Families First Therapy, LLC
Information Sheet

Client Information:

Name: _____ DOB: ____/____/____

Gender Identity: __Male__Female__Other: _____ SSN: _____

Biological Sex ___ Male ___ Female

Email, text messaging, and other electronic communications are not secure mediums and therefore, confidentiality cannot be assured. Please use discretion when sending information that is sensitive in nature.

Cell Phone _____ May I leave a message? Yes _____ No _____

Marital Status: _____ May I text you? Yes _____ No _____

Significant Relationships: _____

Email: _____ May I email you? Yes _____ No _____

Address: _____

_____

Home Phone: _____ May I leave a message? Yes _____ No _____

Emergency Contact(s):

_____ Ok to Contact? Yes _____ No _____

(Name) (Relationship) (Telephone Num.)

_____ Ok to Contact? Yes _____ No _____

(Name) (Relationship) (Telephone Num.)

Primary Language: _____ Proficiency of reading / writing in this language: _____

Parent / Guardian(s) Information (if client is a minor only):

Name: _____

Cell Phone: _____ May I leave a message? Yes _____ No _____

May I text you? Yes _____ No _____

Email: _____ May I email you? Yes _____ No _____

Name: _____

Cell Phone: _____ May I leave a message? Yes _____ No _____

May I text you? Yes _____ No _____

Email: _____ May I email you? Yes _____ No _____

Insurance / Payment Information:

Payment Source: _____ Self Pay _____ Sliding Scale _____ Medical Insurance

Insurance Company: _____ Client's Relationship to the Policy Holder:

Policy Holder's Name: _____ ___ Self ___ Partner ___ Dependent

Policy Holder's DOB: ____/____/____ Member #: _____

Policy Holder's SSN: _____ Group #:

Policy Holder's Employer: _____

Referral Information:

How did you hear about this practice? _____

Cell (505) 504-5449
Fax (844) 840-7345
www.familiesfirsttherapy.org
steve@familiesfirsttherapy.org

Families First Therapy, LLC

Intake Questionnaire

Please complete the following questionnaire before your first appointment. This helps me complete an intake assessment and get an overall picture of your current struggles and strengths. While some of these questions may seem like asking a lot of information, most of these questions are required by the norms of the counseling field in order to provide you the best possible service. Thanks!

Reason for seeking counseling: _____

_____

Presenting Concerns (please check all that apply)

_____Suicidal Thoughts
_____Problems with Child / Children: _____
_____Defiance / Oppositionality
_____Anxiety / Worries
_____Confusion
_____Depression
_____Difficulty Being Alone
_____Fatigue
_____Guilt / Shame
_____Hearing Voices / Hallucinations
_____Memory / Concentration Problems
_____Mood Swings
_____Motivation Reduced / Absent
_____Obsessive Thoughts
_____Panic (or Anxiety) Attacks
_____Physical Abuse
_____Low Self-Esteem
_____Sexual Abuse
_____Sleep Problems
_____Trauma / PTSD
_____Struggles Attaching / Having Relationships
_____Grief and Loss
_____Coming out / GLBTQ Concerns
_____Unusual Thoughts
_____Other: _____

_____Anger / Aggression / Violence
_____Parent / Child Conflict
_____Social Struggles
_____Drug / Alcohol Use Concerns
_____Addiction
_____Eating Habits / Problems
_____Lying Frequently
_____Perfectionism
_____Physically Abusive to Self
_____Shy, Uneasy with Others
_____Passive / Unassertive
_____Unwanted Behavior / Habits
_____Withdrawn
_____Employment / School Issues
_____Legal Problems
_____Living Arrangements
_____Money Management Issues
_____Parenting Issues
_____Relationship / Marital Issues
_____Cutting / Self-Harm
_____Existential / Spiritual Struggles
_____Divorce / Separation
_____Communication Struggles
_____Weight Changes
_____ Increase _____ Decrease

Prior Behavioral Health Experiences

1. Outpatient Counseling (most recent, to first)

Dates: From – To	Clinic	Therapist	Reason / Results (How was it?)

