

Couples Questionnaire — one adult completes this form for the couple

Today's Date	Full Name of person completing this form	Date of Birth	Place of Birth
Home Phone	OK to leave message?	Work phone	OK to leave messages?
		Cell Phone	OK to leave messages?

Full name of person NOT completing this form	Date of Birth	Place of Birth	
Home Phone	OK to leave message?	Work phone	OK to leave messages?
		Cell Phone	OK to leave messages?

Primary address of couple - Street Address	City	State/Zip

circle all that apply	how long since married/ cohabiting/separated?	ever been married before?	how many times?	partner ever been married before?	how many times?
married / cohabiting / living apart		yes / no		yes / no	

Email addresses of Person filling out form:

Email address of Partner:

	yourself	your spouse / partner
race / ethnicity		
religion / denomination		
date of birth		
sexual orientation		
names & ages of children conceived with current spouse/ partner		
names & ages of children conceived with previous spouse(s)/ partner(s)		
highest level school completed		
current occupation		
current employer / school		
hours worked each week		
how long worked here?		
second jobs		
how long at this job?		
hours worked each week		
any problems at work / school?		
unemployed?		
why?		
how long unemployed?		

Couples Questionnaire Continued

Summary of previous counseling

Please begin with the FIRST therapist you ever had and move forward to the most recent therapist if you need more room, use back side.

	name of therapist and degree (MD, PhD, MFT, etc.)	start & end dates - - how often did you meet? (weekly?)	reasons for seeking treatment -- reasons for stopping treatment	what type of therapy? was it helpful? did you have any negative reactions?
1				
2				
3				
4				
5				
6				
7				

THANK YOU FOR FILLING OUT ALL THESE FORMS!

Problems and Other Symptoms

(each adult complete this form)

Name: _____ Date: _____

Please check any of the following which may apply to **anyone in the household** – this includes issues not relating to the reasons you are coming to counseling.

<input type="checkbox"/>	problem	who has problem?	<input type="checkbox"/>	problem	who has problem?
<input type="checkbox"/>	alcohol use		<input type="checkbox"/>	inability to relax	
<input type="checkbox"/>	angry outbursts		<input type="checkbox"/>	legal matters	
<input type="checkbox"/>	anorexia or bulimia (past / present)		<input type="checkbox"/>	loneliness	
<input type="checkbox"/>	anxiety		<input type="checkbox"/>	loss of interest in things	
<input type="checkbox"/>	bad dreams		<input type="checkbox"/>	loss of sexual interest or desire	
<input type="checkbox"/>	boredom		<input type="checkbox"/>	marriage problems	
<input type="checkbox"/>	can't get motivated to do things they usually enjoy		<input type="checkbox"/>	memory problems	
<input type="checkbox"/>	career choices		<input type="checkbox"/>	nervousness	
<input type="checkbox"/>	crying easily		<input type="checkbox"/>	overeating	
<input type="checkbox"/>	depression		<input type="checkbox"/>	parent - child conflict	
<input type="checkbox"/>	difficulty concentrating		<input type="checkbox"/>	poor appetite	
<input type="checkbox"/>	difficulty falling asleep or staying asleep		<input type="checkbox"/>	poor or decreased ambition	
<input type="checkbox"/>	difficulty getting up in the morning		<input type="checkbox"/>	pornography use	
<input type="checkbox"/>	difficulty making decisions		<input type="checkbox"/>	preoccupation with death	
<input type="checkbox"/>	difficulty parenting		<input type="checkbox"/>	school problems	
<input type="checkbox"/>	divorce		<input type="checkbox"/>	self-confidence	
<input type="checkbox"/>	drug use		<input type="checkbox"/>	self-mutilation	
<input type="checkbox"/>	easily annoyed or irritated		<input type="checkbox"/>	sexual problems	
<input type="checkbox"/>	energy problems		<input type="checkbox"/>	shyness	
<input type="checkbox"/>	extreme fear of places or events		<input type="checkbox"/>	stuttering	
<input type="checkbox"/>	faintness or dizziness		<input type="checkbox"/>	suicidal attempts	
<input type="checkbox"/>	fatigue		<input type="checkbox"/>	suicidal thoughts	
<input type="checkbox"/>	feeling fearful		<input type="checkbox"/>	thoughts hard to get rid of	
<input type="checkbox"/>	feeling inferior to others		<input type="checkbox"/>	trouble remembering things	
<input type="checkbox"/>	feeling tense or nervous		<input type="checkbox"/>	uncontrollable outbursts of temper	
<input type="checkbox"/>	financial problems		<input type="checkbox"/>	unhappiness	
<input type="checkbox"/>	friendship problems		<input type="checkbox"/>	violent behavior	
<input type="checkbox"/>	gambling		<input type="checkbox"/>	violent thoughts	
<input type="checkbox"/>	guilt		<input type="checkbox"/>	work problems	
<input type="checkbox"/>	impulsiveness		<input type="checkbox"/>	worrying about things	

