FULFILLMENT FAMILY THERAPY

(Please Print Legibly)

Today's date:			Email:	
PATIENT INFORMATION				
Patient's last name: First: Middle:		Mr. Mrs.	Miss Ms.	Marital status: Single / Mar / Div / Sep / Wid / Other
	Sex: M F Other	Birth date: / /	Age:	
Street address:		Apt.#		Best contact phone no.: ( )
OK to leave message? Email Y / N Phone Y / N	City:	State:	ZIP Code:	
Occupation:	Employer:			
How did you hear about us? (circle one):	Doctor	Church	EAP	Google
Family	Friend	Psychology Today	Insurance	Other (please list):
Names and ages of other household members living with you:				

BACKGROUND INFORMATION				
Please list any medications you are currently taking:		Physician:		
Any previous counseling? Yes No Explain:				
Sexual Orientation:	Straight	Gay/Lesbian	Bisexual	Other:
Please list any religious affiliations:				

IN CASE OF EMERGENCY			
Nearest friend or relative (not living with you):	Relationship to patient:	Best phone no.: ( )	Alt. phone: ( )
I certify the above information is true and correct to the best of my knowledge. When applicable, I authorize Fulfillment Family Therapy to obtain insurance verification, authorization and to use my information for the submission and processing of claims for billing purposes. I understand that I am financially responsible for all service fees.			
Patient/Guardian signature		***Date***	

FULFILLMENT FAMILY THERAPY

CONSENT FOR CREDIT/DEBIT CARD AUTHORIZATION

I, _____ authorize Fulfillment Family Therapy to charge my below stated credit /debit card for any outstanding balances. (This may include any unpaid/late/overdue balances or cancellation fees). I understand all fees are due at the time of service, that I am responsible for any fees denied by my insurance company, and that if I change and/or cancel my scheduled appointment without a sufficient 24-hour notice, this credit card/debit card will be billed for the $60 cancellation fee at the time of the original scheduled appointment.

Note: All patients, including those using insurance benefits will be held responsible for the cancellation fee as insurance does not cover missed appointments or cancellations. We apologize in advance for any future inconvenience this may cause. We deeply appreciate your understanding of the necessity in this matter.

Circle One: MasterCard / VISA / Discover / American Express

Credit Card Number: _____

Expiration Date: _____

Security Code on back of card: _____

Billing Address Zip Code:_____

Name Appearing on Card: _____

Authorized Signature: _____ Date: _____

Patient Insurance Information Form

If you plan to use your insurance benefits, this form is used for billing purposes and to review your health insurance policy coverage to help determine if your policy contains coverage for services rendered. Completion of this form will not guarantee your approval for services. Should your health insurance provider deny payment for any services, you will be responsible for the charges. We cannot be held liable for any incorrect information provided to you by your health insurance provider.

Complete the following with the information from your health insurance card:

Patient Name:

ID Number:

Patient Date of Birth:

Subscriber Name: (if different than client)

Subscriber Date of Birth:

Insurance Name:

Insurance phone number:

Is there any secondary coverage? Y / N

If yes, please complete below:

Patient Name:

ID Number:

Patient Date of Birth:

Subscriber Name: (if different than client)

Subscriber Date of Birth:

Insurance Name:

Insurance phone number:

CLIENT QUESTIONNAIRE

Name: _____ Date: _____

1. Describe the recent events or problems you have been having that led you to seek mental health services? (Include when these problems began and how frequently they occur).

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2. Describe any significant events in the past or current stressful experiences that might be contributing to current problems.

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3. Describe how the problems above affect your daily functioning (i.e. do they cause problems at school, with your job, with relationships, physical problems, etc.?)

FULFILLMENT FAMILY THERAPY
ANGELA CAIAZZA, M.S., LMFT
Licensed Marriage & Family Therapist
123 E Powell Boulevard, Suite 303
Gresham, OR 97030
(503) 516-8266

PSYCHOTHERAPY INFORMATION DISCLOSURE STATEMENT

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. The following will address these rights, responsibilities, as well as office policies.

My Responsibilities to You as Your Therapist:

I. Confidentiality, Consent for Release and HIPPA

With the exception of certain specific situations described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me, without your written permission. I will always act to protect your privacy even if you do release me in writing to share information and you may revoke that permission at any time. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law ensures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically, for example, sending bills or faxing information; it will be done with special safeguards to ensure confidentiality. **If you elect to communicate with me via text or email at any point in our work together, please be aware that text and email is not completely confidential.** All text and emails are retained in the logs of internet and phone service providers. While under normal circumstances no one looks at these logs, they are available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record.

