FAMILY THERAPY
CENTER OF BETHESDA
Child, Teen, Family & Individual Therapy

5654 Shields Drive
Bethesda, MD 20814
PH (240) 242-9030
EM admin@familytherapyllc.com

New Client Information: Co-parenting

Today's Date: _____

How did you hear about us? _____

Contact Information:

Name: _____ **Date of Birth**: _____

Gender: _____

Address: _____

Phone Numbers: Home _____ Work _____ Cell _____

Best number to reach you: _____ **Is it OK to leave messages at this number?** ☐ Yes ☐ No

Email: _____

Demographic Information:

Relationship Status: ☐ Single ☐ Dating ☐ Married ☐ Cohabitating ☐ Domestic Partnership
☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____

Name of co-parent: _____

Current living arrangements: _____

Is there a legal separation/custody agreement? ☐ Yes ☐ No * If yes, please provide a copy

Are there other professionals currently involved (i.e. attorneys, coaches, financial professionals)? ☐ Yes ☐ No

If yes, please provide their names:

_____

_____

Name and Birthdates of Children:

_____

_____

What is the current child schedule?

_____

Do you feel this schedule is working? ☐ Yes ☐ No

If no, why not? _____
_____

Health Information:

Name of Physician:_____ **Phone Number:**_____

Current Medications (if any): _____

Have you been treated by a therapist before? _____ Yes _____ No

If yes, please describe _____

Are you currently being treated by another therapist? _____ Yes _____ No

If yes, please describe _____

Have you ever received any psychiatric/psychological diagnosis? _____ Yes _____ No

FAMILY THERAPY
CENTER OF BETHESDA
Child, Teen, Family & Individual Therapy

5654 Shields Drive
Bethesda, MD 20814
PH (240) 242-9030
EM admin@familytherapyllc.com

If yes, what is the diagnosis, when was it given, and by whom? _____

Are there any concerns for the following (please take into account all those participating in therapy)?

Drugs/Alcohol: _____ Yes _____ No Describe (who? what?) _____
Legal Actions: _____ Yes _____ No Describe (who? what?) _____
Danger of abuse: _____ Yes _____ No Describe (who? what?) _____
Risk of suicide, or homicide? _____ Yes _____ No Describe (who? what?) _____

Therapy Information:

What is most concerning to you right now?

_____
_____
_____
_____

Do you have any concerns about your children?

_____
_____

What do you hope to result from the co-parenting work?

_____
_____
_____

Strengths

What activities to you enjoy?

_____
_____
_____

What supports to you have?

_____
_____
_____

FAMILY THERAPY
CENTER OF BETHESDA
Child, Teen, Family & Individual Therapy

5654 Shields Drive
Bethesda, MD 20814
PH (240) 242-9030
EM admin@familytherapyllc.com

Practice Policies

Our Philosophy of Therapy
As a Marriage and Family Therapists we specialize in working with individuals, couples, families, and groups. We approach therapy from a systemic perspective, meaning that we focus on the dynamics *between* people rather than solely on the individual. Our approach draws from a variety of tools including solution focused and cognitive behavioral techniques, play therapy, experiential exercises, and homework assignments in order to best achieve your personal goals. We view counseling as a vessel to help people find and capitalize on the strengths and skills they already possess as well as to develop and strengthen new skills and tools.

One of the key aspects of successful therapy is building a relationship between therapist and client that is defined by trust, honesty, and openness. Therefore, the beginning of therapy focuses on me getting to know you and working with you to better understand your problem/situation. As the problem becomes clear we can begin to develop goals which we will use to help guide our sessions. Sometimes as we achieve goals you may find that your goals may change or new goals may come to the forefront. Because of this, therapy may last a few sessions but may also last several months or years. Therapy ends when you feel that you have all of the tools to address future problem(s)/situation(s) successfully on your own.

As therapy is a collaborative process, you have the ability at any time to ask us to explain why we are requesting information or suggesting a new approach. We are always open to your questions and feedback. Below is a list of possible risks and benefits associated with therapy.

Possible Benefits
- A better ability to handle relationship, family, and other interpersonal issues.
- Increased self awareness.
- Increased understanding of family and personal goals and values.
- A healthy of emotional wounds inflicted in the past or present.
- Development of tools and healthy coping skills to assist you in managing future problems.
- Greater happiness and overall life satisfaction.
- Resolution of specific concerns brought to therapy.