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<input type="checkbox"/>	gambling		<input type="checkbox"/>	violent thoughts	
<input type="checkbox"/>	guilt		<input type="checkbox"/>	work problems	
<input type="checkbox"/>	impulsiveness		<input type="checkbox"/>	worrying about things	

Name _____

(each adult complete this form)

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always Agree	Almost Always Agree	Occa- sionally Disagree	Fre- quently Disagree	Almost Always Disagree	Always Disagree
1. Handling family finances	0	0	0	0	0	0
2. Matters of recreation	0	0	0	0	0	0
3. Religious matters	0	0	0	0	0	0
4. Demonstrations of affection	0	0	0	0	0	0
5. Friends	0	0	0	0	0	0
6. Sex relations	0	0	0	0	0	0
7. Conventionality (correct or proper behavior)	0	0	0	0	0	0
8. Philosophy of life	0	0	0	0	0	0
9. Ways of dealing with parents or in-laws	0	0	0	0	0	0
10. Aims, goals, and things believed important	0	0	0	0	0	0
11. Amount of time spent together	0	0	0	0	0	0
12. Making major decisions	0	0	0	0	0	0
13. Household tasks	0	0	0	0	0	0
14. Leisure time interests and activities	0	0	0	0	0	0
15. Career decisions	0	0	0	0	0	0

	All the time	Most of the time	More often than not	Occa- sionally	Rarely	Never
16. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	0	0	0	0	0	0
17. How often do you or your mate leave the house after a fight?	0	0	0	0	0	0
18. In general, how often do you think that things between you and your partner are going well?	0	0	0	0	0	0
19. Do you confide in your mate?	0	0	0	0	0	0
20. Do you ever regret that you married? (or lived together)	0	0	0	0	0	0
21. How often do you and your partner quarrel?	0	0	0	0	0	0
22. How often do you and your mate "get on each other's nerves?"	0	0	0	0	0	0

Name _____

(each adult complete this form)

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20. Do you ever regret that you married? (or lived together)	0	0	0	0	0	0
21. How often do you and your partner quarrel?	0	0	0	0	0	0
22. How often do you and your mate "get on each other's nerves?"	0	0	0	0	0	0

	Every Day	Almost Every Day	Occasionally	Rarely	Never
23. Do you kiss your mate?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	All of them	Most of them	Some of them	Very few of them	None of them
24. Do you and your mate engage in outside interests together?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How often would you say the following events occur between you and your mate?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
25. Have a stimulating exchange of ideas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Laugh together	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Calmly discuss something	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. Work together on a project	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

These are some things about which couples sometimes agree and sometime disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks. (Check yes or no)

	Yes	No	
29.	<input type="radio"/>	<input type="radio"/>	Being too tired for sex.
30.	<input type="radio"/>	<input type="radio"/>	Not showing love.

31. The circles on the following line represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Please fill in the circle which best describes the degree of happiness, all things considered, of your relationship.