2. Intensive Treatment (including residential treatment, treatment foster care, and hospitalizations)

Dates: From – To	Clinic	Therapist	Reason / Results (How was it?)

Medical History (current and in the past)

Medical Conditions in the lasts year: _____

Chronic Illnesses: _____

Surgeries: _____

Head Injuries (TBI diagnosed or otherwise): _____

Disabilities (physical or developmental): _____

Allergies: _____

Advanced Directives (if applicable): _____

Medication	Dose/Frequency	Start Date	End Date	Reason for RX	Prescribed By

Drug and Alcohol Use History:

Past Use	Type	Quantity	Frequency	Date Started (If applicable)	Date Ended (If applicable)
Alcohol					
Tobacco					
Non-Prescribed Drugs					

Have there been any undesirable results of your drug or alcohol use? [YES] [No]
(struggles at school / job, physical health problems, relationship problems, legal problems)

Have you ever been concerned about your drug or alcohol use? [YES] [No]

Have others expressed concern about your drug or alcohol use? [YES] [No]

Have others you are close to struggled with problems related to drug or alcohol use? [YES] [No]

Have you ever attended a 12-step support group (AA, NA, Al-Anon, etc.)? [YES] [No]

Are you currently attending a 12-step support group? [YES] [No]

Describe your daily caffeine consumption (tea, coffee, energy drinks, chocolate, soda): _____

_____

Education and Employment (if applicable):

1. Education History

Highest level of education to date: _____

Current School / Field of Study: _____

2. Employment History

Are you currently employed? ___ No ___Yes Job Title: _____

Do you have any concerns about employment? ___ No ___Yes: _____

3. Military Experience

Have you been in any branch of the military? ___ No _____Yes: Branch _____ Position _____

Reason for Discharge: _____

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Outcome Rating Scale (ORS)

Name _____Age (Yrs):____ Gender_____
Session # ____ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

Overall
(General sense of well-being)

I----------I

International Center for Clinical Excellence

www.scottdmiller.com

Families First Therapy, LLC
CONSENT TO TREATMENT

It is the policy of Families First Therapy LLC that clients have the right to say whether or not they wish to receive Outpatient services. Each client has impartial access to treatment, regardless of race, religion, gender identity, ethnicity, age, sexual preference or disability, within the range and diagnostic criteria for which Families First Therapy LLC provides treatment.

The undersigned acknowledges that Families First Therapy LLC makes no guarantees to the undersigned or the client as to the results or likelihood of success of Families First Therapy LLC services.

The undersigned acknowledges that if a client becomes dangerous to him/herself or to others, the staff will exercise the necessary precautions in order to protect the client or others.

The undersigned acknowledges receiving a copy of information about Families First Therapy including policies and procedures, Informed Consent, HIPPA compliance protocols, and Notice of Privacy Practices.

The undersigned releases Families First Therapy LLC staff from any liability for the loss or damage of personal property and/or money while receiving services at Families First Therapy LLC or at the client's home.

These services are completely voluntary:

☐ **Yes; I Consent** to receive outpatient services from Families First Therapy LLC for myself or on the behalf of the client.

☐ **No; I Do Not Consent** to receive outpatient services from Families First Therapy LLC for myself or on the behalf of the client. Referrals for outside services or alternative services can be supplied upon request.

My signature below attests to the fact that I have read this form, understand its content and request that the above information be released as specified.

_____ _____

CLIENT SIGNATURE (14 YEARS OR OLDER) DATE

_____ _____

PARENT /GUARDIAN (IF APPLICABLE) DATE

I have discussed the notice of privacy practices, informed consent, consent to treatment, consent to policies and disclosure to insurance company, consent to payment policies, consent to cancellation policy, and client rights and responsibilities with the client(s) and/or their parent/guardian (if applicable). My observations of their behavior and responses give me reason to believe that this person is fully competent to give informed and willing consent. My signature below attests to this statement.

