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,

Susanna De Mari, LMFT
Clinical & Program Director

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.

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Client Name: _____
Client ID#: _____

INTAKE FORM - GROUP

Name: _____ DOB: _____

Male: _____ Female: _____ Marital Status: _____

Address: _____
Street Address (Apt. #)_City State Zip

Phone: (_____)_____ # of Household Members: _____
OK to say TMCC? Yes ___No

Email: _____

I would like to receive email updates from TMCC ☐**Yes** ☐**No**

Employer: _____ Phone: (_____)_____
OK to say TMCC? Yes ____ No

Address: _____
Street Address (Apt. #)_City State Zip

In Case of Emergency Notify: _____Phone: (_____)_____
OK to say TMCC? Yes ____ No

Responsible Adult (if minor): _____Phone: (_____)_____

Primary Care Physician: _____Phone: (_____)_____

Psychiatrist: _____Phone: (_____)_____

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.

	None	Mild	Moderate	Severe
Sadness or Depression	0	1	2	3
Suicidal Thoughts	0	1	2	3
Sleep Problems	0	1	2	3
Change in Appetite	0	1	2	3
Weight Change	0	1	2	3
Inability to Concentrate	0	1	2	3
Obsessive Thoughts	0	1	2	3
Tension/Anxiety	0	1	2	3
Panic Attacks	0	1	2	3

	None	Mild	Moderate	Severe
Memory Problems	0	1	2	3
Compulsive Behavior	0	1	2	3
Feelings of Hostility	0	1	2	3
Acts of Violence	0	1	2	3
Social Isolation	0	1	2	3
Strange Thoughts	0	1	2	3
Sexual Problems	0	1	2	3
Other				

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

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

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

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

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

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

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

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

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

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

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? _____

****

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For Intake Worker -- Additional Comments: _____

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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 <u>you</u> 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.

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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: _____

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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

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	Employed
Federal	Corporate	Small Business	Retired
Municipal	Non-Profit	Disabled	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 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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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:

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