Family First Psychotherapy Services, LLC
Couples Intake Form

Date of Intake: *(mm/dd/yyyy)*		Insurance:	
File Number:		**Insurance ID #:**	
Name (Partner A):		**Name (Partner B):**	
Address:		**Address:**	
Date of Birth:	**Age:**	**Date of Birth:**	**Age:**
Social Security #:		**Social Security #:**	
Phone: **(H)** ____________________ **(W)** ____________________ **(C)** ____________________		**Phone:** **(H)** ____________________ **(W)** ____________________ **(C)** ____________________	
Email:		**Email:**	

(Giving my email address means that I approve of receiving emails from FFPS) Initial (Partner A)_______ (Partner B) _______

Referral Source:

Date Married:	Previous Marriages: Yes ______ No ______

Do you have children together? Yes ______ No ______

Did you have children before marriage? Yes ______ No ________

NAMES OF CHILDREN	AGES	DATE OF BIRTH	CURRENTLY LIVES

OCCUPATIONAL DATA

Place of Employment (Partner A)	How long	Position
Place of Employment (Partner B)	How long	Position

REASONS FOR SEEKING THERAPY

Partner A:

Partner B:

STATED GOALS FOR THERAPY

Partner A:

Partner B:

Quality of Sexual Connection

PREVIOUS COUNSELING OR OTHER TREATMENT FOR MARITAL PROBLEMS		
Dates	*Problem Type*	*Treating Professional/Agency*
Dates	*Problem Type*	*Treating Professional/Agency*

HISTORY/FUNCTIONING AREAS – PARTNER A		
Functioning at home:		
Functioning at work:		
Functioning in social relationships and leisure activities:		
How have your faith-based principles affected your life?		
Legal Involvement: (Criminal/ Civil)	□ Yes	□ No
Describe:		
Substance Abuse Dependence:	□ Yes	□ No
Describe:		
Financial Concerns:		

PHYSICAL HEALTH				
How Many Alcoholic Beverages do you consume per:	□ Day	□ Week	□ Month	□ Year
Do You Smoke?			□ Yes	□ No
If yes,		□ Cigarettes	□ Cigars	□ Pipe
Appetite:				
Sleep Pattern:				
Last Physical:				
Major/ Chronic Health Problems:				
Medications:				
Primary Physician:				

MENTAL STATUS		
Psychological Diagnosis:		
Medications:		
Name of Psychiatrist:		
Date of last psychiatric visit:		
Have you had individual therapy or counseling before?	□ Yes	□ No
If yes, please list the dates, names, and location of the provider(s):		
Hospitalizations for Mental Diagnosis:		
If so, what was the nature of the therapy?		
Was therapy helpful to you?	□ Yes	□ No
If not, why?		
Do you have a history of trauma?	□ Yes	□ No
If yes, please describe:		
Describe any Suicidal Ideations or Homicidal Ideations (Present or Previous)		
Orientation:		
Speech:		
Memory:		
Motor Activity:		
Affect:		
Mood:		
Thought Process:		
Thought Content:		
Attention, Concentration, & Memory:		
Abstract Thinking:		
Insight Judgement:		

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Marriage & Family Therapy

RELATIONSHIP AND SEXUAL HISTORY
How did you learn about sex and who told you?
What type of contraceptives do you use?
What are your thoughts on sex?
How often do you have sexual activity?
Is this your first sexual relationship?
How has desire played a role in your life previously?
Many people engage in self-pleasures; tell me about your experiences.
Many people have marital affairs, tell me about your experiences.
Are you sexually satisfied in this marriage?
Have you experienced any sexual traumas?
Sexual pain, obsessions, or perceived abnormalities?

HISTORY/FUNCTIONING AREAS – PARTNER B				
Functioning at home:				
Functioning at work:				
Functioning in social relationships and leisure activities:				
How have your faith-based principles affected your life?				
Legal Involvement: (Criminal/ Civil)			□ Yes	□ No
Describe:				
Substance Abuse Dependence:			□ Yes	□ No
Describe:				
Financial Concerns:				

PHYSICAL HEALTH				
How Many Alcoholic Beverages do you consume per:	□ Day	□ Week	□ Month	□ Year
Do You Smoke?			□ Yes	□ No
If yes,		□ Cigarettes	□ Cigars	□ Pipe
Appetite:				
Sleep Pattern:				
Last Physical:				
Major/ Chronic Health Problems:				
Medications:				
Primary Physician:				

MENTAL STATUS		
Psychological Diagnosis:		
Medications:		
Name of Psychiatrist:		
Date of last psychiatric visit:		
Have you had individual therapy or counseling before?	□ Yes	□ No
If yes, please list the dates, names, and location of the provider(s):		
Hospitalizations for Mental Diagnosis:		