_____ _____

STEPHEN RATCLIFF, MA, LPCC DATE

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Families First Therapy, LLC

CONSENT TO POLICIES AND CONSENT TO DISCLOSURE TO INSURANCE COMPANY

Thank you for choosing Families First Therapy as your therapy provider. Please review carefully the consent to disclosure to insurance companies (if applicable) and receipt of notice of privacy practices below. If you agree to each item, please initial next to each statement indicating your agreement and sign at the bottom.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____I acknowledge that I have been provided a Notice of Privacy Practices that fully explains the uses and disclosures that Families First Therapy will make with respect to my individually identifiable health information. I understand that I have the right to review said notice before signing this consent. Additional copies of this notice are posted on the website www.familiesfirsttherapy.org and also in the office lobby. I also understand that Families First Therapy reserves the right to change its notice and the practices detailed therein prospectively, and will notify me of any changes.

RECEIPT AND CONSENT TO INFORMED CONSENT AND ADDITIONAL POLICIES

_____I acknowledge that I have been provided and reviewed a copy of Informed Consent, additional privacy policies and cancellation and no show policy. I understand these policies and agree to abide by the boundaries and stipulations therein.

_____I was given, have reviewed, and understand privacy concerns pertaining to technology and electronic communications.

CONSENT TO DISCLOSURE TO INSURANCE COMPANY (IF APPLICABLE; OPTIONAL)

N/A I understand that I do not have to consent to the uses or disclosure of my individually identifiable health information for treatment, payment, and health-care operation. I also understand that if I do not consent, Families First Therapy may refuse to provide me health-care services unless applicable state or federal law requires Families First Therapy to provide such services.

N/A I understand that I may revoke this consent in writing, but that the revocation will not be effective to the extent that Families First Therapy has already taken action in reliance on my earlier effective consent.

N/A I understand that as part of my healthcare, Families First Therapy originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among health professionals who contribute to my care.
- A source of information for applying my diagnosis information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.

N/A I understand that if my medical insurance company is providing payment for services rendered at Families First Therapy, the following disclosures of my identifiable health information may apply:

- Families First Therapy will have to release information including dates of sessions, CPT codes billed, and diagnostic information about me to my insurance company, or their legal representative in order to obtain payment.
- If records are requested by my insurance company as a requirement to process payment for services rendered, Families First Therapy will attempt to notify me of the documents being disclosed and permit me to review them prior to their disclosure. Documents may include any documents generated by Families First Therapy about me.
- I will have to authorize my insurance company to make benefits payable to Families First Therapy.

My signature below attests to the fact that I have read this form, understand its content, and agree to these conditions.

_____ _____

CLIENT SIGNATURE (14 YEARS OR OLDER) DATE

_____ _____

PARENT /GUARDIAN (IF APPLICABLE) DATE

_____ _____

STEPHEN RATCLIFF, MA, LPCC DATE

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Families First Therapy, LLC

Please review carefully the boundaries and expectations outlined below. Please initial next to each statement indicating your agreement and sign at the bottom. These are considered a necessary condition for treatment.

CONSENT TO PAYMENT POLICIES

PAYMENT POLICIES

_____ I understand that all Copays, Deductible payments, Self-pay, or Sliding-scale fees are due at the time or service. If my insurance company denies paying for my services or indicates a deductible payment or different copay amount than indicates on my insurance card, then these payments are due five business days after I am invoiced.

_____I understand that if I don't have insurance, I will be expected to pay the noted fee (or sliding scale fee) for these services at each appointment. Any payments may be made via cash, check, or credit card.

_____I understand that the full-scale fees for services are as follows: Individual / Family Intake Appointment **$130**, Subsequent Individual / Family Appointments **$110** per hour, and Couples / Relationship Counseling **$90** per hour and a one time **$30** fee for the Gottman Relationship Checkup Assessment Measures.

_____I understand that any balances not paid within 30 calendar days may be turned over to collections with an additional 2% late fee added. I understand that if my bill must be turned over to collections due to not paying my balance after 30 calendar days, I am responsible for the collections fees (typically 40% of the total bill).

