William C. LaForge, Ph.D.
28362 Vincent Moraga Drive
Suite C
Temecula, CA 92590
951/699-9055

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# INFORMATION AND PROCEDURES

**CLIENTS**
Clients often have many questions regarding therapy and their therapist. This is intended to answer many of the questions you might have. If you have any further questions either about the therapeutic process or about your therapist at anytime, do not hesitate to ask. You have the right to be informed and you can get that by asking questions. Please become familiar with the following:

**THERAPIST**
Dr. LaForge is a licensed Psychologist and a licensed Marriage, Family and Child Therapist. He has been in the field of Psychology for 29 years.

**HOURS**
Our office is open for scheduled appointments Monday through Thursday, 8:00 a.m. to 5:30 p.m. and Friday 8:00 a.m. to 12:00 p.m. We maintain a 24-hour answering service for your convenience with paging for emergency.

**SESSIONS**
A standard counseling session is 45 minutes long for the client. Please arrive for sessions a few minutes early. Please have payment or co-pay ready before the session.

**APPOINTMENTS**
Clients are seen by appointment only. Unlike medical doctors or dentists a full 45 minutes is reserved for each client. If you need to reschedule or cancel an appointment, please do so as far in advance as possible. Appointments that are not cancelled 24 hours in advance will be charged $70.00 for the session. The client is automatically responsible for payment. In addition, if you arrive late to your session, you will have whatever remaining time left of your scheduled session.

# INTAKE FORM

Patient's name Birthdate age Date

Street Apartment number

City State Zip Code

Social Security Number Email Address

Home phone Cell phone Work phone

Marital Status: (Circle one) Single Married Cohabiting Separated Divorced Widowed Other

Partner's name and occupation: _____

If married or living together, for how long? _____

Your first marriage? ____ Spouse's first? ____

How long since you were separated, divorced or widowed? _____

How many children do you have (include ages and names)?

**MEDICATION**

Current medications/dosage/managed by: _____

Primary Care Physician: _____

Any known allergies/adverse reactions: _____

Current Medical Conditions: _____

**EDUCATION AND EMPLOYMENT**

Number of years of schooling completed: _____ Occupation: _____

Length of employment: _____ Current Salary: _____

If unemployed, why? _____

**INSURANCE AND DISABILITY STATUS**

Are you receiving or seeking disability? _____ What type? _____

Are you engaged in or contemplating any legal proceedings? _____

**CONTACTS FOR EMERGENCIES OR CONSULTATIONS**

| | Name | Relationship | Phone |
|---|---|---|---|
| Relative we can reach for emergency: | | | |
| Other professional who is treating you: | | | |
| Past mental health provider: | | | |
| Other: | | | |

**Referred to this office by:** _____

**IF PATIENT IS UNDER 18, PLEASE COMPLETE THE FOLLOWING:**

FAMILY INFORMATION:

| | Age | Highest Level of Education Reached | Currently living in home |
|---|---|---|---|
| Father: _____ ( ) Biological ( ) Step ( ) Foster ( ) Adopted | ____ | _____ | Yes No |
| Occupation: _____ | | | |
| Mother: _____ ( ) Biological ( ) Step ( ) Foster ( ) Adopted | ____ | _____ | Yes No |
| Occupation: _____ | | | |

If a parent is not currently living in home with patient, please list their current telephone number: _____

**OTHER CHILDREN**: (In chronological order)

| | | | |
|---|---|---|---|
| _____ ( ) Biological ( ) Step ( ) Foster ( ) Adopted | ____ | _____ | Yes No |
| _____ ( ) Biological ( ) Step ( ) Foster ( ) Adopted | ____ | _____ | Yes No |
| _____ ( ) Biological ( ) Step ( ) Foster ( ) Adopted | ____ | _____ | Yes No |
| _____ ( ) Biological ( ) Step ( ) Foster ( ) Adopted | ____ | _____ | Yes No |

