Dear Client,

You have just taken a very positive step by deciding to seek counseling. We are happy that you have chosen The Maple Counseling Center (TMCC) and want to take a moment to tell you a little about this remarkable nonprofit agency.

We started in 1972 when concerned Beverly Hills volunteers began working on problems of teenage drug abuse. Now we are considered one of the most comprehensive and innovative community mental health and counseling centers in the country.

The Center is open to anyone regardless of where you live. Fees for counseling are on a sliding scale, based on your ability to pay. As you know, we do ask that you prove financial need with appropriate documentation. Since we have an annual budget of more than $1 million, client fees help to keep the Center open. The rest of the revenue comes from grants, fundraisers and donations. Every time a client is seen, it costs the Center significantly more than our average fee per session for counselor supervision, training and overhead expenses. You can and should discuss any concerns regarding your financial status with your counselor especially if your financial situation should change or improve. Additionally, once per year your fee will be reevaluated and if it is determined you are able to pay more, your fee may be adjusted.

More than 500 clients are seen each week in individual, couple, family or group therapy. We offer parenting classes and support groups for divorce, seniors, women’s issues, bereavement and other relevant topics. The Center recognizes the special needs of seniors with a senior peer counseling program for those over the age of 62. The Center has outstanding programs for families and their children. In the Beverly Hills Schools District, our counselors provide one-on-one and group sessions. Volunteers run a highly effective after school academic tutoring program and Community Circle groups to help children enhance self-esteem and communication skills.

The Center prides itself on its ability to respond to community needs and crisis situations. In 1998, the Center initiated a crisis response team program to respond quickly to traumatic situations. A team is sent out to an accident scene at the request of the Beverly Hills and West Hollywood police and fire departments. Victims of burglary, car accidents, domestic violence, shootings and other trauma situations are given short term crisis intervention and support free of charge.

Our intern training program is highly sought after and attracts top candidates seeking licensure as PhD’s, social workers and marriage, family and child counselors. The Center has an excellent reputation for its intensive supervision and training curriculum.

We invite you to learn more about the Center. Feel free to ask about the many services available for you and your family. Welcome to the Center – we hope it will be a positive experience for you.

Warmly,

Susanna De Mari, LMFT
Clinical & Program Director
Welcome to The Maple Counseling Center. We ask your cooperation in filling out the following forms. This information is confidential and will assist your intake counselor in assessing your needs.

In order to set the fee for your ongoing therapy, we ask that you provide proof of income. Examples may be: last year’s tax form, a current pay stub or if no income, a written monthly budget.

Thank You.
INTAKE FORM - GROUP

Name: ____________________________ DOB: __________
Male: _____ Female: _____ Marital Status: __________
Address: __________________________________________
Street Address (Apt. #) City State Zip
Phone: (_____) # of Household Members: ______________
Fax: (_____) OK to say TMCC? Yes ___ No ___
Email: ___________________________________________________________________________________________
I would like to receive email updates from TMCC ☐ Yes ☐ No
Employer: __________________________________________ Phone: (_____) ______________
Fax: (_____) OK to say TMCC? Yes ___ No ___
Address: __________________________________________
Street Address (Apt. #) City State Zip
In Case of Emergency Notify: __________________________________________ Phone: (_____) ______________
Fax: (_____) OK to say TMCC? Yes ___ No ___
Responsible Adult (if minor): __________________________________________ Phone: (_____) ______________
Fax: (_____) OK to say TMCC? Yes ___ No ___
Primary Care Physician: __________________________________________ Phone: (_____) ______________
Fax: (_____) OK to say TMCC? Yes ___ No ___
Psychiatrist: __________________________________________ Phone: (_____) ______________
Fax: (_____) OK to say TMCC? Yes ___ No ___
Medical Problems: __________________________________________
List all medications that are currently being prescribed: __________________________________________
How did you hear about TMCC? ___________________________________________________________________
Type of support Group: __________________________________________

Please circle the symptoms you are currently experiencing.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness or Depression</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Suicidal Thoughts</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sleep Problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Change in Appetite</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Weight Change</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Inability to Concentrate</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Obsessive Thoughts</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Tension/Anxiety</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Panic Attacks</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Memory Problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Compulsive Behavior</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feelings of Hostility</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Acts of Violence</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Social Isolation</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Strange Thoughts</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sexual Problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. Please check the box which best describes how well you are doing on your job:

<table>
<thead>
<tr>
<th></th>
<th>0</th>
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<th>2</th>
<th>3</th>
<th>4</th>
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<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Working</td>
<td>Cannot Function</td>
<td>Serious Problems</td>
<td>Moderate Problem</td>
<td>Mild Problems</td>
<td>No Problems</td>
<td></td>
<td></td>
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</tbody>
</table>

