

**Kristin Sorensen Alldredge
Licensed Marriage and Family Therapist
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INFORMATION AND TREATMENT AGREEMENT

Date _____

Name _____ Age _____ Date of birth _____

Address _____ City _____

State _____ Zip Code _____ Gender _____ Marital status _____

Home phone _____ Cell phone _____ Business Phone _____

Permission to leave messages at these numbers? _____ Preferred number to contact you _____

Email _____ May I email you? _____

*note that email correspondence is not considered to be a confidential medium of communication

Occupation _____ Workplace _____

Highest Grade Completed In School _____ Where? _____

Referral Source _____

Family Physician _____ Date of last check up _____

Previous individual or couples therapy _____ When _____

Therapists seen _____

Name and Phone to contact in an emergency: _____

Partner's Name _____ phone _____

Are Your Parents Living? _____ Children (names & ages) _____

List the members of your family and all others in your home

Name	Age	Relationship	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Briefly describe your reason for seeking help:

BRIEF HEALTH HISTORY

Physicians and health care providers _____

Health concerns _____

Current medications and dosages _____

Nonprescription, supplements, vitamins _____

Smoker? _____ packs per day: _____ year

stopped _____

Caffeine drinks per day: coffee _____ tea _____ cola _____ other _____

Current diet _____ Current exercise _____

Alcohol use: type _____ per day _____ per week _____ last time used _____

Drugs: type _____ per day _____ per week _____ last time used _____

Has any blood relative ever had the following?

high blood pressure epilepsy cancer heart trouble diabetes migraines

eating disorders anxiety drug abuse alcohol abuse

mental illness depression suicide other health issues _____

Any issues that are of concern to you _____

Please Circle any of the following which pertain to you:

Nervousness

Depression

Fear

Shyness

Sexual Problems

Suicidal Thoughts

Separation/Divorce

Career choices

Financial Problems

Drug Use

Alcohol Use

Friends

Anger

Self-control

Unhappiness

Sleep

Stress

Work

Relaxation

Headaches

Tiredness

Legal Matters

Memory

Making Decisions

Energy

Insomnia

Dealing with Parents

Loneliness

Inferiority Feelings

Concentration

Health problems

Eating Problems

Children

Marriage/Relationship

Nightmares

Being a Parent

Appetite

Stomach Trouble

My Thoughts

TREATMENT AGREEMENT

COUNSELING AND PSYCHOTHERAPY It is my intention to provide services that will assist you in reaching the goals that we will set. Therapy is a joint effort and the progress depends on many factors including motivation, effort, life circumstances and other relationships. Although I view therapy as primarily a positive experience, the process may involve unpleasant emotions and the results cannot be guaranteed. The benefits may be that you will be better able to handle or cope with your family or other relationships, and that you may gain a better understanding of your personal goals and values. This may lead to greater satisfaction and growth for you.

THERAPIST I am a Licensed Marriage and Family Therapist, having received my bachelors and masters degrees from Arizona State University. I have been licensed with the State of California since 1986 and participate regularly in professional post graduate education. I have worked with individuals, couples, and groups in a variety of settings. In working with couples, I want you to know that while I have taken training in the Gottman Method of couples therapy and have become a Certified Gottman Therapist, I am completely independent in providing you with clinical services. I alone am fully responsible for those Services and the Gottman Institute has no responsibility for the services you receive here.

CONFIDENTIALITY I am bound by ethical responsibility to keep confidential the information you share with me during our sessions. However, by law I am required to report instances of suspected child or elder abuse as well as to break confidentiality if you present a serious danger of physical violence to yourself or another person.

No Secrets Policy: When I agree to work with a couple or family, I consider that couple/family unit to be the patient. During the course of our work, I may see one member for one or more sessions as I deem to be helpful. These sessions should be considered part of the therapy and the information gathered there may be shared with the rest of the unit as I deem appropriate. Some information may be essential to ensure proper treatment and I will exercise my clinical judgment regarding this. If you should feel it necessary to talk about matters that you want kept unshared, I may recommend another therapist for you to see who can treat you individually.

SESSION LENGTH AND FEES Sessions are 45 to 50 minutes in length unless otherwise scheduled. Payment is expected at the time of each session.

\$100 for a 45-50 minute session for individual therapy

\$125 for a onetime 1 hour consultation

\$125 for a 45-50 minute session for couples therapy

\$50 for couples assessment scoring

I do not bill insurance, but can provide you with a super bill at the end of the month if you wish to submit the sessions for possible reimbursement from your insurance company. Be aware that insurance plans generally limit coverage to certain diagnosable mental conditions and services. Many do not cover relationship/marriage counseling. Although I am willing to assist you, you are responsible for verifying and understanding the limits of your medical coverage.

APPOINTMENTS AND CANCELLATIONS I normally schedule appointments of Mondays, Wednesdays and Thursdays and return telephone calls about routine matters on those days. I do not typically check messages in the evenings or on days that I am not in my office. When I reserve a time for you, you will be charged for that time whether or not you keep the appointment, unless you give me at least 24 hours notice. This can be done by leaving your message by voice mail or email.

EMERGENCIES: In the event of a medical emergency or an after hours emergency requiring immediate assistance, please call 911, crisis services 800.320.1616 or go directly to Kaweah Delta's Emergency room. Aside from routine matters, my time for telephone calls is limited, and phone contact is not the best method. An important goal in our therapy will be for you to be able to reassure yourself effectively when stresses arise between sessions.

LEGAL PARTICIPATION: I am not an expert in matters involving the law, and do not conduct evaluations ordered by a court. If you are involved in, or intend to commence a legal proceeding in which any aspect of your mental functioning or relationship will be examined, it is essential that you tell me as soon as possible so that the appropriate referrals can be made.

REFERRAL TO ANOTHER THERAPIST. In certain circumstances, such as if you are not making progress in treatment, it becomes apparent that your necessary treatment is not within my area of expertise, your needs cannot be met within the constraints of my private practice availability, or in case of a conflict of interest, it may be necessary to refer you to another therapist or therapeutic setting.

Your signature indicates that you understand and accept this agreement.

Client signature

Date

Reviewed with Client

Client Signature

Date

Reviewed with Client