Maple Counseling Center

Transformational Psychotherapy

Today's Date:_____ Referred By: _____

Clients

Name:_____

Age:_____ Date of Birth:_____ DL# _____ Marital status:_____

Address:_____

City:_____ State:_____ Zip:_____

Client's Employer:_____ Is client a Student? Yes___or No___

Spouse/Partners Name:_____ Date of Birth:_____

Main phone: _____ E-mail:_____

Preferred Language:_____ Preferred Contact Method: Text: ____ Phone:____

Emergency Contact: _____Phone:_____

Relationship to client: _____ Preferred Language:_____

Any Court involvement? _____ Type?_____

Health Insurance Company:_____

Insurance ID#: _____Insured Date Of Birth: _____

PLEASE PRESENT INSURANCE CARD and/or CREDIT CARD FOR PHOTOCOPYING AUTHORIZATION TO PAY

I/We _____do hereby authorize Gold Coast Insurance to pay directly to Maple Counseling Center/Transformational Counseling Center medical benefits otherwise payable to me for mental health services.

I understand that I am financially responsible for charges not paid by my insurance company.

Date: _____ Signature:_____

I/We, hereby authorize Maple Counseling Center/Transformational Counseling Center to release to my insurance company any information required in the course of my treatment, for billing and/or audit purposes.

Date:_____ Signature:_____

Provider: _____

Maple Counseling Center

CONSENT FOR TREATMENT

I, _____authorize and request Maple Counseling Center's Therapist Staff to provide treatment and/or diagnostic procedures which, now or during the course of my/my child's care as a client, are deemed advisable. The frequency and type of treatment will be decided between the therapist and myself.

Please initial that you understand each of the statements below:

I understand that my treatment therapist may be a Marriage and Family Therapist Associate under supervision and cases are discussed with supervisor and in group format. Only first names are used when discussed in group supervision. If multiple therapists are involved treating multiple family members cases will be shared to achieve optimum outcomes. **Please Initial Here_____**

I understand that the purpose of such procedures will be explained to me and be subject to my verbal agreement. **Please Initial Here_____**

I understand that, while there is an expectation that I/my child will benefit from psychotherapy, there is no guarantee that this will occur. **Please Initial Here_____**

I understand that maximum benefit will occur with consistent attendance and that I may feel conflicted about my/my child's therapy as the process, at times, can be uncomfortable. **Please Initial Here_____**

I will notify if I have decided to end treatment. Therapy can be terminated for any reason, at any time by either party. I/we consider you to no longer be a client if 1 month has passed since our last session/contact. When medical necessity is no longer met we will give you the option to terminate or switch to cash payments. **Please Initial Here_____**

I understand all communication between parties and therapist will be in group format through text or email. **Please Initial Here_____**

Court involved Therapy

I understand any court involvement requires Releases of Information to speak to all parties (i.e. Probation Officer, Social Worker, Attorney etc.) **Please Initial Here_____**

Maple Counseling Center----------

Minor Clients

I affirm that I am the legal guardian of _____ and hereby grant permission for my child to participate in counseling/related services with a Maple Counseling's Therapist. I understand that all information pertaining to services shall remain completely confidential except in those cases where confidentiality is limited. I further understand that any release of information concerning our services shall occur only with our written consent, except in previously explained cases. I have provided legal proof of guardianship, if necessary, and contact information for other parents or guardians as applicable to our situation. **PLEASE INITIAL HERE. _____**

I have provided the most updated custody documentation that is available and pertains to this child prior to start of therapy. **PLEASE INITIAL HERE. _____**

I understand if custody disputes or co-parenting are part of treatment Releases of Information will be needed to speak to all involved parties. **Please Initial Here _____**

TELEMEDICINE/TELEHEALTH INFORMED CONSENT

I _____ [name of patient] hereby consent to engaging in telemedicine at Maple Counseling Center as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in California State.

