LISA L. BERGFELD, M.A., LMFT

LICENSED MARRIAGE & FAMILY THERAPIST

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1. Patient Information

NAME (OR PARENT OF MINOR) _____ DATE _____

ADDRESS _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ EMAIL _____ PAGER _____

MAY WE CALL YOU AT ❍ Home ❍ Work ❍ Cell MAY WE LEAVE A MESSAGE AT ❍ Home ❍ Work ❍ Cell

DATE OF BIRTH _____ PLACE OF BIRTH _____ ETHNICITY _____

EDUCATION (YRS) _____ DEGREE _____ AREA _____

OCCUPATION _____ EMPLOYER _____ HOW LONG? _____

SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____

NAME OF SPOUSE/PARTNER _____

ADDRESS _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ EMAIL _____ PAGER _____

MAY WE CALL YOU AT ❍ Home ❍ Work ❍ Cell MAY WE LEAVE A MESSAGE AT ❍ Home ❍ Work ❍ Cell

DATE OF BIRTH _____ PLACE OF BIRTH _____ ETHNICITY _____

EDUCATION (YRS) _____ DEGREE _____ MAJOR _____

OCCUPATION _____ EMPLOYER _____ HOW LONG? _____

SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____

MARITAL STATUS ❍ Single ❍ Married ❍ Separated ❍ Divorced ❍ Widowed ❍ Domestic Partnership

IF MARRIED: AGE OF SPOUSE: _____ DATE OF MARRIAGE: _____

IF DIVORCED: DATE OF MARRIAGE TO EX-SPOUSE: _____ DATE OF DIVORCE: _____

IF DIVORCED MORE THAN ONCE: DATES OF PREVIOUS MARRIAGE & DIVORCE: _____

IF SEPARATED: DATE OF SEPARATION: _____

IF INVOLVED WITH A SIGNIFICANT OTHER: HIS/HER NAME: _____ OCCUPATION: _____

IF YOU LIVE TOGETHER: SINCE WHEN? _____ HOW LONG KNOWN? _____

WOULD YOU DESCRIBE YOUR INTIMATE RELATIONS AS SATISFACTORY OR UNSATISFACTORY? _____

NAMES OF CHILDREN	DOB	AGE	NAMES OF CHILDREN	DOB	AGE
1.			4.		
2.			5.		
3.			6.		

Are your children living with you?_____Other children living with you: Names, ages and relationship to you:_____

_____

PATIENT NAME _____ DATE _____

2. Medical Information

This is a confidential record. Information contained in it will not be released to anyone unless authorized by you or required by law as explained in our informed consent to treatment. Please fill out completely.

PRIMARY CARE PHYSICIAN _____ PHONE _____ Date of last Physical _____

ADDRESS _____ ZIP _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____

RELATION _____ PHONE 1 _____ PHONE 2 _____

ADDRESS _____ ZIP _____

Current Weight _____ One year ago _____ Maximum _____ When _____

Do you exercise Regularly? Y/N How? _____

Do you Sleep Well? Y/N Amount of Hours? _____ Easy to get to sleep? _____

What recreation do you enjoy? _____

The hardest time in your development was: Preschool ❒ Grade School ❒ Jr. High ❒ High School ❒ College ❒ Now ❒

MEDICAL CONDITIONS
Please check all that apply to you:

	Never	Seldom	Sometimes	Often
Insomnia	❒	❒	❒	❒
Loss of Appetite	❒	❒	❒	❒
Back Pain	❒	❒	❒	❒
Asthma	❒	❒	❒	❒
Headaches	❒	❒	❒	❒
Phobias (fears)	❒	❒	❒	❒
Nausea	❒	❒	❒	❒
Allergies	❒	❒	❒	❒
Nervousness	❒	❒	❒	❒
Loss of Temper	❒	❒	❒	❒
Fatigue	❒	❒	❒	❒
Depression	❒	❒	❒	❒
High Blood Pressure	❒	❒	❒	❒
Constipation	❒	❒	❒	❒
Diarrhea	❒	❒	❒	❒
Over-eating	❒	❒	❒	❒
Mood Swings	❒	❒	❒	❒

