Les Jones MFT # 30691

Name_____Birth Date _____

Address_____City/Zip_____

Telephone #s Home _____Work _____Cell _____

Email Address_____ Social Security #_____

Marital Status _____ or Current Relationship _____ How long? _____

Children - Names & Ages: _____

_____ Living With You? _____

Employer/Occupation _____How long? _____

Referred By _____

Personal Physician(s) _____

Current Medications & Reasons:_____

_____

Have you been in previous treatment? With Whom? _____

Explain briefly please:_____

Are you currently involved in legal matters? _____

_____

Fee Statement

We cannot render services on the assumption that our charge will be paid by an insurance company. We will assist, of course, in preparing necessary forms to expedite your claim. Upon request, we will supply you with reimbursement information for your sessions that you may submit to your insurance company.

Our fee for services is $_____per session (50 minutes), per therapist.

I agree to pay this fee at the time of each session. _____(Initial here please)
I will typically be paying with cash _____, check _____, MasterCard or Visa _____

Credit Card # _____Expires on_____

GUIDELINES FOR COUNSELING

Counseling and psychotherapy occur within a relationship, which is close, and intimate, yet professional, in order to be therapeutic. Keeping professional boundaries clearly facilitates the therapeutic process. These guidelines are designed so that we may optimize our therapeutic relationship.

Appointments

You are responsible for making and keeping your appointments. If you decide to engage in ongoing therapy after the initial consultation, we will negotiate a convenient appointment time to meet, although this may vary periodically.

Should you fail to show up, cancel or postpone your appointment without 24 hours notification, you will be charged for a full session. The fee for a canceled or missed appointment is payable at the beginning of your next scheduled appointment.

Upon request, we will supply you with reimbursement information for your sessions that you may submit to your insurance company. Please note, most insurance companies will not reimburse you for missed or cancelled appointments.

Confidentiality Statement

All information between Les Jones MFT and client is held strictly confidential unless:

1. The client authorizes in writing, a release of information
2. The therapist is ordered by a court to release information
3. A client presents a physical danger to self or others
4. Child or elder abuse or neglect is suspected.

In the latter two cases I am required by law to inform potential victims and authorities so that protective measures can be taken.

I HAVE READ THE ABOVE, UNDERSTAND ITS CONTENT, AND AGREE TO THESE CONDITIONS.

Signature _____ **Date** _____

Termination of Therapy

When you decide to terminate or take a break from therapy, please schedule an appointment specifically for that purpose. This allows me to properly do a final assessment and create closure to our sessions together.