I have read and fully understand this Consent for Treatment form

Signature:_____Date:_____

(Client or Parent/Guardian)

Signature:_____Date:_____

(Client or Parent/Guardian)

Maple Counseling Center----------

Client Name:	**Date:**
Primary Doctor:	Release Signed**:**
Medications**:**	
	Please add on back if there are more
Other Information**:**	
Action Items**:** (for office use)	Date:

Psychiatrist:	Release Signed:
Medications**:**	
	Please add on back if there are more
Other information**:**	
Action Items: (for office use)	Date:

Probation officer, Social Worker, Attorney, any other party involved: Name and contact information	Release signed?
Action Items: (for office use)	Date:

Maple Counseling Center----------

Authorization to Release Confidential Information

I, [Name of Patient] _____("Patient")

hereby authorize]_____**Maple Counseling Center**_____("Provider") to release confidential information obtained during the course of my treatment to [name or function of the person(s) or entities to whom information is to be released] _____("Recipient").

This Authorization permits the release of the following information:

____ Diagnosis ____ Treatment Plan ____ Progress to Date

____ Prognosis Clinical ____ Test Results ____ Dates of Treatment

_**X**_ Any and All Information Necessary

____ Other (specify)

_____

I authorize the release of the information described above for the following purpose(s): ___Case Managment_____

The specific uses and limitations on the types of information to be released are as follows: _____

_____

_____

The specific uses and limitations on the use of the information by Recipient are as follows: _____

_____

_____

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing.

The Authorization shall remain valid until: _____ ("Expiration Date")

By: _____ Date: _____

(Patient or Patient's Representative)

Maple Counseling Center
Transformational Psychotherapy

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, CONSENT FOR TREATMENT AND OFFICE POLICIES

By signing this form, you acknowledge receipt of my Notice of Privacy Practices, and executed copies of the Consent for Treatment and Office Policies forms that I have given to you.

We have reviewed the Consent for Treatment and Office Policies forms.
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 as listed above.

If you have any questions about my Notice of Privacy Practices, please contact me.

I acknowledge receipt of the Notice of Privacy Practices and executed copies of the Consent for Treatment and Office Policies of the Maple Counseling Center.

Client Name:_____

Signature:_____Date:_____
(Client/Parent/Conservator/Guardian)

Signature:_____Date:_____
(Client/Parent/Conservator/Guardian)

Maple Counseling Center

OFFICE POLICIES

Payment: Full payment for service is due at the beginning of each session unless other prior arrangements have been made. Please notify us if any problem arises during therapy regarding your ability to pay for services.

Insurance: We will bill your insurance company for services. Please notify us if you change insurance companies or no longer have insurance coverage. At intake, please have your insurance card ready for copying. ***You are responsible for any charges not paid by your Insurance company.*** See Professional Fees*

Cancellation: Please contact us at least **48 hours** in advance of any appointment you must miss.
For cash clients, the full fee of the session missed must be paid prior to rescheduling.
For insured client, **2 late cancels or 1 no show and/or frequent timely cancellations will result in being removed from the set weekly schedule.** It is at your therapist's discretion to offer further appointments on a week by week basis.
We are not allowed to bill your insurance company for missed appointments.

Confidentiality: All information disclosed within sessions, including that of a minor, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law.
Disclosure may be required in the following circumstances:

1. When there is reasonable suspicion of abuse of a child or a dependent or elder adult.
2. When the client communicates a threat of bodily injury to others.
3. When the client is suicidal.
4. When disclosure is required pursuant to a legal proceeding (e.g., court subpoena).

Our Notice of Privacy Practices (attached) provides specifics on safeguarding your information.

Emergency Procedures: If you need to contact me between sessions, please call and leave a message. Reasonable effort will be exerted to return your call as quickly as possible during business hours.
If you cannot reach someone in our office and/or it is a true emergency, please call 911.

*Professional Fees

Individual/Family/ Consultations/Reports/Phone**/ Email**/45-50 minute sessions	LMFT: $130 AMFT: $110 Specialty Licensed Professionals [Supervisors]: $140 All fees are applicable unless other arrangements have been made with therapist.
Group	$30 per session per person
Professional Supervision	$100 per session
Cancellation Fee (Cash pay only)	Full Fee
Court	Retainer of $2000 covers 3 hours in court
Gold Coast Insured	Same Charges as above if service is not billable through insurance

**These services will be prorated every 15 minutes.

Cost/Session:_____ Financially Responsible Party:_____ Date:_____

**Phone and Email are charged in 15 minute increments.

Please direct any complaints to supervisor and owner of Maple Counseling Center at 805-669-8846.

