Demographics and Consent For Treatment

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General Information

Client Name: _____

Date of Birth: _____

Age: _____

Today's date: _____

If under 16, please give mother's name _____

and father's name _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ☐Other_____

Current status: ☐Student ☐Employed ☐Unemployed ☐Homemaker ☐Retired ☐Other: _____

Gender: ☐Male ☐Female ☐Unspecified

If student, are you Full Time or Part Time? ☐FT ☐PT Please give School attended _____

If working, please give Occupation _____

and Place of Employment _____

Emergency contact _____ Relationship _____

Emergency contact Phone Number _____ Alternative Phone Number _____

If person filling out form is not client, check here: ☐ What is your relationship to client? _____

Address & Contact Information

Home Address

_____ Home phone: _____ Okay to call? ☐

_____ Cell phone: _____ Okay to call? ☐

State_____ Zip_____ Work phone: _____ Okay to call? ☐

Email *(used for scheduling issues and payment reminders)* _____

Any special instructions when calling, leaving messages or emailing _____

_____

Initials and Signatures

_____ I understand it is my responsibility to pay for the session at the time of service.

_____ I affirm that I have willingly sought treatment from Dr. Delpassand for issues relating to the field of mental health. I recognize that such treatment may involve exploration of my personal and family experience and has the potential to be emotionally unsettling. I agree and consent to receive treatment from Dr. Delpassand at this time. I understand that I have the right to terminate such treatment at any time.

_____ I acknowledge that I have received, read, signed and consent to abiding by the Client Rights and Responsibilities document.

_____ I acknowledge that I have read and consent to the Notice of Privacy Practices document, which explains in detail my rights to access my Personal Health Information and how, when and with whom that information may be shared.

_____ I acknowledge that if Dr. Delpassand deems the treatment I require to be beyond her level of training or resources as a solo practitioner that it is her ethical duty to provide referrals to other professionals or agencies. In the event that such referrals are, in her professional opinion, necessary for treatment to be effective, I recognize that in order to continue in therapy with Dr. Delpassand I will need to follow up on such referrals and/or obtain additional licensed clinical responsibility for my care. Such situations may include (but are not limited to): recurrent suicidality, alcohol or chemical dependency, eating disorders, domestic violence, symptoms of bipolar, psychosis or a personality disorder.

_____ I agree that Dr. Delpassand's sole responsibility is in working with me as a therapist and that I will not enlist her in any legal proceedings related to my case. I further agree that neither her records nor her testimony will be subpoenaed for deposition or court testimony, and she will be exempt from conversations with social service personnel, parenting consultants, attorneys and members of the justice system.

_____

Client Name (please print legibly)

_____

Client Signature

_____

Date

_____

Parent Name

_____

Parent Signature

_____

Date