Steven Herbert, MS, MFT
Center for Marital & Personal Therapy
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CLIENT INFORMATION SHEET

CLIENT INFORMATION

First Name ________________________ Last Name ____________________________
Address ________________________________ City __________________ Zip _______
Home Phone _________________ Work _______________ Cell _________________
Please indicate where you prefer to receive calls. Home ____ Work ____ Cell ____
Email ____ (print clearly)
Employer ___________________________ Address _____________________________
SS# _________________ Birthdate ________ Age ____ Occupation ______________
Marital Status: Single __ Married ___ (# years) Separated __ Divorced __ Widowed __

SPOUSE INFORMATION

Name ____________________________ Birthdate ________ SS# _________________
Employer ___________________________ Address _____________________________
Work Phone _______________ Cell _________________ Occupation _____________
Other Household Members ____
____

RESPONSIBLE PARTY

NAME ______________________________ PHONE # _______________________________

Referred by ____________________________ Family Physician ________________________
Reason for my visit ____
In case of emergency, please notify: ____
Relationship ____________________________ Phone _______________________________

I give permission to Steven Herbert to send emails to me that do not contain my personal information. I authorize all benefits to be paid directly to Steven Herbert, MS, LMFT. I understand that I am fully responsible for all expenses associated with my therapy services, including appointments not cancelled 24 hours in advance.

SIGNATURE ____ DATE ____________________

CONSENT TO TREATMENT & CLIENT CONTRACT

Welcome to my practice. Please read the following policies. If you have any questions or concerns, clean discuss them with me before signing below.

1. GENERAL COUNSELING SERVICES

   Therapy services vary depending on the personalities of the therapist and client, and the particular concerns you bring forward. Services will include evaluation and history taking, assessments when recommended, record keeping, treatment plan, and in-office consultations.

   Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, and frustration. On the other hand, counseling has also been shown to have benefits and often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience, although my clients generally report positive outcomes.

   I usually schedule one 50-minute session per week at a time we agree on. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24-hour advance notice of cancellation. If it is possible, I will try to find another time to reschedule the appointment.

2. ABOUT ME

   I am a Licensed Marriage and Family Therapist in the State of Nevada. Marriage and Family Therapists are licensed to diagnose and treat mental health issues in addition to having extra training in providing couples and family therapy. I attended graduate school at the Our Lady of the Lake University in San Antonio, TX. I am a resident of Las Vegas, Nevada.

3. CONTACTING ME

   I will make every effort to answer or return your call the same day you make it, with the exception of weekends and holidays. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my internet service providers. While it is unlikely that someone will be looking at these logs, they are available to be read by system administrator(s) of the internet service providers and I otherwise cannot guarantee the confidentiality of non-encrypted e-mailed communication.

4. EMERGENCIES

If your issue is an emergency and you feel you or somebody else may be in imminent danger of harm, please call 911 or go to the nearest emergency room.

4. CONFIDENTIALITY

The law protects the privacy of communications between a therapist and client. The information you share during consultation is confidential and will not be revealed to anyone without your express written permission.

There are some situations in which I am legally obligated to take action, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a client's treatment. These situations are unusual in my practice:

a. Suspected or known child abuse/neglect,
b. Suspected or known elder abuse/neglect, exploitation or isolation,
c. Risk of imminent serious harm to another or yourself.

If such situation arises, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to what is necessary.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

a. Court order for information about your psychotherapy if you are involved in litigation (consult with your attorney if you are involved in or contemplating litigation)
b. Government agency requesting information for health oversight activities.
c. If a client files a complaint or lawsuit against me, I may disclose information about that client in order to defend myself.
d. Small claims court for breach of contract if the client does not play his or her bill.
e. Filing of an insurance claim requires I reveal a client's clinical diagnosis, other clinical information such as treatment plans or summaries, or copies of your entire clinical record.
f. If the client is a minor the parents have right to information and the clinical record.
g. Licensed therapists are allowed to discuss cases with other licensed therapists where disclosure is to help in the diagnosis or treatment of a client. When I consult with a colleague regarding a case, I do not provide identifying information (client name) and my colleague is also bound by confidentiality regulations.

In order to protect the confidentiality, in the event that I see my client(s) in public, I will not engage in conversation or acknowledge our association unless the client(s) approach me first. Further, if clients do approach me or acknowledge our association, they accept the possibility that my nearby friends/family will become aware of their client status.

** Couples Counseling: I will not keep secrets from your partner. Although I may meet with you individually at times, those are not times to share information with me you don't want your partner to know. Involving me in withholding information from your partner would result in ineffective couples counseling.

3. BILLING AND PAYMENTS

- Successful treatment depends on your attendance at each scheduled session.

