



Franconia Family Therapy Center

CENTER APPLICATION FORM

Today's Date: _____

--Please print--

Client's Name:		Date of Birth: / /		Age: _____	
First _____	MI _____	Last _____			
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



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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



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)

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Impulsivity	Other Symptoms:
<input type="checkbox"/> Guilt	<input type="checkbox"/> Appetite Issues	
<input type="checkbox"/> Loss of Interest	<input type="checkbox"/> Panic Attacks	
<input type="checkbox"/> Sleep Changes	<input type="checkbox"/> Hallucinations	
<input type="checkbox"/> Racing Thoughts	<input type="checkbox"/> Excessive Energy	
<input type="checkbox"/> Risky	<input type="checkbox"/> Fatigue	
<input type="checkbox"/> Suspiciousness	<input type="checkbox"/> Depression	
<input type="checkbox"/> Avoidance	<input type="checkbox"/> Crying Spells	

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 ___

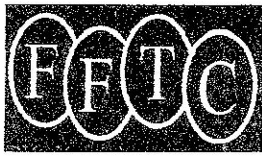
Current Medications for Medical Condition(s):

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: _____



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:



Franconia Family Therapy Center

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 _____