Possible Risks
- Therapy can sometimes lead to individual decisions that can be disruptive for your self or family.
- Some health insurance companies will not cover the cost of therapy.
- The experiencing of intense and uncomfortable feelings as unpleasant events, relationship patterns, and other concerns are addressed.
- Therapy is not an exact science, so there is no guarantee as to the outcomes. Some people experience no improvement in their situation, and a few may think that things are worse after treatment.

Consent to Release and Exchange Information: At times it will be important for us to contact other professionals who are working with you or your child to ensure you are getting the best, most collaborative care possible. Such professionals may be psychiatrists, doctors, school teachers, or attorneys. We will always ask for written permission before contacting any of these professionals.

Case Consultation: In order to provide the best care possible and in accordance with customary professional behavior, we regularly consult with other experienced therapists regarding client issues. However, we do not reveal any identifying information about our clients during these consultations.

FAMILY THERAPY
CENTER OF BETHESDA
Child, Teen, Family & Individual Therapy

5654 Shields Drive
Bethesda, MD 20814
PH (240) 242-9030
EM admin@familytherapyllc.com

General Policies

Fees: Payment is expected in full at the time of service. Acceptable forms of payment are cash, check, or credit card. You are required to have a credit card on file in case of missed appointments or late cancelations. If your check is deposited with insufficient funds, you will be charged $35.00 to cover bank fees. If a check is returned by the bank more than two times during treatment, FTCB reserves the right to refuse any future checks and an alternative method of payment will be required. We do not bill insurance companies directly. However, we can provide you with a statement of services for you to submit to your insurance company. Session and other fees are as follows:

- 50 minute therapy hour: $175.00
- 90 minute therapy hour: $310.00
- Fees for additional services, including, but are not limited to, consultation with other professionals, school meetings, preparation of reports or correspondence, any necessary court appearances, and phone conversations lasting over 15 minutes will be charged at $175.00 an hour.
- Travel fees for school based services are $10/session for schools within 15 miles of my office. Any school outside that radius will incur a $15 travel fee/session.

Please note that if do not have a session for 90 days, your case will be moved to inactive status. If you choose to return, you will need to sign a new Policies & Procedures form and will be subject to any fee increases that occurred during your inactivity.

Cancellation Policy: The full fee for the session will be charged in the event of missed appointments or cancellations without 24 hours notice. In some instances, (i.e. true emergencies or circumstances clearly beyond your control), and at our discretion, the charge may be waived.

If you do not contact your therapist and/or your therapist is unable to reach you to schedule future appointments, a letter will be sent informing you that your case is in danger of being closed. If you do not respond, your case will be closed on the date listed in the letter.

Legal Proceedings: It is the mission of FTCB to provide clients with a safe and confidential space in which to work towards their goals. While we am aware that some clients may be involved in or may become involved in various legal proceedings, it is our belief that therapist involvement can be detrimental to the therapeutic relationship and thus a client's ultimate personal and relationship goals. As such, to contain our costs and remain focused on the primary therapeutic goals, it is our longstanding policy and practice not to complete character references or offer court testimony of any kind. To clarify, we will write a case summary of a client's attendance and progress in therapy for him/her to take to court, however, we will not appear voluntarily for a legal proceeding. If we are subpoenaed, despite the policy, the cost of such services is $500/hour per person subpoenaed.

Contact Information: The practice phone number is (240) 600-0968. We will return calls in a timely manner, between 8 a.m. and 6 p.m. Monday-Friday. We will return weekend calls on Monday, unless Monday is a holiday. The practice email is info@familytherapyllc.com.

Email and Phone Policy: To be in complete accordance with HIPPA regulations and to provide you with the greatest level of security for your confidentiality, we use email only for scheduling and clarifying appointment dates and times (or other administrative business). Should you need to speak with your therapist about clinical issues related to therapy, please call and your therapist will be happy to speak with you. Phone conversations lasting over 15 minutes will incur a charge of $175.00 an hour. If family or couple issues arise over the week, please write them down and save them for your next family/couple session. This is optimal to keep the therapeutic relationship balanced, fair, and secret free for participating members and prevents me from acting as a mediator over the phone.