- A typical session lasts 50 minutes. Clients can also choose to schedule extended sessions. A session and a half is 75 minutes (not 90 minutes).

- The hourly rate for one 50-minute session is $160, or promotional rate of _____. Payment must be received at the time of service. I also accept cash and personal checks.

- **Cancellation Policy:** If you are sick or are unable to attend your scheduled session, please notify me as soon as possible so I can adjust my schedule and reschedule you for another time. **Clients who cancel less than 24 hours prior to their scheduled appointment will be charged the full session fee.** ______ **Initial**

- You have a responsibility to pay for any services you receive before you terminate services. Fees accrued must be received on or before the next scheduled appointment. Further appointments will not be scheduled until a zero balance is obtained.

- I do not participate in any court-related services for clients, including depositions, hearings, consultations with lawyers, or attendance at courtroom proceedings. I ask that you respect the integrity of the therapeutic process and refrain from asking for my participation. ______ **Initial**

- In the event that a client requires the therapist's testimony or involvement in legal or court proceedings, client consent will be required. Court appearances, either requested or subpoenaed, as well as depositions and settlement conferences, are billed at an hourly rate of $200. This rate will be charged at a minimum of four hours which includes time spent on preparation, travel, waiting, and testimony. These charges are the sole responsibility of the client. Because it is often difficult to accurately determine the needed time to appear in court, there is a need for the therapist to clear the day's entire appointment schedule. Such scheduling makes it necessary to charge in this manner. ______ **Initial**

I give permission to Steven Herbert to evaluate my case and provide treatment. I have read the office practices and policies and have had any questions answered about these policies. I understand and agree to the policies described above. I further understand that any psychotherapy has risks and benefits, but that these cannot be fully described here in anticipation of a potential for treatment.

Client(s) Signature **Date**

ELECTRONIC COMMUNICATION POLICY

E-mail and text messaging offer easy and convenient ways for the therapist and client to communicate. However, both have inherent disadvantages and risks. Below are some guidelines for communication via e-mail and text messaging.

- E-mail and texting are **NEVER** appropriate for urgent or emergency problems. Please use the telephone or call 911 for life threatening emergencies.
- E-mail and texting are great for asking those little questions that do not require a lot of discussion, appointment requests, and notifications.
- E-mails or texts should not be used to communicate sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health information, etc.
- E-mail and texting are not confidential. You should also know that if you are sending e-mails from work, your employer has a legal right to read your e-mail if he or she chooses.
- E-mail and texting are not a substitute for seeing me. If you think that you might need to be seen, please book an appointment.

Please check (1) of the following boxes if you DO want to communicate electronically:

I want to communicate with Steven Herbert for regarding scheduling, appointment reminders, etc. via ___ **E-MAIL ONLY** ___ **TEXT ONLY** ___ **E-MAIL AND TEXT**

OR

___ It is NOT permissible for Steven Herbert to contact me via e-mail or text.

I have read the above information and understand the limitations of security on information transmitted. I understand that Mr. Herbert may not be able to communicate with me electronically about my specific condition if there are concerns regarding confidentiality.

Client Name (Printed) **email**

Client Signature **date** **Cell Phone #**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

I. CONFIDENTIALITY

As a general rule, I will disclose no information about you, or the fact that you are my client, without your written consent. My formal treatment record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis, and progress. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes.

II. LIMTS OF CONFIDENTIALITY

There are some important exceptions to the rule of confidentiality described above. I may use or disclose records or other information about you without your consent or authorization in the following circumstances:

Emergency: If you are involved in a life-threatening emergency, and I cannot ask your permission, I will share your information if I believe you would have wanted me to do so, or if I believe it will be helpful to you (for example, if you collapse in my office and I know you are diabetic, I will inform emergency responders of your medical condition).

Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by law to report the matter to Nevada Department of Child Protective Services or law enforcement.

Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected, or exploited, I am required by law to make a report and provide relevant information to Nevada Department of Social Services or law enforcement.

Court Proceedings: If I receive a subpoena for records or testimony, I will notify you so you can file a motion to attempt to quash (block) the subpoena. I can be court ordered to provide records or testimony at the discretion of a presiding judge.

Serious Threat to Health or Safety: If you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s) if under 18, 2) notifying a law enforcement officer, and/or 3) seeking your hospitalization.

I am also required to take action to protect you to prevent immediate, serious threat to your own health and safety if you have the intent and ability to carry out an imminent threat to harm yourself.

Records of Minors: Parents and legal guardians may not be denied access to a chid's records.

Other Uses and Disclosures: Other uses and disclosures of information not covered by this notice or by the state and/or federal law that apply to me will be made only with your written permission.

