Y ___N

If yes, please describe:____

Are you currently experiencing chronic pain? ___Y ___N

If yes, please describe:____

How often do you drink alcohol during the week?________________________________

How often do you engage in recreational drug use? __Daily __Weekly __Monthly __Infrequently __Never

Are you currently in a romantic relationship? __Y __N If yes, for how long?____________

On a scale of 1-10 (1=poor, 10=great) how would you rate your relationship?_____________

Do you have a history of suicide attempts? __Y __N

If yes, please describe:____

What significant life changes or stressful events have you experienced recently?__________

____

Family Mental Health History

In this section, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (ex/ father, grandmother, uncle, etc).

	Please circle	List family member
Alcohol/Substance Abuse	Yes/No	_________________
Anxiety	Yes/No	_________________
Depression	Yes/No	_________________
Domestic Violence	Yes/No	_________________
Eating Disorders	Yes/No	_________________
Obesity	Yes/No	_________________
Obsessive Compulsive Behavior	Yes/No	_________________
Schizophrenia	Yes/No	_________________
Suicide attempts	Yes/No	_________________

Additional Information

Are you currently employed? ___Y ___N

If yes, what is your current employment situation? **_____________________________________**

Do you enjoy your work? Is there anything stressful about your work?________________

____

What do you consider to be some of your personal strengths?__________________________

What do you consider to be some of your personal weaknesses?________________________

What would you like to accomplish out of your time in therapy?________________________

____

Any additional information you feel that I should know?______________________________

____

____ ________________________

Client Signature **Date**

Bonnie Dooms, Licensed Marriage and Family Psychotherapist #95035
225 E. Carrillo Street, Suite 203 Santa Barbara, CA 93101
(925) 642-2052. Fax 888-920-2109. bonniedooms@gmail.com
www.bonniedoomslmft.com

AGREEMENT FOR SERVICE/ INFORMED CONSENT

Introduction

This agreement is intended to provide (name of patient)___________________________ with important information regarding the practices, policies and procedures of **Bonnie Dooms, LMFT** (herein "Therapist"), and to clarify the term of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of the Agreement should be discussed with Therapist prior to signing it.

Risks and Benefits of Therapy

Psychotherapy is a process in which Therapist and Patient discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so Patient can experience his/her life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties Patient may be experiencing. Psychotherapy is a joint effort between Patient and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other factors. Participating in therapy may results in a number of benefits to Patient, including but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on the part of the Patient, including an active participant in the therapeutic process, honesty, and a willingness to change feeling, thoughts and behaviors. There is no guarantee that therapy will yield any or all o the benefits listed above. Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Patient's perceptions and assumptions, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships. Patient should be aware that any decision on the status of his/her personal relationships is the responsibility of Patient. During the therapeutic process, may patients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. Patient should address any concerns he/she has regarding his/her progress in therapy with Therapist.

Professional Consultation

Professional consultation is an important component of a healthy psychotherapy practice.
As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Patient.

Records and Record Keeping

Therapist may take notes during session, and will also produce other notes and records regarding Patient's treatment. These notes constitute Therapist's clinical and business records, which by law,

Therapist is required to maintain. Such records are the sole property of Therapist. Therapist will not alter his/her normal record keeping process at the request of any patient or representative. Should Patient or Representative request a copy of Therapist's records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Patient, or Representative, with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Therapist will maintain Patient's records for ten years following termination of therapy. However, after ten years, Patient's records will be destroyed in a manner that preserves Patient's confidentiality.

Confidentiality

The information disclosed by Patient is generally confidential and will not be released to any third party without written authorization from Patient, *except* where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another.

Patient Litigation

Therapist will not voluntarily participate in any litigation, or custody dispute in which Patient, or Representative, and another individual, or entity, are parties. Therapist has a policy of not communicating with Representative's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's, or Representative's, legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Patient, Representative agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made him/herself available for such an appearance at Therapist's usual and customary hourly rate of $350.00.

Psychotherapist-Patient Privilege

The information disclosed by Patient, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Patient's behalf until instructed, in writing, to do otherwise by Patient or Patient's representative. Patient should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/her mental or emotional state an issue in a legal proceeding. Patient should address any concerns regarding the psychotherapist-patient privilege with his/her attorney.

