

*Debbie Steele Ph.D, LMFT*

**CLIENT INFORMATION FORM**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Home address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Education: Last grade completed \_\_\_\_\_ Year \_\_\_\_\_

Marital status: \_\_\_\_\_ If divorced, how long? \_\_\_\_\_

Current Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Name of parent, spouse, or significant other: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Give full name of children and their ages:

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

Clinic/Doctor's name: \_\_\_\_\_ Phone#: \_\_\_\_\_

List all medications you are currently taking: \_\_\_\_\_

\_\_\_\_\_

In what way would you like the therapist to assist you? \_\_\_\_\_

\_\_\_\_\_

Have you or any family member received previous counseling? \_\_\_\_\_

Your religious affiliation: \_\_\_\_\_ Church name: \_\_\_\_\_

Referred by: \_\_\_\_\_

\_\_\_\_\_

(Client signature)

*Debbie Steele Ph.D*  
*Licensed Marriage and Family Therapist*  
*License # 42282*  
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*Vallejo, CA 94591*  
*(559) 341-0307*  
*debbiesteele@ggbts.edu*

## **AGREEMENT FOR SERVICES / INFORMED CONSENT**

This agreement is intended to provide (name of client) \_\_\_\_\_ with important information regarding the practices, policies, and procedures of Debbie Steele, Ph.D, LMFT and to clarify the terms of the professional therapeutic relationship. Any questions or concerns regarding the contents of this Agreement should be discussed with the therapist prior to signing it.

The therapist's theoretical orientation can be described as family systems theory and the belief that the family is the basic building block for society, as ordained by God. Having received a Ph.D degree in Marriage and Family Counseling from New Orleans Baptist Theological Seminary, the therapist provides biblical counseling, in tandem with common counseling methodologies such as cognitive-behavioral, brief/narrative, structural, and intergenerational.

Psychotherapy is a process in which the therapist and client discuss a myriad of issues, events, experiences and memories for the purpose of creating positive change so the client can experience life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as, any problems or difficulties you may be experiencing. Psychotherapy is a joint effort between client and therapist.

Participation in therapy may result in a number of benefits to the client, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may also require substantial effort on your part, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participation in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which the therapist will challenge the client's perceptions and assumptions, and offer differential perspectives. The issues presented by the client may result in unintended outcomes, including changes in personal relationships.

During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating. The client should address any concerns regarding progress in therapy with the therapist.

The therapist may take notes during sessions, and will also produce other notes and records regarding the client's treatment. These notes constitute the therapist's clinical and business records, which by law, the therapist is required to maintain. Such records are the sole property of the therapist. The therapist will not alter her normal record keeping process at the request of any client. Should the client request a copy of the therapist's records, such a request must be made in writing. The therapist reserves the right, under California law, to provide the client with a treatment summary in lieu of actual records. The therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. The therapist will maintain client records for ten years following termination of therapy. However, after ten years, the records will be destroyed in a manner that preserves the client's confidentiality.

The information disclosed by the client is generally confidential and will not be released to any third party without written authorization from the client, except where required or permitted by law. Exceptions to confidentiality include reporting child, elder and dependent adult abuse, when a client makes a serious threat of violence towards a reasonably identifiable victim, or when a client is dangerous to him/herself.

The therapist will not voluntarily participate in any litigation, or custody dispute in which the client and another individual, or entity, are parties. The therapist has a policy of not communicating with the client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in client's legal matter. The therapist will generally not provide records or testimony unless compelled to do so. Should the therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving the client, the client agrees to reimburse the therapist for any time spent for preparation, travel, or other time in which the therapist has made herself available for such an appearance at the therapist's usual and customary hourly rate of \$150.00.

The information disclosed by the client, as well as any records created, is subject to the psychotherapist-client privilege. The psychotherapist-client privilege results from the special relationship between the therapist and the client in the eyes of the law. Typically, the client is the holder of the psychotherapist-client privilege. If the therapist received a subpoena for records, deposition, testimony, or testimony in a court of law, the therapist will assert the psychotherapist-client privilege on the client's behalf until instructed, in writing, to do otherwise.

The usual and customary fee for service is \$150.00 per 50-minute session. Sessions longer than 50-minutes are charged for the additional time pro rata. The therapist reserves the right to periodically adjust this fee. The client will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with any third-party payers.

This agreed upon fee between the therapist and the client is \_\_\_\_\_. Clients are expected to pay for services at the times services are rendered. The therapist accepts cash and checks only.

From time to time, the therapist may engage in telephone contact with the client for purposes other than scheduled sessions. The client is responsible for payment of the agreed upon fee for any telephone calls longer than ten minutes. In addition, from time-to-time, the therapist may engage in telephone contact with third parties at the client's request and with advanced written authorization. The client is responsible for payment of the agreed upon fee for any telephone calls longer than ten minutes.

The therapist is not a contracted provider with any insurance company or managed care organization. Should the client choose to use his/her insurance, the therapist will provide a statement, which the client can submit to the third-party to seek reimbursement of fees already paid.

The client is responsible for payment of the fee for any session(s) missed without at least a 24-hour notice of cancellation. Cancellation notice should be left on the therapist's confidential voice mail at (559) 341-0307. In the event of an emergency, the client should call 911 or go to the nearest emergency room.

The therapist reserves the right to terminate therapy at her discretion. Reasons for termination include, by are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflict of interest, failure to participate in therapy, client's needs are outside the therapist's scope of competence or practice, or the client is not making adequate progress in therapy. The client has the right to terminate therapy at her discretion. Upon either party's decision to terminate therapy, the therapist will generally recommend that the client participate in at least one more termination session. This session is intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. The therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to the client.

By signing below, I acknowledge that I have reviewed and fully understand the terms and conditions of this agreement. All my questions have been answered to my satisfaction. I agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy.

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Client's Name (please print)

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Signature of Client(s) or authorized representative