_____I understand that if payment for the services I receive is not made, the therapist may stop my treatment.

_____I understand that if I pay by check or credit card and the payment is later recouped (e.g. the check bounces), a fee of **$30** will be added to the balance. I understand that this balance must be paid by alternative means in 5 days.

ADDITIONAL SERVICES

_____ I understand that any out of session communication (telephone call or other medium) lasting more than 5 minutes will result in a fee of **$25** per 15 minutes. There will be no fee for contacts lasting less than 5 minutes.

_____ I understand that other services such as record preparation, report writing, and other documentation are charged at the rate of **$25** per 15 minutes.

_____ I understand that if I choose to subpoena Stephen Ratcliff, all legal services including preparation time, testimony time, transportation time, and commute time will incur a fee of **$300** due prior to testimony date.

CONSENT TO CANCELLATION POLICY

_____I understand that if I am unable to attend my scheduled therapy appointment, I must first notify Families First Therapy by email or at 505-504-5449 by text or voicemail 24 hours in advance of my appointment.

_____ I understand that If I do not call to cancel or reschedule my appointment, this will be considered a **no-show**. Additionally, arriving later than 20 minutes for my scheduled therapy appointment time constitutes a no-show. No-shows to appointments are not covered by my health insurance and will result in a subsequent fee. The fee is **$25** for all clients.

_____ If extenuating circumstances arise and I cancel in advance of my appointment but not with 24 hours notice, Families First Therapy may choose to waive this fee on a case-by-case basis.

_____ I understand that if I miss my scheduled appointment, it is my responsibility to call to set up subsequent appointments. Failure to cancel with 24-hour prior notice *may* result in me loosing my preferred time slot. If I am failing to maintain contact, Families First Therapy may take this as communication that I am terminating services.

My signature below attests to the fact that I have read this form, understand its content, and agree to these conditions.

_____ _____

CLIENT SIGNATURE (14 YEARS OR OLDER) DATE

_____ _____

PARENT /GUARDIAN (IF APPLICABLE) DATE

_____ _____

STEPHEN RATCLIFF, MA, LPCC DATE

Cell (505) 504-5449 Fax (844) 840-7345 www.familiesfirsttherapy.org steve@familiesfirsttherapy.org

Families First Therapy, LLC
CLIENTS RIGHTS AND RESPONSIBILITIES

Client's Rights

1. The right to efficient and equal service, regardless of race, gender, religion, ethnic background, education, social class, physical or mental disability, sexual orientation, gender identity, or economic status.
2. The right of considerate, courteous and respectful care from all Families First Therapy, LLC staff.
3. The right to informed consent and full discussion of risks and benefits prior to any invasive procedure, except in an emergency. Alternative to the proposed procedure must be discussed with the client.
4. The right to receive information in an understandable manner.
5. The right to obtain a referral for bi-lingual services or to have an interpreter present in session if needed.
6. The right to the names, titles, and professions of Families First Therapy, LLC staff with whom the client speaks and from whom services or information are received.
7. The right to refuse examination, discussion, and/or procedures to the extent permitted by law and to be informed of the health and legal consequences of this refusal.
8. The right of access to the client's own personal health record.
9. The right to confidentiality and privacy of the client's personal mental health records as provided by the law. The details of the clients life and treatment are shared only with the client's parent's or guardian's permission and the client's explicit consent.
10. The right to expect reasonable continuity of care within the scope of services of Families First Therapy, LLC.
11. The right to examine and receive a full explanation of any charges made by Families First Therapy, LLC regardless of the source of payment.
12. The right of respect for the client's civil rights and religious opinions.
13. The right to be represented by a family member of guardian if the client is unable to fully participate in treatment decisions.

Client's Responsibilities

1. Provide accurate and complete information relevant to your treatment at Families First Therapy, LLC.
2. Ask questions if you do not understand any aspect of your treatment.
3. Report safety concerns immediately to your therapist.
4. Avoid drugs, alcoholic beverages or toxic substances while in attendance of your therapy session.
5. Accept the consequences if you do not follow the care, service, or treatment plan provided to you.
6. Respect the property of other people and of Families First Therapy, LLC.
7. Be considerate of other clients.
8. Sign a written acknowledgement that you have received the applicable Notice of Privacy Practices.
9. Provide accurate information needed for processing your insurance coverage.
10. Be responsible for payment of all services, either through your third party payers (insurance company) or by personally making payment for any service that are not covered by your insurance policy(s) including second opinions or consultations.