The following are legal exceptions to your right to confidentiality. I would inform you of any time these may need to be put into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 24 hours and Adult Protective Services immediately.
3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.
4. If there becomes some legal involvement in your case, (this includes defending claims brought by a client against me) I may be court ordered to release records or testimony. In such cases, I will typically attempt to assert confidentiality; however, a judge may overrule this if he or she determines that this information is necessary. **I strongly discourage the use of treatment with me to further legal goals such as divorce, custody evaluation or abuse investigation. The purpose of my services is to promote client well-being. If courts or lawyers become involved, I will refer you out to continue your therapy with another therapist as this changes the therapeutic relationship and I can no longer be objective. If you are seeking services for legal reasons, we should discuss referrals to another resource.**

II. My Training and Approach to Therapy, Benefits/Risks of Treatment, & Office Policies

I have a M.S. in Counseling earned in 2007 at University of Nevada Las Vegas. I am a licensed marriage and family therapist in the state of Oregon (#T0828). My areas of special training and expertise include family, couple and group therapy, with an emphasis on infidelity, life transitions, family members and spouses of those struggling with substance abuse, mood/anxiety disorders and grief. I use an eclectic approach depending on the specific problems you are facing. Some of the approaches I work from include Cognitive-Behavioral, Psychodynamic, Bowen Family Systems and Experiential therapies. These philosophies of psychotherapy look at present thoughts, feelings and behaviors as well as developmental experiences and interactions within relationships. As a licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I will abide by its Code of Ethics. To maintain my license, I am required to participate in annual continuing education, taking classes dealing with subjects relevant to this profession. I do not have social or sexual relationships with clients or former clients. Not only would that be unethical and illegal, it would also be an abuse of power as a therapist. **Should we run into each other outside of therapy, you are welcome to approach/acknowledge me but I will respect your privacy should you choose not to. If I am with family and friends, I will always introduce you as friends unless you choose to share otherwise. Therapy also has potential emotional risks.** Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings, some of them painful at times. It is important that you consider carefully whether these risks are worth the benefits. Most people who take these risks find that therapy is helpful. You will typically be the one who decides therapy will end, with three exceptions. If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract. If I am not able to help you because of the kind of problem you have or because my training and skills are not appropriate for the problem(s) you are facing, I will inform you of this and refer you to another therapist who can meet your needs. If you do violence to, threaten, (verbally or physically) or harass myself, the office, or my family; I reserve the right to terminate your treatment with me immediately. If I terminate you from therapy, I will offer you referrals to other sources of care but cannot guarantee that they will accept you for therapy. I am rarely available outside of sessions. **Please keep contact limited to our session time. I will be available for brief between-session phone calls only if necessary during normal business hours. If you are experiencing an emergency outside of my regular office hours please call 911, your local county crisis team, or go to the nearest hospital emergency room for assistance.**

Client Rights:

II. As a client of an Oregon registered intern, you have the following rights:

- To expect that a licensee has met the minimal qualifications of training and experience required by state law;
- To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
- To obtain a copy of the Code of Ethics;
- To report complaints to the Board;
- To be informed of the cost of professional services before receiving the services;
- To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions described above.
- To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

Your Responsibilities as a Therapy Client:

Your responsibilities include coming to your session on time and at the time we have scheduled. Sessions last for 45 minutes. If you are late, we will end on time and not run over into the next person's session. **You must cancel 24 hours in advance to avoid being charged a $60 cancellation fee.** My fees are $200 for intake (your first session) and $150 for future sessions and can be paid **preferably via cash or check**, or credit/debit card if necessary prior to starting your session. If you choose to use your insurance benefits, it is important that you find out exactly what mental health services your insurance policy covers since you, not the insurance company are responsible for all service fees. Should you choose not to utilize your insurance benefits; a sliding scale may be offered during any financial hardship (no access to medical benefits, job loss, bankruptcy, etc). **I am unable to offer services outside of session,** such as additional phone calls**,** coordination of care, FMLA, legal or disability paperwork services, should the need arise for any of these or copies of records, I will charge my hourly fee of $150 for each service. Should I ever be court ordered to appear in court, I charge $1100.00 per appearance. These services are not billable to insurance. I am unable to have clients run a bill with me, I cannot barter for therapy and I do not provide court-mandated treatment.

Complaints

I ask that you speak with me about any complaints you may have regarding your care so that I can respond to your concerns. I will take such criticism seriously and with respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you can contact the Oregon Examining Board:

Board of Licensed Professional Counselors and Therapists
3218 Pringle Rd. SE, Ste 120
Salem, OR 97302-6312
(503) 378-5499

Client Consent to Psychotherapy

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to and understand it. I understand the limits to confidentiality required by law. I agree to pay service fees prior to each session. I understand my rights and responsibilities as a client and my therapist's responsibilities to me. I agree to undertake therapy with Angela Caiazza, M.S., LMFT. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by my therapist. I acknowledge I am over the age of fourteen. When applicable, I authorize Fulfillment Family Therapy to obtain insurance verification, authorization and to use my information for the submission and processing of claims for billing purposes.

Signed:_____Date:_____

Signed:_____Date:_____
(Spouse/Partner/Legal Guardian if minor)

Witness:_____Date:_____