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:_____

_____

What do you see as the biggest relationship issue?

_____

_____

_____

_____

_____

_____

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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.

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.

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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. 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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Permission to Video Taping Therapy Sessions

I/We_____

Consent to the video taping of therapy sessions with Erin Miguelgorry, LMFT.

I/We are aware of the presence of the video equipment and permit the use of all or part of the video tapes for the purpose of:

_____(initial) Our therapist review of our case to assist in our therapy

_____(initial) Our therapist's consultation with a supervisory/peer consultant.

In no way will the refusal to grant consent for this video taping affect our getting assistance for ourselves. If at any time during the treatment process, we wish to stop the taping, we may do so and still continue treatment.

Signature_____ Signature_____

Printed Name_____Printed Name_____

Date_____ Date_____

Therapist's Signature_____

Therapist's Printed Name_____

Date_____

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"No Secrets" Policy

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the _____(couple/family or other unit) being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Erin Miguelgorry, LMFT (the therapist), and that we enter couple/family therapy in agreement with this policy.

Dated:_____ Signature_____

Dated:_____ Signature_____

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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 or cash. 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:_____