Erin Miguelgorry, MA, LMFT
101 Parkshore Dr. Folsom, CA 95630
(916)804-4471
FolsomTherapy@gmail.com
www.ErinMFT.com

New Client Information

Date:_____

Name:_____

Date of Birth:_____ Age:_____ Identified Gender:_____

Marital Status:____ Single ____Married ____Partnered ____Significant Other ____Separated ____Divorced ____Widowed

Home Phone:(_____)_____ Cell Phone:(_____)_____

Work Phone:(_____)_____ Preferred Contact: ____Home ____Cell ____ Work

Email:_____

Home Address (No., Street, City, State, Zip):_____

_____

Emergency Contact:_____Phone:(_____)_____Relationship:_____

Referral Source: Psychology Today, Website, Friend/Family:_____, Other:_____

Occupation/Place of Work:_____

Highest Level of Education:_____

Physician's Name:_____ Phone Number:(____)_____

Medications currently taking and dose:

_____

_____

If you are currently being treated (or have been treated previously) for a medical condition please explain below:_____

_____

Have you had any previous hospitalizations (mental health or physical)? (reason, date and length of stay)

_____

_____

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Have you had previous psychotherapy? Yes___ No___ Date and purpose for previous therapy:

_____

_____

Why are you seeking psychotherapy now?_____

_____

_____

What are the 3 most important goals for you in therapy?

1._____

_____

2._____

_____

3._____

_____

Who are the most important people in your life? (name, relationship, age and years known)

_____

_____

_____

_____

_____

_____

_____

Do you have an active spiritual practice? Please explain:

_____

_____

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In a few words describe the following as it pertains to your life in the past month:

Sleep:_____

_____

Exercise:_____

_____

Food:_____

_____

Work:_____

_____

Family:_____

_____

Personal relationships:_____

_____

Sexual satisfaction:_____

_____

Current emotional state:_____

_____

Desired emotional state:_____

_____

Anything else you would like me to know?

_____

_____

_____

_____

_____

_____

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Please check the feelings that apply to you in the past month:

____*I feel tense most of the time.*

____*I have a lot of physical problems that can't be explained.*

____*I worry most of the time.*

____*I have experienced sensations of shortness of breath, heart palpitations or shakiness when feeling stressed, overwhelmed or scared.*

____*I avoid social situations because I am fearful.*

____*I get tired for no reason.*

____*There are some things that I am really afraid of that interfere with my life.*

____*I think about dying or killing myself.*

____*I have thoughts constantly in my mind which interfere with my ability to concentrate and function effectively.*

____*I no longer have interest in the things that used to interest me.*

____*I have routines or rituals that interfere with my daily activities ie: hand washing, checking locked doors, etc.*

____*I have nightmares and/or flashbacks of events.*

____*I "explode" when angry and feel like I have little control over my reaction.*

____*I feel hopeless about the future.*

____*I can't make decisions because I have a difficult time concentrating.*

____*I feel sluggish or restless.*

____*I am gaining or losing weight without trying.*

____*I'm sleeping too much or too little.*

____*I feel unhappy.*

____*I become irritable or anxious easily.*

____*I have spontaneous urges to cry.*

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Office Policy and Informed Consent

CONFIENTIALITY: Any information you reveal to me is considered private and it is your right to have that information kept confidential. The exceptions to the limits of confidentiality are as follows: (1) you consent in writing to release information (2) the life or safety of you or someone else is threatened (3)disclosure is required by law*.

HOURS and EMERGENCIES: I can be reached during regular business hours Monday through Friday and typically return calls within 48 hours. When I am out of town, I will make arrangements for another therapist to cover crisis calls. Text messages and emails are not guaranteed to be secure and are used to discuss scheduling only. In the event of an emergency, and I can not be reached quickly, you may call your family physician, the Sacramento County Emergency Crisis Line at 916-875-1000, or 911.

THERAPEUTIC RISK: While it is anticipated that therapeutic services will be helpful to you, there is the possibility that you will experience some life disruption and emotional distress. You are free to discontinue treatment at any time.