Fee and Fee Arrangements

The usual and customary fee for service is **$ ____ per 50-minute session.** Sessions longer than 50-minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Patient will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, HMOs, managed care organizations, or other third-party payors, or by agreement with Therapist.

The agreed upon fee between Therapist and Representative is **$______ per 50-minute session.** Therapist reserves the right to periodically adjust fee. Patient will be notified of any fee adjustment in advance.

From time-to-time, Therapist may engage in telephone contact with Patient for purposes other than scheduling sessions. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. In addition, from time-to-time, Therapist may engage in telephone contact with third parties at the request of Patient and with the advance written authorization of Patient. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. Patient is expected to pay for services at the time services are rendered. Therapist accepts cash, checks, and major credit cards.

Insurance

Patient is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. *Patient is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles.* If Patient intends to use benefits of his/her health insurance policy, Patient agrees to inform Therapist in advance.

OR

Therapist is not a contracted provider with any insurance company, managed care organization. Should Patient choose to use his/her insurance, Therapist will provide Patient with a statement, which Patient can submit to the third-party of his/her choice to seek reimbursement of fees already paid.

Therapist Availability

Therapist's office is equipped with a confidential voice mail system that allows Patient to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Patient is feeling unsafe or requires immediate medical or psychiatric assistance, Patient should call 911, or go to the nearest emergency room.

Termination of Therapy

Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Patient needs are outside of Therapist's scope of competence or practice, or Patient is not making adequate progress in therapy. Patient has the right to terminate therapy at his/her discretion. Upon either party's decision to terminate therapy, Therapist will generally recommend that Patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Patient.

Acknowledgement

By signing below, Patient acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Patient has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by the terms and conditions of this Agreement and consents to

participate in psychotherapy with Therapist. Moreover, Patient agrees to hold 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.

I have read and understand the above.

____

Patient Name (please print)

____ ____________

Signature of Patient **Date**

I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

____

Name of Responsible Party (Please print)

____ ____________

Signature of Responsible Party **Date**

My therapist may call/leave message or communicate with client by:

____My therapist may call me at my home. My home phone number is: (   )________________

____My therapist may call me on my cell phone. My cell phone number is: (   )________________

____My therapist may call me at work. My work phone number is: (   )________________

____My Therapist may send mail to me at my home address.

____My Therapist may communicate with me by email. My email address is:_________________________

Cancellation Policy

If Patient or Representative needs to cancel their session, they must do so **48 hours in advance,** so that therapist can waive their weekly session fee and have an option to schedule a client who is in need during that time. If Patient or Representative cancels their appointment within **48 hours, or no show to the appointment,** *they will still be billed for the session time at the full rate.* If they have an emergency, they must contact Therapist as soon as possible so that they can offer an alternative time or mode of treatment (phone or video), if available. Cancellation notice should be left on Therapist's voice mail at 925-642-2052.

If Patient or Representative fails to pay the balance due for a missed appointment within **48 hours, or no show appointment,** Therapist will mail an invoice for the past due balance to the Patient or Representative. If Patient or Representative fails to respond to the invoice with payment in 48 hour period of time, Therapist will contact a collections agency to collect the past due balance.

Credit Card information for Patient or Representative will remain on file in case of failure to meet **48 hours in advance** of cancel and/or **no show appointments.**

Name on Credit Card: ____

Credit Card Number: ____

Expiration Date: ____

CVV Code: ____

Billing Zipcode: ____

I have read and understand the above.

____

Patient Name (please print)

____ ____________

Signature of Patient (if Patient is 12 or older) Date

____ ____________

Signature of Representative (and relationship to Patient) Date

____ ____________

Signature of Representative (and relationship to Patient) Date

Bonnie Dooms, Licensed Marriage and Family Psychotherapist #95035
225 E. Carrillo Street, Suite 203 Santa Barbara, CA 93101
(925) 642-2052. Fax 888-920-2109.   bonniedooms@gmail.com
www.bonniedoomslmft.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at **Bonnie Dooms, LMFT at 925-642-2052.**

If you have any questions about my Notice of Privacy Practices, please contact me at: **[225 E. Carrillo Street, Suite 203 Santa Barbara, CA 93101].**

I acknowledge receipt of the Notice of Privacy Practices of **[Bonnie Dooms, LMFT**].

Signature:___________________________________ Date:________________________
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including:____________________________________.
However, because of ____ I was unable to obtain my patient's acknowledgement.

Signature of Provider:______________________________ Date:___________________