**MARITAL STATUS OF PARENTS:**

Current Marriage: Date of: Marriage: _____
Separation: _____
Divorce: _____

Prior Marriage(s): Mother: Date Married: _____ to _____

Father: Date Married: _____ to _____

**CURRENT SCHOOL SITUATION:**

Name of current School: _____ City: _____

Grade in School: _____ Type of Classroom: Regular _____ Other: _____
Name of School Counselor (if involved): _____
Name of Teacher (if involved): _____

Name of Patient: _____ Date:_____

# INSURANCE INFORMATION

Name of Person who holds policy: _____

Social Security Number: _____ Date of Birth: _____

Mailing Address: _____
Street City State Zip
Home Telephone: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____

Employer Address: _____ Work Telephone: _____

**PRIMARY INSURANCE INFORMATION:**

Name of Primary Insurance Company:

Address: _____
City: _____ State: _____ Zip Code: _____

Telephone Numbers: _____
I.D. Number: _____
Group Number (or name): _____
Authorization Number: _____

**IS THE PATIENT COVERED UNDER ANY OTHER INSURANCE POLICY?**
**YES NO (Circle one)**

**SECONDARY INSURANCE INFORMATION:**

Name of Secondary Insurance Company:

Address: _____
City: _____ State: _____ Zip Code: _____

Telephone Numbers: _____
I.D. Number: _____
Group Number (or name): _____

**William LaForge, Ph.D.**
**Psychologist**
**28362 Vincent Moraga Drive * Suite C * Temecula, CA 92590-3656 * 951/699-9055**

**NAME OF PATIENT:** _____

**CONFIDENTIALITY AND LIMITS TO CONFIDENTIALITY**

Patient confidentiality is a vital component of psychotherapy. It is extremely important that patients feel secure that what they discuss in therapy will not be shared.

There are three circumstances in which a therapist is required by California State Law to report confidential information to state public welfare officials. These are when the therapist has reasonable suspicion of the occurrence of (1) child abuse, (2) physical abuse of an elder or dependent adult living in the home, and (3) expressed intent to harm yourself or another person.

We provide you with this information so you can choose whether or not to discuss such events with your therapist. However, it is in everyone's best interest to discuss such information to provide safety to all parties concerned.

I have read, understand, and agree to the terms stated herein.

Signature: _____ Date: _____

**ACKNOWLEDGEMENT OF RECEIPT OF PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT AND NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have read the Psychotherapist-Patient Services Agreement and agree to its terms. I have also received a copy of Dr. LaForge's Policies and Practices to Protect the Privacy of your Health Information Notice.

I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended notice of privacy practices.

Signature: _____ Date: _____

Print Name: _____ Telephone: _____
If not signed by the patient, please indicate relationship:
O Parent or guardian of minor patient O Guardian or conservator of an incompetent patient
O Beneficiary or personal representative of decreased patient

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby assign the insurance benefit payments to which I am entitled directly to William LaForge, Ph.D. A Photostat of this original authorization is accepted with the same authority as the original.

Insured's Signature: _____ Date: _____

**AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY**

I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government benefits to the party who accepts assignment.

Insured's Signature: _____ Date: _____

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# COUNSELING CONTRACT

1. I agree to give 24 hours notice to cancel sessions (telephone messages taken 24 hours a day at 951/699-9055.) I understand that I will be charged a cancellation fee of $70.00 for sessions cancelled less than 24 hours in advance and for "No Shows."

   Dr. LaForge will answer any questions you have about this agreement.

2. I understand that William LaForge, Ph.D. will bill my insurance. However, I understand that I am responsible for my therapy bill regardless of insurance reimbursement.

Date: _____ Client: _____
(Signature)

Parent: _____

Witness: _____ Guardian: _____
William C. LaForge, Ph.D.

