

Client Information Form

Please fill out this form and bring to your first session. All information is kept confidential.

Name _____ Date of 1st visit _____

What do you prefer to be called? _____

Date of Birth _____ Age _____ Place of Birth _____

Cell Phone _____ Is it okay to leave a message at this #? _____

Work Phone _____ Is it okay to leave a message at this #? _____

If you would prefer that I not leave voicemails at the above numbers, what is the best way to reach you while protecting your confidentiality?

Home address _____

Emergency Contact Person _____

Relationship _____

Emergency Contact Number _____

EMPLOYMENT

Cross what best applies: Full time / Part time / Student / Unemployed

Occupation _____

Place of employment _____

What would be your dream job/career? _____

EDUCATION

Highest level of schooling achieved _____

Areas of study _____

Plans/dreams to learn about _____

CULTURE

Please describe yourself as fully as you feel comfortable. (check as many apply.)

Gender

- Female
- Male
- Transgender
- Transsexual
- Other: _____

Ethnicity

- African American
- Alaskan Native
- Arab American
- Asian American
- Chicano/a, Latino/a, Hispanic
- Multi-racial
- Native American
- Pacific Islander
- White/European American
- Other: _____

Relationship Status

- Single
- Married/Partnered
- Separated
- Widowed
- Divorced
- Engaged
- Other: _____

Sexual Orientation

- Heterosexual
- Gay or lesbian
- Bisexual
- Questioning
- Other: _____

What was your religious upbringing?

What is your current religious or spiritual orientation and interest?

CURRENT FAMILY

Please add others who live in your household currently.

Person	Age	Occupation	Mental Health Concerns	Physical Health Concerns
Spouse/partner				
Children: m/f				
m/f				
m/f				
others				

FAMILY HISTORY

List your major caregivers and your relationship to them

List other adults who were involved in your childhood. Use a noun or an adjective to describe each person

List siblings and birth order. (include yourself) Use a noun or adjective to describe each person

Name/relationship	Age	Description
-------------------	-----	-------------

If you were adopted, at what age were you adopted? _____ If your caregivers have separated, please let me know how old you were then? _____

If either mother or father remarried, please describe who remarried and your age at the time. (the term father and mother indicating biological or adoptive parents and/or mother or father substitutes)

List time of year and how old you were when significant people in your life passed away

Describe yourself as a child

HEALTH

Use the back page if needed

Do you have any physical health concerns? Please list surgeries, medication history (dates & ages).

Do you have any allergies? If yes, what types?

Do you have a disability? No Yes (Please specify if 'yes') _____

Are you currently on medication? If yes, please list the medications, the reason, and how they are helpful. Are there any negative side effects?

Please describe the following

	Times/week	Amount
Alcohol	_____	_____
Tobacco	_____	_____
Recreational Drugs	_____	_____

Have you been treated for substance abuse or other addictive behavior? Yes No
If yes, please describe the nature of the addiction and the location/dates of treatment

Have you been hospitalized for depression or other emotional stress? Please describe.

Have you ever considered suicide? Yes No

Have you ever attempted suicide? Yes No

Did you have a plan? Yes No

Do you feel suicidal now? Yes No

Have you been in any car accidents? If yes, please list the dates

Have you ever experienced:

Physical abuse? Yes No

Emotional/Psychological/Verbal abuse? Yes No

Sexual abuse? Yes No

Can you give me some details?

Were there other traumatic events that occurred in your life? The Present

Daily Functioning- how is your sleep? Your relationship with food?

Please rate your level of stress from 1-10 (1 being lowest, 10 highest rate)

Have you been in psychotherapy before? If yes, how long and for what reason?

In in therapy previously please describe how your past experience was helpful/unhelpful. What did you like most/least about the therapist?

Please state briefly your reasons for seeking therapy at this time and what you hope to achieve?

How long have you been experiencing these problems/problem?

How can I, as a therapist, be most helpful to you?

SELF CARE

What do you like to do for self-care?

How often do you exercise, do you enjoy it, and what kind of exercise do you choose?

What activities/hobbies/interests have meaning for you or make you feel alive?

What do you consider unique about yourself?