OTHER CONCERNS

Smoking	❒	❒	❒	❒
Number of Packs per week:				
Alcohol Intake	❒	❒	❒	❒
What do you drink? _____ Frequency (per week) _____ How Much?				
Marijuana	❒	❒	❒	❒
Amount per week:				
Drugs (not medications)	❒	❒	❒	❒
What? _____ Frequency				

PATIENT NAME _____ DATE _____

MEDICATION HISTORY				
	Never	Seldom	Sometimes	Often
Appetite Suppressants	❒	❒	❒	❒
Pain Relievers	❒	❒	❒	❒
Sedatives/Tranquilizers	❒	❒	❒	❒
Sleep Aids	❒	❒	❒	❒
Stimulants	❒	❒	❒	❒
Blood Pressure Meds	❒	❒	❒	❒
Heart Medicine	❒	❒	❒	❒
Vitamins	❒	❒	❒	❒
Other (please specify below)	❒	❒	❒	❒

List medications you are currently taking:

1.	4.
2.	5.
3.	6.

3. Additional Background Information

Are you currently in therapy elsewhere? ❍ Yes ❍ No Have you had previous therapy? ❍ Yes ❍ No

Problem	Date	Therapist & Location	Was Therapy Successful?

FAMILY HISTORY

Parents: Father's Age _____ Occupation _____
Mother's Age _____ Occupation _____
Did you grow up with both parents in the home? ❍ Yes ❍ No
If your parents divorced, what age were you? _____
Custody Arrangements _____
Step-father's Age _____ Step-mother's Age _____
Do you feel closest to your ❍ Father ❍ Mother ❍ Step-Father ❍ Step-mother ❍ None ❍ Other
Briefly describe your relationship with your father _____
With your mother _____

Siblings: Brother's first names & ages _____
Sisters' first names & ages _____

Other: Please explain if any member of your family has ever suffered from anything which could be described as an "emotional" or "psychological" problem: _____

Please mention any history of domestic violence, child abuse or sexual abuse in your family: _____

Please comment on any history of alcohol abuse or illegal drug use in your family: _____

PATIENT NAME _____ DATE _____

List names and ages of family members involved in therapy:

1.	4.
2.	5
3.	6.

In your own words, please state the nature of your main problem:_____

_____

_____

_____

_____

_____

_____

How would you rate how serious this problem feels to you?

Circle One: 1 2 3 4 5
Mildly Upsetting - Extremely Serious

Have you ever attempted suicide? _____ If Yes, when? _____

If Yes, method used _____

Have you ever been hospitalized for psychiatric reasons? _____ If yes, when & how long? _____

What goal(s) would you like to accomplish through counseling?_____

_____

_____

_____

_____

_____

Would you like spiritual/religious issues to be a part of your therapy? ❍ Yes ❍ No ❍ Don't know

Note: It is important for the patient and therapist to determine together what part spiritual/religious issues will or will not take in therapy.

Church Affiliation (*if any*):_____

_____

Insurance information:

PROVIDER:_____ GROUP # _____ INSURANCE ID # _____

WHO REFERRED YOU TO THIS OFFICE? _____

MAY WE CONTACT THIS PERSON TO THANK HIM/HER FOR THE REFERRAL? _____ (INITITALS) _____

PATIENT NAME _____ DATE _____

4. Informed Consent For Treatment

Please carefully read this document and sign, indicating that you understand and accept these conditions. It is important that you feel comfortable with your therapist and confident in his or her approach. Please contact me to discuss any condition that may be of concern to you.

OFFICE POLICIES: Your therapist can be reached for an appointment at (949) 709-8567. Your therapist will take at least two weeks of vacation per year. If you have a life threatening emergency dial 911 or go to your local hospital.