**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**
**TO PRIMARY CARE PHYSICIANS AND/OR OTHER HEALTH CARE PRACTITIONERS**

**PATIENT INFORMATION:**

Name: _____ ID#: _____
Address: _____ Date of Birth: _____
_____ Telephone #: _____

**TO PRIMARY CARE PHYSICIAN**: **FROM PROVIDER**:

Name: _____ Name: William C. LaForge, Ph.D.
Psychologist
Address: _____ Address: 28362 Vincent Moraga Drive, Suite C
_____ Temecula, CA 92590-3656
Telephone #: _____ Telephone #: 951/699-9055
Fax #: _____ Fax #: 951/699-8586

Patient Behavioral Health Information:

Date of Initial Assessment: _____ DSM-IV Code: _____
Current Symptoms: _____
Current Medications/Dosage/Managed by: _____
_____
Any known allergies/adverse reactions: _____

I authorize the provider and primary physician to release/obtain all medical records and information concerning patient. I understand that the release of this information is to permit my treating physician and other health care practitioners to monitor my health status and to coordinate all the care which I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time by giving written notice to the parties above, except to the extent action has been taken in reliance hereon. If not earlier revoked or instructed, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to the authorized recipient(s) only. I further understand that I have a right to receive a copy of this authorization upon my request. A photocopy/FAX copy shall be as valid as the original.

Confidentiality of alcohol and drug abuse patient records is protected under federal law. Federal regulations (42 CFR, part 2) prohibit anyone from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

_____ _____ _____
Signature of Patient/Legal Guardian Relationship to Patient (if applicable) Date

*** Please send only information that may relate to your patient's behavioral healthcare (examples: chronic medical problems, sensitivities to medications, current medications and dosages, current medical conditions that might contribute to emotional distress or other circumstances that might affect their psychological treatment.)

Bill LaForge, Ph.D.
Psychologist
28362 Vincent Moraga Drive * Suite C * Temecula, CA * 92590-3656 * 951/699-9055

Date sent: _____

# AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize:
(Please print your name)

Name and Title: _____
(Name of the person or company with whom you want Dr. LaForge to share information)

Address: _____

_____

Telephone No: _____ FAX No.: _____

to disclose records and information in the course of my diagnosis and treatment to William LaForge, Ph.D. I also authorize William LaForge, Ph.D. to disclose records and information in the course of my diagnosis and treatment with the above named provider. This information may include medical and psychological diagnosis, testing, treatment modalities and educational records.

Patient Name: _____ Patient's birth date: _____
(Please print patient's name)

_____ _____
(Signature of patient, guardian, or authorized representative of patient) Date

_____
(If signed by other than patient, indicate legally responsible relationship)

Please send records to: William LaForge, Ph.D.
28362 Vincent Moraga, Suite C
Temecula, CA 92590-3656
951/699-9055

This authorization shall remain in effect for five years from the date of signature unless revoked in writing by the patient. A photocopy/FAX copy shall be as valid as the original. The person giving signature to this release has the right to receive a copy of this authorization.

## *Burns Depression Checklist*

**Instructions: Place a check in the box to the right of each of the 15 symptoms to indicate how much of this type of feeling has been bothering you in the past several days.**

| | 0 – NOT AT ALL | 1 – SOMEWHAT | 2 – MODERATELY | 3 – A LOT |
|---|---|---|---|---|
| 1. Sadness: Have you been feeling sad or down in the dumps? | | | | |
| 2. Discouragement: Does the future look bleak or hopeless? | | | | |
| 3. Low self-esteem: Do you feel worthless or think of yourself as a loser? | | | | |
| 4. Inferiority: Do you feel inadequate or inferior to others? | | | | |
| 5. Guilt: Do you get self-critical and blame yourself? | | | | |
| 6. Indecisiveness: Is it hard to make decisions? | | | | |
| 7. Irritability and Frustration: Have you been feeling angry or resentful? | | | | |
| 8. Loss of interest in life: Have you lost interest in your career, hobbies, family, or friends? | | | | |
| 9. Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things? | | | | |
| 10. Poor self-image: Do you think you're looking old or unattractive? | | | | |
| 11. Appetite changes: have you lost your appetite? Or, do you overeat compulsively? | | | | |
| 12. Sleep changes: Is it hard to get a good night's sleep? Are you tired and sleeping too much? | | | | |
| 13. Loss of libido: Have you lost your interest in sex? | | | | |
| 14. Hypochondriasis: Do you worry a lot about your health? | | | | |
| 15. Suicidal impulses: Do you think life is not worth living or think you'd be better off dead? | | | | |
| ***Total Score on items #1 - #15 →*** | | | | |