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

32. Which of the following statements best describes how you feel about the future of your relationship? I want desperately for my relationship to succeed, and *would go to almost any length* to see that it does.

- I want very much for my relationship to succeed, and *will do all I can* to see that it does.
- I want very much for my relationship to succeed, and *will do my fair share* to see that it does.
- It would be nice if my relationship succeeded, but *I can't do much more than I am doing now* to help it succeed.
- It would be nice if it succeeded, but *I refuse to do any more than I am doing now* to keep the relationship going.
- My relationship can never succeed, and *there is no more that I can do* to keep the relationship going.

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AUTOBIOGRAPHY

I would like to receive an autobiography from each of you in advance. I would like it to be your own narrative of your life thus far, including some sense of what you see as the problem(s) in your relationship which led you to come to me. What would you like me to know about you? It can be of any length. Please email them to stuart@thecouplesexpertscottsdale.com.

Office Policy and Financial Responsibility Statement

Responsible party if other than patient: _____

I UNDERSTAND THAT:

Therapy sessions are **45 minutes** in length and are billed at **\$150 per session**. Payment of cash, check or credit card is due at each visit.

- Sessions of late arrivals will end on time and be billed the full fee.
- *Parents/Guardians who provide transportation are required to stay at the office while their child(ren) are being seen.*

The rate of \$150.00 will also apply to time spent on providing special services, such as telephone sessions, texts, phone calls, case consultations, and time spent discussing treatment with other authorized professionals.

Stuart Fensterheim does not participate with third party payers, such as managed care organizations and insurance companies. By signing this form, I am agreeing to pay the entire bill at the time of service. If requested, I may receive a "super-bill" as a receipt to submit to a third party payer.

- **I must give 24-hour notice of appointment cancellation or I will be billed in full. MONDAY appointments must be cancelled by Friday at 5:00pm. The credit card below will be billed in full for "no show" appointments, late cancelled appointments, and unpaid balances unless other arrangements are made. CONTACT ME BEFORE OUR FIRST SESSION IF YOU ARE UNABLE TO LEAVE A CREDIT CARD ON FILE.**

initial _____

 card number

 expiration date

 name as it appears on card

 CVV Code

 card holder's signature

 date

I understand that I am financially responsible for any and all charges incurred for the treatment of the above-named. I have read the above office policy regarding length of sessions, late arrivals, charges, missed appointments, etc. **I understand and agree to the stated terms.**

Signature of Client (or Parent of Minor child)

Date

Limitation on Confidentiality when Providing Therapy to Couples

There are slightly different expectations and limits about confidentiality in couples therapy than there are in individual therapy. When I agree to treat a couple I consider that couple to be the patient. For instance, if there is a request for the treatment records of the couple, I will need the authorization of both members before I release confidential information. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the couple, not just an individual.

During the course of my work with a couple I may see either individual alone for one or more sessions. These sessions are a part of the work that I am doing with the couple, unless otherwise indicated. If you are involved in one or more of these sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple, I would also seek the authorization of the other individual before releasing confidential information to a third party. However, I may need to share information learned in an individual session with both members of the couple, if I am to effectively serve the couple being treated. I will use my best judgment as to whether, when, and to what extent I will make such disclosures and will also, if appropriate, first give the individual the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with a different therapist who can treat you separately.

This “no secrets” policy is intended to allow me to treat the couple more effectively by preventing, to the extent possible, a conflict of interest that might arise if an individual’s interests are not consistent with the interests of the couple being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple. If I am not free to exercise my clinical judgment regarding the need to bring this information to the couple during their therapy, I might be placed in a situation where I will have to terminate treatment. This policy is intended to prevent the need for such a termination.

We acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Stuart Fensterheim LCSW and that we enter couple therapy in agreement with this policy.

