

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 missed session. Insurance cannot be billed for late cancellation or missed sessions.
3. Payments are to be made at the time of each appointment which include insurance co-payments and unmet deductibles. The fee for sessions whether individual or couples is \$120.00 per session. Please talk to me about your financial situation if necessary.
4. 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* (_____)
5. 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* (_____)
6. I am requesting that you bill my insurance company and that payment be sent directly to Penny Joss Fletcher, MFT. *Initial* (_____)
7. I will be paying cash and will not use insurance, or will bill them myself (please ask for insurance receipts. *Initial* (_____)
8. NOTICE TO CLIENTS: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

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 _____ Cell Phone () _____

Home Address _____
(number and street)

(city) (state) (zip code)

Date of Birth: _____

Employed by _____ Business Phone () _____
May we 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: _____ Subscriber Birthdate: _____

Insurance Billing Address: _____

Member Number: _____ Authorization 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

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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 | Headaches |
| In-laws | Body Image | Infertility | Lying | Nightmares |
| Parenting | Self Esteem | | Worrying | Dreams |
| Family | Obsessions | | Apathy | |
| | | | Death | |
| 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.
- **CONJOINT COUNSELING:** When working interchangeably with individual and conjoint sessions, information from individual sessions will not be given out in conjoint sessions.

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

Signed: _____ Dated: _____

Witness: _____ Dated: _____