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CONSENT FOR THERAPY

My signature below indicates that I have read and understand the **Welcome** (Informed consent) document. I understand that I do not have to sign this form. I understand I can choose to discuss any questions regarding this consent form with my therapist, **Thomas Stein**, at this time or at any point during the course of my therapy. I understand that after therapy begins I can choose to withdraw my consent to therapy at any time, for any reason. However, if I make this choice, I will make every effort to discuss my concerns with my therapist.

I hereby agree to enter into therapy with **Thomas Stein, LMFT** (or to have my child), as shown by my signature here.

Printed Name

Signature

Date

Signature of parent or guardian if applicable

Date

I consent to participate in family counseling:

Name:_____

Date:_____

Name:_____

Date:_____

Name:_____

Date:_____

Name:_____

Date:_____

I, Thomas Stein, LMFT, have met with person(s) named above (and/or his or her parent / guardian or family members) and have informed him or her of the issues and points raised in this consent form. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into therapy with the client, as shown by my signature here.

Signature of therapist

Date

Date: _____ Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone numbers: Home: _____ Work: _____ Cell/Other: _____

Can I contact you at home? Y N Work? Y N Can I leave you messages at home? Y N

Can I mail information to you at the address provided above? Y N

Can I email information to you? Y N Email address: _____

Occupation: _____

Primary Care Physician: _____ Phone#: _____ Date of last visit: _____

Other health care providers: _____ Phone#: _____ Date of last visit: _____

_____ Phone#: _____ Date of last visit: _____

_____ Phone#: _____ Date of last visit: _____

Please list any prescription medications you are taking:

Medication	Dose/Frequency	Reason	Date began	Prescribing physician
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you been in psychotherapy? _____ If yes, with whom: _____ When: _____

Concerns addressed: _____

Was it helpful? _____

Referred by: _____

In case of an emergency, whom would you like notified?

Name _____ Relationship to you: _____ Phone#: _____

Address: _____

List persons living in your home:

Name	Age	Relationship to you	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

In an average week, how often do you use:

Alcohol _____ how much _____

Marijuana _____ how much _____

Other _____ how much _____

Other _____ how much _____

Other _____ how much _____

Does a family member or anyone you are living with have an alcohol or drug problem? _____
Is there verbal or physical violence of any kind in your home? _____
Are you having any thoughts of hurting yourself or another? _____
Have you had any self-harming thoughts, plans, or attempts in the past? _____ When? _____
Have you ever been hospitalized? _____ When? _____ For what purpose: _____
Have you been court ordered to pursue counseling? _____
Are there any issues not covered above which concern your situation? _____

Why are you seeking therapy at this time? _____

What do you hope to gain from therapy? _____

***If client is under the age of 18, please complete the following information:

School: _____ Grade: _____

Parent/guardian: _____ Birthdate: _____
Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell

Phone: _____ Occupation: _____

Relationship to child: _____

Parent/guardian: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell

Phone: _____ Occupation: _____

Relationship to child: _____

Custody Status: _____

NOTE: If separated or divorced, I will need a copy of the court document indicating your child's current custody status in order to provide treatment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have provided for you. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at **(805) 881-3136**.

If you have any questions about my Notice of Privacy Practices, please contact me at:
700 Mar Vista Dr, Los Osos, CA 93402 (805) 881-3136.

I acknowledge receipt of the *Notice of Privacy Practices* of **Thomas Stein, LMFT**.

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

**INABILITY TO OBTAIN
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES**

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my *Notice of Privacy Practices*, including:

However, because of

I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____ Date: _____