PHYSICAL EXAMINATION: We strongly recommend that each client obtain a thorough physical exam prior to commencing therapy. This is especially important if you are suffering symptoms of anxiety or depression, headaches, and/or weight gain/loss. Symptoms may be biologically caused or may be there for a protective reason.

PAYMENT: Fees are payable at the time of your appointment to Conscious Path Therapy unless other arrangements have been made in advance. You are responsible for payment of services received even if insurance is billed. **Be aware that insurance authorizations do not guarantee payment**. If special arrangements are made for assignment of benefits, you are responsible for any deductible or copayment at the time of your appointment. There is a fifteen-dollar ($15.00) service charge for all checks returned by the bank. Insurance will not be billed for couples therapy.

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CANCELATION and MISSED APPOINTMENTS: Your appointment time is reserved for you. Without **24 hour cancellation notice,** you are responsible for payment of the missed or late cancel appointment at $130/hour. **Insurance companies can not be billed for missed or late cancel appointments, and you are solely responsible for paying the charge of the scheduled appointment.**

*Additional fees are associated.

I, (Print Name)_____understand this form and accept it as the terms of my participation in counseling/therapy with Erin Miguelgorry, LMFT.

Your Signature_____Date_____

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ACKNOWLEDGEMENT OF RECEIPT OF OFFICE POLICY AND INFORMED CONSENT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices, Office Policy, and Informed Consent that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information, payment, and office policy. 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 916-804-4471. If you have any questions about my Notice of Privacy Practices, please contact me at: Folsomtherapy@gmail.com.

I acknowledge receipt of the Notice of Privacy Practices of Conscious Path Marriage and Family Therapy, Inc.

Signature:_____(patient/parent/conservator/guardian)

Date:_____

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 _____[insert reasons why acknowledgement was not obtained] I was unable to obtain my patient's acknowledgement.

Signature of Provider:_____

Date:_____

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Private Payment for Therapy

If your insurance is not in-network or you are choosing to pay out of pocket, payment is due at the time of each session. We will provide a "Super-bill" if you are eligible for re-imbursement from your insurance company at your request. Services may be covered in full or in part by your health insurance company or employee benefit plan.

You are responsible for payment for all services rendered either by check, cash, or credit card. All checks will be paid to Conscious Path Therapy.

Agreement:

I _____(print name) have read and understand the terms of payment and services at Conscious Path Therapy.

Signature:_____ Date:_____

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Insurance Form*

*To be completed if using insurance. Please check with CPT to see if we accept your insurance.

Insured's I.D. Number: _____

Client Legal Name (First, Middle Init, Last):_____

Client's Birthdate:_____

Client's Sex:_____

Insured's Name (First, Middle Init, Last):_____

Client's Address (No., Street, City, State, Zip): _____

_____

Patient Relationship to Insured: _____ Self _____ Spouse _____Child _____ Other

Insured's Address (No., Street, City, State, Zip):_____

_____

Client Status: _____ Single _____ Married _____ Other

Client Status: _____ Employed _____ Full-Time Student _____ Part-Time Student _____ Other

Client's Condition Related to: ____ Employment ____ Auto Accident ____ Other Accident ____ None

Insured's Policy or FECA Number:_____

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Primary Insured Date of Birth:_____

Primary Insured Sex:_____

Primary Insured Employer's Name or School Name:_____

Insurance Plan or Program Name:_____

Payer Name (Mental Health Coverage):_____

Address of Payer (No., Street, City, State, Zip):_____

_____

Phone Number for Provider/ Mental Health Claims:_____

Current Co-Pay: $_____

Insurance coverage is not guaranteed and depends on your plan benefits. Fees are payable at the time of your appointment to Conscious Path Therapy unless other arrangements have been made in advance. You are responsible for payment of services received even if insurance is billed. **Be aware that insurance authorizations do not guarantee payment**. You will be held responsible for any balance insurance does not cover. If special arrangements are made for assignment of benefits, you are responsible for any deductible or copayment at the time of your appointment.

PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.

Name:_____

Signature:_____ Date:_____