



The
Maple
Counseling
Center

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,

Sharon Schwartz, PhD
Assistant Clinical Director

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9107 Wilshire Boulevard, Lower Level Beverly Hills, CA 90210 (310) 271-9999 Fax (310) 247-4910
Website: www.tmcc.org



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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.

Today's charges:

Adult fee for Intake Assessment	\$65.00
City employees of Beverly Hills	\$20.00
BHUSD employees	\$20.00

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

Thank You.



ADOLESCENT/ CHILD INTAKE FORM

Child's Name: _____ Age: _____ DOB: _____

Sibling: _____ Age: _____ DOB: _____

Sibling: _____ Age: _____ DOB: _____

Sibling: _____ Age: _____ DOB: _____

Sibling: _____ Age: _____ DOB: _____

1. Parent's Name: _____ DOB: _____

Address (City, State and Zip): _____

Marital Status: _____ Male/Female: _____

Phone: H(____) _____ W(____) _____ C(____) _____
OK to say TMCC? Yes _____ No _____

Emergency contact (name and phone #) _____

Email: _____

I would like to receive email updates from TMCC Yes No

2. Parent's Name: _____ DOB: _____

Address (City, State and Zip): _____

Marital Status: _____ Male/Female: _____

Phone: H(____) _____ W(____) _____ C(____) _____
OK to say TMCC? Yes _____ No _____

Emergency contact (name and phone #) _____

Email: _____

I would like to receive email updates from TMCC Yes No

3. Step Parent(s)/Guardian(s): _____ DOB: _____

Address (City, State and Zip): _____

Marital Status: _____ Male/Female: _____

Phone: H(____) _____ W(____) _____ C(____) _____
OK to say TMCC? Yes _____ No _____

Emergency contact (name and phone #) _____

Email: _____

I would like to receive email updates from TMCC Yes No

History of Problem

Please describe what concerns you have regarding your child: _____

Name: _____

Client ID#: _____

How long has the problem existed? _____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial problems, in the last several years?

What attempts have been made to resolve the difficulties? _____

Please check the symptoms that the child is currently experiencing. Please indicate to which family member you are referring, as well as duration, and severity.

Severity of symptom
None Mild Moderate Severe
0 1 2 3

Symptom _____ Name(s) _____ How Long? _____

Sadness or Depression			
Suicidal Thoughts			
Sleep Problems			
Changes in Appetite			
Weight Change			
Inability to Concentrate			
Obsessive Thoughts			
Tension and Anxiety			
Panic Attacks			
Memory Problems			
Compulsive Behaviors			
Feelings of Hostility			
Acts of Violence			
Social Isolation			
Strange Thoughts			
Stomach Aches			
Head Aches			
Bed Wetting			
Phobias			
Others			

Name: _____

Client ID#: _____

Parent Information

Are there any other agencies involved with the family (DCFS, Child Welfare, Courts, etc.)?

For Parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements) _____

Is ex-spouse (biological parent) aware that you are bring their children to TMCC? Yes No

If not, please explain. _____

If adopted, does child know of adoption? Yes No

What age was your child at the time of the adoption? _____

Mother's Name: _____ Age: _____ Occupation: _____

Employment status: _____ Employer's name and address: _____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Current and past psychiatric treatment or counseling: _____

Currently prescribed medications: _____

Current alcohol/drug use (amount, how often, intoxication frequency): _____

History of alcohol/drug use? _____

History of arrest? _____

Primary Care Physician: _____

Psychiatrist: _____

Father's Name: _____ Age: _____ Occupation: _____

Employment status: _____ Employer's name and address: _____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Current and past psychiatric treatment or counseling: _____

Currently prescribed medications: _____

Current alcohol/drug use (amount, how often, intoxication frequency): _____

History of alcohol/drug use? _____

History of arrest? _____

Primary Care Physician: _____

Psychiatrist: _____

Name: _____

Client ID#: _____

Step-parent/Guardian: _____ Age: _____ Occupation: _____

Employment status: _____ Employer's name and address: _____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Current and past psychiatric treatment or counseling: _____