Emergencies: Our aim is to be available for you if an emergency should arise. However, there are times when we may not be available to assist you. If you are in need of immediate attention, do not wait for your therapist to get back to you before

5654 Shields Drive
Bethesda, MD 20814
PH (240) 242-9030
EM admin@familytherapyllc.com

taking action. **Please call 911 or the 24-hour hot line at the Montgomery County Crisis Center, (240) 777-4000 or go to the nearest emergency room.**

Termination and Document Retention: The goal of therapeutic work is to give you the strength and tools necessary to handle difficult and challenging situations on your own in the future. When your goals are met and you feel comfortable and confident in your skills you and your therapist will talk about termination. It is important that there be adequate time given before fully terminating to bring closure to the therapeutic relationship and to review and reinforce the skills learned during our time together. In most cases we recommend first decreasing the frequency of sessions for a few weeks and then having at least 1 termination session. You are welcome to return to therapy at any point in the future, even if you case has been closed.

Documents related to cases are kept for seven years or, if the client is a minor, until a minor child is seven years past the age of 18, as required by law. At that time, all records are destroyed by shredding to protect your confidentiality.

I understand that Family Therapy Center of Bethesda, LLC therapist, _____, will provide professional services to:
Client name(s): _____

My signature below affirms my informed and voluntary consent to enter therapy (and/or have my child/ren enter therapy). I affirm that prior to becoming a client of Family Therapy Center of Bethesda, LLC I was given sufficient information to understand the nature of therapy, including the possible risks and benefits, and also the nature of confidentiality. I understand FTCB office policies and procedures and cancellation policy. I have had an opportunity to ask questions and have had my questions answered satisfactorily. I understand that I can ask questions and raise concerns about the treatment any time during therapy.

_____	_____	_____
Name (Please Print)	Signature	Date
_____	_____	_____
Name (Please Print)	Signature	Date
_____	_____	_____
Name (Please Print)	Signature	Date
_____	_____	_____
Name (Please Print)	Signature	Date

FAMILY THERAPY
CENTER OF BETHESDA
Child, Teen, Family & Individual Therapy

5654 Shields Drive
Bethesda, MD 20814
PH (240) 242-9030
EM admin@familytherapyllc.com

Confidentiality

1. As your therapist I strive to provide you with a safe place in which you can openly explore very personal and difficult issues. I am committed to guarding your right to privacy, within the limits of the law. There are issues surrounding confidentiality of which you should be aware.
2. There are certain situations in which a **therapist is required by law to disclose information** obtained during therapy. Disclosure is required by law in the following circumstances:
    a. A reasonable suspicion of abuse/neglect of a child or vulnerable adult. A report will be made to appropriate protective agencies.
    b. When you threaten grave bodily harm to others. As a therapist, I have a duty to warn those you have threatened.
    c. When you are suicidal or threaten significant bodily harm to yourself. I have a duty to obtain help from others such as family members or other professionals to do what is necessary to keep you safe.
    d. When a court of law issues a legitimate court order (signed by a judge).
    e. When you are in a probation or parole period or other legal situation that would require disclosure.
3. Except in the above circumstances, I will release information about you only if you provide a written request. Releases of information for families/couples in therapy required the written permission of every member of the family/couple in treatment able to execute a waiver.
4. We live in a small community. As a result, there may be times that I may run into you in the community. My number one priority is to maintain your confidentiality. Due to this, I will not initiate a conversation with you or acknowledge that I know you. It is your decision whether you want to acknowledge and/or approach me. Please know that if you choose not to acknowledge me, I will not take any offense.
5. Clients under the age of 18 are considered minors and therefore all therapy contracts must be signed by their custodial parent(s) or legal guardian(s). Therefore, custodial parent(s) and/or legal guardian(s) have a right to information discussed during sessions, particularly information pertaining to the minor's safety. However, parent(s) and guardian(s) should be aware that part of the therapeutic process that allows individuals to be open and honest is developing trust and maintaining confidentiality. If parents frequently obtain and use information shared in their child's session with the therapist, the child may not feel safe continuing with therapy in an open and honest way. Therefore, exercising this right to information with discretion is advised. Please know, however, that any time I feel that there is information that is pertinent for a parent/guardian to know, I will share it openly and immediately.
6. There are special confidentiality concerns for families and couples in treatment.
    a. I view the family or couple as a "treatment unit."
    b. There are times when I may see the whole treatment unit and times when I may see parts and/or individuals. Please be aware that I will not reveal any individual's confidences to others in the treatment unit without that person's permission.
    c. It is, however, important for you to be aware that secrets shared individually are generally not healthy for you or for your family and may be causing some of the presenting problems in treatment. Therefore, if an individual member or subset of the treatment unit discloses a secret that has significant bearing on the other members of the unit, I will encourage the person(s) to share this information with the other member(s). I will work with and support the individual(s) in finding healthy and safe ways to disclose this information to the other participating member(s).
    d. Should someone reveal a secret to me that puts me in a position that compromises my honest relationship with the others in the treatment unit and refuses to disclose this secret to other participating member(s), treatment will be terminated.