By signing below, I acknowledge my client's rights and responsibilities listed herein.

_____ _____

CLIENT SIGNATURE (14 YEARS OR OLDER) DATE

_____ _____

PARENT /GUARDIAN (IF APPLICABLE) DATE

_____ _____

STEPHEN RATCLIFF, MA, LPCC DATE

Cell (505) 504-5449 www.familiesfirsttherapy.org
Fax (844) 840-7345 steve@familiesfirsttherapy.org

Families First Therapy, LLC

PRIMARY CARE PHYSICIAN COORDINATION OF CARE RELEASE FORM

CLIENT NAME: _____ DATE OF BIRTH: _____

THIS WILL AUTHORIZE: Families First Therapy, LLC

Tel. (505) 504-5449; Fax (505) 242-4076

TO RELEASE TO: _____

(Facility, organization, individual receiving information)

_____

(Telephone, fax, address)

Cancellation / Expiration: I understand that I may cancel this authorization at any time by sending my health providers my cancellation notice in writing. I understand that my health care providers may have already released records according to this authorization prior to receiving my notice of cancellation.

This authorization shall remain valid for one year from the date of signature unless revoked in writing by the client's guardian or conservator. This authorization releases Families First Therapy, Inc. from any and all legal liability that may arise as a result of compliance with this release of information request.

☐ **I authorize** Families First Therapy, LLC to have contact and release medical records to the Physician noted above.

I specifically authorize the release of my medical records to include the following records (initial):

_____ HIV / AIDS results and treatments
_____ Sexually transmitted or "communicable" disease Information
_____ Prescription Drug Information
_____ Drug, alcohol, or substance abuse Information
_____ Mental health Information (other than psychotherapy notes)

☐ **I do not authorize** Families First Therapy, LLC to release medical records.

My signature below attests to the fact that I have read this form, understand its content and request that the above information be released as specified.

_____ _____

CLIENT SIGNATURE (14 YEARS OR OLDER) DATE

_____ _____

PARENT /GUARDIAN (IF APPLICABLE) DATE

I have discussed the above form and what information may or may not be disclosed with the client(s) and/or their parent/guardian (if applicable). My observations of their behavior and responses give me reason to believe that this person is fully competent to give informed and willing consent. My signature below attests to this statement.

_____ _____

STEPHEN RATCLIFF, MA, LPCC DATE

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steve@familiesfirsttherapy.org

FAMILIES FIRST THERAPY, LLC

DISTANCE SESSION SELF PAY / SLIDING SCALE PAYMENT AGREEMENT

Client Name: _____

Responsible party (if different): _____

I _____, agree to pay $_____ per session, **for psychotherapy services** received through Families First Therapy, LLC based upon my reported household annual income of: $_____ and my total household size of: _____.

I also agree to, and understand, the following conditions:

- Sessions are defined as one hour in length. Extended fees may be incurred for longer sessions.
- The client, or responsible party, will be held responsible for all fees charged.
- Sliding scale fees are to be determined using the client's household income and the number of people in the household. All sliding scale arrangements must be made in advance of the session.
- Fees are due at the time of each session and will be accepted in the form of cash, check, credit card, or money order.
- Fees will only be refunded in the event that the service is not delivered.
- Non-payment of fees could result in the discontinuation of services to the client.
- Clients will be billed for any unpaid services via an invoice by mail. Any unpaid balances may be turned over to collections after 30 days.
- Insurance will NOT be billed for these services; consequently none of the fees for services will be applied to an insurance plan's annual deductible.

_____ _____

Signature of client or responsible party Date

_____ _____

Signature of Stephen Ratcliff, MA, LPCC Date

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steve@familiesfirsttherapy.org
steve@familiesfirsttherapy.org