Signature: _____ Date: _____

Signature: _____ Date: _____

CONTRACT FOR PROFESSIONAL SERVICES

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully. Note any questions you have so we can discuss them. When you sign this document, it will represent a binding agreement between us.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personality of both the client and the therapist and the particular issues you bring to our work. There are many different methods I may use to address the issues you bring to our sessions. Psychotherapy will require a very active effort on both our parts. You will have to work both during our sessions and at home to achieve the most successful outcome.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings and talking about parts of your history that are painful. Psychotherapy has also been shown to have benefits for people who undertake it. It often leads to the significant reduction of distress and the increase of satisfaction with yourself, your relationships and the resolution of specific problems. But there are no guarantees about what you will experience.

Our first few sessions will be an assessment time. I will be able to offer you some initial impressions of what our work may include and a treatment plan to follow. We will focus on some specific goals you wish to accomplish and together we will map out a plan. You too will be doing an assessment and determining. If the services I propose will fit your needs. As therapy involves a large commitment of time, money and energy, it is important that you feel comfortable continuing our work together. If you feel uncomfortable with pursuing our work together, I will be happy to assist you in finding another counselor. I welcome your discussion of how we are proceeding at any time.

CONTACTING ME

My office phone is my cell phone. I turn it off while I am in session or otherwise unavailable. My phone is forwarded to a voice mailbox. I make every effort to return calls the same day with the exception of holidays and weekends. Please leave me your phone numbers **each time you call** as I may not be in the office when I return your call. If you wish to call me, please be aware of the time and day as I use this phone for personal use as well.

EMAIL, TEXT MESSAGING AND SOCIAL MEDIA

If you communicate by text messaging please remember it is not an exact science. At times I may not receive the text so if you don't hear from me please call by telephone. . , I do not schedule via email or text . Please call for all scheduling. So much of our work depends on clear, connected communication. I've found that phone and in-person communication works best.

Please do not email me content related to your therapy sessions as email is not completely secure or confidential. Please talk with me about this if you have questions or concerns.

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

EMERGENCIES

In an emergency, please tell me what is happening and I will make every effort to return the call as quickly as possible. If I am not immediately available, please call your psychiatrist, if you have one, your family physician, local help-line, 911, or go to the nearest emergency room.

When I will be away from the office, I will provide you with the name and phone number of a trusted colleague whom you can contact in an emergency situation.

PROFESSIONAL RECORDS AND CONFIDENTIALITY

Both Arizona law and the standards of my profession require that I keep appropriate treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. You will be charged my hourly rate for any professional time spent in responding to information requests.

All information disclosed within sessions and the written records are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. There are some limitations to strict confidentiality that protect your welfare and that of the public. These limitations provide for a partial breach in confidentiality only under the MOST SERIOUS CIRCUMSTANCES. I am legally required to take action:

If I receive a report of abuse or neglect of a child or vulnerable adult, I may be required to advise the appropriate authorities. If, in my opinion, you present a danger to yourself or others, I may also be required to make a report to the appropriate authorities.

If you threaten serious bodily harm to another person or yourself, I am required to notify the intended victim and appropriate law enforcement agency. Under some

circumstances, I may be required to seek hospitalization for you or contact family members or others who can help provide protection.

If a court of law requires me to release your records, I must do so. Other exceptions exist if you make your mental status a court issue. These will be discussed on a case-by-case basis.

RECORDS AND YOUR RIGHT TO REVIEW THEM

Both the law and the standards of my profession require I keep clinical records for seven years. You have the right to review your records at any time except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful to you. In the case of couple's therapy, I will release records only with the signed authorizations from BOTH people involved in treatment.

FINANCIAL AGREEMENT

The fee for up to a 45 minute session is \$150.00. The fee for up to an 80 minute session is \$240.00. Payments are due at each session. If sessions extend beyond this time frame, they will be charged on a pro-rated basis. I charge this amount for other professional services you may need though I will break down the 45 minute cost into 15 minute segments if I work for periods of less than one hour. Other services include report writing, **telephone conversations lasting more than 15 minutes**, preparation of records or treatment summaries and time spent performing any other service you may request of me. If you are experiencing financial difficulties, please discuss this with me.

