Jennifer Chappell Marsh, MFT
Licensed Marriage & Family Therapist #53559
Estes Therapy & Associates
3333 Camino Del Rio South, Suite #215
San Diego, CA 92108

CONFIDENTIAL CLIENT INTAKE FORM

Client Name____Date______________________

Date of Birth_________________________ Age_______ Social Security __________________

Street Address___________________________________City_________________________________

State ____________Zip Code____________E-mail Address___________________________________

Cell Phone ___________________ Home Phone____________________WorkPhone_______________
May I call you on your cell? Y N at home? Y N at your work? Y N

Employer______________________________Occupation____________________________________

Relationship Status___________________________Children__________________________________

In Case of Emergency

Notify_________________________________Relationship___________________________________

Phone Number___________________________

Referral:
How did you hear about Jennifer Chappell Marsh? (check one please)
___ Friend or Family If so, Who? ____
___ Physician/Psychiatrist If so, Who? ____
___ Television/Magazine/Newspaper
___ Internet
___ Other ______________________________

Presenting Problems:
Please describe your reasons for seeking therapy:
____

____
Please circle the severity of your problem(s) on the scale below:

mildly upsetting moderately upsetting very severe extremely severe totally incapacitating

Circle all that apply to you:

depressed mood/sadness	low energy	tearfulness	excessive guilt
difficulty concentrating	irritability	low motivation	fatigue
sleeping difficulties	appetite changes	change in weight	feel worthless
feeling lonely	excessive guilt	suicidal thoughts	feel like a failure
anxiety/stress	panic attacks	anger problems	fears /phobias
headaches	dizziness	fainting spells	palpitations
stomach trouble	pain (please describe)	unable to relax	restless/nervous
feel "on edge"/tense	nightmares	flashbacks	memory problems
alcohol use	drug use	sexual problems	legal problems
confusion	obsessive thoughts	difficulty trusting	difficulty making decisions
relationship difficulties	financial problems	shy with people	academic/work problems
difficulty making friends	low self-esteem	other not listed:___________________________	

Family History:
Describe any significant emotional, medical or chemical dependency conditions of your parents/family:

____

____

Alcohol/Substance:
Please describe alcohol/substance (drugs, porn, etc) use:_______________________________________

Additional Information:

Additional problems or difficulties you think may be important for the therapist to know:

____

____

Consent for Treatment: I authorize and request that Jennifer Chappell Marsh, MFT, provide assessment, treatments, and/or diagnostic procedures which now or during the course of my care as a client are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable

Your signature below indicates that you have read and understood the information of the Out Patient Service Contract and agree to abide by the terms of the Out Patient Services Contract.

Your signature below indicates that all the information on this form is accurate.

____________________________________ ________________________________ ___________
Client (print) Client (sign) Date

Jennifer Chappell Marsh, MFT
Marriage & Family Therapist #53559

Credit Card Information

The undersigned hereby authorizes Jennifer Chappell Marsh, to charge my credit card (provided below) for the amount of the therapy session if there is an outstanding balance more than 30 days after issuance of an invoice.

A current credit card number must be on file at all times, regardless of your preferred method of payment. Your card will not be charged if you pay by cash or check by the time your payment is due.

The credit card to remain on file is:

1. Please Circle: MasterCard Visa AMEX Discover
2. Card Number: ______________________________
3. Expiration Date: ______________________________
4. Security Code: ______________________________
5. Name as appears on the card: ______________________________
6. Billing Address with zip code: ______________________________
7. Signature of card holder: ______________________________

The Undersigned understands and agrees to be bound to such agreements as outlined in this document. Please provide your signature below. If there is more than one adult participating in treatment, both must sign below.

SIGNATURE: ______________________________

PRINT NAME: ______________________________

SIGNATURE: ______________________________

PRINT NAME: ______________________________

DATE: ________________

OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS AND SCHEDULING

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours [1 day] advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. As therapy sessions are schedule, the therapist will provide a business card with the time of therapy. Since mistakes occur with technology, if you decline the appointment card and a mistake occurs with scheduling you will be responsible for payment. If you would like to cancel the appointment, you must send an email or call within 24 hours.

