COUPLES INTAKE PACKET *(partner 1)*

Dear Client:

Welcome to The Center For Psychological Services Ltd. Attached you will find our registration packet which includes the following forms:

I. BIOGRAPHICAL INFORMATION - *partner 1*

II. COUPLES AGREEMENT FOR SERVICES & CONFIDENTIALTY

III. HIPAA: NOTICE OF PRIVACY PRACTICES - *signature page*

IV. ELECTRONIC COMMUNICATIONS STATEMENT

Please take time to read over the information and sign where necessary. *Be sure to ask your doctor or therapist any questions you may have.*

We look forward to working closely with you on making changes that you and/or your family members hope to make as a result of the therapy process. We have found that those who experience the most successful outcomes here have:

1. **Clearly defined as goals** what they hope to achieve. Usually this is done during the first or second session and revised as necessary.
2. **Formed an effective working relationship** with their therapist or doctor. Be sure to talk over any concerns or questions you have about the therapy process with your therapist or doctor.
3. **Kept appointments as scheduled**; each visit builds on the ones before.
4. **Done any recommended "homework"** between sessions. In many ways, what you do at home, work or school can have a profound effect on your progress.
5. **Have discussed expectations** that may exceed the scope of private practice behavioral health services.

The Center is deeply committed to providing you with the highest quality comprehensive state-of-the-art behavioral health services for children, adolescents, adults, couples, and families. We utilize a variety of therapeutic approaches and services to help you successfully adapt and balance life's stressors and challenges as you move toward a fuller, richer life. We thank you for placing your confidence in us and look forward to meeting with you.

Sincerely,
Victoria L. Williams, MSN, Psy.D., LCP
Licensed Clinical Psychologist
Director, The Center for Psychological Services, Ltd.

SECTION I - BIOGRAPHICAL INFORMATION *(Partner 1)*

Date: __________________ Therapist here to see: __________________________________

CLIENT NAME: ______________________________ DOB: _______________ AGE: ______

SEX: __M __ F__ MARITAL STATUS: __ single __ married __ divorced __
Preferred Pronoun: ______ __ separated __ widow __ minor

ADDRESS: ____
CITY: ______________________ STATE: ________ ZIP: _____________

Home #: ( ) - List Family Members / Ages: ___________________________
Cell #: ( ) - ______________________________________
Work #: ( ) - . ____

Please indicate preferred contact # ___________ May we leave a message: ___ yes ___ no
Our system generates automatic reminder calls or texts to your preferred #.
Please check to choose format: **Call -** ______ **Text-** _____ **No Reminder-**_____

EMPLOYER: _______________________
OCCUPATION/POSITION:_____________________________

EMERGENCY CONTACT: ____________________ RELATIONSHIP TO CLIENT: __________
EMERGENCY CONTACT PHONE #: ( ) - .

If there should be a need for us to contact your emergency contact person, we will only disclose any information that is related to the emergency situation. Please initial here that you understand this.
I understand that in an emergency situation, relevant information will be disclosed. _________
initial

How did you hear about us?

___ website: ___ friend: ___ relative: ___ school: ___ physician: ___ other: ___________________

FOR OFFICE USE:
DX: ____________ Session fee: ______ Agreement for Services form read & signed __ Yes __ No
copy of insurance card ___ Driver's license ____ Credit card on file ____

Name of Partner:_______________________________________

Relationship Status: (check all that apply)

□ Married □ Separated □ Divorced □ Dating

□ Cohabitating □ Living together □ Living apart

Length of time in current relationship: _______________

As you think about the primary reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?

Concern	***Frequency***
□ No concern	□ No occurrence
□ Little concern	□ Occurs rarely
□ Moderate concern	□ Occurs sometimes
□ Serious concern	□ Occurs frequently
□ Very serious concern	□ Occurs nearly always

What do you hope to accomplish through counseling?

____

____

What have you already done to deal with the difficulties?

____

____

What are your biggest strengths as a couple?

____

____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.

1 2 3 4 5 6 7 8 9 10

(extremely unhappy) (extremely happy)

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does.

____

____

Have you received prior couples counseling related to any of the above problems?

□ Yes □ No

If yes, when: ______________________________ Where: ________________________________

By whom: ______________________________ Length of treatment: _____________________

Problems treated:

____

____

What was the outcome (check one)?

□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse

Have either you or your partner been in *individual* counseling before?

□ Yes □ No If so, give a brief summary of concerns that you addressed.

____

____

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication?

□ Yes □ No If yes for either, who, how often and what drugs or alcohol?

____

Have either you or your partner struck, physically restrained, used violence against or injured the other person?

