Dr. Eugene G. Devers and Associates

www.PhillyFamilyLifeCounseling.com

NEW CLIENT QUESTIONNAIRE

Welcome! We look forward to meeting you. Thank you for taking a few minutes to fill out this form. The information you provide is confidential, and will be helpful for our first meeting. *Both partners please complete your individual questionnaire*. If you have any questions, just ask!

Today's Date_____

Client Name_____ Age _____ Date of Birth _____/_____/____

Spouse/Partner Name _____ Age _____Their Occupation _____

Address _____
Street City State zip

Phone (Primary) _____ (Secondary)_____

Email (please print clearly) ___

Ethnicity_____ Where did you grow up? _____

Education _____ School: _____Occupation _____

What is you religious background / involvement _____

Emergency contact person (name, relationship, phone, address) _____
_____

Closest Relationships (please list name, birth date, relationship, and whether they live with you)

Name	Birth Date	Relationship	Living with you?
_____	_____	_____	_____
_____	_____	_____	_____

Please describe your current living arrangement (Do you live with others?)

_____

Have you participated in any therapy before? Y___N___ If yes, when? _____ Reason _____

Are you, currently seeing a psychiatrist, therapist, or helper? Y____ N___

If yes, please explain who and the reason: _____

Have you or a family member ever been hospitalized for mental or emotional illness? Y_____ N_____

If yes, please explain—dates, where, reason: _____

Substance abuse / addiction history? No _____ Yes (please explain) _____

Legal History (arrests, prison, DUI, parking tickets?) _____

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Medical Information: Doctor's name, phone, and address:

_____

_____

May I send your doctor a short note, letting him / her know you've come to see us? (I do not release details other than your name, for referral purposes) Y____ N____

Are you on any medications? Y___N___ If so, what and for what reason?

_____.

_____

_.

How can I help? Please tell me in your own words what brings you here today_____

_____

_____

What are your 2 most important goals for therapy?

1. _____

2. _____

Common problem/symptom checklist. Fill in: 0 - none, 1 - mild, 2 - moderate, 3 - severe.

___marriage	___divorce/separation	___alcohol/drugs	___God/faith
___pre-marital	___child custody	___other addictions	___church/ministry
___being single	___disabled	___grief/loss	___past hurts
___sexual issues	___work/career	___depression	___codependency
___family	___school/learning	___fear/anxiety	___intimacy
___children	___money/budgeting	___anger control	___communication
___parents	___aging/dependency	___loneliness	___self-esteem
___in-laws	___weight control	___mood swings	___stress control

____ other

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Family Information:

Marital Status (check any that apply): Single ___ Dating ___ Committed relationship ___ Engaged ___

Married ___ (how long? _____) Separated ___ (how long? _____) Divorced ___ (how long?_____)

Is a wedding being planned? Y_____ N____ If applicable, what date is scheduled for the wedding? _____

What are the ages of your children? _____

I would describe my friendships as: Close ___ Somewhat close____ Distant____ Conflicted____
I would describe my relationship with my mother as: Close ___ Somewhat close____ Distant____ Conflicted____
I would describe my relationship with my father as: Close ___ Somewhat close____ Distant____ Conflicted____

How many siblings do you have? _____ What are their ages? _____
How would you describe your relationship? _____

Crisis Information: Are you having any current suicidal thoughts, feelings or actions? Y_____ N_____
If yes, explain _____

Any current homicidal or violent thoughts or feelings, or anger-control problems? Y_____ N_____
If yes, explain _____

Any issues, hospitalizations, or imprisonments for suicidal or assault behavior? Y_____ N_____
If yes, describe _____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Y____ N___
If yes, describe _____

Who referred you to us? _____

What key words did you use in your online search? _____

THANK YOU for taking the time to fill out this information sheet. I will review this with you during your first counseling / life coaching / pre-marital session.

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Credit Card Information to be Used for Missed Appointment and Late Cancellation Fees

Name as it appears on the card:_____

Billing Address: _____

City & State: _____Zip: _____

Card Number:_____-_____-_____-_____;

Expiration Date: _____/_____. 3-digit security number on back of card: _____.

Missed Appointment and Late Cancellation Fee (MAF):

Scheduling and Cancellations: If you need to cancel or reschedule an appointment, please notify us as soon as possible. We **request** a 48-hour notice cancelling your appointment so that our time may be scheduled more productively. However, if you fail to keep an appointment or call to cancel **with less than the required 24-hour advance notice you will be charged a $99 MAF fee**. This is necessary because a professional time commitment is set aside and held exclusively for you. If less than the required notice is given, or if you fail to keep the appointment, including your initial appointment, you agree to pay the **$99 MAF fee** for the missed session before scheduling your next appointment. (Insurance providers will not pay for missed appointments)

I authorize Philly Family Life Counseling to debit this fee from the credit card information that I provided,

Signature _____

Date: _____

Informed Consent and Services Agreement

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Please review this form carefully, and feel free to ask any questions!

Welcome Statement: Welcome to Philly Family Life Counseling. All clinicians are fully licensed to practice in Pennsylvania; Licensed Clinical Social Worker (LCSW), Licensed Marriage & Family Therapist (LMFT), Licensed Professional Counselor (LPC) or Licensed Psychologist. We are governed by various laws and regulations and by the code of ethics of our profession. The ethics code requires that we make you aware of specific office policies and how these procedures may affect you. However, many of these policies will be unrelated to our work together.

