Deborah Phillips, MA, MFT, CCH
Licensed Marriage & Family Therapist LMFT52563
Certified Clinical Hypnotherapist
2011 S. El Camino Real Ste. C San Clemente, Ca 92672
Tel (949) 933-6103 dphillips.mft@gmail.com

Welcome to Therapy!

Every person's motivation for beginning therapy is different and often the first telephone call is a courageous, and sometimes difficult, first step. The therapeutic relationship is a unique professional relationship. Though we will not be 'friends' in the social sense, we will hopefully develop a close and meaningful relationship that will enhance our work together and help you achieve your goals in the context of a safe and caring environment.

Please take time prior to your appointment to complete and read this registration packet. Keep a copy for your records. It includes:

1. Registration for general personal information – Please Complete and Sign
2. Informed Consent (2 pgs.) to give you important information about therapy, office policies, etc. – Read, Initial and Sign
3. No Subpoena Agreement – Read and Sign
4. Question Sheet that will help us begin to focus our work together – Please Complete

Please look at my website: www.therapybythesea.net for helpful information and directions to the office. I look forward to meeting with you and beginning our work together.

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CLIENT REGISTRATION

Primary Client Information

NAME _____

Age _____ Gender M / F DOB _____

SS# _____ (Full number required for insurance Super Bill, otherwise last 4 digits please)

Address _____ City _____

Zip _____

Home Phone ( ) _____ Work/Cell ( ) _____

OK to leave message? Home yes / no Work/Cell yes / no

Email address _____

Ok to contact via email? yes / no

Relationship Status: single committed relationship married separated divorced

years married/in relationship _____

Referred by (Optional) : _____

Spouse or Partner Information

NAME _____

Age _____ Gender M / F DOB _____

SS# _____ (Full number required for insurance Super Bill, otherwise last 4 digits please)

Address _____ City _____

Zip _____

Home Phone ( ) _____ Work/Cell ( ) _____

OK to leave message? Home yes / no Work/Cell yes / no

Email address _____

Ok to contact via email? yes / no

Children

Name: _____ DOB _____ Living at home: Yes No

Name: _____ DOB _____ Living at home: Yes No

Name: _____ DOB _____ Living at home: Yes No

Name: _____ DOB _____ Living at home: Yes No

Name: _____ DOB _____ Living at home: Yes No

Name: _____ DOB _____ Living at home: Yes No

Medical Information

Primary Doctor _____ Tel _____

Psychiatrist _____ Tel _____

Medications currently taking: _____

_____

Employment or School – Primary Client

Employer or School _____

City _____ Grade in school_____

Type of Work or School Major _____

_____

Spouse

Employer or School _____

City _____ Grade in school_____

Type of Work or School Major _____-_____

_____

Hobbies and Interests

What do you do to relax? _____

_____

Spouse?_____

_____

Name 2 people who provide you emotional support?

_____

Spouse:

_____

Religious/Spirituality preference?

_____

Spouse**:** _____

Person to notify in emergency

Name_____ Relationship _____

Tel home- ( ) _____ work- ( )_____

cell-( )_____

Spouse:

Name_____ Relationship _____

Tel home- ( ) _____ work- ( )_____

cell-( )_____

Signature: _____ Date: _____

Print Name: _____

Spouse or Partner _____ Date: _____
(If conjoint therapy)
Print Name: _____

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CLIENT - THERAPIST AGREEMENT / INFORMED CONSENT

Please read the following carefully. If you have any questions do not hesitate to discuss them.

CONFIDENTIALITY

Your appointment and the contents shared during that time are held in strict confidence. This includes all file notes, personal information provided and/or data collected during treatment. No disclosures will be made without your written permission. I do not conduct therapy via computer or email. However, there are times when it may be appropriate to exchange information via email and you should do so only with awareness of the limitations and risks inherent in electronic communication.

Please read the circumstances below, under which I will not, or may not, keep information confidential.

Exceptions and Limits to Confidentiality:
California State Law *mandates* reporting to authorities in the following circumstances:

- Incidents that involve child, dependent adult or elder abuse; including neglect, physical, sexual abuse or unjustifiable mental suffering.
- Disclosures of intent to harm another person.

California State Law *permits* breaking confidentiality in the following circumstances:

- Incidents that involve emotional and/or psychological abuse of a dependent adult or elder.
- Indications of client being a danger to self, others or property.

