**Hi there!**

**Welcome to Philly Family Life Counseling LLC, the practice of Dr. Gene Devers LCSW**. I am asking that you take a few minutes to complete this form in preparation for our initial session. I understand your possible reaction of “*What, I have to fill out another meaningless form?”* I assure you that completing this form will be helpful for me to get a better sense of who you are, what is needing your attention at this time, and to fulfil legal and ethical regulations ensuring that you are aware of your rights and responsibilities in treatment. I would like to guide you through understanding and completing this form.

**“The client”** (i.e.name listed for the appointment), must complete the entire form. ***If “client” is a minor*** child then a parent will complete the form in its entirety. The minor child and all additional treatment participants will only need to complete pages 2-4.

**Pages 2 – 4: Gathering Personal Information and Personal Perspective**: This is to be completed by each treatment participant: “the client”, spouse/partner, children, siblings, etc.

**Page 5: Credit Card Information as deposit to be Used for Missed Appointment and Late Cancellation Fees** and must be completed for services to be initiated and continued. This information will be used exclusively for Late Cancellation and/or No-show Fee.

**Pages 6 – 8: Information for your understanding about Behavioral Health Treatment/ Life coaching:** *particularly note page 8 that contains important financial information.*

**Pages 9 – 10: Information about online telehealth treatment**: We use *doxy.me* to provide HIPAA compliant secure online therapy sessions and to collect online copay fees via credit card. You will use the link **<https://doxy.me/drgenedevers>** to access the online site and follow instructions to enter the virtual waiting room. ***You will continue to call 215/677-3810 to schedule all appointments: online and in-office, if you did not do so during our session.***

**Pages 8 & 10: Needed signature** of “the client” and all other treatment participants (spouse/partner, parents, children, siblings, etc). Please use a signature font for signatures and date.

**It is requested that this completed form be** uploaded during our initial conversation using the link [**https://doxy.me/drgenedevers**](https://doxy.me/drgenedevers)to access the virtual waiting room. While there, please scroll through in order to see all that is available in the waiting room. Once the session begins you will be sent a secure invitation to upload your completed form.

**If you choose not to keep your appointment,** online or in-office, remember to notify scheduling team, 21/677-3810, at least 48-24 hours prior to your appointment time. IF not, you will be charged the Late Cancellation/No-Show fee, which will need to be paid prior to any further appointments being scheduled.

Looking forward to speaking with you and It’s my goal is to offer you a positive, empowering, and life-enriching experience

Gene Devers

**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, and/or parents 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/place of work \_

Child Name (if focus of family Counseling) Age \_ Grade \_

Address \_

 Street City State zip

Phone (Primary) \_ (Secondary)\_

Email (please print clearly and In CAPS) \_

Ethnicity\_ Where did you grow up? \_

Your Education \_ School: \_Your Occupation/Place of work \_

What is your spiritual/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? \_\_

1: \_ \_ \_ \_

2: \_ \_ \_ \_

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?) \_\_\_

**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

**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:** 1: Are you having any current suicidal thoughts, feelings or actions? Y\_ N\_

***If yes, explain*** \_

2. Any current homicidal or violent thoughts or feelings, or anger-control problems? Y\_ N\_

 If yes, explain \_

3. Any issues, hospitalizations, or imprisonments for suicidal or assault behavior? Y\_ N\_

 If yes, describe \_

4. Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Y\_ N\_

 If yes, describe \_

How were you referred you? \_

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.

**\*****Credit Card Information as deposit 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:*** Ifyou 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 as a deposit,***

Signature \_\_

 Date: \_

\*This form must be completed for services to continue

**Informed Consent and Services Agreement**

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](http://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 our 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.

***Confidentiality Specific to Couples and Family Therapy: Private communication is NEVER confidential to the other partner. There always exists a “no-secrets policy”.*** 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 clinician’s judgment it is pertinent and may benefit the work with the couple or family.

***Electronic Communication:*** Cell phones, Email, and Texts 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, text, or email and may send a newsletter. If you would prefer not to be contacted via one of these methods, simply initial here and inform your clinician, and your preferences will be respected.

***Phone and E-mail Accessibility:***  We willreturn 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 business 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:*** Ifyou 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 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. If a client does not show for an appointment and no contact is made explaining, all future appointments previously scheduled will be cancelled.

***I authorize Philly Family Life Counseling to debit this fee from the credit card information that I provided as a deposit, 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 your 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 and/or agency.