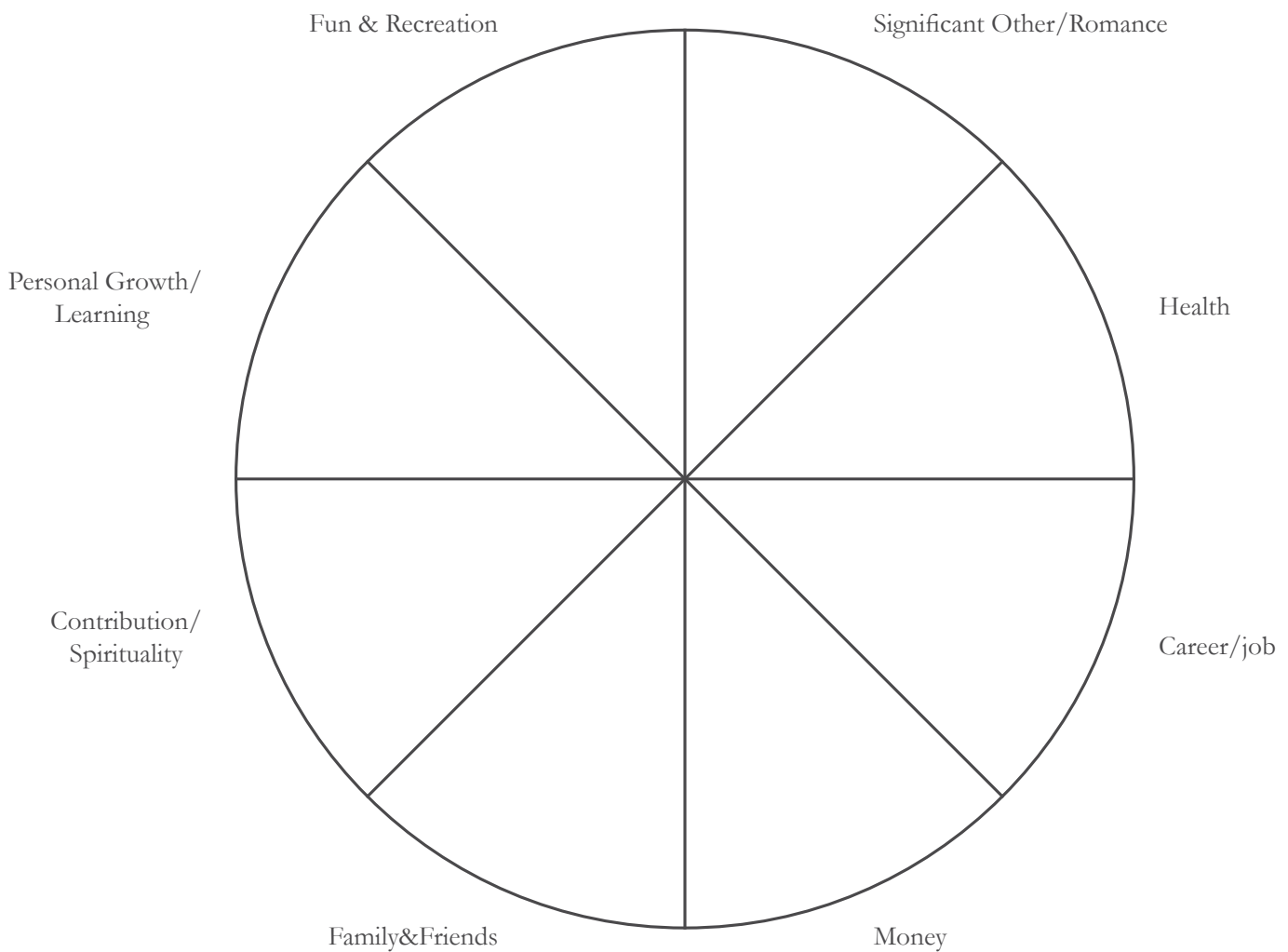
Do you have a favorite movie or book? What is it and why?

Are there other things you would like me to know? (hopes, fears, recent events, details about specific relationships, your strengths, what you like about yourself, etc..) Please feel free to write as little or as much as you like and use the other side of the page if need be.

WHEEL OF BALANCE

Thriving involves balance. Using the circle, shade your level of satisfaction in each area as it relates to you. For example, if you absolutely love your career then shade the entire pie shape.

Do the same for each area, starting in the middle and radiating outwards.



Informed Consent To Psychotherapy and Office Policies

Please read the following carefully and ask for specifications about any element you do not fully understand.