PROFESSIONAL FEES

My hourly fee is **$150.00** payment method is cash, check, or credit card. All checks payable to Jennifer Chappell Marsh. The fee shall be paid in full at the end of each therapy session. A $20.00 charge will be added to any returned checks. Therapist will provide a 1 month notice of fee changes. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations or lengthy emails (billed in 6 minute increments), attendance at

meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge $200.00 per hour for preparation and attendance at any legal proceeding.]

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. [In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

CANCELLED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. Cancellations **must be made 24 hours** in advance; otherwise, client is responsible for the full session fee.

INSURANCE REIMBURSEMENT

I do not take insurance at this time; however, I will provide a monthly receipt that you can submit to your insurance for reimbursement. Please let me know if you need a printed up receipt and I will be happy to provide you with one. The form will include CPT Codes and DSM-IV Diagnostic codes for the insurance company.

CONTACTING ME

I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voicemail that I monitor frequently. I will make every effort to return your call within 1 business day, with the exception of holidays. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist, psychiatrist or Mental Health worker on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. If you are having a psychiatric emergency, please contact San Diego Crisis hotline: 1-800-479-3339 or call 911.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep 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. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

LITIGATION LIMITATION

Jennifer Chappell Marsh, IMF, does not do court work (such as testifying in divorce and custody disputes, injuries, lawsuits, etc…). If you need these services, I will give you referrals to forensic psychologists who specialize in these cases. To be in psychotherapy with Jennifer Chappell Marsh, you must agree that neither you, nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of psychotherapy records be requested for legal proceedings.

MINORS
If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

CONFIDENTIALITY
In general, the privacy of all communications between a patient and a therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person or disabled person is being abused, I am required to file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am [may be] required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. [If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues.]

"No Secrets Policy" for couples therapy. During the course of my work with a couple, I may see a smaller part of the unit (e.g., an individual) for one or more sessions. If you are involved in one or more of such 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 have written consent or required by law. However, if relevant information is disclosed and I may need to address the issue in the couple's session, I will give the individual opportunity to make the disclosure to the partner. If I am not free to exercise my clinical judgment regarding the need to bring this information to the couple during the therapy, I might be placed in a situation where I will have to terminate treatment of the couple. This policy is intended to prevent the need for such a termination.

My office space is a shared office space with other therapists/practitioners and we each work independently of each other and are **not** a part of a group practice.

VIDEO CONSENT FOR EFT CONSULTATION

In order to provide the best possible therapy treatment for you and your family, I, Jennifer Chappell Marsh, provide an extra service by participating in consultation and training groups with seasoned mental health professionals on a regular basis. In order to effectively train therapists and provide the best possible therapy treatment, it is common for supervisors and other therapist or therapist-in-training to watch a therapy session on videotape recording. By video taping sessions, it allows me as your therapist to watch the counseling session half way through the week and make sure I am not missing any vital information in the therapy room. If at any point I get stuck, I will inform you immediately and I will show a part of the session (typically 10 mins) with the consultation group. In order for a supervisor, therapist, or therapist-in- training to observe a session, clients must give written consent.

By initialing below, you give your consent to allow therapy sessions with Jennifer Chappell Marsh to be videotape and observed by a therapist, a team of therapists, or therapist-in-training. I understand that any supervisor, therapist, or therapist-in-training who observes my therapy session is under the same confidentiality requirements as my therapist. Furthermore, I understand that if by chance any supervisor, therapist, or therapist-in- training knows me socially, he/she will immediately leave the session and will not observe, seek, or be given any information about my case. I also understand that the purpose of allowing observation of my therapy session is to enhance the effectiveness of the therapy treatment I am receiving with Jennifer Chappell Marsh, LMFT. I understand that I may withdraw this consent at any time and that I will be notified if any live observations or taking is going to occur before my arrival.

________ I give consent to have my therapy sessions recorded via videotape for Jennifer Chappell Marsh review in between sessions, along with the EFT training/consultation groups.

________ I do not give consent to have my sessions videotaped.

OUTPATIENT SERVICES CONTRACT

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

____ ____________________

Client Signature Date

____ ____________________

Client Signature Date

____ ____________________

Therapist Signature, Jennifer Chappell Marsh MFC#53559 Date