The Maple Counseling Center

November 1, 2019

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 the problems caused by 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 you 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 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 re-evaluated and if it is determined you are able to pay more, your fee may be adjusted.

More than 600 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 School District, our counselors provide one-on-one and group sessions. Volunteers run highly effective after school Community Circle groups to help children enhance self-esteem and communication skills.

Our intern training program is highly sought after and attracts top candidates seeking licensure as PhDs, 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

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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.

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FOR INDIVIDUAL ADULT CLIENTS

Counseling I am seeking: ☐**Individual** ☐**Couple** ☐**Group Therapy** ☐**Senior Peer**

CLIENT INFO	**EMPLOYER & STATUS**
Date of Birth: ____/_____/_____ Name: _____ Preferred Name: _____ Preferred Gender Pronouns:_____ Gender: M ☐ F ☐ Other: _____ Address: _____ City: _____ Zip: _____ Email: _____ I would like to receive email updates from TMCC ☐**Yes** ☐**No** Home #: _____ Cell #:_____ Work #:_____ Other #:_____ On what number may we leave a **confidential message**: ☐Home ❑Cell ☐Other	Company: _____ Address: _____ City: _____Zip: _____ ☐ I am self-employed ☐ I am unemployed ☐ I am retired Does an immediate relative work for the City of Beverly Hills or BHUSD? ☐**Yes** ☐**No** I am: Single ❑ Married ☐ Divorced ☐ How many people live in your household? __

How did you hear about TMCC?

Another Counseling or Mental Health Treatment Center	☐	Internet Search	☐
Referral from relative, friend or TMCC Client	☐	DCFS	☐
Therapist, Psychiatrist, Physician or Hospital Staff	❑	Other	☐

EMERGENCY CONTACT INFO

Notify: _____ Phone: _____

Relationship to client: _____

HEALTH AND MEDICAL

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Please list any medical problems: _____

Please list any current medications:

WHEN ARE YOU AVAILABLE FOR A WEEKLY APPOINTMENT? (☑ all availability)

50 Minute Sessions	MON	TUES	WEDS	THURS	FRI	SAT
9am, 10am, 11am, 12noon						
1pm, 2pm, 3pm, 4pm						
5pm, 6pm, 7pm, 8pm						

ADDITIONAL INFO

Are you required by a court of law to receive counseling as part of a legal proceeding? ☐**Yes** ☐**No**

Have you obtained services from TMCC before? ☐**Yes** ☐**No** If yes, when? _____

Are you currently affiliated with any of TMCC's volunteer or adjunctive programs? ☐**Yes** ☐**No**

Are you interested in group therapy? ☐**Yes** ☐**No** If yes, what kind?

Client name: _____
Client ID#: _____

Symptom Assessment

Please give as accurate account as you can and if you have any questions or concerns, we invite you to discuss them with your intake counselor.

(✓ your concerns)

I AM EXPERIENCING…	Never	Seldom	Often	Always	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					
I AM FEELING…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					
I NOTICE...	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
I am Angry, Irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					
I HAVE…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

Client name: _____
Client ID#: _____

I HAVE…	Never	Seldom	Often	Always	For how long?
Risk Taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					
I USE THE FOLLOWING….	**Never**	**Seldom**	**Often**	**Daily**	**For how long?**
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					
MY EATING INVOLVES…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss or gain					
I HAVE…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Concern about my sexual function					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					

EMPLOYMENT & SELF-CARE	Never	Seldom	Often	Always	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

PERSONAL AND FAMILY HISTORY

Have <u>you or a close relative</u> ever been hospitalized for a psychiatric illness? ☐**Yes** ☐**No**
Does anyone in your family have a mental illness? ☐**Yes** ☐**No**
Has anyone in your family every attempted or committed suicide? ☐**Yes** ☐**No**
Does anyone in your family have a substance abuse problem? ☐**Yes** ☐**No**
Have you ever been arrested? ☐**Yes** ☐**No**

If "yes" to any of the above, please briefly explain: _____
_____
_____
_____
_____

Client name: _____
Client ID#: _____

1) How well you are doing on your job: **(✓)**

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Not Working	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

2) How well you are doing in your marital/significant other relationship:

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
N/A	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

3) How well you are doing in your family relationships:

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
N/A	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

4) How well you are doing in relationships with people outside your family:

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
N/A	Cannot Function		Serious Problems		Moderate Problem		Mild Problems		No Problems

5) Please rate your current physical health:

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Very Poor									Excellent

6) Please rate your general happiness and well-being:

0 ☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Very Poor									Excellent