APPOINTMENTS: You appointment time is reserved for you. It is your responsibility to notify your therapist at least 24 hours in advance if you are unable to attend. Cancellations of appointments less than 24 hours in advance and "no shows" are subject to the full fee for the appointment time.

TREATMENT PROCESS AGREEMENT: Initially your therapist will gather information concerning your presenting problem. He or she will take a history of your presenting situation and once your problem is well defined, you and your therapist will collaborate to set goals. Throughout treatment you may be asked to do homework between sessions. Completing your homework will help you in reaching your set goals in a timely manner. Signing this document indicates that you are in acceptance with the therapists policies and procedures.

POTENTIAL RISKS AND BENEFITS: Therapy is helpful to most patients, however, there are no guarantees of success. Patients may experience strong emotions such as anxiety, frustration, sadness and anger when dealing with troubling situations or unpleasant past events. Therapy can bring up memories or realizations that may be distressing and some clients may experience unanticipated personal dilemmas, worries or nightmares. In addition, trying to resolve issues with family members or other important people in your life can lead to discomfort and may lead to unexpected changes or results that were not originally intended. Like any professional or medical service, therapy may not succeed in producing successful results and for some people, symptoms or problems may become worse. In general, however, the discomfort experienced is part of the process of delving into uncomfortable feelings or problems so that you might emerge at a more satisfying and rewarding place in your life and relationships.

5. Disclosure of Special Circumstances

SPECIAL CIRCUMSTANCES: Please share any special circumstances below: _____

PATIENT NAME _____ DATE _____

6. Terms Regarding Confidentiality & Privacy

LIMITS ON CONFIDENTIALITY: Confidentiality is the legal right to privacy for all patients who receive therapy and is protected by both ethical practice and California law. I understand that there are some situations in which a therapist is legally obligated to take actions that he or she believes are necessary to attempt to protect the client or others from harm, and he or she may be required to reveal some information about a client's treatment.

- CHILD ABUSE: If a therapist has knowledge of or reasonably suspects that a child under the age of 18 has been the victim of child abuse or neglect, the law requires that the therapist file a report with the appropriate governmental agency. A therapist also may make the report if he or she reasonably suspects mental suffering has been inflicted upon a child or that his or her emotional well being is endangered in any other way. Once such a report is filed, the therapist may be required to provide additional information.

- ELDER/DEPENDENT ADULT ABUSE: If a therapist observes or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, or if an elder or dependent adult credibly reports that he or she has experienced behavior including an act or omission constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect, or reasonably suspects that abuse, the law requires that the therapist report to the appropriate governmental agency. Once a report is filed, the therapist may be required to provide additional information.

- THREAT OF VIOLENCE TO OTHERS: If a client communicates a **serious threat of physical violence** against an identifiable victim, the therapist must take protective actions, including notifying the potential victim and contacting the police. The therapist may also seek hospitalization of the client or contact others who can assist in protecting the victim.

- DANGER TO SELF: If a therapist has a reasonable cause to believe that the client is in such mental condition as to be dangerous to himself of herself, the therapist may be obligated to take protective action, including seeking hospitalization or contacting family members or others who can help provide protection. *If such a situation arises, your therapist will limit disclosures to what is necessary*.

REGARDING CHILDREN'S CONFIDENTIALITY: If my minor child participates in therapy, I understand the importance of allowing him or her to develop a semi-confidential relationship with his or her therapist. As such, I understand that the most personal information that my child discusses with his or her therapist will not ordinarily be shared with me. Rather, my child's therapist will provide me with general summaries of my child's progress without private details. However, I understand that the therapist is committed to informing me about unusual or dangerous symptoms or behaviors (including violence, criminal activities, child abuse, self abuse, suicidality, or intentions to harm others, harm oneself, alcohol and substance use).

PRIVACY: The law protects the privacy of all communications between a client and a therapist. This begins at the beginning of the consultation process. In most situations, your therapist can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by state law and or HIPAA. However, **there are some situations where your therapist is permitted or required to disclose information** without either your consent or authorization.

