



## Personal History

(This information will be held in strict confidence)

- Instruction   
  Counseling   
  Full Assessment   
  Primary Assessment  
 Gate Assessment   
  AD/HD Assessment   
  Dyslexia Assessment   
  Advocacy

Client's Name		Birth Date	Today's Date
Address		City	Zip
Grade:	School:	Teacher:	School Phone#
*What phone number can we contact you at, and can we leave a message? Yes / No			Phone #
Would you like to be on our mailing list? Yes / No			
Would you like to receive our e-newsletter? Yes / No		e-mail address:	
How did you hear about us?			

Parent or Guardian's Name		Who to notify in an emergency other than the parent	
Address		Address	
City/State	Zip	City/State	Zip
Phone #	e-mail:	Phone #	Relationship

**Payment Policy:** Payment is required at time of service (unless a payment plan has been arranged in advance of receiving service.)

**Appointment Policy:** **24 hour notice is required for appointment cancellation.**

Failure to keep an appointment without prior notice will result in a full service charge

Who will pay this account? Mailing Address:

Phone # e-mail:

Please indicate how payments will be made: Cash \_\_\_\_\_ Check \_\_\_\_\_ Visa/Mastercard \_\_\_\_\_

(Card # \_\_\_\_\_) Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Security Code \_\_\_\_\_

Signature of Cardholder:

Signature of responsible party, client, parent/guardian: Date:

☞ **Financial Assistance Requested:** Yes \_\_\_\_\_ No \_\_\_\_\_ (If **yes**, please request a financial aid packet.)

☞ **Primary Language Spoken in the Home:** English \_\_\_\_\_ Spanish \_\_\_\_\_ Filipino \_\_\_\_\_ Chinese \_\_\_\_\_ Other \_\_\_\_\_

☞ **Ethnicity:** Caucasian \_\_\_\_\_ Latino \_\_\_\_\_ African American \_\_\_\_\_ Asian \_\_\_\_\_ Other \_\_\_\_\_

☞ **Family Information:**

Parents: Two Parent Family \_\_\_\_\_ Divorced/Separated \_\_\_\_\_ Single \_\_\_\_\_ Mother Deceased \_\_\_\_\_  
 Father Deceased \_\_\_\_\_ Child: # of Siblings \_\_\_\_\_ **Total # in Family** \_\_\_\_\_

☞ **Gross Family Income:**

A. \$16,000 or under \_\_\_\_\_ B. \$16,000 - \$22,000 \_\_\_\_\_ C. \$22,000 - \$30,000 \_\_\_\_\_ D. \$30,000-\$40,000 \_\_\_\_\_  
 E. \$40,000 - \$55,000 \_\_\_\_\_ F. \$55,000 - \$70,000 \_\_\_\_\_ G. \$70,000 or above \_\_\_\_\_

cc: admin. \_\_\_\_\_ acctg. \_\_\_\_\_ dept. \_\_\_\_\_



**OFFICE POLICIES & GENERAL INFORMATION AGREEMENT FOR COUNSELING SERVICES**

**HOURS & AVAILABILITY OF APPOINTMENTS:** Mercy Education Resource Center (Mercy Ed.) is open Monday through Thursday 8:30 – 5:30 p.m. We are not a walk in clinic and only accept scheduled appointments. If you are interested in an evening or Friday appointment, please communicate your needs to your therapist and they will do their best to meet your request.

**CONFIDENTIALITY:** All communications made in session will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with requested items and prohibits the therapist from disclosing to the client that the FBI sought or obtained the items.

- Minors and Confidentiality:** Communications between therapists and clients who are minors (under the age of 18) *are confidential*. However, parents and other guardians who provide authorization for their child's treatment are encouraged to be involved in their treatment. Consequently, your child's therapist may discuss the *treatment progress* of a minor client with the parent or caretaker, but not details that would decrease trust between the minor and the therapist. Clients, who are minors, and their parents, are urged to discuss any questions or concerns that they have on this topic with their child's therapist.
- Emergencies:** If there is an emergency during treatment or after termination where your therapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, your therapist will do whatever they can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, they may also contact the person whose name you have provided on the Personal History sheet for emergency purposes.
- Health Insurance & confidentiality of records:** Mercy Ed. does not currently accept or bill insurance companies for treatment with interns or trainees, except for Victim Witness. We are willing to assist you in obtaining insurance reimbursement. It is the client's sole responsibility for obtaining reimbursement. We cannot guarantee your insurance carrier will cover the services we provide, based either on the fact that our therapist are unlicensed or you are not "covered" with our Counseling Center.
- Confidentiality of E-Mail communication:** It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular are vulnerable to such unauthorized access due to the fact that our server has unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify your Mercy Ed. therapist if you decide to avoid or limit in any way the use of any or all of the above mentioned communication devices. Please do not use e-mail or Faxes for emergencies.

- ❑ **Litigation Limitation:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney's, nor anyone else acting on your behalf will call on a Mercy Ed. therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. It is our policy to not write letters on behalf of our clients.
- ❑ **Consultation:** Mercy Ed. Therapists consult regularly with other professionals regarding his/her clients; however, client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.
- ❑ **Your Right to Review Records:** Both law and the standards of my profession require that we keep appropriate treatment records. As a client, you have the right to receive a summary of your records at any time, except in limited legal or emergency circumstances or when your Mercy Ed. Therapist assesses that releasing such information might be harmful in any way. In such a case your therapist will provide the summary to an appropriate and legitimate mental health professional of your choice.

Considering all of the above exclusions, if it is still appropriate, upon your request, your therapist will release information to any agency/person you specify unless your therapist assesses that releasing such information might be harmful in any way.