APPOINTMENTS ~ AVAILABILITY ~ THERAPY PROCESS

The length of a standard individual therapy session is 50 minutes. Arrangements can be made for longer sessions for family and/or conjoint appointments, or when appropriate for individual clients. The length of a standard couple or family therapy session is 90 minutes. Fees and the length of these sessions will be discussed prior to scheduling any special appointments.

A telephone voice mail system is available 24 hours for messages and I normally I return calls the same day. When I am not available (i.e., vacations), my message will provide the name and telephone number of an on-call therapist. **If you experience a life-threatening emergency, call 911 or go to the nearest hospital emergency room.** Please be aware that email may not be reliable for scheduling/rescheduling appointments.

The client-therapist relationship is a collaborative working partnership established and maintained by mutual trust and respect. As your therapist, I commit to provide you professional services within my scope of practice and competence. If, at any time, I determine that another professional might better serve you, I will make the necessary referrals and/or resources available to you. It is my intention to provide services that will assist you in reaching your goals. Based on the information you provide and the specifics of your situation, I will give you feedback and provide recommendations regarding your treatment. You have the right to agree or disagree and are responsible for making your own decisions.

The therapy process involves certain risks and benefits. Due to the varying nature and severity of problems and the individuality of each client, it is not possible to predict or guarantee a specific outcome or result of therapy.

Deborah Phillips, LMFT is an independent, sole-proprietor and provides services only through her own private practice. No one else is legally connected to or responsible for the work of Deborah Phillips.

_____ **Initial** _____**Initial**

CANCELLATIONS / RESCHEDULING

I appreciate as much notice as possible when you need to cancel or reschedule an appointment. *Appointments must be cancelled 24 hours in advance in order to avoid charges*. It is understood that emergencies arise. If something unexpected does arise, please phone as soon as possible so that we can reschedule your appointment.

_____ **Initial** _____ **Initial**

FEES / PAYMENT

As the client, you are fully responsible for payment of all services rendered. Payment is due at each session unless other arrangements have been made. Charge for missed/cancelled sessions when less than 24 hours notice is given is $50.00, and can be mailed or brought to the next appointment if less than one week away. The fee for service will remain constant unless notified of a change 30 days prior to the change.

Insurance

***Please Note*: I do not bill insurance directly, but will be happy to provide you with a monthly statement of services ("superbill") for you to submit to your insurance company. Payment is due at the time of service and your insurance company will reimburse you according to your policy**.

FEES FOR SERVICES RENDERED:

Please remember that cancellations must be made at least 24 hours in advance to avoid being charged for the missed appointment. Please make payment at the beginning of your session (cash or check - payable to Deborah Phillips, credit card)**.** Additional fees will be charged for telephone counseling in excess of 15 minutes, letters, reports and legal-related matters.

_____ **Initial** _____ **Initial**

Type of Session/Fee

Initial Intake Appointment (60 min.)	$120.00
Standard Individual Session (50 min)	$120.00
Standard Couple or Family Session (60-90 min)	$150.00
Missed/cancelled sessions when less than 24 hours notice is given	$50.00

Longer session must be prearranged, charges will be discussed at that time.

Between session telephone counseling/contact (No charge for calls 10 min. or less) $25.per each 15 min.

_____ **Initial** _____ **Initial**

I have had the opportunity to discuss this informed consent statement with my therapist. I understand its meaning and consent voluntarily to receiving services based on this understanding.

SIGNATURES:

Client _____ Date: _____

Spouse or Partner _____ Date: _____

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NO SUBPOENA AGREEMENT

Due to the nature of the therapeutic process and the fact it often involves disclosing information with regard to many matters which may be of a personal and confidential nature, I agree that neither I nor my attorney nor anyone else acting on my behalf will call on Deborah Phillips, MA, LMFT:

- To become a witness to testify in court, at depositions or any other legal proceeding
- To disclose client psychotherapy records
- To communicate with child custody evaluator/s or other representatives of the court

I understand the reason for this agreement is that the purpose and interests of the courts may not be in the best interests of, and may interfere with, my own therapeutic work.

_____

Name (print)

_____

Signature

_____

Date

Please take a few minutes to answer the following questions.

1. Briefly describe the situation that influenced you to seek therapy (What's not working in your life right now?).

2. Are there other concerns that you would like to address?

3. What is the effect this situation has had/is having on you?

4. What has helped in this type of situation or worked for you in the past?

5. What would you like to be different or change as a result of therapy?

6. On a 1-10 scale, how important is this change to you? _____

7. On a 1-10 scale, how committed are you to making this change? _____

8. How do you think therapy can help you?

9. Describe, in detail, a peaceful, calming place for you. (Hawaii, a lake, a room, your back yard)