□ Yes □ No If yes for either, who, how often and what happened.

____

____

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems?

□ Yes □ No If yes, who? ___Me ___Partner ___Both of us

If married, have either you or your partner consulted with a lawyer about divorce?

□ Yes □ No If yes, who? ___Me ___Partner ___Both of us

Do you perceive that either you or your partner has withdrawn from the relationship?

□ Yes □ No If yes, which of you has withdrawn? ___Me ___Partner ___Both of us

How frequently have you had sexual relations during the last month? ________times

How enjoyable is your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unhappy) (extremely happy)

How satisfied are you with the frequency of your sexual relations? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unhappy) (extremely happy)

What is your current level of stress (overall)? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unhappy) (extremely happy)

What is your current level of stress (in the relationship)? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unhappy) (extremely happy)

Rank order the top three concerns that you have in your relationship with your partner (1 being the most problematic):

1. ____

2. ____

3. ____

Thank you for completing this section. Please note that you will be asked to talk about your answers in sessions but your partner will not be shown this form.

SECTION II - COUPLES AGREEMENT FOR SERVICES CONFIDENTIALITY & INFORMED CONSENT

Please read this document carefully as it outlines our professional service policies. When you sign this document, it will represent an agreement between us.

COUPLES THERAPY

Couples therapy is a process of identifying interaction and communication patterns that are negatively impacting the friendship, intimacy, and fulfillment of needs of one or both partners in a relationship. This can involve discussing unpleasant aspects of your partnership, which can lead to uncomfortable feelings, (e.g sadness, shame, guilt, anger) As a result, you may even feel worse for a period of time.

Couples therapy invites both partners to honestly examine their own interaction and communication styles, identify and express their own feelings, and attempt to learn new methods of communicating and interacting. Changes made as a result, may affect both partners and those around them. Each partner will

be encouraged to clarify their own level of commitment to the relationship and the outcome desired. The process of couples therapy may lead to increased satisfaction with the partnership or increased clarity with the decision to part ways.

One of the best predictors of success in achieving your goals is the "goodness of fit" between you and your couples therapist. If either partner has any doubts about working with your therapist for any reason, we welcome you to share your concerns. Your therapist will do likewise, including if your needs as a couple go beyond the scope of this private practice. We are fortunate to have a large team of therapists at our Center, as well as connections within the community, so that we can offer additional recommendations better suited for you, should this be appropriate.

The beginning of services will involve an evaluation of your needs and goals as a couple. In the first few meetings we will discuss initial impressions, treatment plan, and methodologies that are most likely to be useful for your partnership.

APPOINTMENTS

Appointments will ordinarily be once per week or as agreed upon. Typically sessions become less frequent as you gain traction in achieving your goals. It is important to be on time for your scheduled appointments since sessions will end on time regardless of your arrival time.

Should you need to cancel or reschedule a session, **please give at least 24 hrs notice**. Insurance companies do not provide reimbursement for canceled sessions. If you miss a session without canceling or cancel with less than 24 hrs notice, **our policy is to collect $50 per missed therapy session or $150 for missed testing sessions** (unless we both agree that you were unable to attend due to circumstances beyond your control). If it is possible, we will try to find another time to reschedule your appointment.

PROFESSIONAL FEES

The standard fee is $168 per hour. It is our practice to charge this amount on a prorated basis for sessions that require more time (e.g., Emergency Evaluations or Wellbeing Checks), other professional services that you may require such as report writing, telephone conversations that last longer than 10 minutes, attendance at meetings or consultations which you have requested, or the time required to perform other services which you may request.

PAYMENT TERMS AND INSURANCE

We strongly believe that part of a **healthy working alliance involves staying current with your account** here at The Center for Psychological Services. This enables us to pay your therapist/counselor for services rendered.

When you initiate services, our Billing Office will obtain a **quote of benefits from your insurance company** and will share that information with you. ***(as a reminder, this is a quote of benefits, not a guarantee of payment)***

If your insurance carrier or coverage should change, you are responsible for notifying us of this fact. If this results in an increase of your session fee, you are responsible for this additional payment; should it reduce your fee, we will adjust on our end.

If our Center is not a participating provider for services in your insurance plan, we will supply you with the invoice necessary to submit to your insurance company. We also offer a "fee for service" option.

Your portion of the session fee is due at the point of service. Please check in with our Front Desk to pay fees before your session; should our Front Desk not be available, kindly pay your therapist by the end of your session. If someone from your family is receiving services and not responsible for payment, please be sure payment arrangements are made before the session. We welcome credit cards, cash or check; there is a $30 charge for returned checks. Future appointments are scheduled when accounts are current.