Client's Rights: Our relationship is strictly voluntary and you may leave the psychotherapy relationship anytime you wish. It will be beneficial that you speak with your clinician/life coach about your decision to end your therapeutic relationship beforehand, so that together we can create a positive sense of closure and ending to our relationship. We are always ready to welcome returning clients

About Our Services: It's our goal to offer a positive, empowering, and life-enriching experience for our clients. Our practice orientation is one in which you and your clinician are Treatment Partners; engaging in purposeful conversations as we explore difficulties and search for understanding and new perspectives and options. The potential benefits of counseling are many and include improved functioning, relationships, insight, communication, self-image, mood, and the attainment of personal goals. However, in some cases persons have reported feeling worse after starting counseling. Clients understand that healing and growth is difficult, and some discomfort will likely be a part of the counseling process. Additionally, participating in marriage/couples and family therapy can lead to outcomes viewed as undesirable by one or more of the participants. You are encouraged to visit our web page www.PhillyFamilyLifeCounseling.com to review clinician's background, therapeutic orientation, and browse possible helpful links. As always, if you ever have any questions, just ask!

It is my goal and confidence that working in a collaborative relationship we can:

Discover Better Solutions
Detect Alternate Understandings
Develop New Possibilities
Discern the Sacred
Design an Improved Process of Change ©

Confidentiality: All communications and records are held in strict confidence. If a couple or family is being seen for therapy the client, regarding confidentiality, is considered to be all of those involved in services. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Information may be released, in accordance with state law and the Duty to Warn and Protect mandate when: (1) the client signs a written consent to release; (2) the client expresses serious intent to harm self or someone else; (3) there is reasonable suspicion of abuse against a minor, elderly person, or dependent adult; (4) for billing purposes; or (5) a subpoena or court order is received. When applicable Insurance companies and other third-party payers are given information that they request regarding services to clients, such information includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

To protect your privacy to the greatest extent of the law, it is our policy to assert either (a) privileged communication in the event of #5 or (b) the right to consult with clients, if at all possible, before mandated disclosure in the event of #2 or #3.

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Confidentiality Specific to Couples and Family Therapy: ***Private communication is NEVER confidential to the other partner.*** Whatever you share with your clinician individually - individual session, telephone conversation, email and text correspondence, written message, etc. - may be communicated to the other Treatment Partners, if in my judgment it is pertinent and may benefit the work with the couple or family.

Electronic Communication: Telephone, Email, and Skype are not encrypted methods of communication, and some confidentiality risk exists with their use. We communicate using these mediums. Occasionally, we may follow up with you by telephone or email. If you would prefer not to be contacted via one of these methods, simply initial here and inform me, and your preferences will be respected. If we and a client are communicating at a distance, the point-of-service will be deemed to be in Pennsylvania, which is our state of licensure and practice, and will abide by those laws and ethical code.

Phone and E-mail Accessibility: We will return telephone calls and emails as soon as possible, should you need to speak to us between sessions. However, we cannot guarantee an immediate return response to your message, and will make best effort to return messages within 24 hours. In the event of a lengthy telephone session or repetitive out of session contacts, you will be charged at the hourly session fee (insurance will not pay for telephone sessions).

Scheduling and Cancellations: If you need to cancel or reschedule an appointment, please notify me as soon as possible. We **request** a 48-hour notice cancelling your appointment so that we may schedule our time more productively. However, if you fail to keep an appointment or call to cancel with **less than a 24-hour advance notice** you **will be charged** a $99 Missed Appointment Fee (MAF). This is necessary because a professional time commitment is set aside and held exclusively for you. If less than the required notice is given, or if you fail to keep the appointment, you agree to pay the $99 MAF for the missed session (insurance will not pay for missed appointments) before scheduling your next appointment.

I authorize Philly Family Life Counseling to debit this fee from the credit card information that I provided as a down payment, when reserving the time of my initial appointment.

Conflicts: We work hard to ensure that you have a positive experience and greatly value our therapeutic relationship. We are consistently eager to hear your candid assessments and reactions to our work together. We are convinced that this ongoing open discussion is vital to your successful outcomes. If an unlikely conflict should occur, we very much desire you to talk with clinician, or Dr. Gene Devers, about your concerns that are creating conflict, in order for us to find a resolution. Should our discussions be unable to result in a satisfactory outcome, then we are committed to aid in your referral to another therapist.

Emergency Contacts: I will request emergency contacts for you, such as a family member, a mobile phone, or work phone number. These contacts may be used if I/we perceive a need. If you are in crisis go directly to the nearest hospital emergency room and/or call 911, do not wait for an email or telephone response. I return all e-mails and telephone voicemail messages at my first opportunity.

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Service Fees: Payment, including insurance co-pay, is due at the time of the service. Credit/Debit cards, including Medical Health Fund cards, and cash are accepted for payment. In addition, new and returning clients are requested to pay an annual subscription fee of $59. This additional fee supports Philly Family Life Counseling's exceptional level of care, which goes well beyond customary standards required by insurance providers and offered by other counseling services. This fee is voluntary and if unable to pay then a waiver may be issued. We will not refuse treatment to any client who chooses not to pay the subscription fee. A full description of the many extra benefits that full membership entitles you is viewable on our webpage **phillyfamilylifecounseling.com**

Clients understand they are fully responsible for all fees if insurance or other vendor does not pay for any reason. Every effort is made to confirm your copay; however the actual amount can only be confirmed after insurance payment. You are responsible for all payments. *You may find it helpful and reassuring to contact your insurance provider directly and confirm your actual copayment amount.*

Additional Services:

You may inspect the fees associated with other services such as court appearances, written reports, etc. that are posted in the office. We, the client and Philly Family Life Counseling Clinician, have read and fully understand and agree to honor this agreement.

Client(s) Signature _____Date _____

Client(s) Signature _____Date _____

Clinician _____Date_____

*form updated February 2018