I, Rosanna Maria, have the following qualifications: Master's degree in clinical mental health counseling from Southwestern College in Santa Fe, NM working toward licensure under the supervision of Sabrina Bajakian LCPC. Workshops and trainings in mindfulness meditation, transpersonal psychotherapy, sandtray therapy, child development and parenting, art therapy, love addiction/love avoidance, and somatic trauma therapy.

I utilize a holistic framework incorporating the health of the body, mind and spirit. During the course of therapy, I am likely to draw on various theoretical approaches according to the problem presented and my assessment of what will be most beneficial to you. These approaches include humanistic, developmental, psycho-educational, transpersonal, narrative, behavioral/and or cognitive. If you have any questions about the therapeutic process please feel free to ask.

Process, Benefits, and Risks of Psychotherapy:

Participating in therapy can provide a number of benefits to you. These benefits include the possibility of reducing or eliminating psychological symptoms, improving interpersonal relationships, as well as resolving the specific concerns that led you to seek therapy. Benefits may also include increased capacity for intimacy, decreased negative ideation, decreased self-defeating behaviors, and improved mindfulness. Working toward these benefits require effort on your part. Psychotherapy is most beneficial with your active involvement including honesty and openness to make positive changes in your life. Psychotherapy requires action on your part including applying the skills, ideas, tasks, and suggestions discussed during the session in your every day life outside of therapy. Your feedback and views on your therapy is key to the process. Your feedback on your therapy is an important piece of the process.

During the therapeutic process, discomfort may be experienced by remembering or talking about unpleasant events, feelings, or thoughts. These discussions may evoke strong feelings of anger, sadness, worry, or fear. You may experience an increase in symptoms associated with anxiety, depression, or insomnia. I may challenge some of your assumptions and perceptions or propose different ways of viewing, thinking about, or handling situations. These challenges may evoke feelings of anger, upset, hurt, disappointment, or resentment, all of which are appropriate feelings to discuss within our therapeutic relationship.

Attempting to resolve the issues that prompted you to seek therapy may result in changes that were not originally intended. Psychotherapy may be a catalyst for you making new decisions about changing behavior, employment, schooling, housing, or relationships. Sometimes a decision that is positive for one family member may be viewed negatively by another family member. During the course of psychotherapy, things may feel like they are getting worse before they get better. Change can be easy and swift, but more often it will be slow and challenging before the relief is felt.

I consult with other health professionals regarding my clients in order to increase the effectiveness of the services I provide. I do not use first or last names or other identifying information during these consultations in order to assure that full confidentiality is maintained.

If at any point during our work together either one of us decides that I am not effective in helping you reach your therapeutic goals treatment can be terminated. In the event of termination, I would be happy to provide you with referrals to other therapists should you wish to continue treatment. With your written consent, I will provide him/her with the information needed for proper assessment and evaluation.

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 law requires disclosure. Law, in the following circumstances, may require disclosure:

1. When you have signed a “release of information form” from me or from another professional or agency stating exactly what information can be released and to whom it may be released;
2. When I believe that there may be a physical danger to you or to others through actions of yours, appropriate authorities, individuals and/or relatives will be notified.
3. When I become aware of actual or suspected child and or elder abuse, I am required by law to report such cases to the local welfare authorities.

The intent of such requirements is that a therapist has a legal and ethical responsibility to take action to protect endangered individuals from harm when the therapist’s judgment indicates that danger exists. It is my policy to fully disclose these matters with my clients before any action is taken, unless there is a compelling reason not to do so.

Client Rights:

As a client, you have the right to review or receive a summary of your psychotherapy record at any time, except in limited legal or emergency circumstances, or when I assess that releasing such information may be harmful to you in any way. In such circumstances, I may provide you with a summary of your records, or may provide the records or its summary to an appropriate mental health professional of your choice.

Upon your authorization, I will release information to any agency/person you specify unless I assess that releasing information will be harmful to you in any way. You will be charged an appropriate fee for any professional time spent in responding to an information request regarding you or your treatment. I am happy to discuss any of these rights with you.

Appointments, Availabilities and Emergency Procedures:

Generally, meeting on a weekly basis at first gives both the therapist and the client a chance to develop an understanding of the problem as well as to get to know each other. The office does not have a receptionist; therefore you will almost always get the voicemail when you call due to my inability to answer the phone while with clients or after business hours. Please leave a detailed message and I will respond within 24 hours. Texting is a good option for scheduling or canceling appointments.

If I am unavailable during an emergency you may leave a message on my voicemail and I will attempt to get back in touch with you. In the event that I am unavailable and you need to talk to someone right away, you can call the 24-hour hotline at the Help Center at 406-586-3333 or go to the emergency room (Bozeman Deaconess Hospital, 406-585-1000).

