If You're Here For Your First Appointment

Welcome to our Center! We ask that you fill out the attached forms prior to your first appointment with your therapist, so that you will not have to do this paperwork during your session. This will allow you more time in session to talk to your therapist about your current concerns or issues.

Your therapist will also sign the forms that require a witness's signature.

Please read the attached *"Welcome to the Center for Creative Growth"* Orientation Packet. It contains a description of our orientation and also has important information about our policies and procedures, including a statement about our Privacy Practices.

Client Information Form

Name _____ Birthdate _____ Age _____

Address _____ City _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

E-Mail _____ Occupation _____ Employer _____

How did you learn about our Center? _____

Are you (circle one): Single In a relationship Engaged Married/Domestic Partnership Separated

Divorced Widowed Length of Time for Above Question _____

Have you had previous therapy or counseling? Yes _____ No _____
If yes, list name(s), dates, and type of therapy below. Use other side, if needed.

_____

_____

_____

May we say who we are if we phone your home? Yes _____ No _____

Do you need a statement from us for insurance reimbursement purposes? Yes _____ No _____
If yes, please read our insurance reimbursement policy in the *Welcome Packet.*

Emergency Contact Information **Be sure to update this information with your therapist if it changes.**

In Case of Emergency, contact: _____ Relationship to you: _____
Address _____ City _____
Phone numbers: Home (____) _____ Work (____) _____ Cell (____) _____
Your car: Make _____ Color _____ License plate number _____

Thank you for taking the time to complete this form!

========== **OFFICE USE** ==========

Therapist _____ Individual Couple Family CTP HIC Men's

Fee _____ Start Date _____ End Date _____

Insurance Company _____ # of Authorized Sessions: _____

Referring Physician _____
Do you have physician's referral (prescription or letter) Yes _____ No _____

Did you give: Welcome Packet _____ Info on: LLF Group ____ Men's Group ____ CTP____
Did you have client sign:

___ Consent for Treatment (required)
___ Authorization to Release/Obtain Information Among Center for Creative Growth Staff (required)
___ Notification of Trainee/Intern Status and Authorization to Audiotape Sessions (required)
___ Release to talk to other (previous or current) therapist
___ Group Agreements for HIC/LLF or Men's Group
___ Release for Physician/Psychiatrist
___ Other (specify): _____

Consent for Treatment and Acknowledgement of Receipt of Privacy Practices Notice

In signing this form below, I give permission to my therapist at the *Center for Creative Growth* to provide counseling and psychotherapy to me.

I understand that, according to California law, communication between a client and her/his therapist is both privileged and confidential. This means the therapist/counselor cannot identify a client by name while discussing information about the client, orally or in writing, without the client's express written permission. There are some situations, however, in which California law has mandated that confidentiality may or must be broken:

1. If a client is a danger to him/herself or to others, the legal protection of confidentiality is no longer in effect. The therapist is required to warn a potential victim, the police, or the family of the client who intends to harm her/himself.

2. If there is reasonable suspicion of child abuse, the therapist must report this to designated authorities.

3. Any reasonable suspicion of physical abuse of a dependent or elder must be reported by the therapist.

4. There are specific legal situations in which privilege is waived. For example, to establish competence, to determine sanity, or when the therapist asserts the privilege, but is ordered by a judge to testify.

In signing this form below, I acknowledge that I have read the above and understand my therapist's ethical/legal responsibility to make such decisions when necessary, either during the course of my therapy work or after the termination of my therapy. In signing this form, I also acknowledge receipt of the Center's Welcome Packet, which includes the Center's policies and procedures, as well as the Center's *Notice of Privacy Practices*, as required by Federal HIPAA laws and regulations.

Please print your name: _____

Your signature: : _____ Date: _____

Therapist/Witness: _____ Date: _____

Authorization to Release/Obtain Information Among Center for Creative Growth Staff

In signing this form below, I hereby acknowledge my understanding that the therapist I am seeing at the *Center for Creative Growth* (CCG) is a member of a team of clinical therapists at the *Center for Creative Growth* and its satellite offices. I understand that my therapist may share information about me gained in my therapy work with these other *Center for Creative Growth* therapists for the purposes of clinical supervision and authorize him/her to do so when my therapist deems it necessary. I understand that all information shared in this manner remains confidential among the team of therapists at the *Center for Creative Growth.* This is ***not*** an authorization for my therapist to share information about me or my therapy work with a therapist ***outside*** of the *Center for Creative Growth.*

I also authorize my CCG therapist to release and share any information about me gained in my therapy work at the *Center for Creative Growth* with, and to obtain any and all information deemed necessary about me from other therapists at CCG and its satellite offices with whom I may be in adjunctive therapies with, including but not limited to couples, family, group, or individual therapy.

If I was referred to CCG by another therapist not connected to CCG, or by someone who is, or has been, a client at CCG, I also give my permission to the Center's staff to contact this person and thank him or her for referring me to the *Center for Creative Growth.*

This authorization shall remain in effect during the course of my therapy work with my therapist, and for whatever follow-up may be necessary. I understand that I may obtain a copy of this authorization at my request.

Please print your name: _____

Your signature: _____ Date: _____

Therapist/Witness: _____ Date: _____

Credit Card Authorization

Typically, the *Center for Creative Growth* prefers that you pay for your therapy sessions with a personal check, cash, or money order. However, there are times when we may need to charge your credit or debit card for therapy fees. The following five situations describe the circumstances under which we may charge your credit/debit card for the amount due:

1. If you cancel a scheduled session with less than 24 hours advance notice.

2. If you have not brought a check, cash, or money order to pay for that day's therapy session.

3. If a personal check is returned to the Center for insufficient funds or other reasons.

4. If an outstanding balance is not paid in a timely way.

5. If your therapy session is conducted by phone or other online method.

For these purposes, please provide your credit/debit card information below. In signing below, you are authorizing the *Center for Creative Growth* to charge your credit/debit card for any outstanding balance that may be due as per the above circumstances. Please note: The fee that is set in your phone intake session prior to your first appointment is our "discount" rate and is based on your paying for your sessions with either cash or check. Session fees paid by credit or debit card are not eligible for our "discount rate" and therefore cost $4 more per session than our "discount rate." Your credit card information will be kept in the strictest confidence and will not be used for any other purpose without your permission. This authorization will remain in effect from the date of signing until one month after the termination of therapy services provided by our Center.

Name on Credit Card: _____

Address: (include zip) _____

_____

Type of Credit Card (circle one): Visa MasterCard Discover

Credit Card Number: _____

Expiration Date: _____

3-Digit Security Code (on back of Card): _____

Your signature: _____ Date: _____