I affirm that I have read about the nature of confidentiality in therapy set forth above. I have had an opportunity to ask questions and have had my questions answered satisfactorily.

_____	_____	_____
Name (Please Print)	Signature	Date
_____	_____	_____
Name (Please Print)	Signature	Date

FAMILY THERAPY
CENTER OF BETHESDA
Child, Teen, Family & Individual Therapy

5654 Shields Drive
Bethesda, MD 20814
PH (240) 242-9030
EM admin@familytherapyllc.com

Name (Please Print) _____ Signature _____ Date _____

Electronic Communication Policy

Email and texting often offers an easy and convenient way for therapists and clients to communicate, but they can also introduce unique confidentiality challenges. At Family Therapy Center of Bethesda, LLC (FTCB), we are dedicated to protecting your privacy. Below are some guidelines for contacting your FTCB therapist using email or text.

- We prefer only to use email to arrange or modify appointments. Please know that if you choose to email content related to your therapy sessions, the information is not completely secure or confidential. If you wish to use email for more detailed communication, please know that your therapist will remind you of this policy in writing and reserves the right to not respond via email or text but instead contact you by phone to discuss.
- For emergencies, please go to an emergency room. Do not use email or text for emergencies.
- Email and texting is not a substitute for seeing your therapist. If you think you might need to be seen, please call and schedule an appointment.
- Emails and texts should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- Email and texting is not confidential. Be aware that if you send emails from work or texts from a work phone, your employer has a legal right to read the content.
- Emails and texts are part of your legal record; a copy will be put in your file.
- Either you or your therapist can revoke permission to use email or texting at any time.
- Please note that like phone calls, emails and texts will be responded to within normal business hours. Any emails or texts sent after hours or over the weekend will be responded to on the next business day.

Please initial below:

_____ I have read the above information and understand the limitations of electronic communication. I understand that my therapist at FTCB may not be able to communicate with me electronically about my specific issue if there are concerns regarding confidentiality. I also understand that if I choose to communicate personal therapy-related content via email or text, I alone assume all potential risks regarding confidentiality.

Please mark your choice(s) regarding how we handle electronic communications with you:

_____ It is permissible for my therapist at FTCB to contact me via email regarding scheduling.
_____ It is permissible for my therapist at FTCB to contact me via text regarding scheduling.
_____ It is not permissible for my therapist at FTCB to contact me via email.
_____ It is not permissible for my therapist at FTCB to contact me via text.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date

FAMILY THERAPY
CENTER OF BETHESDA
Child, Teen, Family & Individual Therapy

5654 Shields Drive
Bethesda, MD 20814
PH (240) 242-9030
EM admin@familytherapyllc.com

Electronic Payment Authorization

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: Cash, Check, Visa, MasterCard and Discover.

Payment Source: ☐ **Credit Card** ☐ **Check** ☐ **Cash**

Client Information:

Client Name: _____ Date of Birth: _____

Cardholder Information (if different from above):

If using credit card, please indicate the name and address associated with the credit or debit card you wish to use.

Name: _____

Address: _____ City_____ State: _____ Zip: _____

Email: _____

I authorize any service fees to be deducted from the credit or debit card ending in _____ (provide the last four digits of the card).

_____ _____
Cardholder Signature Date

Credit/Debit Card Information:

If using credit card, please provide your payment information below. The debit or credit card information you provide on this form will be shredded once your first payment has been made.

Card Type (circle one): Visa MasterCard Discover

Card Number: _____

Expiration Date: _____ CVV: _____

FAMILY THERAPY
CENTER OF BETHESDA
Child, Teen, Family & Individual Therapy

5654 Shields Drive
Bethesda, MD 20814
PH (240) 242-9030
EM admin@familytherapyllc.com

Newsletter

Want to get great resources for you, your kids, and your family right to your inbox each month?!? Family Therapy Center of Bethesda now offers a free monthly newsletter! Sign up today to receive the following great resources each month:

- Book recommendations
- Community events
- Blog
- Parenting tips
- Therapist Q&A

Please initial below to indicate your preference. Feel free to cancel your subscription anytime.

_____ Sign me up!
_____ No thanks, I'll pass

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date