**TELEPHONE & EMERGENCY PROCEDURES:** If you need to contact your therapist between sessions, please leave a message in their voice mail (916) 737-6026 and your call will be returned as soon as possible. If you have tried to reach your therapist and have not had a response, within in 24 hours (except for [Holidays and](#) weekends), please call back and ask to speak with the Clinical Coordinator of Counseling Services. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, you can call the Police (911).

**PAYMENTS & INSURANCE REIMBURSEMENT:** Clients are expected to pay the standard fee of **\$85** per 50 minute session at the beginning of each session, unless other financial arrangements have been made with the Director or Accountant. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please notify your therapist if any problem arises during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance company. Unless agreed upon differently, your therapist can provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose.

**THE PROCESS OF THERAPY/EVALUATION:** Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits; however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Your therapist will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation.

Your therapist will discuss with you their understanding of the problem, treatment plan, therapeutic objectives and their view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, the possible risks, or your therapist expertise in employing them, please ask. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that we do not provide, we have an ethical obligation to assist you in obtaining those treatments.

**Termination:** The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination in collaboration with your therapist. They will discuss a plan for termination with you as you approach the completion of your treatment goals.

**Initial** \_\_\_\_\_ **Date** \_\_\_\_\_

You may discontinue therapy at any time. If you or your therapist determine that you are not benefiting from treatment, either you or your therapist may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

- Financial Aid:** If you are receiving financial aid and are limited to a certain number of sessions, it is important that you are aware of when your financial aid ends. Your therapist will also alert you a month prior to when your financial aid is up. At that time, you have the option to, reapply for financial aid by bringing in the required documents, begin paying the regular rate of \$85 per session, or end treatment with your therapist. If you decide to end therapy with your Mercy Ed. therapist, yet still desire to continue in therapy, we will provide you with referrals.

**CANCELLATION POLICY:** A minimum of 24 hours (1 full day) notice is required for re-scheduling or canceling an appointment. If you are cancelling a Monday session it is important that you cancel by Thursday evening due to our office hours and Mercy Ed. is not regularly open on Fridays. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

**I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them:**

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Client name (print)	Date	Signature
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Client name (print)	Date	Signature
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Therapist (print)	Date	Signature
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**Initial** \_\_\_\_\_ **Date** \_\_\_\_\_



**Client Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Single  Married  Divorced  Widowed  Live with someone – name: \_\_\_\_\_ years: \_\_\_\_  
Occupation: \_\_\_\_\_ Religious preference: \_\_\_\_\_

Others living in the home:

\_\_\_\_\_  
Age: \_\_\_\_\_  
\_\_\_\_\_  
Age: \_\_\_\_\_  
\_\_\_\_\_  
Age: \_\_\_\_\_  
\_\_\_\_\_  
Age: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Date of last physical: \_\_\_\_\_

Relevant medical conditions (history, current condition, changes in condition): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications (dosage, dates of initial prescriptions, name of prescribing professional): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

History of counseling, psychiatric hospitalizations, alcohol or other drug problems: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies/adverse reactions to treatment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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**Please answer the following questions as thoroughly and as accurately as possible.**

Reason for seeking counseling today: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long has this been a concern? \_\_\_\_\_

\_\_\_\_\_

What have you tried so far? \_\_\_\_\_

\_\_\_\_\_

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Do you now have, or have you ever had: (circle the appropriate answer)

Fainting spells	no	now	past	Loss of consciousness	no	now	past
Convulsions	no	now	past	Dizziness	no	now	past
Frequent headaches	no	now	past	Depression/anxiety	no	now	past
Difficulty concentrating	no	now	past	Extreme tiredness	no	now	past
Hallucinations	no	now	past	Chest pains	no	now	past
Shortness of breath	no	now	past	Night sweats	no	now	past
Palpitations	no	now	past	Fluttering heart	no	now	past
Abnormal thirst	no	now	past	Indigestion	no	now	past
Stomach trouble/ulcer	no	now	past	Swollen feet/ankles	no	now	past
Memory problems	no	now	past	Paralysis	no	now	past
Impaired hearing	no	now	past	Impaired eyesight	no	now	past

Please use the rest of the form to tell me any other information that you think I may need to know:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Authorization to Release Confidential Information**

I, \_\_\_\_\_ hereby authorize for Mercy Education Resource Center to release and exchange confidential information, including but not limited to history, functioning, symptoms, diagnoses, treatment, prognoses, etc., for the purpose of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The release and exchange of mental health information between:

Mercy Education Resource Center  
6007 Folsom Blvd. Ste. 200  
Sacramento, Ca 95819

AND

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid until the end of treatment, unless revoked in writing and received by Mercy Education Resource Center.

A fax or photocopy of this release is to be considered as valid as the original.

Client's signature \_\_\_\_\_ Date: \_\_\_\_\_

Caregiver's signature \_\_\_\_\_ Date: \_\_\_\_\_

Therapist's signature \_\_\_\_\_ Date: \_\_\_\_\_

Copy given to:  Client  Other party  Parent/Guardian  Representative  Copy kept by therapist



# Mercy Education Resource Center | Maximizing Potential

## CHILD & ADOLESCENT CONSENT FORM

If you are under eighteen years of age, please be aware that the law may give your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. It is my policy to request a written agreement from your parents or guardians indicating that they consent to give up access to such information and/or to your records. If they agree, I will provide them only with general information about our work together subject to your approval, or, if I feel it is important for them to know in order to make sure that you and people around you are safe. If I think it is appropriate, I will involve them if I feel that there is a high risk that you will seriously harm yourself or another/others. Before giving them any verbal or written information, I will discuss the matter with you, if possible. I will do the best I can to resolve any differences that you and I may have about what I am prepared to discuss.

I, \_\_\_\_\_ give my permission to Mercy Education Resource Center to see my son/daughter \_\_\_\_\_ for counseling.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date