Lenore Tate, PhD

LICENSED PHYCOLOGIST
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Individual/Family Information

Name _____Date of Birth_____
Gender: Male Female Education completed _____Religion _____
Occupation _____Employer _____
Home Address _____
Home Phone # _____Work Phone # _____Cell Phone #_____
Place an asterisk (*) next to all numbers at which it is okay for me to leave a message.

Spouse/Partner's Name _____Date of Birth_____
Gender: Male Female Education completed _____Religion _____
Occupation _____Employer _____
Home Address (if different from above)_____
Home Phone # _____ Work Phone # _____Cell Phone #_____
Place an asterisk (*) next to all numbers at which it is okay for me to leave a message.

Individual/Family combined annual income (circle one)
$0-49,999 $50-74,999 $75-99,999 $100-124,999 $125-149,999 $ 150,000+

Number of marriages (including current) for you _____Your partner _____

Years of current marriage/relationship ___

Please list below all children from this or previous marriages/relationships whether or not they live in your household.

Name(s)	*Age*	*Gender*

Please list below any medication(s) members of your family are currently taking.

Name	*Medication*	*Dosage*

Medical Concerns: _____

Physician:_____Phone:_____
Date of last physical:_____

Past Mental Health Service Providers (therapists, psychiatrists, etc.):
_____

Are you willing to sign a release for me to coordinate care with them?: yes no

Has anyone being seen ever abused drugs? Yes No If yes, who and which drugs:
_____
_____

Please list below any physical or emotional health problems that members of your family have suffered now or in the past (Include relevant extended family such as parents).
Name *Physical or Emotional Health Problem*
_____
_____
_____
_____

Has any member of your family ever participated in counseling or therapy? Yes No
Who? _____
Reason(s)? _____
What led you to end counseling or therapy?_____
_____

Please check any of the following that have been an issue with individuals or relationships in the family:

- Drinking Problem
- Drug Problem
- Depression
- Anxiety
- Eating Disorder
- School Problems
- Sexual Abuse
- Sexual Problems
- Physical Abuse
- Sexual Addiction
- Financial Difficulties
- Suicide attempts
- Legal Problems
- Chronic Stress
- Controlling or verbal abuse
- Parenting Stress
- Acting out Children
- In-Law or extended family problems
- Physical Aggression (pushing, slapping, etc)

What are your goals for therapy?
_____
_____

How did you hear about me? _____

Signature of person filling out form: _____Date:_____

Informed Consent for Treatment and Disclosure of Fees

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask any questions that you may have regarding its contents.

Fees:
The fee for service is: $150.00 per individual, family, or couple's therapy session $250.00 per hour for time in court/ testimony. A session is 45-50 minutes. Sessions longer than 50 minutes are billed in 30-minute
increments.

Fees are payable at the time that services are rendered. If you wish to discuss a written agreement that specifies an alternative payment procedure, please do so prior to session. If for some reason you find that you are unable to continue paying for your therapy, please inform me and I will help you consider any options that may be available to you at that time.

Appointment Scheduling and Cancellation Policies:
Sessions are typically scheduled weekly or bi-weekly (sometimes more or less depending on need) at the same time and day if possible. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify me at least 24 hours in advance of your appointment. *If you do not provide me with at least 24 hours' notice in advance, you are responsible for full payment for the missed session*.

Please initial here to indicate your agreement with the fees, scheduling, and cancellation policies _____

Confidentiality:
All communications made in session will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release.

There are exceptions to confidentiality. Therapists are required to report instances of suspected child or elder abuse. Therapists are also required to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances to provide FBI agents with requested items and prohibits the therapist from disclosing to the client that the FBI sought or obtained the items.

Minors and Confidentiality:
Parents have the legal right to be appraised of the details of their minor (under the age of 18) child's treatment. Parents and other guardians who provide authorization for their child's treatment are encouraged to be involved in their treatment. However, treatment with a minor often progresses best with a good-faith agreement to confidentiality between the parents and their child so that the child can be assured of his or her confidentiality in therapy sessions. Consequently, I may discuss the *treatment progress* of a minor client with the parent or caretaker, but preferably not details that would decrease trust between the minor and me. Minor clients and their parents are urged to discuss any questions or concerns that they have on this topic.

Therapist Availability/ Emergencies:
Telephone consultations between office visits are welcome. However, I will attempt to keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions. Telephone conversations lasting longer than ten minutes will be billed at the ½ hour rate of $75 per hour.

You may leave a message for me at any time in my confidential voicemail at (916) 844-4615. If you would like for me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. **If you have a medical or psychiatric emergency, please call 911 or A.C.C.E.S.S. at 916-787-8860.**

About the Therapy Process:
It is my intention to provide professional services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and clients are partners in the therapeutic process, so if you are not happy with the services received, it is your responsibility to make that known so we can discuss any hindrances to your progress. I will also periodically initiate discussions about the progress of treatment. Due to the varying nature and severity of problems and the individuality of each client, I am unable to predict the length of your therapy or guarantee a specific outcome or result.

Termination of Therapy:
The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination in collaboration with myself. I will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either you or I may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents.
Signing on the right hand side indicates consent to work with all members of my family under the age of 18 and that this agreement will serve as **"Consent to Treat a Minor Child."** Please ask if you have any questions.

Adult Client	Date	Minor Client	Date
Adult Client	Date	Minor Client	Date
Adult Client	Date	Parent or Guardian	Date
Therapist	Date	Parent or Guardian	Date