THE SOUL CARE HOUSE

MARRIAGE AND FAMILY THERAPY
1427 LEWIS ST. SAN DIEGO, CA 92103
619.272.6485 / SOULCAREHOUSE.COM

I am here to see: _____ Date: _____

PERSONAL INFORMATION

Client Name: _____

Primary Phone: _____Secondary Phone: _____

Address: _____

Occupation: _____ Employer/School:_____

Age: _____ D.O.B: _____ Marital Status: _____

Spouse's Name: _____Age:_____D.O.B.:_____

Primary Phone:_____ Secondary Phone: _____

Address (if different than above) _____

Occupation _____ Employer/School _____

Children's names and ages _____

Who lives in your home? _____

ADDITIONAL INFORMATION

What concern brings you to therapy? _____

What medications are you currently taking?_____

How did you hear about us? _____

Emergency Contact: _____ Phone Number:_____

Is it alright for your therapist to leave a message for you at: (Please Circle)
Primary Number: Yes or No Secondary Number: Yes or No

Would you like to be notified of events & workshops happening at The Soul Care House? Yes or No

E-Mail (optional) _____

Signature: _____ Date: _____

Printed Name: _____

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POLICIES & PROCEDURES

Please feel free to discuss any questions or concerns you have about our policies with your therapist.

CONFIDENTIALITY

What you share in therapy sessions is completely confidential. The fact of your presence in therapy, any written or other documentation which you might give to your therapist, and all of your therapist's clinical notes are protected as confidential information. It is important that you understand there are legal exceptions to confidentiality and those are when a client:

- Is a danger to self;
- Is a danger to others;
- Discloses information regarding suspected child or elder abuse

The client's confidentiality is also waived when the client signs an authorization to release information or when a minor client's legal guardian signs such a release. Confidentiality can also be waived when the therapist is served with a court-ordered subpoena and is advised by professional legal counsel to release the subpoenaed information. Additionally, in order to ensure excellent professional care, your therapist will regularly engage in peer consultation or supervision during which relevant information about clients may be disclosed. Initial Here ____

COMMUNICATION

You may leave messages with us at any time on our 24-Hour voicemail system. Your therapist will respond as soon as he or she is able. If you are in a situation where you need to speak with someone immediately, please call 911, or the crisis hotline at 1-800-479-3339. If a call with your therapists takes more than a few minutes the therapist will assess a pro-rated charge. Initial Here ____

APPOINTMENTS

When appointments are scheduled, that time is reserved only for you. If you are unable to keep a scheduled appointment, please give us a twenty-four (24) hour notification. We will be happy to reschedule for a more suitable time. Be advised, however, that a full session charge will be assessed for any late cancellations or missed appointments, unless necessitated by an emergency.
Initial Here ____

FINANCIAL ARRANGEMENTS

Our therapy charges are based on current and customary fees for this area. We have agreed that your fee(s) for professional services are $_____ per individual/couples/family session, and/or $_____ per group session. Payment is due at the time services are rendered either by Cash, Check, or Credit Card.
Additionally, consultations with other professionals and reports prepared on your behalf will be charged a pro-rated fee. Assessment testing is charged on a per instrument basis. A $25 charge is made for any check returned to us as non-payable for any reason. Accounts over 90 days past due may be sent to collections and additional fees may be applied. Initial Here ____

INSURANCE

Since we are an out-of-network healthcare provider, we are limited in billing insurance for treatment; however, you can obtain a ‘‘superbill’’ which is a type of receipt that you can submit to your insurance company for reimbursement. Initial Here____

APPROPRIATE PROFESSIONAL CONDUCT

As with any professional relationship, the psychotherapeutic relationship requires high standards of moral, ethical, and appropriate conduct on the part of the psychotherapist. Specifically, any form of sexual intimacy between a therapist and a client is never appropriate. The booklet ‘‘Therapy Never Includes Sex’’ is available to you upon your request if sexual intimacy has ever occurred between you and a therapist during any previous courses of psychotherapy.

As a client, I have read and understand (or have asked for clarification about) the information presented in this form, as well as "The Notice of Privacy Practices", and consent to treatment within the aforementioned guidelines.

1._____
Signature Print Name Date

2._____
Signature Print Name Date

Therapist:_____
Signature Print Name Date

Credit card information will be kept on file to be used for session fees in which I do not provide payment (unless arrangements have been made with the therapist). Additionally, I authorize charges for missed appointments not cancelled within the 24 hours advanced notice, returned check fees and the amount of the check paid, and overdue balances of more than 30 days. I understand my credit card will only be used under these circumstances and/or when I have not provided payment in another form (i.e. cash or check). By signing below and providing my credit card information, I authorize The Soul Care House to charge my credit card.

_____
Signature Print Name Date

For your convenience, we also offer automated charges. By signing below, I authorize The Soul Care House to keep my signature on file and automatically charge my card after each session.

_____
Signature Print Name Date

Name on Credit Card: _____

Billing Zip Code on Card: _____

Credit Card Number: _____

Expiration Date: _____ Credit Card Type: Visa MasterCard