

Treatment Information and Consent Form

Evaluation: Our first few sessions will involve an evaluation of your history, treatment needs and to determine if I am the therapist for you. By the end of the evaluation period I will make recommendations for treatment and you will want to make your own assessment about whether you feel comfortable working with me. It is important that you are working with a therapist that is a good match for you as therapy involves a large commitment of time, money, and energy. If either of us has concerns about our initial connection or treatment recommendations, I am happy assist you with other referrals.

Appointments: Please come is a few minutes early so that you have an opportunity to refocus on what you would like to get out of session. I begin and end sessions on time and it is to your advantage to come in early so as that we do not miss any of our session time. If you are late, we will still end on time. If you have specific concerns you would like to make sure we cover in session please let me know at the beginning of our appointment, otherwise I will make treatment recommendations based on our treatment plan and your weekly reports on your progress and concerns.

➤ **Each session is scheduled for 45 minutes unless you request a longer session at the time of scheduling.**

Payments: All services are provided for a fee due at the time of the service. Please be prepared to pay by cash or check at the beginning of each session. My hourly fee is \$150 for a 45 minute session and \$225 for a 75 minute session. I charge a prorated rate for other professional services you may require such as report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings or consultations with other professionals which you have authorized and requested. I have the right to terminate service to you if fees are not paid in a timely manner.

➤ **Please have your check or cash payment ready prior to starting the session in order to maximize your session time.**

Insurance: I do not accept insurance. If you have a PPO insurance plan you can choose to submit a bill to them for partial reimbursement for an “out of network” provider. You may want to contact your PPO to find out if you have a deductible and how much they will reimburse for “out of network outpatient mental health” (a 45 minute session is coded as a “90834” and a 75-80 minute session is an “90837”) Your insurance company can tell you how much they reimburse for each of these services.

24 Hour Cancellation Policy: If you need to cancel or change your appointment time please ***call me at least 24 hours prior to your appointment time to avoid being charged the full session price. Please call or text to cancel or request a change in your appointment. I cannot guarantee that I will receive an e-mail in time to cancel your appointment without a charge.***

Contacting Me: I am in the office Tuesdays-Thursdays and I am often not immediately available by telephone. When I am unavailable, you can leave a voice mail message for me, always including your phone number. If you leave a message, please leave me times when you will be available. If you need to speak to a counselor right away, and I am not available, please

call the 24 hour **crisis line: 1(888) 724-7240**. If it is an emergency please call 911, go to your closest emergency room, or contact your physician.

Please remember that e-mail is not confidential and technical problems can occasionally interfere with my ability to respond. If I have not responded promptly, do not hesitate to contact me again. Unless you specify not to contact you by e-mail (on your registration form) I may occasionally send resource or scheduling information by e-mail. It is not appropriate for us to discuss deep therapy issues over e-mail.

I can receive or may send you a text regarding schedule changes unless you prefer not to communicate by text as indicated on your registration information.

Confidentiality: Confidentiality of communication between patient and clinical social worker are protected by law and I can only release information about you and our work to others with your written permission. However, there are a number of exceptions when a clinical social worker is required by law to disclose confidential information.

I am legally required to take action to protect others from harm, even though that requires revealing some information about your treatment. For example, if I believe that a child, an elderly person, or a disabled person is being abused, I must file a report with the appropriate state agency. If I believe that you are threatening serious bodily harm to another, I am required to take protective actions, which may include notifying the potential victim, notifying the police, and seeking appropriate hospitalization. If you threaten to harm yourself, I may be required to seek hospitalization for you or to contact family members who can help provide protection. Should any of these situations occur, I will usually discuss this with you before taking any action and you are welcome to ask me about this as needed.

I may occasionally find it helpful to consult about a case with other professionals. In these consultations, I do not reveal any identifying information of my patient. The consultant is, of course, also legally bound to keep information confidential. Unless you object, I will not tell you about these consultations unless I feel it is important to our work together.

