CLIENT INFORMATION
MINOR

Date:_____

Counselor:_____

Name:_____

Phone (Home):_____ Phone (Cell):_____

Email:_____ DOB:_____Age:_____

If we call, may we identify ourselves as being from Anew Day? Yes: ☐ No: ☐

Home Address:_____City/State/Zip:_____

Mailing Address (If different):_____

School:_____ Grade:_____

Parent/Legal Guardian Name:_____Phone:_____

Household:

(Include Step) Name	Age	Name	Age
Name	Age	Name	Age
Name	Age	Name	Age

Family Physician:_____

Name Address Phone

Are you currently under medical treatment?_____

Current medication/drug use:_____

Who referred you to Anew Day? (If local church please name)_____

Are you currently receiving counseling elsewhere?_____(Y/N)

If yes, with whom:_____

Have you ever had thoughts of harming yourself?_____(Y/N)

Briefly explain why you are here today:_____

_____

_____

STATUS NOTIFICATION

Date:_____

Counselor:_____

Client Number:_____

I understand and acknowledge that _____ has informed me of his/her status as a MFT/PCC trainee or registered MFT/PCC Associate with the State of California of Behavioral Science and that he/she is receiving weekly supervision by a Licensed Marriage and Family Therapist.

Date:_____

Client Name:_____

Signature:_____

Date:_____

Client Name:_____

Signature:_____

FEE AGREEMENT

Date:_____

Counselor:_____

Client Number:_____

The sliding scale fees for service provided by a Registered MFT/PCC Associate or MFT/PCC Trainee are per 50 minute session and are to be paid at the beginning of each appointment. Associates do not carry change so if you intend to pay in cash, please bring the exact amount. Anew Day does not carry balances due. Please be prepared to pay at the time of service. All checks are to be made payable to Anew Day. Cash, debit and credit cards are accepted. All cards will be run as credit.

There is a 24 hour cancellation policy. If you have an appointment and cannot make your appointment, please cancel 24 hours before you are scheduled. If you cancel within 24 hours of your session, or fail to attend your session without the 24 hour notice, you are required to pay your full session fee for the missed appointment.

By signing this form, I, _____ agree to pay $_____per 50 minute session and I also agree to the above terms.

Date:_____

Name:_____

Signature:_____

RULES OF CONFIDENTIALITY

Date:_____

Counselor:_____

Client Number:_____

According to California State Law, all information regarding counseling sessions is confidential between the therapist and the client(s) who are present in the session, except for the following:

1.) If the therapist has information which leads her/him to suspect:

   A. Child Abuse
   B. Elder Abuse
   C. Intent to harm self or others
   D. Is a danger to self, or others, or property
   E. Inability to take care of self

   In such situations, the therapist is legally obligated to report all information to the proper authorities (CPS, the Sheriff, Police, etc.) or to warn the intended victim.

2.) If the client(s) sign a written release of information to a particular person or agency.

3.) If there is any court subpoenas issued to the counselor, the counselor has to respond to the subpoena but will not release information without a direct order from the court.

I have read and understand this form.

Client Name_____

Client Signature:_____Date_____

Client Name_____

Client Signature:_____Date_____

CONSENT TO TREAT

Date:_____

Counselor:_____

Client Number:_____

I_____ give consent to _____,

Registered MFT/PCC Associate or MFT/PCC Trainee to administer therapeutic services to me and/or my minor children. I have been informed of all financial and privacy information and requirements.

Name of Minors:

_____ _____

_____ _____

_____ _____

Client Name:_____Date_____

Signature:_____

(Signature of Client/Parent or Guardian)