I will provide you with a statement of all charges and payments on a monthly basis. I do not contract with any insurance panels but will be happy to provide you with a superbill to submit for reimbursement with out of network benefits. Please check with your insurance provider regarding this.

I understand and agree to give my therapist 24 hour or more notice of cancellation or rescheduling. In the event of less than 24 hours cancellation, I understand that I am responsible for the entire fee for the session.

If your personal check is returned for insufficient funds, you will be charged \$35.00 which is the fee the bank charges me to reprocess the check.

You can expect to receive monthly statements of your account if there is a balance. You agree to inform me if there are any changes in your ability to pay for your counseling.

Signed _____ Date:

Consent for Evaluation and Treatment

Your signature below indicates that you have received a copy of the INFORMED CONSENT and the HIPPA PRIVACY NOTICE that follow, and that you agree to abide by their terms during our professional relationship.

Name of client _____

Signature of client (or guardian if client is a minor) _____

How did you hear about me? (please circle): **Friend • Family • Doctor • Psychiatrist • Google • Bing/Yahoo**

Online Directory: Theravive GoodTherapy NetworkTherapy

Other: _____

I give_____ or do not give_____ Stuart Fensterheim permission to contact the referral source to acknowledge and express appreciation for this referral. _____

I have received a copy of the contract for professional Services _____(signature)

I give_____ or do not give_____ Stuart Fensterheim permission to put me on his mailing list for updates, articles, and newsletter related to my practice. Your email will never be shared. You will receive an email to confirm this agreement in order to begin receiving the bi monthly newsletter. Stuart Fensterheim also blogs on his website and is a writer for yourtango.com and goodtherapy.org as a content expert on relationships.

Did you look at my website before making an appointment? **yes** **no**

What did you like about it? _____

What did you dislike_? _____

**Client Notification of Privacy Rights (HIPAA)
Federal Medical Privacy Rule: 45 CFR 164**

This document describes how your mental health records may be used and disclosed and how you can get access to this information. Please read it carefully.

Uses and Disclosure for Treatment, Payment and Health Care Operations

I may use or disclose your protected health information (PHI) for treatment, payment and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- PHI refers to information in your health record that could identify you.
- Treatment, Payment and Health Care Operations
Treatment-is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another counselor/psychologist/psychiatrist.
Payment- is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
Health Care Operations - activities that relate to the performance and operation of my practice. Examples of health care operations are business-related matters such as bookkeeping, administrative services, case management and care coordination.
- Use applies only to activities within my office such as sharing, employing, applying, utilizing, examining, analyzing information that identifies you.
- Disclosure-applies to activities outside my office such as releasing, transferring or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. Psychotherapy notes are notes I have made about our conversation during a private, group, joint or family counseling session which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all authorization (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent Nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child abuse – I am required to report PHI to the appropriate authorities when I have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.

- Adult and Domestic Abuse - If I have the responsibility for the care of an incapacitated or vulnerable adult, I am required to disclose PHI when I have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.
- Health Oversight Activities – If the Arizona Board of Behavioral Health Examiners is conducting an investigation, then I am required to disclose PHI upon receipt of a subpoena from the Board.
- Judicial and Administrative Proceedings - If you are involved in a court proceeding and a request is made about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety – If you communicate to me an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and I believe you have the intent and ability to carry out such threat, I have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If I believe there is an imminent risk that you will inflict serious harm on yourself, I may disclose information in order to protect you.
- Worker's Compensation – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient's Rights and Counselor Duties

- Rights to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations
- You have the right to request and receive confidential communications of PHI by alternative means at alternative locations. For example, you may not want a family member to know that you are seeing me. On your request, I will send your statements/bills to another address.

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Counselor's Duties

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you written notice.

Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2014. I reserve the right to change the terms of this notice and make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in writing.