Lisa Montalvo, MFT, CEAP, SAP
1395 San Carlos Avenue, Suite C#4
San Carlos, California 94070
(650) 631-0909
www.BayAreaCounselingService.com

Date _____/_____/_____

Patient Information:

Child's Name_____

Address_____

City_____State_____Zip_____

Birth Date ____/_____/_____ Age_____

Child Social Security Number_____

Name of those living in household	Relation to patient	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/ Guardian Information:

Name of person completing form_____ Relationship_____

Check one: □Married □Divorced □Separated □Unmarried

If divorced, who has legal custody? _____

Mother's name_____ Address_____
Home Phone_____ Work Phone_____

Father's Name_____ Address_____
Home Phone_____ Work Phone_____

Guardian's name, if different_____

Health Insurance Information:

Name of Insured (name on insurance card) _____

Social Security Number of Insured_____

Company_____Plan Name_____

Group or Policy Number _____

Address_____City_____State_____Zip_____ Phone_____/_____/_____

How were you referred?_____

Have you had previous counseling?____ With Whom?_____When_____

Briefly describe the difficulties for which you are seeking help:

Medical History Questionnaire

Current Health On a scale of 1 (very poor) to 10 (excellent) how would you rate your present health?

(Circle one) 1 2 3 4 5 6 7 8 9 10

Who is the child/adolescent's pediatrician:

_____

What prescription medications are he/she currently taking and why?

_____ _____ _____

What non-prescription medications are he/she currently taking and why?

_____ _____ _____

Is there any suspected alcohol/drug consumption:

What kind_____

How frequently_____

How much_____

Has it changed recently? _____

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Client Agreement Form for a Minor

Fee Payment My fee is $180.00 per session, per agreement, and appointments are 50 minutes in length. Payment is requested at the beginning or end of each session.

Cancellations I will make every effort to accommodate your scheduling needs. In return I ask that you help out by keeping your scheduled appointment, and by notifying me in advance if you are unable to do so. With advance notice, I am often able to accommodate other clients that are waiting to get an appointment.
ALL APPOINTMENTS THAT ARE CANCELLED WITH LESS THAN 48 HOURS ADVANCE NOTICE ARE SUBJECT TO A MISSED APPOINTMENT FEE. 48 hour cancellation policy is Monday – Friday during business hours. Please note that this is NOT covered by insurance/ EAP companies. It is the client's responsibility.

If you fail to arrive for your appointment without 48 hour advance notification, you will be charged the full hourly rate which is $180.00. This fee is due and payable at your next appointment.

Insurance For clients who participate in a qualified insurance or EAP plan, applicable co-payments and deductibles will be collected during the scheduled appointment. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event my insurance plan fails to reimburse, I agree to pay all costs accrued.

Assignment of benefits I hereby authorize Lisa Montalvo, MFT, CEAP, SAP to release any information required to process my mental health claims, and I also give authorization for direct payment of mental health claims reimbursement to Lisa Montalvo, MFT, CEAP, SAP.

Acknowledgement of receipt of Notice of Privacy Practices I hereby acknowledge that I have received a copy Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available upon request, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Confidentiality All communications between the therapist and client in the therapeutic sessions are privileged and confidential with the following exceptions mandated by law:

- If there is reasonable cause to believe there is a clear and imminent danger to another person or persons.
- If there is a reasonable cause to believe that the client is in danger to himself/herself.
- If there is reasonable cause to believe there is child, elder or dependent adult abuse.

Consent to Treatment Most people who participate in behavioral or mental health treatment benefit from it. Like most kinds of healthcare, this kind of treatment requires a very active effort on the individuals part. In addition, there may be certain kinds of risks involved. For example, the counseling process can be challenging and sometimes may involve experiencing some uncomfortable feelings, or engaging in difficult interactions, or facing difficult aspects of your life. Nevertheless, most people find the benefits outweigh any such risks.
It is important that the individual participates in this treatment willingly. If you have any questions or concerns about this document, about the services being provided, or about the treatment options, please feel free to ask questions.

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

By signing this agreement, I acknowledge that the patient is a minor, and I am the parent or legal guardian, and I have read this agreement, understood its terms, agree to be subject to its provisions, and voluntarily agree to the minor's participation in the treatment.

Signature of Parent or Legal Guardian **Date**

_____ _____

In circumstances where parents are divorced or separated, it is important that both parents are in agreement to the child's treatment. Therefore, the document entitled "**Confidentiality and Consent to Treatment of a Minor**" requires the signature of the parent or legal guardian to ensure that he or she is aware that their child is in counseling.

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