CONFIDENTIAL INFORMATION FORM

Date: _____

Parent Name: _____ DOB : _____

Home Address: _____ Driver's License:_____
City, State: _____ Zipcode: _____

Employer: _____ Occupation: _____
Address: _____ SS#: _____

Phone: Home: _____ OK to leave message ( )
Work: _____ OK to leave message ( )
Cell: _____ OK to leave message ( )

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Liv Tog ( ) Divorced

Partner/Parent Name: _____ DOB: _____

Employer: _____ Occupation: _____
Address: _____ SS#: _____
_____

Phone: Home: _____ OK to leave message ( )
Work: _____ OK to leave message ( )
Other: _____ OK to leave message ( )

Children / Others Living With You: DOB / Age: School / Occupation: Grade:

Name: _____ _____ _____ _____
Name: _____ _____ _____ _____
Name: _____ _____ _____ _____

Emergency Contact: _____ Relationship:_____

Contact's Phone Numbers: _____ Referred by:_____

Informed Consent

Everyone participating in therapy is entitled to confidentiality with certain exceptions. These include situations where a client presents a danger to him/herself, an expressed danger to others, or where the therapist suspects that abuse of a child under the age of 18, an elder over 65 or a dependent adult is occurring or has occurred.

Therapy appointments are made in advance and this reserves my time for you. If you need to cancel, please do so with a minimum of two (2) business days' notice so we may schedule someone else in that slot. If you do not give 2 business days' notice to cancel, you will be charged your full fee for the missed appointment. (Example: to cancel a 10 am Monday appt, call by 10 am on Thursday the week prior; to cancel a Wednesday noon appt, call Monday by noon that week.)

I am not on call for emergencies. To contact me between sessions, please call and leave a message on my confidential voice mail: 949-929-5470 (on business card). Your call will be returned as soon as practically possible within one business day. If there is a life-threatening emergency, please call 911 immediately.

You will be charged a $25.00 service fee for each returned check. Payment of both the usual fee and service fee must be received before therapy will continue. If you wish to have insurance pay for your therapy, I require payment at the time of service; however, I will supply you with a super-bill insurance claim form for you to submit to your insurance carrier. In accordance with your policy, the insurance company will determine coverage and make any reimbursements for services rendered directly to you.

Treatment Agreements:

1. I agree to enter therapy with Amy St. Hilaire, MFT.
2. I understand that the initial intake is a 115 minutes and agree to pay $360.00 and subsequent visits are customarily 85-minutes in length for which I will pay $270.00 at the start of each session, payable by cash, check, or MasterCard/Visa. (When you use a credit card, a 4% transaction fee will be added to the total.)
3. I understand that my therapist is a sole-proprietor and works in her own independent private practice. Although she shares space with others in the Center, I understand that no one is legally connected to or responsible for the work of others in the Center.
4. I have read and understand my rights, the parameters of comprehensive energy psychotherapy, the office policies, the limits of confidentiality and these conditions of our work together. _____

Initial here

Name of Client or Guardian	Name of Clinician
Signature of Client or Guardian	Signature of Clinician
Date	Date

Limits of Confidentiality

Information discussed in the therapy setting is held confidential and not shared without written permission except under the following conditions:

1. If the client threatens suicide.*
2. If the client threatens to harm another person.*

3. If I have reason to suspect that a minor is being abused: including, but not limited to physical abuse, sexual abuse and unjustifiable cruelty or unreasonable punishment.*
4. If I have reason to suspect that an elderly person over 65 years of age or a dependent adult is being abused.*
5. If I am ordered by the courts to break confidentiality to comply with legal requirements.
6. If I consult with other marriage & family therapists, social workers or psychologists in order to provide you with the best care and service.
7. If I have a written release from you, authorizing me to speak with a party you designate such as an insurance company representative, doctor, other healthcare provider, school or family member.

* State law mandates that mental health professionals need to consult with social services to report these situations to the appropriate agency designated to receive such report.

All other communications between therapist and client will be deemed confidential under the laws of the state.

Having read and understood the above, I agree to these limits of confidentiality.

_____ _____

Name of Client or Guardian Date

_____ _____

Signature of Client or Guardian Signature of Clinician

Consent for the Treatment of a Minor

Name of Minor/s: _____ Date of Birth: _____

_____ _____

This is to certify that I am authorized to provide consent and hereby give my permission for the above named minor to participate in psychotherapy with _____Amy St. Hilaire,MFT____. This treatment may include individual or family therapy, counseling, play therapy, art therapy, thought field therapy, muscle testing, Seemorg Matrix, or Healing from the Body Level Up.

This treatment may include conversations with other professionals including doctors, teachers, educational psychologists or nutritionists. If I need to consult with such people, I will have you sign a specific written release authorizing me to consult with them.

California state law mandates that if I have reason to suspect that any minor is being abused, I must consult with social services. (See limits of confidentiality for more details.)

_____
Printed Name of Parent/Guardian

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian

_____ _____
Signature of Parent/Guardian Date

_____ _____
Therapist/Witness Signature Date

Autobiography

- Please list members of your family and describe the nature of your relationship with each person (you may use the back of this page if you like):

- Please list any illnesses, hospitalizations, surgeries, recurring illnesses, injuries or significant accidents:

- Please list any traumatic losses or incidents of violence that you suffered or have witnessed:

- Please tell me how school has been for you. Tell me about the history of your grades and how you feel about school this year and in the past. Give a little school history:

- Please list all the tools/strengths you use to cope with stress (e.g. exercise, positive self-talk, writing in a diary or journal, drawing, playing with friends, talking with parents/teachers, etc.):

- Briefly describe your religious or spiritual upbringing—i.e, that which you got from your parents/the people who raised you or your teachers/school, or any other significant person or event in your life:

- Are there any events in your life that made you wonder whether God is real?

Goals

Please list 3 goals you have for yourself that you would like my help with:

1.

2.

3.

Please list 3 strengths or tools that help you reach your goals:

1.

2.

3.

Please list 3 ways you get in the way of reaching your goals:

1.

2.

3.