Franconia Family Therapy Center

CENTER APPLICATION FORM

Today's Date:_____ --Please print--

Client's Name: First_____ MI____ Last_____			Date of Birth: / / Age:____
Home Address: _____Zip_____			
Mailing Address (if different from above): _____Zip_____			
Contact Information: Preferred contact number: _____ Cell Home Work Alternate contact number: _____ Cell Home Work Preferred email: _____			
Gender: M F	Marital Status: S M D Wid Sep		Occupation:
Employer or name of school:			
Source of Referral:			
Name(s) of Person(s) Living With You	Relationship	Age	Occupation

If Client is a minor, who is the legal guardian?
Name(s)_____ Relationship:_____
Address (if different than above):_____
Non-custodial parent's name:_____
Non-custodial parent's address:_____

Emergency Contact: _____ Relationship:_____
Preferred Phone Number:_____ Alternate Number: _____

Previous therapy and/or psychiatric hospitalization? If so, where:
_____ Date:_____
_____ Date:_____

Name(s) of relatives who have ever received therapy here:
Past:_____
Present:_____

Modified 05/23/2013

Franconia Family Therapy Center

CONSENT TO TREATMENT AND CONFIDENTIALITY

Please read the following and indicate by your signature that you have read, understood and agree to the content of this consent:

1. I have received Franconia Family Therapy Center's *Notice of Privacy Practices* and understand the limits of confidentiality and privileged communication.

2. I consent to participate in treatment at Franconia Family Therapy Center and understand I may terminate at any time.

3. I further consent that I will not attempt to subpoena any testimony or records for a deposition or court hearing of any kind for any reason.

4. I acknowledge the goal of psychotherapy is the amelioration of psychological distress and interpersonal conflict. In order to achieve this goal, I acknowledge that the process of psychotherapy depends on trust and openness during the therapy sessions. Therefore, I understand by engaging the services of Franconia Family Therapy Center, I am agreeing not to use information given during the therapeutic process against any other party in a judicial setting.

_____ _____

Witness **Date** **Client's Signature** **Date**

_____

Parent's/Guardian's Signature **Date**

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Franconia Family Therapy Center

MEDICAL AND MENTAL HEALTH HISTORY

Personal Information

Name: _____ Date: _____

Work: ___ Full Time ___ Part Time ___ Student ___ Unemployed ___ Disabled ___ Fully Retired

Current Symptoms (check all that apply)

___ Anxiety
___ Guilt
___ Loss of Interest
___ Sleep Changes
___ Racing Thoughts
___ Risky
___ Suspiciousness
___ Avoidance
___ Impulsivity
___ Appetite Issues
___ Panic Attacks
___ Hallucinations
___ Excessive Energy
___ Fatigue
___ Depression
___ Crying Spells

Other Symptoms:

Medical History

Primary Physician: _____

Exercise Frequency: _____ Type: _____ Minutes per session _____

Allergies: _____

Medical Condition(s) Current and Previous:

_____ Current ___ Previous ___
_____ Current ___ Previous ___
_____ Current ___ Previous ___
_____ Current ___ Previous ___

Current Medications for Medical Condition(s):

Medication: _____ Condition: _____
Medication: _____ Condition: _____
Medication: _____ Condition: _____
Medication: _____ Condition: _____

Mental Health History

Current or previous Therapist: _____

Previous Mental Health Diagnosis: _____ Date: _____

Current Mental Health Medication(s):

Medication: _____ Condition: _____
Medication: _____ Condition: _____

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Name: _____

Have You Ever Tried the Following (check all that apply)		
___ Alcohol	___ Marijuana	Without a Doctor's Prescription:
___ Heroin	___ Cocaine	___ Tranquilizers
___ Tobacco (smoke or chew)	___ Hallucinogens (LSD)	___ Non-over-the-counter pain killers
___ Methamphetamines	___ Methadone	___ Stimulants i.e. Adderall, Ritalin

If yes to any, list frequency and date of last use:

Substance: _____ Frequency: _____ Last Use: _____

Substance: _____ Frequency: _____ Last Use: _____

Substance: _____ Frequency: _____ Last Use: _____

Have you ever been treated for alcohol and/or drug abuse? Yes ___ No ____

If yes, date(s): _____ Currently in an addiction support group?: Yes ___ No ____

Name and location of support group: _____

Have you ever abused prescription drugs? Yes _____ No _____

If yes, which ones? _____

Anything Else You Want Your Therapist To Know About Your Medical or Mental Health History

_____ _____

Signature Date

Franconia Family Therapy Center 04/21/2014

Franconia Family Therapy Center

It is important that you read the Franconia Family Therapy Center (FFTC) Privacy Notice carefully to know your rights and options in terms of your Personal Health Information (PHI).

FFTC is required by law to give you the option of obtaining a copy of our Privacy Notice. We have made it FFTC policy to go beyond this option and provide a paper copy of the Notice at intake.

Please complete the below for our records. Thank you!

I ACKNOWLEDGE RECEIPT OF THIS NOTICE.

Print Name: _____

Signature: _____

Date: _____

I ALSO ACKNOWLEDGE FFTC HAS PROVIDED A PAPER COPY OF THIS NOTICE THAT I CAN TAKE HOME.

_____ **I received a paper copy of the FFTC Privacy Policy.**

For Office Use Only

_____ Client refused to sign.

_____ Communications barriers prohibited FFTC from obtaining the acknowledgement.

_____ An emergency situation prevented FFTC from obtaining it.
Please explain:-

_____ Other reasons:

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INFORMATION ON FEES AND SERVICES

Center Fees:

Licensed Therapist:	$150.00 - 60 Minute Session
(LCSW, LMFT)	$120.00 - 45 Minute Session
	$130.00 - 45 Minute Session (Client plus others)
Clinical Nurse Specialist:	$150.00 - 60 Minute Session
(RN, MSN, CNS)	$120.00 - 45 Minute Session
	$130.00 - 45 Minute Session (Client plus others)

Telephone consultations and written reports are billed at the above rates.

Group Psychotherapy: $65.00 - 60 Minute Session

Contact office staff for further details.

Payment for all psychotherapy services are due when services are rendered. You may make payments by cash, check, Visa, Master Card, Discover or by using your FSA or HSA cards. Prompt payment will prevent any disruption of treatment. Advance notice will be provided for fee adjustments.

Insurance: Some services may be eligible for reimbursement by your health insurance carrier. Contact your claims representative for details. Feel free to discuss possible ramifications of filing insurance claims. Choosing to use insurance is your responsibility. A copy of your bill will be provided at your request.

Appointments: Always confirm your next appointment. Unforeseen circumstances may necessitate rescheduling your session. **There will be no charge for a session that you cancel 24 hours in advance. You may leave a message 24 hours per day. Standard Center fees will be charged for missed appointments not cancelled 24 hours in advance.

We hope this description of Center policies and procedures will answer your questions.

****

I understand and agree to the Center policies and procedures stated above.

Signature _____

Date _____

FFTC is authorized to use the following credit card for a regularly scheduled appointment, missed appointment, returned check (additional $6.50 fee), delinquent account (more than 30 days), or client request.

VISA MC DISCOVER #_____ _____ _____ _____

Exp Date (MM/YY) _____/_____ **Security Code** _____ **Billing Zip Code** _____

**** Copy given to client** _____ **Signature** _____

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