I acknowledge that I have carefully read and understand the above policies and procedures and agree to comply with them.

_____	_____	_____
PRINT NAME: Client or Parent/Guardian	DATE	SIGNATURE
_____	_____	_____
PRINT NAME: Client or Parent/Guardian	DATE	SIGNATURE

Maple Counseling Center

Name:_____ Date: _____

Brief Mood Survey*

Instructions. Use checks (✓) to indicate how you've been feeling **over the past week, including today.**

Please answer all the items.

	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
Depression					
1. Sad or down in the dumps					
2. Discouraged or hopeless					
3. Low self-esteem					
4. Worthless or inadequate					
5. Loss of pleasure or satisfaction in life					
Total Items 1 to 5 →					
Suicidal Urges					
1. Do you have any suicidal thoughts?					
2. Would you like to end your life?					
Total Items 1 to 2 →					
Anxiety					
1. Anxious					
2. Frightened					
3. Worrying about things					
4. Tense or on edge					
5. Nervous					
Total Items 1 to 5 →					
Anger					
1. Frustrated					
2. Annoyed					
3. Resentful					
4. Angry					
5. Irritated					
Total Items 1 to 5 →					
Violent Urges					
1. I've had thoughts or fantasies of hurting people.					
2. I've had the urge to do something harmful or violent.					
Total Items 1 to 2 →					

Substance Use	**Y**	**N**
1. Have you ever felt you ought to cut down on your drinking or drug use?		
2. Have people annoyed you by criticizing your drinking or drug use?		
3. Have you felt bad or guilty about your drinking or drug use?		
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?		

Maple Counseling Center-------

COVID-19 Liability Waiver

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing.
I further acknowledge that Maple Counseling Center has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.
I further acknowledge that Maple Counseling Center cannot guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, counseling center staff, and other counseling center clients and their families.
I voluntarily seek services provided by Maple Counseling Center and acknowledge that I am increasing my risk to exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.
I attest that:

* I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
* I have not traveled internationally within the last 14 days.
* I have not traveled to a highly impacted area within the United States of America in the last 14 days.
* I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
* I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non-contagious by state or local public health authorities.
* I am following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.

I hereby release and agree to hold Maple Counseling Center harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the counseling center, or that may otherwise arise in any way in connection with any services received from Maple Counseling Center. I understand that this release discharges Maple Counseling Center from any liability or claim that I, my heirs, or any personal representatives may have against the counseling center with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from Maple and Transformational Counseling Centers. This liability waiver and release extends to the owner, Destiny Champion and all the employees of Maple Counseling Center and Transformational Counseling Center.

Protocol to be Seen in Person:

To meet the states guidelines and minimize the risk of spreading the virus we will be following this protocol in all of our offices:

The lobby doors will remain locked. Please call or text your therapist when you arrive for your appointment and they will get you from outside.

Your temperature will be taken with a no touch thermometer. If you are over 100 degrees you will not be able to come inside and a phone session will need to be conducted.

You are required to wear a mask and clean your hands with hand sanitizer as you enter the lobby.

Inside the therapy room you will be asked to take a seat in a designated seat to assure that the room can offer social distance of 6 ft. between you and your therapist. It will be between you and your therapist at this time whether the masks can be taken off for the duration of the session.

At the end of the session you will be asked to re-mask as you exit the therapy room and the lobby.

Together we will come through this unharmed and stronger.

Name(s): _____

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

Maple Counseling Center
Transformational Psychotherapy

Eligibility/Insurance

Please send a picture of your insurance card(s) front and back.

If you have health insurance or you are covered on a spouse or parent's insurance, please send that card along with your Beacon/Gold Coast card.

You can take a picture with your phone, or scan to your computer and email to info@maplecounseling.org.

Please do this ASAP. Thank you!