If so, what was the nature of the therapy?		
Was therapy helpful to you?	□ Yes	□ No
If not, why?		
Do you have a history of trauma?	□ Yes	□ No
If yes, please describe:		
Describe any Suicidal Ideations or Homicidal Ideations (Present or Previous)		
Orientation:		
Speech:		
Memory:		
Motor Activity:		
Affect:		
Mood:		
Thought Process:		
Thought Content:		
Attention, Concentration, & Memory:		
Abstract Thinking:		
Insight Judgement:		

RELATIONSHIP AND SEXUAL HISTORY

How did you learn about sex and who told you?
What type of contraceptives do you use?
What are your thoughts on sex?
How often do you have sexual activity?

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Is this your first sexual relationship?
How has desire played a role in your life previously?
Many people engage in self-pleasures; tell me about your experiences.
Many people have marital affairs, tell me about your experiences.
Are you sexually satisfied in this marriage?
Have you experienced any sexual traumas?
Sexual pain, obsessions, or perceived abnormalities?

Informed Consent I for Individuals in Couples Treatment

I, the undersigned, do hereby acknowledge, understand and consent to the following conditions of counseling or therapy:

1. The counseling or therapy I will receive is conducted by a licensed professional or a supervised licensed graduate professional.

2. I understand this counseling will utilize verbal psychotherapeutic techniques intended to assist me in growing as an individual, within a relationship and/or as a member of a family or social group.

3. I understand that the therapists at Family First Psychotherapy Services (FFPS) are not physicians and therefore cannot prescribe medications. I understand that a therapist is a "consultant" and a professional resource and cannot guarantee the client's wished outcome. I understand that the interventions suggested and recommendations offered may be freely accepted or rejected and are also my responsibility to follow.

4. I understand that in this office no nudity, no physical examination, nor any overt sexual behavior will be involved in the treatment of sexual concerns.

5. I understand that a social relationship with the therapist outside of the therapy office is prohibited.

6. I am entitled by law to freely ask questions about the therapist's education, training and philosophies, and this therapeutic process.

7. Therapy sessions with couples can range from 10-35 sessions. I understand that therapy can be most productive if we, the couple, are dedicated to completing 10 sessions minimally initially.

8. I understand termination of therapy is predicated upon reaching the agreed upon treatment goals and/or intentional ending of therapy. I understand that to terminate without the consent of the therapist therefore not reaching all agreed upon goals would be at my own risk.

9. Once it is determined that my goals cannot be reached in treatment with aforementioned therapist then said therapist will make referrals to a more appropriate resource.

10. I understand that after I sign this documentation it will constitute a binding agreement between myself and the staff of FFPS.

____ ____

Client's Signature Date Client's Signature Date

Family First Psychotherapy Services Marriage & Family Therapy

INFORMED CONSENT II FOR INDIVIDUALS IN COUPLES THERAPY

This document deals with privacy issues specific to couples and supplements the document already given to you that deals with related issues in therapy. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

First, I wish to reassure you that I am personally and professionally committed to protecting your privacy. I realize that therapy can only take place in a setting in which everyone feels secure in the knowledge that his or her thoughts and feelings will remain protected and secure within the confines of the therapy office. To protect your privacy, I have put the following policies into effect.

To prevent an inadvertent breach of confidence, I have a policy of not greeting a client whom I meet outside of my office. Thus, should we happen to meet in public, I will intentionally not say hello to you to protect your confidentiality. You may, however, feel free to greet me in public, if you so desire.

Issues concerning personal privacy and professional confidentiality are somewhat more complicated when working with married or unmarried couples and sometimes require certain additional compromises in privacy.

For example, part of our couples work will require that I meet individually with you and at other times individually with your spouse or partner. During those individual meetings, I will require permission from you to share with your partner anything that I deem appropriate. I will strive to use my best professional judgment to share this information as considerately and kindly as possible. Therefore, although I would hope you would be completely honest with me about your personal as well as relationship concerns, you might choose not to share with me certain information if you are concerned about the possibility of your partner learning of it. Essentially, what I am saying is that unless we make a prior agreement about certain specific information, I will use my professional judgment in deciding whether any information you have shared with me will subsequently be shared with your spouse or partner.

In this regard, there may be times when you or your partner requests that I keep certain information secret from the other. At times I might agree to keep your secret. Thus, there may be times when I might have learned something from you that I will agree to keep secret from your partner. I believe that couples are best served by giving each member of the couple the opportunity to meet with me individually. Unfortunately, with that flexibility goes certain inevitable confidentiality complications.

What are some of the complications that can arise from this policy? I might uncover or discover secrets about you or your partner/spouse that the other is unaware of. For example, I might learn that (a) your partner/spouse had an affair that is now ended; (b) is still having an affair and wants help in ending it, or (c) is still having an affair and has no intention of ending it.