III. CLIENT'S RIGHTS AND PROVIDER'S DUTIES

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit of the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me 1) what information you want to limit; 2) whether you want me to limit my use, disclosure, or both; and 3) to whom you want the limits to apply.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send communication to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages). To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

Right to an Accounting of Disclosures: You generally have the right to receive and accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section II of this Notice). On your written request, I will discuss with you the details of the accounting process.

Right to Inspect and Copy: In most cases, you have the right to inspect and copy your medical and billing records. If you request a copy of the information, I may deny your request to inspect and copy in some circumstances.

Right to Amend: If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, you request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request; I will add your request to the information record. I may deny your request if you ask me to amend information that 1) was not created by me; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; and 4) is accurate and complete.

Right to a Copy of This Notice: You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you can notify the U.S. Department of Health and Human Services.

Steven Herbert, MS, MFT
Center for Marital & Personal Therapy

CONFIDENTIAL CLIENT INFORMATION FORM

DIRECTIONS: This information is for me to get an initial idea about the nature of your concerns. This information, like anything else you provide to me, will be kept confidential. Please fill out this form as completely as possible. If you have any questions, feel free to ask me.

Name: ____ Date: _____________
Address:____

____

Home Phone: _____________________ Work Phone: __________________________
Cell Phone: _____________________
At which number should I call you? __ Home __ Cell __ Work
How discrete should I be? __ Very __ Somewhat __ Not at all
Date of Birth: ______________________
Ethnicity: __ Hispanic __ African-American __ Asian-American
__ Native American __ Caucasian __ Other (specify): _________
Faith/Spirituality Affiliation: ____
Occupation: ____
Current Relationship Status:____
Who lives in your house?
Name ____Age_______ Gender: M F
Relationship: ____
Name ____Age_______ Gender: M F
Relationship: ____
Name ____Age_______ Gender: M F
Relationship: ____
Name ____Age_______ Gender: M F
Relationship: ____
Name ____Age_______ Gender: M F
Relationship: ____
Name ____Age_______ Gender: M F
Relationship: ____

What brings you to therapy? ____
____
____
____
____
____

How long has this been going on?____
____

What do you hope to accomplish through counseling? _______________________________
____

Please list any personal and family history of substance abuse you would like your counselor to know about:

____
____
____
____

Please list any medical condition, physical concerns, or medications you would like your counselor to know about:

____
____
____

Is there anything else that you think I need to know?

____
____
____

Have you attended counseling in the past? __ Yes __ No
If yes, when? _______________________ Therapist's name: ________________________

For what concerns and did you receive a clinical diagnosis?

____
____

How was your experience?

____

Concern List:

Please circle any/all that apply. This does not limit what we will/can talk about nor does it mean we have to discuss only what you circle. This is a way to indicate your concerns as you feel them today.

Academic concerns	Depression	Parenting
Adjustment issues	Eating disorder	Phobia
Alcohol/Drug use	Fatigue	Post Trauma concerns
Anger Management	Financial concerns	Relationships
Anxiety	Goal setting	Self-Esteem
Body image	Health	Sexual assault
Chronic Pain	Identity concerns	Sexual Orientation
Clarifying personal strengths/weaknesses	Intimate partner violence	Sleeping concerns
Codependency	Living Situations	Spirituality
Criminal concerns	Loneliness	Suicidal thoughts
Cultural Concerns	Loss and/or grief	Time management
Decision-making	Marriage and/or divorce/separation	Work concerns

How did you find out about my therapy services?
____ Google Search
____ Yelp reviews
____ Referral - Who referred you? ____
____ Other (please explain) ____

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Acknowledgement of Receipt of Notice of Privacy Practices

* You may refuse to sign this acknowledgement

I _________________________ have received a copy of this office's Notice of Privacy Practice.

Name (please print)

Client(s) Signature Date

For Office Use Only:

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refusal to sign
Other

Therapist Name (please print)

Therapist Signature Date

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CREDIT CARD AUTHORIZATION

Please debit my card in the amount of $160 or or promotional rate of _____.

____ for professional services rendered each session,
____ for late cancellations or missed appointments ****Required.**

I understand that this amount will be debited as long as our coaching or counseling relationship continues (unless I notify you to stop or modify this arrangement).

MC/VISA/DISCOVER/AMERICAN EXPRESS CARD NUMBER _________________________

EXPIRATION DATE ______________________ SECURITY CODE _____________

EXACT NAME ON CARD ____

EXACT BILLING ADDRESS ____

CITY _______________________ ZIP CODE _____________________

PHONE NUMBER ____

EMAIL ADDRESS ____

SIGNATURE ____

DATE ____________