Philly Family Life Counseling

Dr. Eugene Devers and Associates

Telehealth Link: http://doxy.me/drgenedevers

www.PhillyFamilyLifeCounseling.com

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! Upload Completed form to Theraportal.com *with access information sent separately by email from theraportal*

Today's Date _____

Client Name _____ Age _____ Date of Birth _____

Spouse/Partner Name _____ Age _____ Their Occupation _____

Child Name _____ Age _____ Grade _____ School _____
(if focus of family Counseling)

Address _____
Street City State zip

Phone (Cell) _____ Spouse/Partner: _____

Email Client _____ Spouse/Partner _____

Ethnicity _____ Where did you grow up? _____

Your Education _____ School: _____ Your Occupation _____

What is your spiritual/religious background / involvement? _____

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

_____

Besides family members, approximately how many people can you really count on right now for friendship or emotional support? _____ List two people you can reach out to today if necessary

Name	Age	Relationship	Live with you?
			☐ Y ☐ N ☐ Sometimes
			☐ Y ☐ N ☐ Sometimes

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, when? _____ 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☐

Do you have a State Medical Marijuana (Cannabis) Card? Y☐N☐ If yes what is reason?

Are you on any medications? Y☐ N☐ If yes,

Name, Dosage, Start Date, Reason Prescriber	Name, Dosage, Start Date, Reason Prescriber

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/concern 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
☐ Self-Control	☐ Choices I made	☐ Self-care/harm	☐ Panic attacks
			☐ Other

Any additional comments regarding the above?

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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?

Do you have any children? Y ☐ N ☐ If yes:

Name	Age	Live with you?	Name	Age	Live with you
		☐ Y ☐ N ☐ Sometimes			☐ Y ☐ N ☐ Sometimes
		☐ Y ☐ N ☐ Sometimes			☐ Y ☐ N ☐ Sometimes
		☐ Y ☐ N ☐ Sometimes			☐ Y ☐ N ☐ Sometimes
		☐ Y ☐ N ☐ Sometimes			☐ Y ☐ N ☐ Sometimes
		☐ Y ☐ N ☐ Sometimes			☐ Y ☐ N ☐ Sometimes

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?

Have you ever served in the Armed Forces? Y ☐ N ☐ Do you currently serve? Y ☐ N ☐

Are you a family member of an active or retired member of the Armed Forces? Y ☐ N ☐

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 as Deposit to be Used for Missed Appointment and Late Cancellation Fees, as Well as Any Outstanding Balance Following the Conclusion of Services

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 as a deposit,

Signature _____ Signed Electronically

Date: _____

This form must be completed for services to continue

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Dr. Eugene Devers and Associates

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Consent to Treatment

I/We, have reviewed the Informed Consent and Services Agreement and Online Treatment Agreement and voluntarily agree to receive online therapy/services for an assessment, continued care, treatment, or other services; *if deemed an appropriate and beneficial form of treatment*. I/we authorize Philly Family Life Counseling, Dr. Eugene Devers and Associates 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 and Associates, at any time. I understand Philly Family Life Counseling, Dr. Eugene Devers and Associates will determine on an ongoing 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/us to ask questions and seek clarification of anything unclear to me/us.

Client Signature *Signed Electronically* Date

Email:

Spouse/Partner *Signed Electronically* Date

Email:

Participating Family Member or Parent *Signed Electronically* Date

Email:

Participating Family Member or Parent *Signed Electronically* Date

Email:

Clinician: *Dr. Eugene Devers, ACSW, AAMFT, LCSW*

Signed Electronically

*After saving, please upload completed form to **THERAPORTAL.COM,***
which is your secure HIPAA compliant e-file.
Access Information: (user name & password) has been emailed directly to you from Theraportal.

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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), Licensed Psychologist, or Certified Life Coach. 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: You have the right to privacy, a right to decide the time/place/extent of self-disclosure and to be a participant in the treatment/therapy process. It is your Clinician/Life Coach's responsibility to ensure an atmosphere of safety for you. To protect your privacy if paths cross in the community, there will be no discussion of the clinical relationship/work. Those discussions occur only in the therapeutic setting. Our relationship is strictly voluntary and professional in nature. 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 eager 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/life coach 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 may include improved functioning, relationships, insight, communication, self-image, mood, and the attainment of personal goals. We cannot guarantee these benefits, of course, but it is our goal is to create a safe environment where together we develop, and therapeutically work toward your goals. However, in some cases persons have reported feeling worse after starting counseling. Clients understand that healing and growth is difficult, and some discomfort may 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 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 AND all treatment participants. 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; (5) when consulting with another clinician or exploring a referral; (6) 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. The exchange of information is strictly guided by HIPAA regulations

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 #6 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. You are encouraged to use the Theraportal.com to securely send emails, upload forms, adjust appointments, and access your billing information. You can also print your payment receipts! Occasionally, we may follow up with you by telephone, text, or email and may send newsletter. Please request an encrypted link for any confidential email communications that you choose not to send through Theraportal.com. If you would prefer not to be contacted via one of these methods, simply inform the scheduling team at 215/677-3810 and your preference will be respected. If you should have any difficulties setting up your Theraportal.com account please call 215/677-3810 for assistance.

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 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: If you need to cancel or reschedule an appointment, please notify us as soon as possible at **215/677-3810**. 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.

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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 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 Philly Family Life Counseling.

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 is received. 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.* The client is responsible to manage account billing statements to ensure accuracy, especially after services are completed. Copays may change during the time that services were provided, which may result in a balance or credit due. Please call **215/677-3810** for explanation of any statements, to pay off balance, or request a credit refund.

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/Life Coach, have read and fully understand and agree to honor this agreement.

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ONLINE THERAPY

Online therapy or teletherapy is defined as the use of technology to have a therapy session. If online therapy is agreed to and considered an appropriate and beneficial form of treatment, and we will use **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. Any data that is transferred on the Doxy.me platform, including credit card information for the collection of co-payments, 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 or New Jersey, which is the states 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. 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.

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, safe, 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/We understand that I/we must receive all services while being physically present within the state of Pennsylvania or New Jersey to use the link **https://doxy.me/drgenedevers** to access teletherapy services.