

FAMILY INTAKE FORM

Dr. Pruedence Brooks, Licensed Psychologist

Please provide the following information and answer the questions below.

NOTE: The information you provide here is protected as confidential information.

Names of family members who will be participating:

Name: _____ DOB: _____
(Last) (First)

Name: _____ DOB: _____
(Last) (First)

Name: _____ DOB: _____
(Last) (First)

Name: _____ DOB: _____
(Last) (First)

Primary Home Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: (_____) _____ May we leave a message? Yes No

Cell/Other Phone: (_____) _____ May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

What significant stressful events has your family experienced recently?

What do you consider to be some of your family strengths?

What do you consider to be some of your familial weaknesses?

What would you like to accomplish out of your time in family therapy?

Referral Source:

- American Psychological Association
- PsychologyToday.com
- GoodTherapy.org
- NetworkTherapy.org
- Relationship911.com
- Other Online Sources: _____
- Friend
- Yellow Pages
- Unknown
- Other: _____

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Abuse of Self

If a client states or threatens that he or she will hurt themselves, the therapist will make every effort to enlist their cooperation in ensuring their safety. If they do not cooperate, further measures may be taken without their permission in order to ensure their safety.

Abuse of Another Person

If a client states or threatens that he or she will hurt another person, the therapist will contact the authorities.

Abuse of Previous Therapist

If a client states that he or she has been abused by a previous therapist, this information must be reported to the appropriate legal authorities and/or ethics board.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Signature Today's Date: _____

Witness Today's Date: _____

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full fee of \$ 135.00 is charged for missed appointments or no show cancellations with less than a 24 hour notice unless due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment. Please note that your insurance company cannot be billed for missed appointments.

Thank you for your consideration regarding this important matter. Your signature below indicates your agreement to adhere to Dr. Brooks' Cancellation Policy.

_____ Today's Date: _____
Client Signature

INFORMED CONSENT FOR FAMILY THERAPY

We understand that family therapy begins with an evaluation of our relationship, past and present. While Dr. Brooks is deciding whether she is the appropriate therapist for us, we will decide whether we wish to begin family therapy with her. We understand that because of the commitment of time and money, plus the potential impact on us and others, it is important to make an informed choice for a family therapist.

We understand all policies as described on the *Client Information Form* and accept them as conditions for entering into therapy with Dr. Brooks. We have read (or had read to us) and understand the potential limits of confidentiality, including those imposed by Dr. Brooks' policies and by state law, and we have received a copy to keep. We have been given the opportunity to ask questions and discuss confidentiality and disclosure policies with Dr. Brooks. We understand that anything either of us tells Dr. Brooks individually, whether on the phone or in an individual meeting, may not be held as confidential, and at Dr. Brooks' discretion may be shared with the rest of the family during a subsequent session.

We understand that information discussed in family therapy is for therapeutic purposes only and is not intended for use in any legal proceedings involving family members. We agree not to subpoena Dr. Brooks to testify for or against any party or to provide records in a court action.

We agree to share responsibility with Dr. Brooks for the therapy process, including goal setting and termination. By entering into family therapy, we accept that we both understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapy goals. We understand that the changes one or both of us makes will have an impact on our family and on others around us. We accept that such changes can have both positive and negative effects and agree to clarify and evaluate potential effects of changes before undertaking them.

We understand that no promises have been made to us as to the results of treatment or of any procedures provided by Dr. Brooks. We are aware that we may stop my treatment with Dr. Brooks at any time. The only thing we will still be responsible for is paying for the services we have already received. We understand that if payment for the services we receive here is not made, the therapist may stop our treatment.

Dr. Brooks has explained that her therapeutic focus in family therapy is on preserving and enhancing the relationship rather than a focus on individual happiness.

By signing below, we agree to accept mental health services from Dr. Brooks at \$135 per hour and accept full responsibility for payment of such services.

Printed Name _____

Signature _____ **Date** _____

Printed Name _____

Signature _____ **Date** _____

Printed Name _____

Signature _____ **Date** _____

Printed Name _____

Signature _____ **Date** _____

I, Dr. Brooks, have discussed the issues above with the family. My observations of each person's behavior and responses give me no reason to believe that he or she is not fully competent to give informed and willing consent.

Psychologist _____ **Date** _____