In most judicial proceedings, you have the right to prevent information about your treatment to be disclosed. However, in very rare circumstances a judge can sign a court order that may require my testimony if he or she determines that resolution of the issues before him or her demands it.

Authorization for Services: I have read the information in this treatment information and consent and I have asked questions about anything I have not understood. By signing this form, I freely acknowledge my willingness to participate in psychotherapy to be facilitated by Alicia Outcalt, LCSW. I understand that I can end treatment at any time and will pay for all services rendered.

Signature

Date

Print Name

Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Cell: _____ Work: _____

Can I leave a message at these numbers? Home: **yes / no** Cell: **yes / no** Work: **yes / no**

Can I contact you by text? **yes / no** *TEXT is not confidential & only used for scheduling changes.

*E-mail Address: _____

Please do not contact me by e-mail. *E-mail is not confidential and therefore used infrequently.

Emergency Contact: _____ Phone: _____

Please complete a release of information for any professional or personal contact that you would like me to communicate with.

Medical Information

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Allergies: _____

Current medications: _____

Past medical conditions & Surgeries: _____

Current medical concerns: _____

General physical health is: Excellent Good Fair Poor

Coffee/Caffeine _____ cups per day

Alcohol _____ drinks per day

Cigarettes per day _____ For how long? _____

Drug use daily weekly monthly occasional For how long? _____

Any problems related to substance use (DUI, work, relationships) Yes No

Any kind of substance use treatment (detox, 12 step, outpatient, residential) Yes No

Treatment Information

Referred by: _____

Reason for your visit/What made you decide to come in for this treatment: _____

How would you know that treatment was successful? _____

Past treatment experiences: (Please comment on reasons for treatment, length of treatment, and if it was helpful or a negative experience)

Personal History

It can be difficult to get through the initial assessment process but the following information will be helpful in this process and can help us move more quickly into addressing what is most important to you. The more that I know about you and your background the better I can tailor my interventions to you. I understand that it is difficult to answer these questions openly before we have met. Please do not feel obligated to answer anything that you are not ready to share with me at this time or in this written format. You can simply leave certain areas blank and make comments on areas that you feel comfortable with. Feel free to add any other information I have not asked but that you want to make sure that I know right away.

Where did you grow up? (list as many places with ages or dates as appropriate)

Who lived with you when you were a child? (list by dates or ages as appropriate)

Please list your siblings, their ages and what part of the country they live in now. _____

How did you do in school both academically and socially? _____

Highest Grade/Degree Earned (include date and area of study) _____

Current Occupation/Employer: _____

Length of time with this employer? _____

Longest time with one employer? _____

Who lives with you at this time? _____

Who do you count on for emotional support? _____

Hobbies _____

Accomplishments: _____

What has been the best time of your life/When do you feel you were at your best? _____

Significant past events: _____

Family Members with emotional issues or substance use problems (include suicide attempts)

Your own past suicide attempts, cutting, past substance use, disordered eating, gambling or other significant problems you have struggled with: _____

Current substance use and what each substance does for you: _____

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often...
Swear at you, insult you, put you down, or humiliate you? Yes No
Act in a way that made you afraid that you might be physically hurt? Yes No
2. Did a parent or other adult in the household often or very often...
Push, grab, slap, or throw something at you? Yes No
Ever hit you so hard that you had marks or were injured? Yes No
3. Did an adult or person at least 5 years older than you ever...
Touch or fondle you or have you touch their body in a sexual way? Yes No
Attempt or actually have oral, anal, or vaginal intercourse with you? Yes No
4. Did you often or very often feel that ...
No one in your family loved you or thought you were important or special? Yes No
Your family didn't look out for each other, feel close to each other, or support each other? Yes No
5. Did you often or very often feel that ...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Yes No
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? Yes No
6. Were your parents ever separated or divorced? Yes No
7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her? Yes No
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Yes No
Ever repeatedly hit at least a few minutes or threatened with a gun or knife? Yes No
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? Yes No
9. Was a household member depressed or mentally ill, or did a household member attempt suicide? Yes No
10. Did a household member go to prison? Yes No