2. Please check the box which best describes how well you are doing in your marital/significant other relationship:

<table>
<thead>
<tr>
<th></th>
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<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Applicable</td>
<td>Cannot Function</td>
<td>Serious Problems</td>
<td>Moderate Problem</td>
<td>Mild Problems</td>
<td>No Problems</td>
<td></td>
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</table>

3. Please check the box which best describes how well you are doing in your family relationships:

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
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<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Applicable</td>
<td>Cannot Function</td>
<td>Serious Problems</td>
<td>Moderate Problem</td>
<td>Mild Problems</td>
<td>No Problems</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

4. Please check the box which best describes how well you are doing in relationships with people outside your family:

<table>
<thead>
<tr>
<th></th>
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<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Applicable</td>
<td>Cannot Function</td>
<td>Serious Problems</td>
<td>Moderate Problem</td>
<td>Mild Problems</td>
<td>No Problems</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

5. Please check the box which best describes your current physical health:

<table>
<thead>
<tr>
<th></th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Poor</td>
<td>Excellent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Please check the box which best describes your general happiness and well-being:

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Poor</td>
<td>Excellent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please Circle:

**Alcohol Use:** Never 1-4 timer per month 2-3 per week Daily How Long

**Level of Consumption:** 1-2 drinks per sitting 3-4 drinks per setting 5 drinks or more

**Intoxication Frequency:** Never 1-4 timer per month 2-3 per week Daily

**Substance Abuse Assessment:** None Marijuana Sedatives Stimulants Cocaine Opiates Hallucinogenic

**Frequency:** Never 1-4 timer per month 2-3 per week Daily

Do you or anyone in your family have a history of alcohol or chemical abuse? ______________

Have you ever been arrested? ________________________________

****************************************************************************
Consent for Treatment (Group)

Please read carefully.

I. Fees and Appointments
1. Group sessions ordinarily take place one time per week, unless otherwise arranged. If you are unable to attend a group session, please contact your group leader to inform them of your absence as soon as possible.
2. During your initial appointment you will be assigned a fee for your weekly sessions. We ask that you pay your counselor at the beginning of each session on a weekly basis. We reserve the right to suspend therapy for services rendered and not paid for after three sessions.
3. Groups are significantly affected when group members are absent. Therefore, attendance is strongly encouraged. Even though you may be absent from time to time, your place in the group is reserved and you are responsible to pay for any missed sessions.
4. There will be a $14.00 service fee for any returned checks.
5. You can and should discuss any concerns regarding your financial status with your counselor especially if your financial situation should change or improve. Additionally, once per year your fee will be reevaluated and if it is determined you are able to pay more, your fee may be adjusted.

II. Confidentiality
1. Communication between you and the group leaders is both privileged and confidential. This means that group leaders cannot discuss your case orally or in writing, except with The Maple Counseling Center clinical supervisors and staff.
2. Confidentiality is strongly encouraged among group members.
3. Your group leaders have an ethical and legal obligation to break confidentiality under the following circumstances:
   a. If there is a reason to believe there is an occurrence of child, elder or dependent adult abuse or neglect.
   b. If there is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit.
   c. If you introduce your emotional condition into a legal proceeding, or your counselor is subpoenaed to give testimony.
   d. If you disclose that you knowingly develop, duplicate, print, download, stream, or access through any electronic or digital media or exchanges, a film, photograph, video in which a child is engaged in an act of obscene sexual conduct.
   e. If there is a court order for release of your records.

III. Training and Supervision
1. The Center is a training center for Masters or Doctoral level counseling and psychology interns and for paraprofessionals. All Interns are under the direct supervision of licensed mental health professionals.
2. Interns who facilitate your group are on a time-limited, contractual basis with TMCC. Therefore, it is possible that an intern may leave TMCC prior to the end of your group therapy experience. If this does occur TMCC will do everything possible to ensure a competent replacement.

IV. Counselor Availability and After Hours Emergencies
Counselors check for voice mail messages during normal business hours. Messages left outside of normal Maple Center hours of operation will be picked up the next business day. If you have an emergency that needs immediate attention you may need to seek assistance at the nearest emergency services department.
V.  Child Care Release
The Center does not provide child care and is not responsible for children and/or adolescents left unsupervised, or not picked up prior to closing hours. If you must leave your child in the waiting room during a session, it is your responsibility to provide appropriate supervision for that child. Children under the age of 10 will not be left without supervision in the waiting room.