If an emergency situation arises in which you are being harmed or are in danger of harming yourself or someone else, please call 911.

Payments & Cancellation Policies:

I offer a complimentary 20-minute initial consultation session. In this session, we will decide together if we will continue to work together. Subsequent therapy sessions are 50 min or 80 minutes long, dependent on the work we are doing. Length of sessions will be discussed up front and agreed upon together.

My fee is \$75 per hour. Payment is required before session begins if it is a phone or Skype session or directly after if in office. Payment can be made via cash, check, or card. Please make checks payable to Rosanna Maria Psychotherapy & Coaching. There is a \$30 fee for returned checks.

Cancellations happen. Since the scheduling of an appointment involves the reservation of time especially for you, a \$25 fee will be charged for sessions missed without a 24-hour notice of cancellation. For no shows, the missed session is charged in full: \$75. Please be sure to call or text-message in the event that you need to cancel.

Social Media Policy:

I do not accept friend requests, contact requests, or connect online with any current or former clients. I believe that adding clients as friends or contacts on social media sites can compromise your confidentiality and privacy. The exception to the rule is my business Facebook page and business Instagram account.

I accept these terms during our professional relationship. Based on the terms of this agreement, I consent to participate in an evaluation and treatment with Rosanna Maria. I understand that this agreement can be withdrawn at any time.

Client signature _____ Date _____

Art & Soul Counseling, LLC

Rosanna Timmer, Psychotherapist
Supervisor: Sabrina Husain Bajakian, LCPC



DX: _____

Patient Name _____ Date of birth _____ Age _____ M or F

Address _____ City _____ State _____ Zip code _____

Social Security # _____ Marital Status _____ Student? Yes ___ No ___

Home Phone # _____ Cell or Work# _____

Employer name & address _____

Responsible Party Name _____ Date of Birth _____

Social Security # _____

Referred by _____

BILLING INFORMATION

Primary Insurance _____ Phone number _____

Address _____

Policy Holder name _____ DOB _____ Policy# _____ Group# _____

Secondary Insurance _____ Phone number _____

Address _____

Policy Holder name _____ DOB _____ Policy# _____ Group# _____

FEE POLICY

Charge for the initial visit is \$170 and subsequent visits are \$150 per hour.

If you are covered by insurance, your insurance will be billed. However, until insurance accepts the claim, you will be fully responsible for cost of services. Balances over 30 days will be billed to the credit card on file and are subject to billing charges, collection services and fees. In the event any unpaid balance is placed for collections with any third party collection agency, a fee of **50%** of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and any other fees so stated elsewhere. The authorized fee of **50%** and the additional costs and charges listed above represent the actual costs incurred by Sabrina Bajakian & Art and Soul Counseling, LLC, to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement.

A \$100 fee will be charged for No Shows and appointments canceled without a 24-hour notice. If you do not show up for two consecutive appointments, treatment will be terminated. Your signature on this form authorizes the release of any medical or other information necessary to process a claim to insurance and authorizes payment of medical benefits to Sabrina Bajakian, LCPC at Art and Soul Counseling, LLC.

INFORMED CONSENT

My professional ethics and Montana State law require personal information be kept confidential. This means information about you is not revealed to other persons or agencies without your clear and deliberate permission. The written record of any information you share is kept in a locked file.

HIPAA ACKNOWLEDGEMENT

Protecting your privacy is very important to me. By Federal law, I am required to inform you of my office HIPAA Privacy Practices. By signing this form, I am indicating that I have been provided a copy of Sabrina Bajakian & Art & Soul Counseling's, Notice of Privacy Practices related to health information. I understand that the Notice is subject to change, and I can obtain a current Notice by contacting this office.

Signature of Client

Date

Signature of Guardian

Date

Credit Card Authorization Form

Client Name _____

VISA _____ Mastercard _____ American Express _____ Discover _____

Name on Card _____

Card Number _____

Expiration Date _____ CVV Code (on back) _____

I, _____, authorize Rosanna Maria Psychotherapy & Coaching LLC to charge my credit card for any and all balances on the account. This includes full session fees, insurance co-pays, and any missed appointment fees cancelled within 24 hours of scheduled appointments. I understand that my credit card information will be saved in my clinical file and this authorization remains in effect until cancelled.

Client/Legal Guardian Signature

Date