LIMITS OF CONFIDENTIALITY

When you attend couples therapy sessions, **you as the couple are considered to be "the client"** and your mental health records therefore belong to both of you. This means that except in the circumstances below, your therapist will need a written consent from both of you in order to disclose any information from your record to a third party.

- In most legal proceedings, you have the right to prevent us from providing any information about your treatment. *In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order our testimony.* However, such an order is unlikely. We would advise you never to agree to any release of information without first discussing it with us.

- There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a client's treatment. For example, *if we believe that a child, elderly person or disabled person is being abused, we must file a report with the appropriate state agency.*
- *If we believe that a client is threatening bodily harm to another, we may be required to take protective actions.* These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for our clients.

- *If a client threatens harm to herself/himself, we may be obligated to seek a higher level of care including hospitalization, and/or to contact family members who may help provide protection.* If a similar situation occurs in the course of our work together, we will attempt to fully discuss it with you before taking any action.

Legal Proceedings: You also understand that couples therapy is for therapeutic purposes and not intended for use in any legal proceedings involving the partners. You agree not to subpoena your therapist to testify for or against either party or to provide records in a court action.

Boundaries: Because the relationship is the main focus of couples therapy both partners of a couple must be present for the couples session to start. It is often not in the best interest of the couple to distribute time unevenly between partners, or to have unplanned meetings with only one partner present. *If one partner is late arriving or does not show for the appointment, we reserve the right to delay the start of the session or to cancel the session if necessary, which could result in charging a late cancellation or no-show fee.*

No Secrets: We have a policy of no secrets. Your therapist, who is entrusted with information from both partners of a relationship, cannot promise to protect secrets of either partner from the other person. This is especially the case if the secret is harmful or destructive to the process of the therapy itself, or undermines the agreed upon intention of the therapy.

Length of couples therapy: The length of time for couples therapy depends on the severity level of the problems, history of past trauma/infidelity/or betrayals, and the presence of co-occurring emotional or psychological issues.

Limitations to Couples Therapy: Couples therapy can only be effective in cases where both partners put in a good faith effort to work on their problems and their relationship. Deliberate dishonesty or deceit, unwillingness to introspect or take responsibility for one's actions, or lack of interest or motivation to engage in the couples therapy process, by one or both partners, will undermine the therapy.

CONTACTING YOUR THERAPIST

We check our voicemails throughout the business day at the Center and return calls typically within 24 hours except weekends and holidays. When leaving a voicemail or electronic communication, please be specific and brief.

If for unseen reasons, you do not hear from your therapist or there is difficulty in reaching you, and safety is a concern for you or your child, please go to your nearest Emergency Room or call 911 and ask to speak to the mental health worker on call.

Your therapist will let you know in advance of planned absences, and provide you with contact information of a mental health professional to contact if necessary.

** We the client, understand and consent to the above terms, and agree to initiate treatment at The Center for Psychological Services.**

____________________________________ ____________________________________

Printed name of partner **Signature name** of partner

____

Therapist signature / Date

SECTION III - HIPAA- NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA) - *notice of policy and practices to protect the privacy of your health information.*

Please review the HIPAA policy document located under "Forms" on our website *cpstherapy.com* **and sign & date below that you have read it: (if you're in the office filling this out, please refer to the HIPAA document attached to the clipboard.**

I, ___________________________________ , do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information form.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax:

I fully understand and accept the terms of this consent.

_______________________________ __________ _______________________________

Signature of client (at least 12 yrs of age) Date **Printed name** of client

IV - ELECTRONIC COMMUNICATIONS STATEMENT

Electronic Medical Records/Communication:
At The Center for Psychological Services, we use an electronic medical records system and patient portal messaging system that is HIPAA compliant.

Email Communication:
This form of communication is not advised. Please use the "message" feature via your Patient Portal.

Text Communication:
Should you have an agreement with your therapist to utilize texting as means to communicate, Please be advised that due to the nature of variable security measures and phone service providers, we do not encourage or promote a text exchange that goes beyond non-personal dialogue, i.e. rescheduling/confirming an appointment.

Social Media:
Our center policy is to not communicate with clients through social media platforms like Twitter, or Facebook. In addition, if your therapist discovers that he/she has accidentally established an online relationship with you, they will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

Website:

We have a website which we use for professional reasons to provide information to others about our practice. You are welcome to access and review the information that is on the website, and if you have any questions about it, we should discuss this during your therapy sessions.

____

Signature of client (at least 12 yrs of age) Date **Printed name** of client