**Upstate Family Solutions**

**Amy L. Wood, MMFT, LMFT**

**License #4587**

Upstate Family Solutions does not discriminate based on race, color, religious affiliations, sexual orientation, national or ethnic origin.

**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clients’ full name and the names of family members living in the household:

**Name**  **Date of Birth**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing and email Addresses:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone Numbers:**

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I leave a message and identify myself? Write yes or no

Home: \_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_ Alternate: \_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_

**How did you find me?** Please circle: Google search Psychology Today Word of Mouth

Direct Referral by : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you been to a therapist previously?**  YES\_\_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_ If yes, please explain reason for visits and approximate dates of attendance:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship Status:**

Single\_\_\_\_\_\_\_ Married\_\_\_\_\_\_\_ Widowed\_\_\_\_\_\_\_ Separated\_\_\_\_\_\_\_

Divorced\_\_\_\_\_\_\_ Engaged\_\_\_\_\_\_\_ Domestic Partnership\_\_\_\_\_\_\_ Dating \_\_\_\_\_\_\_

Committed Relationship \_\_\_\_\_\_\_

**List any medications you are currently taking:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appointment Etiquette and Billing:**

Appointments are typically 50 minutes long. Please arrive on time. If you are unable to keep an appointment, 24 hour notice is required or you will be charged a late fee as if you attended therapy. Payment must be rendered at each session in order to schedule further appointments. Payment may be rendered in the form of cash, check, credit card, or flex spending account. There is a $35 fee on all returned checks.

**The fee schedule is as follows:**

Individual therapy sessions (50 Mins): $100

Couple or family sessions: (50 Mins): $100

75 Mins sessions: $125

Professional written reports or legal letters (one week notice is required): $25 per 30 minute increments for preparation time

Fee for missed appointments: The cost of a session

**I understand the fee schedule and that the fee is collected at the end of the appointment.**

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confidentiality and Release of information:**

Information shared during your therapy sessions will be held in strictest confidence as Protected Health Information. Therapy records cannot be distributed to anyone without expressed informed and voluntary written consent. Exceptions to your confidentiality rights are as follow:

1. Where there is suspicion or evidence of child or elder abuse
2. Where there is reasonable suspicion or evidence that the client is a danger to self (duty to protect) or others (duty to warn)
3. Court order
4. I may disclose specific information if I have a signed waiver from each participant in therapy

Client signature(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Information:**

I strive to return all calls in a timely manner. I will check voice mail and emails throughout the day and will respond within 48 hours of receipt. I have office hours Monday to Saturday by appointment only. If you have an emergency and I am unable to be contacted please call 911.

**Benefits and Consequences of Therapy:**

Therapy is about change and clients usually begin to feel differently about themselves, their relationships, and their life situation during the therapeutic process. You may experience significant improvement in emotions, behaviors, attitude, and beliefs. Therapy is collaboration between the client and the therapist. However, the therapist cannot guarantee that therapy will accomplish all the goals set forth by the client. If you have any questions about the benefit and/risks of therapy, it is appropriate to raise these concerns with your therapist. Participation in therapy is strictly voluntary (unless court ordered) and may be terminated at any time. If you believe that your needs may be better served elsewhere, your therapist will gladly provide referral options at any time.

In compliance with SC law, you are advised that sexual contact between therapist and client is never appropriate, is illegal, and should be reported to the Grievance Board of the SC LLR Board. Other dual relationships are prohibited. In the event of a legitimate concern that your therapist has acted in an unethical manner, please register a complaint with the Board of Examiners:

SC LLR Board

P.O.Box 11329

Columbia, SC 29211-1329

**Clients Rights and Consent for Treatment:**

I understand that my participation (or my minor child’s participation) in therapy is voluntary. I may terminate the therapeutic relationship at any time, and I may discuss the reasons for doing so with my therapist. I may ask questions about the services I am receiving. I have the right to review my case file, ask questions, and make comments or complaints to my therapist.

I understand that all the information shared is held in strict confidence and is only released by my written permission to specific individuals or institutions for specific purposes. In addition, I have been informed of the legal exceptions to confidentiality.

I have read and understand this notice and give consent for treatment.

Signature of the Client(s) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of the Therapist Date

**Confidentiality**

**Although shared personal information is confidential, there are exceptions set by my professional code of ethics and the law.**

1. I must report what is mandated by law, such as child abuse or elder neglect.
2. I must report if there is a clear and present danger to a person or persons such as suicide or homicide.
3. I may disclose specific information if I have a signed waiver from each person participating in therapy.
4. I must disclose if it is determined that you are in need of hospitalization.
5. I must disclose if I believe your mental/emotional condition makes you unable to care for yourself or people for whom you responsible.
6. I must disclose if I am court ordered by a judge.
7. I may disclose information in order to defend myself against charges arising from therapy. I am subject to subpoenas.
8. I may disclose for the purpose of insurance filing/third party payment.

Emergency Numbers

Emergency Services 911

Greenville Memorial Hospital Info Line 864-455-7000

Greenville Mental Health Crisis Line 864-241-1040

Greenville Rape Crisis and Child Abuse Line 864-467-3633

Suicide Prevention/Crisis Intervention Hotline 864-271-8888

Safe Harbor Domestic Violence Crisis Line 864-467-3636

**I have read the above policies and give information consent for therapy**.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_