

Leland E. McHatton, MFT

Marriage Family Therapist

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530.566.1212

CLIENT QUESTIONNAIRE

Client's Name: _____ Date of Birth: _____

Spouse's or Parent's Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip Code: _____

Phone: Home: _____ Work: _____ Cell: _____

Occupation: _____ Social Security Number: _____

Married: _____ How Long: _____ How Many Times: _____ Single: _____ Widowed: _____ Divorced: _____

Spouse's Occupation: _____ Spouse's Social Security Number: _____

Spouse's Work Phone: _____ Health Insurance: _____

Referred By: _____

Church/Religious Affiliation: _____

Members of Household/Family Members

Relationship

_____	D.O.B. _____	_____
_____	D.O.B. _____	_____
_____	D.O.B. _____	_____
_____	D.O.B. _____	_____
_____	D.O.B. _____	_____

Client's general health: _____

Name of Physician: _____

Medications: _____

Client's spouse or parent's general health: _____

Are you or your spouse currently under the care of a psychiatrist, psychologist or counselor? _____

YES _____ NO _____ If YES, please indicate name(s) and address(es): _____

CLIENT QUESTIONNAIRE CON'T.

Have you, your child or your spouse received professional counseling or psychiatrist care in the past?

YES _____ NO _____ If YES, please indicate name(s) and address(es): _____

Have you, your child or your spouse ever been hospitalized for an emotional or psychological reason? YES _____ NO _____

If YES, when? _____ Where? _____

List Use of Drugs and/or Alcohol (Past and Present):

Drug(s)	How Often	First Date of Use	Last Date of Use
_____	_____	_____	_____
_____	_____	_____	_____

Alcohol	How Often	First Date of Use	Last Date of Use
_____	_____	_____	_____
_____	_____	_____	_____

Tobacco	How Often	First Date of Use	Last Date of Use
_____	_____	_____	_____
_____	_____	_____	_____

Ever had suicidal thoughts? _____

Any suicidal attempts? _____

Were you sexually molested? _____ By whom? _____

Were you ever physically abused? _____ By whom? _____

Were you ever emotionally abused? _____ By whom? _____

Client Signature: _____ Date: _____

Spouse's/Parent's Signature: _____ Date: _____

Primary Concern:

Goal(s) for Counseling:

OFFICE POLICIES & GENERAL INFORMATION AGREEMENT FOR PSYCHOTHERAPY SERVICES

This form provides you (patient) with information that is additional to that detailed in the *Disclosure of Health Information* form given out at your first session.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure are described in the Disclosure of Health Information form.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled (for more details see also Disclosure of Health Information).

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Lee McHatton. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgment when revealing such information to any outside party. I will not release any records unless authorized to do so by all adult family members who were part of the treatment.

Emergencies: If there is an emergency during our work together, or in the future after termination, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct me only the minimum necessary information will be communicated to the carrier. Unless authorized by you explicitly the Psychotherapy Notes will not be disclosed to your insurance carrier. I have no control or knowledge over what insurance companies do with the information I submit or who has access to the information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and soon will also be reported to the congress-approved, National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to have been sold, stolen or accessed by enforcement agencies; therefore, you are in a vulnerable position.

Confidentiality of E-mail, Cell Phone and Faxes Communication: It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify me at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail or faxes for emergencies.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Consultation: I consult regularly with other professionals regarding my clients; however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous and confidentiality is fully maintained.

- * Considering all of the above exclusions, if it is still appropriate, upon your request, I will release information to any agency/person you specify unless I conclude that releasing such information might be harmful in any way.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave a message with the office phone 530-879-8985 ext.2144 and your call will be returned as soon as possible. I check my messages a few times a day, unless out of town, and on weekends my home number is left for emergency contact. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, you can call Butte County Behavioral Health, the 24-hour crisis line at 530-891-2810 or the Police (911).

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee of \$100.00 per 45-50 minute session at the end of each session unless other arrangements have been made. If payment is not made at the time of service, a \$10 per session billing fee will be added to compensate a third party billing service. Payment methods include check and VISA/MC. **Please make checks payable to: Lee McHatton, MFT.** Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please notify me if any problem arises during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, I will provide you with a copy of your receipt at the time of service, which you can then submit to your insurance company for reimbursement if you so choose. As was indicated in the section, *Health Insurance & Confidentiality of Records*, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

CANCELLATION: Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48-hour notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

MEDIATION & ARBITRATION: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of myself and the client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Butte County, California in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

THE PROCESS OF THERAPY/EVALUATION: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty and openness in order to change your thoughts, feelings and/or behavior. I will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. I will challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, I am likely to draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family), or psycho-educational.

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

Termination: As set forth above, after the first couple of meetings, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals that you can contact. If at any point during psychotherapy I determine that I am not effective in helping you reach the therapeutic goals, I am obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, I would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and, if I have your written consent, I will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, I will offer to provide you with the names of other qualified professionals whose services you might prefer.

Dual Relationships: Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs my objectivity, clinical judgment or therapeutic effectiveness or can be exploitive in nature. I will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. Chico is a small community and many clients know each other and me from the community. Consequently, you may bump into someone you know in the waiting room or into me out in the community. I will never acknowledge working therapeutically with anyone without his/her written permission. Many clients choose me as their therapist because they know me before they enter into therapy with me and/or are aware of my stance on the topic. Nevertheless, I will discuss with you, my client/s, the often-existing complexities, potential benefits and difficulties that may be involved in such relationships. Dual or multiple relationships can enhance therapeutic effectiveness but can also detract from it and often it is impossible to know that ahead of time. It is your, the client's, responsibility to communicate to me if the dual relationship becomes uncomfortable for you in any way. I will always listen carefully and respond accordingly to your feedback. I will discontinue the dual relationship if I find it interfering with the effectiveness of the therapeutic process or the welfare of the client and, of course, you can do the same at any time.

I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them.

Client Name (print)	Date	Signature
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Client Name (print)	Date	Signature
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Therapist	Date	Signature
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I have received a copy of the Disclosure of Protected Health Information.

Signature	Date
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