Currently prescribed medications: _____

Current alcohol/drug use (amount, how often, intoxication frequency): _____

History of alcohol/drug use? _____

History of arrest? _____

Primary Care Physician: _____

Psychiatrist: _____

Child Information:

1). Name of Child: _____ Age: _____ Child lives with: _____

School: _____ Grade: _____ Teacher: _____

History of psychiatric treatment or counseling: _____

Current or past drug or alcohol use (indicate past or present amount, frequency) _____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

Pediatrician: _____

Psychiatrist: _____

2). Name of Child: _____ Age: _____ Child lives with: _____

School: _____ Grade: _____ Teacher: _____

History of psychiatric treatment or counseling: _____

Current or past drug or alcohol use (indicate past or present amount, frequency) _____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

Pediatrician: _____

Psychiatrist: _____

3). Name of Child: _____ Age: _____ Child lives with: _____

School: _____ Grade: _____ Teacher: _____

History of psychiatric treatment or counseling: _____

Current or past drug or alcohol use (indicate past or present amount, frequency) _____

Name: _____

Client ID#: _____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

Medications currently prescribed: _____

Pediatrician: _____

Psychiatrist: _____

How did you hear about TMCC? _____

WHEN ARE YOU AVAILABLE FOR A WEEKLY APPOINTMENT? (<input checked="" type="checkbox"/> all availability)						
50 Minute Sessions	MON	TUES	WEDS	THURS	FRI	SAT
9am, 10am, 11am, 12noon						
1pm, 2pm, 3pm, 4pm						
5pm, 6pm, 7pm, 8pm						



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Name:	Account#
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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, American	Caucasian/White
Hispanic/Latino	Multi Race
Asian/Pacific Islander/Asian American	Decline to State
Middle Eastern (Persian/Israeli)	



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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

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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 Category	Employment Status
Circle all that apply	Circle One
County	Disabled
Federal	Employed
Municipal	Retired
	Self-Employed
	Unemployed

Ethnicity

Circle One

African, American	Caucasian/White
Hispanic/Latino	Multi Race
Asian/Pacific Islander/Asian American	Decline to State
Middle Eastern (Persian/Israeli)	



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Consent for Treatment of a Family or a Child

Please read carefully

This is to certify that I give permission to The Maple Counseling Center (TMCC) for my family or child's participation in therapy. The names of the family members in therapy are outlined below. Additional children may be listed on the back of page 2.

Name of Child: _____ Date of Birth: _____ Age: _____

Name of Child: _____ Date of Birth: _____ Age: _____

Mother's /Legal Guardian's Name: _____ Date of Birth: _____ Age: _____

Father's/Legal Guardian's Name: _____ Date of Birth: _____ Age: _____

I. Fees and Appointments

1. Appointments are 50 minutes, and ordinarily take place one time per week. Your family/child's specific hour is held by their counselor from week to week. If your family/child is unable to keep an appointment, please contact their counselor to cancel 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. You **are allowed to cancel** four sessions within a one-year period. **The one year will commence on the date of your family/child's intake/initial appointment. After four cancelled appointments you will be responsible for the payment of any future sessions that your family/child does not attend within the balance of that one-year period.** If you are able to reschedule your family/child's appointment within five working days it will not count as one of the four allowed missed sessions.
4. **If you miss an appointment and have not contacted your counselor prior to the missed appointment, it will not be considered one of your four cancellations and you will be charged for that "no show" appointment.**
5. There will be 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.
6. 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 your family/child's counselor is both privileged and confidential. This means that without your written permission the counselor cannot discuss your family/child's case orally or in writing, except with **The Maple Counseling Center** clinical supervisors and staff.
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 your child or a member of your family has serious intent to harm themselves, someone else, or property by a violent act they may commit.
 - c. If you introduce a family member's emotional condition into a legal proceeding, or your counselor is subpoenaed to give testimony.