VI. Client Rights and Responsibilities
In addition to your right to confidentiality, you have the right to end your therapy at any time, for whatever reason without any obligation except for fees already incurred. You also have the right to question any aspect of your treatment with your group leaders and to expect that we would work with you to meet your needs for adjunctive or alternative treatment. You also have the right to expect that your group leaders will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, which would greatly compromise the therapeutic relationship.

I also understand that TMCC does not provide psychological testing, acting as a witness in court cases, or report writing of any kind (except for providing evidence of attendance, upon request). I agree that I will not request any of these services from TMCC.

Group therapy involves a partnership between group members and group leaders. Your group leaders will contribute knowledge, skills, and a willingness to do their best. The determination of success, however, will ultimately depend upon your commitment to your own personal growth and care.

Please feel free to ask any questions or discuss any of this information with your group leaders. Your signature below indicates that you have read and understand this information and have received a copy of this consent form and give permission to TMCC to provide counseling services and that this contract is binding for all future sessions you may have with this agency.

Signature of Client: _______________________________ Date: ____________________
### Occupation

<table>
<thead>
<tr>
<th>Accounting</th>
<th>Construction</th>
<th>Homemaker</th>
<th>Nursing occupations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acting, performing arts</td>
<td>Cook, chef, caterer</td>
<td>Interior design occupation</td>
<td>Photographer</td>
</tr>
<tr>
<td>Administrative, clerical</td>
<td>Cosmetology, beautician</td>
<td>Law professional</td>
<td>Physician</td>
</tr>
<tr>
<td>Administrator, manager</td>
<td>Domestic, service industry</td>
<td>Machine operators &amp; tenders</td>
<td>Protective services (police, fire)</td>
</tr>
<tr>
<td>Advertising, Marketing, P/R</td>
<td>Engineer, natural scientist</td>
<td>Mechanics</td>
<td>Publishing occupation</td>
</tr>
<tr>
<td>Architect</td>
<td>Entertainment exec, or related</td>
<td>Medical techs &amp; therapists</td>
<td>Real estate, property mgmt.</td>
</tr>
<tr>
<td>Artist or design specialist</td>
<td>Entertainment tech (i.e. cameraman)</td>
<td>Mental health professional</td>
<td>Retail, sales occupations</td>
</tr>
<tr>
<td>Banking, investments</td>
<td>Executive</td>
<td>Misc. gov’t (i.e. postal, sanitation)</td>
<td>Student</td>
</tr>
<tr>
<td>Cashier</td>
<td>Farming, forestry, fishing</td>
<td>Model</td>
<td>Teaching professional, librarian</td>
</tr>
<tr>
<td>Clergy</td>
<td>Fashion industry</td>
<td>Motor vehicle operators</td>
<td>Technical support occupation</td>
</tr>
<tr>
<td>Computer related</td>
<td>Health diagnosing (i.e. x-ray tech)</td>
<td>News media personnel</td>
<td>Writer</td>
</tr>
</tbody>
</table>

#### Beverly Hills Information
- **Beverly Hills City Employee**
- **Position:** Beverly Hills Student
- **Grade:** Police Department
- **Position:** Live in Beverly Hills
- **Live in Beverly Hills:** Work in Beverly Hills

#### W. Hollywood Information
- **West Hollywood City Employee**
- **Position:** Fire Department
- **Grade:** Police Department
- **Position:** Live in West Hollywood
- **Live in West Hollywood:** Work in West Hollywood

#### Completed Education Level
- **Grades 1-12**
- **BA or BS**
- **MA or MS**
- **PhD**
- **MD**
- **Professional School Graduate**

#### Income Level
- **Less than $10,000**
- **$10,000 to $14,999**
- **$15,000 to $19,999**
- **$20,000 to $29,000**
- **$30,000 to $49,999**
- **$50,000 to $99,999**
- **$100,000 and above**

#### Employment Category
- **County**
- **Municipal**
- **School District employee**

#### Employment Status
- **Self-Employed**
- **Small Business**
- **Disabled**
- **Self-Employed**
- **Unemployed**

#### Ethnicity
- **African, American**
- **Hispanic/Latino**
- **Asian/Pacific Islander/Asian American**
- **Middle Eastern (Persian/Israeli)**
CONSENT TO USE OR DISCLOSE HEALTH INFORMATION
FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, AND
ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Patient Name: ___________________________________________________________
Patient Address: _________________________________________________________
Patient Phone Number: ___________________________________________________

In the course of providing services to you, we may create, receive, and store individually identifiable
information, including information that relates to health care and payment for health care (“Personal
Information”). It is often necessary to use and disclose this Personal Information in order to treat you, to
obtain payment for our services, and to conduct health care operations involving our office.