The Maple Counseling Center Statistical Information

Name:			Account#
	Occupation		
Circle One			
Accounting	Construction	Homemaker	Nursing occupations
Acting, performing arts	Cook, chef, caterer	Interior design occupation	Photographer
Administrative, clerical	Cosmetology, beautician	Law professional	Physician
Administrator, manager	Domestic, service industry	Machine operators & tenders	Protective services (police,fire)
Advertising, Marketing, P/R	Engineer, natural scientist	Mechanics	Publishing occupation
Architect	Entertainment exec, or related	Medical techs & therapists	Real estate, property mgmt
Artist or design specialist	Entertainment tech (ie cameraman)	Mental health professional	Retail, sales occupations
Banking, investments	Executive	Misc gov't (ie postal, sanitation)	Student
Cashier	Farming, forestry, fishing	Model	Teaching professional, librarian
Clergy	Fashion industry	Motor vehicle operators	Technical support occupation
Computer related	Health diagnosing (ie x-ray tech)	News media personnel	Writer
Beverly Hills Information	**W. Hollywood Information**	**Completed Education Level**	**Income Level**
Circle all that apply	Circle all that apply	Circle One	Circle One
Beverly Hills City Employee	West Hollywood City Employee	Grades 1-12	Less than $10,000
Position:	Position:	AA degree	$10,000 to $14,999
Beverly Hills Student	Fire Department	BA or BS	$15,000 to $19,999
Grade:	Police Department	MA or MS	$20,000 to $29,000
Fire Department	Live in West Hollywood	PhD	$30,000 to $49,999
Live in Beverly Hills	Work in West Hollywood	MD	$50,000 to $99,999
Police Department		Professional School Graduate	$100,000 and above
School District employee			
Work in Beverly Hills			
Employment Category			**Employment Status**
Circle all that apply			Circle One
County	State	Self-Employed	Disabled
Federal	Corporate	Small Business	Employed
Municipal	Non-Profit		Retired
			Self-Employed
			Unemployed
	Ethnicity		
Circle One			
African, African-American, Black	Asian and African-American	Hispanic origin, Latino	Unknown
African-Caucasian	Asian, Pacific Islander	Iranian	Unwilling to be identified by race
African-Hispanic	Asian-American	Israeli	White, Indo-European
Amer Indian, Native Amer, Eskimo, Aleut	Asian-Hispanic	Korean	

The Maple Counseling Center

Consent for Treatment

Please read carefully

Psychotherapy is a working cooperative relationship between you and your counselor. Each member of this cooperative relationship has certain responsibilities. Your counselor will contribute their knowledge, expertise, and clinical skills. You, as the client, have the responsibility to bring an attitude of collaboration and a commitment to the therapeutic process. While there are no guarantees regarding the outcome of the treatment, your commitment may increase the likelihood of a satisfactory experience.

I. Fees and Appointments

1. Appointments are 50 minutes in length, and take place on a weekly basis. Your counselor holds your specific hour for you each week. If you are unable to keep an appointment, please cancel as soon as possible. You will be allowed to cancel four sessions within a one-year period with no charge. The year begins on the date of your Intake Appointment. After four cancelled appointments you will be responsible for payment of missed sessions. If you are able to reschedule your appointment within five working days, it will not count as a cancellation. We ask that you pay the receptionist prior to your session each week. We reserve the right to suspend therapy if services are rendered and not paid for after three sessions.
2. During your initial appointment you will be assigned a fee for your weekly sessions based on your ability to pay. Please 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. If it is determined that, based on your circumstances, you are able to pay more, your fee may be adjusted. All client fees are reviewed on an annual basis.
3. There is a $14.00 service fee for any returned checks. If determined that therapy will continue, you must agree in writing to a specific payment plan to reduce your overdue balance to zero, while continuing to pay the weekly agreed upon fee.

II. Confidentiality

1. Communication between you and your counselor is confidential. This means that your counselor will not discuss your case orally or in writing without your expressed written permission (please see the following section on "Training and Supervision").
2. Your counselor has 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 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.
   d. If <u>you</u> introduce your emotional condition into a legal proceeding.
   e. If there is a court order for release of your records.

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III. Training and Clinical Supervision

1. The Maple Counseling Center is a training center for Master's and Doctoral level counseling and psychology interns and Senior Peer paraprofessional counselors. All counselors at TMCC are under the supervision of licensed mental health professionals.
2. In order to ensure that counselors receive the best possible training, and that clients are well served, sessions will be video or audio taped. Tapes are viewed by TMCC counselors and clinical supervisors only, and are erased in a timely manner. You must agree to be taped to receive counseling services at TMCC.
3. Counselors are generally on a time limited contract with TMCC. Therefore, it is possible that your counselor may leave TMCC prior to the end of your therapy. If this occurs we will take reasonable steps to ensure a smooth transition.

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

TMCC does not provide childcare and is not responsible for children or adolescents left unsupervised in the waiting room. Minors must be picked up following their appointments on time. 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 may not be left without supervision in the waiting room.

VI. Additional Rights and Responsibilities

In addition to your right to confidentiality, you have the right to end your counseling at any time, for whatever reason and without any obligation, with the exception of payment of fees for services already provided. You have the right to question any aspect of your treatment with your counselor. You also have the right to expect that your counselor will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you.

TMCC reserves the right to discontinue counseling at any time including, but not limited to, a violation by you of this Consent for Treatment, a change or reevaluation by TMCC of your therapeutic needs, TMCC's ability to address those needs, or other circumstances that lead TMCC to conclude in its sole and absolute discretion that your counseling needs would be better served at an another counseling facility. Under such circumstances, TMCC will suggest an appropriate counselor(s) or counseling agency.

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 entity.

Print Name: _____ Date: _____

Signature of Client #1: _____

Print Name: _____ Date: _____

Signature of Client #2: _____

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Print Name: _____ Date: _____

Signature of Client #2: _____

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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: _____

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Intake Financial Agreement

Personal Information

	Case #:
Client #1 Name:	
Client #2 Name:	
Home Address:	
Phone #1: ( )	Cell#: ( )
Phone #2: ( )	Cell#: ( )
Email Address:	
Email Address:	
Number of Dependents:	

Financial Information

Income		**Expenses**	
Annual Gross Salary	$	Rent or Mortgage	$
Monthly salary	$	Food	$
Spouse Monthly Salary	$	Medical Insurance	$
Unemployment Benefit	$	Child Support	$
Disability	$	Utilities	$
SSI Benefit	$	Education Expenses	$
Public Benefit	$	**Total Expenses**	$
Other Income	$		
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: _____