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**

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AGREEMENT FOR SERVICE / INFORMED CONSENT FOR MINORS

Introduction

This Agreement has been created for the purpose of outlining the terms and conditions of services to be provided by **Bonnie Dooms, LMFT** (herein "Therapist") for the minor child(ren _____(herein "Patient") and is intended to provide [name of parent(s)/legal guardian(s)] _____(herein "Representative(s)") with important information regarding the practices, polices and procedures of [insert therapist's name] (herein "Therapist"), and to clarify the terms of the professional therapeutic relationship between Therapist and Patient. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

Policy Regarding Consent for the Treatment of a Minor Child

Therapist generally requires the consent of both parents prior to providing any services to a minor child. If any question exists regarding the authority of Representative to give consent for psychotherapy, Therapist will require that Representative submit supporting legal documentation, such as a custody order, prior to the commencement of services.

Risks and Benefits of Therapy

A minor patient will benefit most from psychotherapy when his/her parents, guardians or other caregivers are supportive of the therapeutic process.

Psychotherapy is a process in which Therapist and Patient, and sometimes other family members, 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 result 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, school, and family settings, and increased self-confidence. Such benefits may also require substantial effort on the part of Patient, as well as his/her caregivers and/or family members, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. This discomfort may also extend to other family members, as they may be asked to address difficult issues and family dynamics. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge the perceptions and assumptions of the Patient or other family members, and offer different perspectives. The issues presented by Patient may result in unintended outcomes, including changes in personal relationships.

During the therapeutic process, many 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 or Patient's family members or caregivers.

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. Representative will generally have the right to access the records regarding Patient. However, this right is subject to certain exceptions set forth in California law. Should Representative request access to Therapist's records, such a request will be responded to in accordance with California law.
Therapist will maintain Patient's records for ten years following termination of therapy, or when Patient is 21 years of age, whichever is longer. 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.

Representative should be aware that Therapist is not a conduit of information from Patient. Psychotherapy can only be effective if there is a trusting a confidential relationship between Therapist and Patient. Although Representative can expect to be kept up to date as to Patient's progress in therapy, he/she will typically not be privy to detailed discussions between Therapist and Patient. However, Representative can expect to be informed in the event of any serious concerns Therapist might have regarding the safety or well-being of Patient, including suicidality.

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. In addition, Therapist will not make any recommendation as to custody or visitation regarding Patient. Therapist will make efforts to be uninvolved in any custody dispute between Patient's parents.

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 a person with the authority to waive the privilege on Patient's behalf. When a patient is a minor child, the holder of the psychotherapist-patient privilege is either the minor, a court appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law. Representative is encouraged to discuss any concerns regarding the psychotherapist-patient privilege with his/her attorney.

Patient, or Representative, 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, or Representative, should address any concerns he/she might have 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. Representative 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. Representative will be notified of any fee adjustment in advance.

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

Insurance

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

Therapist is not a contracted provider with any insurance company, managed care organization. Should Representative choose to use his/her insurance, Therapist will provide Representative with a statement, which Representative 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 or Representative 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 or Representative 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 or Representative 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 or Representative.

Acknowledgement

By signing below, Representative acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Representative has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Representative's satisfaction. Representative agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Representative 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 (if Patient is 12 or older) **Date**

_____ _____

Signature of Representative (and relationship to Patient) **Date**

_____ _____

Signature of Representative (and relationship to 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 (and relationship to Patient) Date

_____
Name of Responsible Party (Please print)

_____ _____
Signature of Responsible Party (and relationship to Patient) 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**

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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:_____