Client Name: _____

Account # _____

- 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. In order to ensure that counselors receive the best possible training, and that clients are well served, some sessions will be video or audio taped. Tapes are viewed by **The Maple Counseling Center** counselors and clinical supervisors only, and are erased in a timely manner. There will be advance notice of a taping and it will be with your full and complete awareness. You must agree to have your family/child's sessions taped in order to receive services at **The Maple Counseling Center**.
- 3. The intern who is assigned to you is on a time-limited, contractual basis with **TMCC**. Therefore, it is possible that the intern may leave **TMCC** prior to the end of your therapy. If this does occur **TMCC** will do everything possible to ensure a smooth transfer to another counselor.

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 adolescents left unsupervised. If you must leave your child in the waiting room during a session, please be advised that children under 10 must have appropriate supervision. Children over the age of 10 will be allowed to wait in the waiting room at the discretion of The Center staff.

VI. Client Rights and Responsibilities

- 1. You have the right to end your family/child's therapy at any time, for whatever reason, without any obligation except for fees already incurred.
- 2. You have the right to question any aspect of your family/child's treatment with your counselor and to expect that we will work with you to meet your needs for adjunctive or alternative treatment.
- 3. If your child sees a counselor individually, you have the right to expect that their counselor, as requested, will communicate with you about your child's therapy. However, as the establishment of trust between your child and their counselor is important for a successful therapeutic outcome, we ask you to keep in mind your child's need for privacy.
- 4. *I realize that if my child is seen in therapy, both parents will be asked to participate in the treatment. This may involve family treatment, parent meetings between you and your child's therapist, or individual therapy for each parent. Your therapist may share information regarding issues that arise in the course of the therapy with either parent.*
- 5. You 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, which would greatly compromise the therapeutic relationship.
- 6. The Center 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**.
- 7. Therapy involves a partnership between therapist and client. Your family's therapist will contribute knowledge, skills, and a willingness to do his/her best. The determination of success, however, is largely dependent upon your commitment to your family's personal growth and care. 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 Parent/Legal Guardian #1: _____

Date: _____

Signature of Parent/Legal Guardian #2: _____

Date: _____



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 - b. If there is reason to believe that your child or a member of your family has serious intent to harm themselves, someone else, or property by a violent act they may commit.
 - c. If you introduce a family member's emotional condition into a legal proceeding, or your counselor is subpoenaed to give testimony.

Client name: _____

Account #: _____

- 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.
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- 4. *I realize that if my child is seen in therapy, both parents will be asked to participate in the treatment. This may involve family treatment, parent meetings between you and your child's therapist, or individual therapy for each parent. Your therapist may share information regarding issues that arise in the course of the therapy with either parent.*
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- 6. The Center 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**.
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Signature of Parent/Legal Guardian #1: _____

Date: _____

Signature of Parent/Legal Guardian #2: _____

Date: _____

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Adolescent Counseling Information

What to expect from therapy:

You can expect that I will do my best to understand your concerns. I will listen non-judgmentally and provide an opportunity for you to learn more about yourself and hopefully together we will find better solutions to the challenges in your life.

You can expect that what we discuss will be kept private.

There are a few exceptions, and here they are:

1. You tell me that you plan to hurt yourself or someone else.
2. You tell me that you are being abused physically, sexually, or emotionally, or that you have been abused in the past.
3. You are involved in a court case and a request is made for information about your counseling or your therapy.
4. You tell me that you are or have engaged in a sexual relationship with someone who is significantly older than you. In most cases I would be required by law to report this to Child Protective Services.

What to expect about my communications with your parent or guardian: Generally speaking... I will keep the specifics of what you share with me private.

There are few exceptions, and here they are:

1. If I do hear that you are involved in risk-taking behavior that becomes serious, then I will need to use my professional judgment to decide whether I must inform your parent/guardian, or we will discuss how to share this with your parent(s) together.
2. Even though I am committed to keeping your information confidential, I may believe that it is important for your parent/guardian to know what is going on in your life. In these situations we will work together to find the best way to discuss these things with your parent(s).
3. When meeting with your parents I will discuss challenges and progress that you have made in counseling. Generally speaking, I will talk about themes rather than specifics. The purpose of meeting with your parent(s) is to support our work together and to facilitate improved family relationships.