## *Burns Anxiety Inventory*

**Instructions: Place a check in the box to the right of each of the 33 symptoms to indicate how much of this type of feeling has been bothering you in the past several days.**

| **CATEGORY 1: ANXIOUS FEELINGS** | 0 – NOT AT ALL | 1 – SOMEWHAT | 2 – MODERATELY | 3 – A LOT |
|---|---|---|---|---|
| 1. Anxiety, nervousness, worry or fear | | | | |
| 2. Feeling things around you are strange or foggy | | | | |
| 3. Feeling detached from all or part of your body | | | | |
| 4. Sudden, unexpected panic spells | | | | |
| 5. Apprehension or a sense of impending doom | | | | |
| 6. Feeling tense, stress, "uptight", or on edge | | | | |
| **CATEOGORY II: ANXIOUS THOUGHTS** | | | | |
| 7. Difficulty concentrating | | | | |
| 8. Racing thoughts | | | | |
| 9. Frightening fantasies or dreams | | | | |
| 10. Feeling on the verge of losing control | | | | |
| 11. Fears of cracking up or going crazy | | | | |
| 12. Fears of fainting or passing out | | | | |
| 13. Fears of illnesses, heart attacks, or dying | | | | |
| 14. Fears of looking foolish in front of others | | | | |
| 15. Fears of being alone, isolated, or abandoned | | | | |
| 16. Fears of criticism or disapproval | | | | |
| 17. Fears that something terrible will happen | | | | |

*(continued on next page)*

## *Burns Anxiety Inventory*

**Instructions: Place a check in the box to the right of each of the 33 symptoms to indicate how much of this type of feeling has been bothering you in the past several days.**

| **CATEGORY III: PHYSICAL SYMPTOMS** | 0 – NOT AT ALL | 1 – SOMEWHAT | 2 – MODERATELY | 3 – A LOT |
|---|---|---|---|---|
| 18. Skipping, racing, or pounding of the heart | | | | |
| 19. Pain, pressure or tightness in the chest | | | | |
| 20. Tingling or numbness in the toes or fingers | | | | |
| 21. Butterflies or discomfort in the stomach | | | | |
| 22. Constipation or diarrhea | | | | |
| 23. Restlessness or jumpiness | | | | |
| 24. Tight, tense muscles | | | | |
| 25. Sweating not brought on by heat | | | | |
| 26. A lump in the throat | | | | |
| 27. Trembling or shaking | | | | |
| 28. Rubbery or "jelly" legs | | | | |
| 29. Feeling dizzy, lightheaded or off balance | | | | |
| 30. Choking or smothering sensations | | | | |
| 31. Headaches or pains in the neck or back | | | | |
| 32. Hot flashes or cold chills | | | | |
| 33. Feeling tired, weak, or easily exhausted | | | | |
| ***Total Score on items #1 - #33 →*** | | | | |

## *Relationship Satisfaction Scale**

**Instructions: Place a check in the box to the right of each category that best describes the amount of satisfaction you feel in your closest relationship.**

| | 0 – VERY DISSATISFIED | 1 – MODERATLY DISSATISFIED | 2 – SLIGHTLY DISSATISFIED | 3 – NEUTRAL | 4 – SLIGHTLY SATISFIED | 5 – MODERATLY SATISFIED | 6 – VERY SATISFIED |
|---|---|---|---|---|---|---|---|
| 1. Communication and openness | | | | | | | |
| 2. Resolving conflicts and arguments | | | | | | | |
| 3. Degree of affection and caring | | | | | | | |
| 4. Intimacy and closeness | | | | | | | |
| 5. Satisfaction with your role in the relationship | | | | | | | |
| 6. Satisfaction with the other person's role in the relationship | | | | | | | |
| 7. Overall satisfaction with your relationship | | | | | | | |
| ***Total Score on items #1 - #7→*** | | | | | | | |