***Emergency Contacts:*** We request emergency contact information for you, such as a family member name, a mobile phone, or work phone number. These contacts may be used if I/we perceive a need. **If you find yourself in crisis, go directly to the nearest hospital emergency department and/or call 911, for your own wellbeing and safety; do not wait for an email or telephone response.** All e-mails and telephone voicemail messages will be returned at first opportunity. Please note that Scheduling Team is available only during normal weekday hours, 9:00 AM – 5:00 PM.

***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. However, once paid there will be no refunds. 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:***

***Requests by 3rd outside parties for information****, other than primary insurance provider, will be honored at the written request of the client; or all participating clients if treatment received is for couples and/or families. There will be a $200 fee for providing the information of each request. This fee will be paid by the authorizing client, at the time of the written request/authorization, and prior to providing the requested information*

You may inspect the fees associated with other services such as court appearances, 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 Spouse/Partner \_Date \_

Client(s) Signature (Parent/Family member): \_Date \_

Client(s) Signature (Parent/Family Member): \_Date \_

Clinician \_**Dr. Eugene Devers,** AAMFT, ACSW, LCSW Date\_ /2020

**INFORMED CONSENT ADDENDUM FOR ONLINE THERAPY**

**<https://doxy.me/drgenedevers>**

***This form is designed to allow you to give informed consent for the use of video technology for online therapy***. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

This is to be used in conjunction with, but does not replace, the Informed Consent document that is required of all clients prior to starting therapy services.

Online therapy or teletherapy is defined as the use of technology to have a therapy session. We will use [**https://doxy.me/drgenedevers**](https://doxy.me/drgenedevers), a HIPAA compliant platform that uses video and audio technology through a webcam on your device and my device to connect us securely.

[**https://doxy.me/drgenedevers**](https://doxy.me/drgenedevers)implements state of the art security and encryption protocols to assure that data integrity and privacy is maintained. Any data that is stored outside of our video session on the Doxy.me platform (such as documents, or messages) is encrypted and meets or exceeds all HIPAA and HITECH guidelines.

The benefits of teletherapy include the convenience of location, time, wait times, and accessibility which allows for better continuity of care. In addition, teletherapy allows for greater accessibility to services for clients with limited mobility or with lack of transportation. Teletherapy can also allow for couples or families to meet when in different locations. If your insurance provider does not cover teletherapy, you may need to pay out-of-pocket for this service. Please confirm coverage with your insurance provider. **However, all services MUST be received within the state of Pennsylvania, which is the state in which Dr. Eugene Devers is licensed.**

With all technology, there are also some limitations. Technology may occasionally fail before or during our session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications exit the session and re-enter [**https://doxy.me/drgenedevers**](https://doxy.me/drgenedevers)**. If** the session cannot be completed via online video, the therapist will either use the in-session video chat to trouble shoot or will call you back to complete the session. Please list your main number and an alternate number here: \_\_\_\_.

*If, for any reason, we are unable to connect and you are in an immediate crisis or a potentially life-threatening situation, get immediate emergency assistance by calling 911.*

**I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION.**

I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

I understand that I am not allowed to do any recording, screenshots, etc. of any kind, of any session, and are grounds for termination of the client-therapist relationship.

I understand that I must receive all services while being physically present within the state of Pennsylvania and use the link [**https://doxy.me/drgenedevers**](https://doxy.me/drgenedevers)to access teletherapy services.

***Consent to Treatment***

I, voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize Philly Family Life Counseling, Dr. Eugene Devers to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Philly Family Life Counseling, Dr. Eugene Devers at any time. I understand Philly Family Life Counseling, Dr. Eugene Devers will determine on an on-going basis whether the condition being assessed and/or treated is appropriate for online therapy.

By signing this Informed Consent, I, the undersigned client, and all participating “family members” acknowledge that I/We have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

\_\_\_ \_

**Client** **Signature** Date

*Email (ALL CAPS):* **\_**

\_\_ \_

**Signature Spouse/Partner** Date

*Email (ALL CAPS):* **\_**

\_\_\_\_ \_\_

**Signature Participating Family Member/ Parent** Date

*Email (ALL CAPS):* \_

\_\_\_\_ \_\_

**Signature Participating Family Member/ Parent** Date

*Email (ALL CAPS):* \_\_

\_\_\_\_ \_\_

**Signature Participating Family Member** Date

*Email (ALL CAPS):* \_