What I expect from you:

1. You agree to attend therapy sessions as scheduled and participate to the best of your ability.
2. You agree to participate in goal setting and take an active role in making positive life changes.
3. You agree to talk with me if you have thoughts or feelings about harming yourself or someone else.

Client name: _____

Account #: _____

What I expect from your Parent/Guardian:

1. You agree to support your child's treatment by doing your best to arrange for regular attendance.
2. You agree to make yourself available for parenting consultations and/or family meetings as requested by your child or his/her counselor.
3. You agree to be supportive of the counseling process.

Counselor's Signature: _____

Date: _____

Minor's Signature: _____

Date: _____

Parent Signature: _____

Date: _____

Parent Signature: _____

Date: _____



Adolescent Counseling Information

What to expect from therapy:

You can expect that I will do my best to understand your concerns. I will listen non-judgmentally and provide an opportunity for you to learn more about yourself and hopefully together we will find better solutions to the challenges in your life.

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1. You agree to support your child's treatment by doing your best to arrange for regular attendance.
2. You agree to make yourself available for parenting consultations and/or family meetings as requested by your child or his/her counselor.
3. You agree to be supportive of the counseling process.

Counselor's Signature: _____

Date: _____

Minor's Signature: _____

Date: _____

Parent Signature: _____

Date: _____

Parent Signature: _____

Date: _____



**CONSENT TO USE OR DISCLOSE HEALTH
INFORMATION FOR THE TREATMENT, PAYMENT AND
HEALTH CARE OPERATIONS**

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health 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 confidential information for purposes of payment may include the submission of your personal information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers of insurers for claims review, determination of benefits and payment; or our submission of your personal information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at our office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform mental health treatment. 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 have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or mental health treatment, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

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

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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MENU CHILD-FAMILY SERVICES

Individual Child/Adolescent Therapy:

These weekly 1 hour sessions are designed to focus on concerns such as; self-esteem, peer relationships, developmental challenges, academic concerns, and family discord. Your child will be assigned to a counselor who has been specially trained and who receives comprehensive supervision in the treatment of children and adolescents.

Family Therapy:

Parents and children of all ages receive assistance in improving communication, establishing healthy boundaries, and learning and practicing effective conflict resolution skills. Your counselor will be an active participant facilitating conversation and providing psycho-education as needed.

Parent Consultation:

Working closely with your child's counselor is essential to your child's growth and development. You will be meeting at least once per month to discuss treatment progress and to receive feedback and assistance in ways to enhance the parent/child relationship. These meetings may take place alone with your child's counselor or in certain instances will include your child. The counselor will discuss with you the importance of your active participation and will be a resource for you and your child.

Parent Education Series:

An integral part of our treatment "package" is our Parent Education Series. All parents are afforded the opportunity to attend a (4-5) session series that will focus on common parenting challenges such as; effective discipline, productive communication, sibling relationships, etc. Your participation in the Series is a mandatory part of your child's treatment, and we have made every effort to make the series affordable and accessible.

Children/Parents of Divorce Series:

Many families face the disruption of conflict and separation. We have developed a program that addresses the needs of both parents and children. Children will meet in a weekly group facilitated by a specially trained counselor to discuss the emotional and practical aspects of divorce. Parents will have a similar opportunity to participate in a supportive, topic driven conversation to explore various aspects of the impact of divorce. These two groups will meet for 5 sessions and will conveniently be held at the same time affording both parent(s) and child the opportunity to participate simultaneously.

I understand the value of my active participation in my child's/family's counseling. I agree to schedule Parent Consultations as requested by my counselor and to attend a Parent Education Series.

Signature: _____

Date: _____

Signature: _____

Date: _____

Date/Time Parent Education Series: _____

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9107 Wilshire Boulevard, Lower Level Beverly Hills, CA 90210 (310) 271-9999 Fax (310) 247-4910
Website: www.tmcc.org



The
Maple
Counseling
Center

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Date: _____

Signature: _____

Date: _____

Date/Time Parent Education Series: _____

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:
