Stacy Harris LMFT

Licensed Marriage and Family Therapist

1314 Oregon St., Redding, CA 96001

Telephone: 530-242-6012 Fax: 530-243-0327

CLIENT INFORMATION

Please fill this form our in its entirety. This information is not only helpful for the Therapist, it is also necessary to set up your client account and for insurance purposes.

Name: _____ Male / Female

Address: _____

City: _____ Zip Code: _____

Phone: _____ Date of Birth: _____ Soc. Sec. # _____

Employer: _____Work Phone: _____Okay to call ○ Yes / ⦿ No

RESPONSIBLE PARTY

(Complete this section only if minor is being seen.)

Parent/ Guardian Name: _____

Address if Different from Above: _____

City _____ Zip Code: _____

Phone: _____ Date of Birth: _____ Soc. Sec. # _____

Employer: _____Work Phone: _____ Okay to call ⦿ Yes / ○ No

I _____Hereby give my consent for my child _____

to receive psychotherapy from Stacy Harris M.F.T.

Signature: _____ Relationship to minor: _____

INSURANCE INFORMATION

Insurance Company _____ ID# _____

Social Security # _____ Relation to insured: _____

Date of Birth: _____ Insurance Telephone: _____

Insured (If other) _____ Insured Date of Birth: _____

I hereby authorize payment for medical befits to the named provider for professional services. I authorize the release of any medical information necessary to process these claim. I also understand that I am responsible for any charges that are not covered by my insurance company. **Please read disclosure in welcome packet about insurance billing and fees ***

Signature: _____ Date: _____

(Signature is valid one year from the date signed for insurance purposes)

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Treatment Agreement

FEE: The fee per 50-minute session is $95.00 (except for the first session, which is $135.). This is payable at the time of our session, unless I have agreed to bill your insurance plan.

CANCELLATIONS: You will be charged $50.00 for missed sessions or those cancelled without 24-hour notice, except in cases of sudden illness or family emergency. Note: Insurance plans will not pay for missed or late-cancelled sessions.

INSURANCE:

Please sign the following, if using your insurance plan or Employee Assistance program:

"I authorize the release of any information (Including treatment summaries and diagnosis) necessary to process insurance or Employee Assistance claim, or to request additional sessions. I authorize payment of benefits to be made to Stacy Harris, LMFT for services provided."

(Sign here) _____

(If applicable, second client sign here)_____

CONFIDENTIALITY: What you say in therapy, your records and your attendance are confidential, except:

- When you give written permission to release information
- When your records are subpoenaed for legal reasons
- When reporting is required or allowed by law (ex. Suspected child abuse or neglect, extreme danger to self, suspected elder abuse, or danger to others)
- It may be necessary to consult with colleagues regarding my clients: however no identifying information is mentioned. Your information remains anonymous and confidentiality is fully maintained. The consultant is also legally bound to keep the discussions confidential.

IN AN EMERGENCY: Leave a message on my answering machine. I will make every effort to return your call within a 24 hour period. In case of a holiday or weekend your call may not be returned until the following business day. If you need immediate assistance, please dial 911 or go to your local emergency room.

ENDINGS: You may end therapy at any time. A final phone call or session is requested for closure.

CONSENT FOR TREATMENT: I have read and been offered a copy of the above information and agree to abide by its terms during our professional relationship and hereby consent to my treatment.

_____

Client Name (Print) Date Signature

Consent to Treat a Minor

I, _____, as the parent/guardian or social worker of this minor_____

(DOB :_____) give permission to Stacy Harris LMFT to provide psychotherapy for the minor.

Parent/Guardian Name (Print) _____Date_____Signature_____

Therapist Signature_____ Date_____

Stacy Harris LMFT

Please list the names, ages and relationships of all those in your current household:

Name	Age	Relationship	Name	Age	Relationship
_____			_____		
_____			_____		
_____			_____		

Your Occupation	Employer	Hours per week	Partner/ Spouse Occupation	Employer	Hours per week
_____			_____		
_____			_____		

Highest level of education: _____ Highest level of education: _____

Religious/Spiritual Preference: _____ Religious/Spiritual Preference: _____

Emergency Contact:

Name: _____ Phone#_____

Address: _____

Are you currently on any medications?

Medication	Dosage	Prescribing Physician	Date Started
_____			
_____			
_____			

Where do you receive your health care (facility or provider)? Who is your physician?

_____

Referral Source_____

Address_____

Telephone Number_____

What is the main issue for which you are seeking therapy?

_____
_____
_____

Have you had therapy in the past? If yes, for what reasons?

_____
_____

Have you ever been hospitalized in a psychiatric facility? If yes, for what reason?

_____
_____

Has anyone in your immediate family had a psychiatric illness? Please list relation and illness:

_____
_____

Have you had thoughts about hurting yourself or others? If so, please explain.

_____
_____

Other issues of concern not listed:

_____
_____
_____
_____
_____

Please include additional comments here; please include critical or unique events that have occurred in your family or other individuals that are connected to you:

_____
_____
_____
_____
_____
_____
_____

In the past three months, have you experienced any of the following symptoms?

- ☐ Anger
- ☐ Aggression
- ☐ Anxiety
- ☐ Apathy
- ☐ Avoidance or Isolation
- ☐ Behavioral Problems
- ☐ Compulsive Behavior
- ☐ Crying
- ☐ Denial
- ☐ Depression
  Medication _____
  _____
- ☐ Difficulty Concentrating
- ☐ Eating Disorder Symptons
- ☐ Emotional Numbing
- ☐ Fear _____
  _____
- ☐ Financial Problems
- ☐ Flashbacks _____
  _____
- ☐ Guilt
- ☐ Substance Abuse

- ☐ Harm or threats to others
- ☐ Hyperactivity Medication _____
- ☐ Hyper Arousal
- ☐ Insomnia / Sleep Problems
- ☐ Irritability
- ☐ Memory Problems
- ☐ Nightmares
- ☐ Obsessive Behavior
- ☐ Panicky Feelings
- ☐ Phobias _____
  _____
  _____
- ☐ Self Blame
- ☐ Self-Destructive Relationships
- ☐ Self Harming Behavior
- ☐ Sexual Acting Out
- ☐ Sexual Dysfunction
- ☐ Somatic Complaints _____
  _____
- ☐ Self Blame
- ☐ Self-Destructive Relationships

Please list any substances that you use and include frequency or NA if not applicable.

- ☐ Alcohol
- ☐ Marijuana
- ☐ Caffeine
- ☐ Tobacco
- ☐ Prescription Medication
  _____

- ☐ Cocaine
- ☐ Psychedelics
- ☐ Methamphetamine
- ☐ Other
  _____
  _____

Check the one response from A and B which best applies

(A) My current concerns and symptoms are:

- ☐ The continuation of a long standing condition
- ☐ A recent worsening of an on-going condition
- ☐ The reoccurence of a previous condition
- ☐ Significantly different from any previous condition
- ☐ My first occurrence of any condition

(B) My current symptoms developed:

- ☐ Suddenly (less than four weeks)
- ☐ Gradually (one to several months)
- ☐ Very gradually (one to several years)