Penny Joss Fletcher, M.A.

Licensed Marriage and Family Therapist
Individual and Marital Psychotherapy
Infertility and Adoption Counseling
515 E. First St., Suite D
Tustin, CA 92780
(714) 730-7996

Welcome to the office of Penny Joss Fletcher. In an attempt to establish a smoothly running office system and a professional relationship with my clients, I have developed the following policies and procedures. I ask that you read and sign this information sheet in order to ensure your understanding and willingness to abide by the policies as established. Please do not hesitate to ask questions, and thank you in advance for your cooperation.

1. Sessions are 50 minutes in length in order to allow me to complete paperwork, return phone calls, and effectively "switch gears" from one client to the next. Overtime or phone consultation time is billable in 15 minute intervals. I would appreciate it if you would fill out your check before the session begins, made payable to "Penny Joss Fletcher", so as to maximize your valuable session time.

2. In order to cancel or change an individual, marital, family or phone appointment, you must notify me at least 24 hours prior to the scheduled appointment. My voice mail handles calls 24 hours/day when I am not in the office. If proper notice is not received, you are responsible for payment for the full cost of the missed session. Insurance cannot be billed for late cancellation or missed sessions.

3. In the event of an emergency, please call 911 or go to your nearest emergency room. I do not carry a pager; however, I do check my messages often. I will make every effort to answer your call as soon as possible.

4. Payments are to be made at the time of each appointment which include insurance co-payments and unmet deductibles. The fee for Individual, Marital/Conjoint and Family Therapy is $100.00 per session. Please talk to me about your financial situation if necessary.

5. Please be advised that the client assumes full responsibility for any therapy bills incurred in this office and that you are responsible for and must pay, in a timely manner, any balance not covered by insurance payment. Note that many insurance plans require preauthorization and/or have a provider panel or a preferred provider panel on which reimbursement is contingent. *Initial* (_____)

6. I hereby authorize this office to release the information required to my insurance/managed care/EAP company required for billing and case management of the treatment received. This information is communicated by phone, U.S. mail, facsimile or via computer Internet. *Initial* (______)

7. I am requesting that you bill my insurance company and that payment be sent directly to Penny Joss Fletcher, MFT. *Initial* (______)

8. I will be paying cash and will not use insurance, or will bill them myself (please ask for insurance receipts. *Initial* (______)

I have read, understood, and agree to the above policies of Penny Joss Fletcher, M.A., MFT.

Signature____Date:_________________________

INTAKE FACE SHEET

The requested information becomes part of your file and is confidential. Please print.

Name____ Home Phone (   )____________________________
May I call you at home?____________________
Home Address____
(number and street)

____ Email: ______________________
(city) (state) (zip code) May I email you?_____________

Date of Birth_________________________________ Cell Phone (   ) ___________________________

Employed by ____________________________________ Business Phone (   )__________________________
May I call you at work?____________________
Business Address____
(number and street)

____
(city) (state) (zip code)

Social Security Number:____________________________ Driver's License Number:___________________

Insurance Co. Name: ______________________________ Name of Subscriber:________________________

Insurance Co. Telephone Number: _______________________ Authorization Number:__________________

Insurance Billing Address:____

Member Number and Group Name and/or Number: ____

Referred by: ____

In case of EMERGENCY contact:

Name:____

Address:____
(number and street) (city) (state) (zip)

Home Phone:______________________________________ Business Phone:_____________________________

Date:__________________________

CONFIDENTIAL BACKGROUND INFORMATION FORM

Please print.

Age__________ Educational Level____________________ Occupation__________________________

Marital Status____ Years Married_______________________

Spouse's Name______________________________________ Spouse's Age_______________________

Spouse's Educational Level___________________________ Occupation__________________________

# of Pregnancies: _______ # of Children________ Names & Ages of Children ____________________

Previous counseling____
(name/names) (how long)

If you are currently under the care of a physician, please provide information:

Physician's Name: _____________________________ Physician's Telephone: ______________________

Date of last physical_________________________ Results____

Hospitalization____
(reason) (how long)

Medication____
(what kind/dosage/prescribed by)

____
(condition being treated by medication)

Current chronic conditions____

Family history of medical problems____

# of Siblings________________ What sibling position are you?______________________________

Parents: Are they alive, still married, divorced?____

Is either parent remarried?____

Describe your mother____

____

Describe your father____

____

Persons living with client____

Relationship/marital history____

____

Raised in what religion: ____________________________ Present religion:_______________________

BACKGROUND INFORMATION FORM
(Page 2)

What are your present concerns or problems? ____

____

____

____

PROBLEM AREAS: Please **circle** those that apply:

Husband	Alcohol	Marital	Emotions	Crisis
Wife	Drugs	Divorce	Fear	Past
Brother	Addictions	Separation	Grief	Future
Sister	Health	Sex Life	Confusion	Personal Growth
Mother	Weight	Sexuality	Nervousness	Depression
Father	Nutrition	Sexual Orientation	Anxiety/Panic	Headaches
In-laws	Eating Disorder	Infertility	Lying	Nightmares
Parenting	Body Image		Worrying	Dreams
Family	Self Esteem		Apathy	Sleeping too little
	Obsessions		Death	Sleeping too much

Job	Sexual Abuse
Boss	Verbal Abuse
Career	Physical Abuse
Retirement	Incest
School	
Finances	
Neighbors	
Friendships	
Relationships	

Other:____

I'm afraid of ____

Now please put a star (*) next to the most pressing problems circled above.

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LIMITS OF CONFIDENTIALITY

The psychotherapeutic relationship and all client records are confidential. No client information will be given out without your written permission with the following exceptions:

- **ABUSE:** If you tell me that you have been mentally, physically or sexually abused as a minor, elder or a dependent adult, or if you indicate that you have in any way been involved in, or have knowledge of anyone being involved in any of the above referenced abuses to a minor, an elder or a dependent adult, I am required by California law to report this information to appropriate legal agencies.

- **THREAT OF HARM TO SELF OR ANOTHER:** Section 1024 of the Evidence Code of the State of California requires me to break confidentiality if I have reasonable cause to believe that a client is in such mental or emotional condition as to be dangerous to her/himself or to the person or property of another.

- **COURT ORDER:** Upon advise of counsel, I will comply with any lawful court order to release information about your contact here.

- **INSURANCE COMPANIES, EAP'S AND MANAGED CARE COMPANIES:** Most authorizing agents of your insurance benefits will require information such as diagnosis, treatment goals and plans, symptoms, mental health and chemical dependency history. This information does not go to your employer.

I DECLARE THAT I HAVE READ AND UNDERSTAND THE ABOVE LIMITATIONS OF CONFIDENTIALITY AND AGREE TO ITS CONTENTS.

Signed:______________________________________ Dated:___________________________________

Witness:_____________________________________ Dated:___________________________________