In brief, my policy concerning private communication is that I reserve for myself the right to share or withhold from you or your partner information that I learn from you or your partner during individual therapy sessions. My commitment to each of you is to assist you in having the kind of relationship you desire. My experience is that the chance of reaching that goal is enhanced if I have the flexibility in those privacy and confidentiality issues spelled out in this article.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

______________________________	______________________________
Client's Signature Date	Client's Signature Date

Office Agreement

Appointments cancelled or rescheduled after 7:00 am the day of the appointment will be assessed a $30 fee for the time that has been booked. All appointments that need to be rescheduled should be done 24 hours before the scheduled appointment.

Appointments in which the client does not show (no show, no call) will be assessed a **$50.00 missed appointment fee**.

Checks that are returned will be assessed a **$35.00 returned check fee** to cover bank costs.

Check cards with the Visa, Discover, Master Card, and American Express logo are accepted. You will incur a $2.00 service fee each time the card is swiped. There will be a **$35 fee accrued by you for an insufficient line of credit causing a service fee for FFPS.**

Agreement to Pay for Professional Services

I am requesting professional psychotherapy consultation with Nicole Daniels, a Licensed Marriage & Family Therapist. **The fee for a 75-minute session is $150. Every 15-minutes beyond the 75-minutes for couples is $15 and should be agreed upon with the clinician. I am aware that payment is collected at the time of service. The accepted payment methods include cash, check, and credit cards**. **All other fees different than previously stated, have to be agreed upon by provider of service rendered.** Also, payment is collected at the time of service for insurance co-pay or co-insurance fees. If I use my insurance, I also agree to pay any remainder of the balance not paid by the insurance. I am aware that FFPS staff is paneled on Tricare Insurance and acts as an “Out of Network” provider for other insurance companies. A detailed receipt will provided as necessary for out-of-network clients. By signing below, I am consenting to this “Agreement to Pay for Professional Services” giving authorization to disclose PHI for the purpose of collection of payment from my insurance company for psychotherapy services, also to bill my credit card on file as agreed to by client and staff for missed appointments or as payment of services. I understand the conditions explained.

Thank you for your business and understanding.
Welcome to Family First Psychotherapy Services.

______________________________ ______________________________

Client’s Signature Date Client’s Signature Date

Welcome to Family First Psychotherapy Services, LLC

Dear Family First Psychotherapy Services Client:
You and your partner/spouse are an important part of the treatment process and you both will be expected to attend all counseling sessions unless otherwise directed/agreed. Your therapist will do everything he/she can to schedule appointments at a time when you can attend.

The Counseling Process
The benefits of counseling can include growth of family members and positive changes in behavior and feelings. However, like any worthwhile project, it requires commitment, hard work, and sticking through the tough times. Your commitment and effort can have great outcomes. Counseling can last from a few weeks to several months depending on the nature of the problem. The therapeutic approach used tends to be experiential and humanistic oriented. The models/approaches used are Emotionally Focused Therapy, Cognitive-Behavioral, Developmental, Spiritual, and Psycho-Educational to aid in reaching treatment goals. Within a reasonable time after the initiation of treatment, the therapist will be able to offer you some initial impressions of what your work will include. You should also make your own assessment about whether you feel comfortable in the therapeutic environment established. If you have any questions about the process of therapy, please make them known.

Recordkeeping
As required by state laws, your therapist will keep written records documenting counseling services. Reports of counseling progress may be made available only to the client or designated individual when requested in writing, and when agreed upon by the counselor or supervisor.

When the participant's case is closed, their record will be placed in our inactive archives. After five years, the record will be destroyed (unless the participant resumes counseling here before the five-year period ends).

An assessment of your functioning will be documented in the file to best identify the proper course of counseling treatment. You have the right to be made aware of your diagnosis and treatment plan. (The diagnosis will also be shared with your insurance carrier as necessary for reimbursement.)

On occasion, your counselor may ask your permission to make an audio or videotape of a counseling session. These recordings are made to assist your counselor in helping you. However, you have the right to refuse any request for taping. These tapes/recordings are destroyed or recorded over after viewing.

Ethical and Professional Standards
Family Psychotherapy Services, LLC licensed professionals or supervised licensed graduate professionals will adhere to the standards for ethical and professional conduct established by the State of Maryland, Professional Counseling Board.

"This information is required by the Maryland Board of Examiners of Professional Counselors which regulates all certified and licensed counselors and therapists."

Maryland Department of Health and Mental Hygiene Board of Professional Counselors and Therapists
4201 Patterson Avenue Baltimore, Maryland 21215 | 410-764-4732
Please keep this document for your records

Updated 03/2017