We have a HIPAA Notice of Privacy Practices that describes these uses and disclosures. As described
in our Notice of Privacy Practices, the use and disclosure of your Personal Information for treatment
purposes not only includes care and services provided here, but also disclosures of your Personal
Information as may be necessary or appropriate for you to receive follow-up care from another health
care professional. Similarly, the use and disclosure of your Personal Information for purposes of payment
may include, for example, the submission of this information to a billing agent for processing claims or
obtaining payment and/or submission of claims to insurers.

When you sign this consent document, you expressly agree that we can and will use and disclose your
Personal Information to treat you, to obtain payment for our services, and to operate The Maple
Counseling Center. You can revoke this consent in writing at any time unless we have already treated you,
sought payment for our services, or performed health care operations in reliance upon our ability to use
or disclose your information in accordance with this consent. We can decline to serve you if you elect not
to sign this consent form.

You also acknowledge, by your signature below, that you have received a copy of our HIPAA Notice of
Privacy Practices.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY
PERSONAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES.

Patient Signature: ____________________________________________ Date: ____________

If you are signing as a personal representative of the patient, describe your relationship to the patient and
the source of your authority to sign this form.

Relationship to Patient: _______________________________________________

Print Name: ___________________________________________________________
Group Psychotherapy Agreement

In deciding to become a member of a psychotherapy group at The Maple Counseling Center, I agree to be responsible for the following agreement:

Attendance
☐ to initially attend for at least 12 sessions
☐ to come on time and stay for the entire session; in the event of necessary absence or lateness, to tell or notify the group in advance

Confidentiality
☐ to respect as confidential what goes on in the group. This means that in speaking of this group outside of the meeting room, I agree to do so in a way that protects the identity of other group members

Group Process
☐ to let other members affect me and be willing to talk openly and honestly about my reactions as I become aware of them
☐ to use the group process to work actively on the problems that brought me into therapy and/or problems that are identified in the course of therapy
☐ to arrange for individual therapy sessions when an issue is not amenable to the group process

Payment
☐ to leave enough time (at least four meetings) to say good-bye and allow for expression of my own and other group members' feelings regarding my leaving, as well as other issues that come up regarding termination, once the decision to terminate has been made

There will be no set agenda or formal structure to the group meetings. Ultimately it is for the group members to decide what to talk about, and part of therapy is to understand your contribution to the way the group develops

Client Name (printed): 

Client Signature: 
Date: 
## Intake Financial Agreement

### Personal Information

<table>
<thead>
<tr>
<th>Case #:</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Client #1 Name:</td>
</tr>
<tr>
<td>Client #2 Name:</td>
</tr>
<tr>
<td>Home Address:</td>
</tr>
<tr>
<td>Phone #1: (  )</td>
</tr>
<tr>
<td>Phone #2: (  )</td>
</tr>
<tr>
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<tr>
<td>Number of Dependents:</td>
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### Financial Information

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<tr>
<td>Monthly salary $</td>
<td>Food $</td>
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<td>Spouse Monthly Salary $</td>
<td>Medical Insurance $</td>
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<td>Child Support $</td>
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<td>SSI Benefit $</td>
<td>Education Expenses $</td>
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<tr>
<td>Public Benefit $</td>
<td>Total Expenses $</td>
</tr>
<tr>
<td>Other Income $</td>
<td></td>
</tr>
</tbody>
</table>

**Total Household Gross Income $**

**Signature: Client #1:** _____________________________  Date: ____________

**Signature: Client #2:** _____________________________  Date: ____________

The center base fee is $100 per session. However, as a nonprofit community mental health agency, fees are assigned using a sliding scale, based on the ability to pay.

Based on my ability to pay, it is my understanding that my fee is $___________________.

**Client has made a verbal agreement.** _____________________________  Date: ____________

**Finance department officer signature** _____________________________  Date: ____________

Attach to this application; two of the following proof of income and expenses.

- Tax return
- Copy of EDD check
- Rent or mortgage receipt
- 2 Month Pay stub
- Bank statement
- Copy of utility bill
- Copy of SSI check
- Proof for public help benefit
- Other

**For office use only:**
We would like to hear from you

We value you as a client and respect your privacy!

TMCC is working hard to strengthen our public relations efforts. This includes providing opportunities to hear from our clients when it is appropriate.

We would like to know if you would be open to allowing us to reach out to you when your time with TMCC has concluded. If you are interested, we will contact you to explore opportunities that may be available to help us promote TMCC. This could include feedback and input to printed materials, testimonials, or other media relations.

We appreciate your support, as your participation will help inform other potential clients on what TMCC has to offer.

___ I am interested in speaking to a TMCC staff member following the conclusion of services.

___ I am not interested in speaking to a TMCC staff member following the conclusion of services. Please do not contact me.

Print Name: ________________________________

Signature: ________________________________

Date: ________________________________