- CONSULTATION: Your therapist may occasionally find it helpful to consult with other health and mental health professionals about a case. During a consultation, he or she will make every effort to

avoid revealing identity of clients. The other professionals are legally bound to keep the information confidential. If you don't object, your therapist will not tell you about these consultations unless he or she feels that it is important to your work together. Your therapist will note all consultations in your Clinical Record.

- COLLECTION: Disclosures required to collect overdue fees are discussed elsewhere in this Agreement. If you do not pay your fee, we are permitted to contact a collection agency.

- COURT PROCEEDINGS: **If** you are involved in a court proceeding and a request is made for information about the professional services provided you, and/or the records thereof, such information is protected by the therapist-patient privilege law, and no information will be provided without your (or your legally appointed representative's) written authorization, court order or compulsory process (subpoena) or discovery request from another party to the court proceeding where that party has given you proper notice (when required), has stated the valid legal grounds for obtaining PHI and your therapist does not have grounds for objecting under state law (or you have instructed him or her not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.

- GOVERNMENT AGENCIES: If a government agency is requesting information for health oversight activities pursuant to their legal authority, your therapist may be required to give it to them.

- LAWSUITS: If a client files a complaint or lawsuit against his or her therapist, relevant information may be disclosed regarding that client in order for the therapist to defend himself or herself.

- WORKER'S COMPENSATION: If a client files a worker's compensation claim, the therapist must, upon request, disclose information relevant to the claimant's condition to the worker's compensation insurer.

- COMMUNICATION METHOD: Your therapist may contact you by cellular phone and E-mail. These technologies are not guaranteed of privacy. May we contact you by cellular phone and email? Y / N

TERMINATION OF THERAPY: Your therapist believes that how long you remain in therapy is a matter best left in your hands. Although your therapist will certainly provide counsel for you in this matter, you must make the ultimate decision about continuing care. We hoe that a decision to end counseling will be discussed candidly and thoroughly with your therapist in advance of leaving.

7. Financial Responsibility

PAYMENT & FEES: You are expected to pay for services at the time they are rendered unless other arrangements have been made. Services are rendered and charged to the client, not to the insurance company. Your therapist will provide you with a receipt to submit to your insurance company for reimbursement.

I agree to be responsible for the payment of $ _____per session (45 – 50 minutes) which is payable by cash or check at the time of the session. I understand that I may also incur charges for phone consultations and emails in 15 minute increments. There is a $25 fee for returned checks. (Please refer to the fee schedule below for additional professional services and rates).

I understand that I am responsible for full payment, even though I may or may not be reimbursed by my insurance company. Checks are to be made payable to "Lisa Bergfeld".

PATIENT NAME _____ DATE _____

PROFESSIONAL SERVICES & RATES:

Professional Services	Time	Rate
Initial Evaluation *(first appointment)*	70-75 minutes	$160
Therapy Sessions	50 minutes	$120
Extended Sessions	Each 15 minute increment	$30
Late Cancellation or No Shows	Scheduled Session	Full Fee
Phone Consultation and E-mail	15 minute increment	$30

I understand that services are provided by appointment only. Your scheduled appointment time is reserved for you alone. I agree to pay a Late Cancellation fee for any missed appointment that I do not call to cancel at least 24 hours in advance and by Friday at 5:00pm for Monday appointments except in the case of emergencies.

My signature below indicates that I have read this agreement in its entirety and agree to its terms. It further serves as an acknowledgement that I have received the HIPAA required notice contained herein and the Privacy Policy provided. I understand that I have the right to end therapy at any time with no obligation except to pay for completed services. I understand that upon request, I may have a photocopy of this agreement.

_____ _____

Client Signature Date

_____ _____

Signature of Parent or Legal Guardian if Client is a minor Date

_____ _____

Signature of Financially Responsible Party Date