The Maple Counseling Center

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.

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

The Maple Counseling Center

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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The Maple Counseling Center

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 (i.e. cameraman)	Mental health professional	Retail, sales occupations
Banking, investments	Executive	Misc. gov't (i.e. postal, sanitation)	Student
Cashier	Farming, forestry, fishing	Model	Teaching professional, librarian
Clergy	Fashion industry	Motor vehicle operators	Technical support occupation
Computer related	Health diagnosing (i.e. 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)	

The Maple Counseling Center

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: _____

The Maple Counseling Center

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 use a fair share of the time
- To put thoughts and feelings into words, not actions
- To arrange for individual therapy sessions when an issue is not amenable to the group process

Payment

- To promptly pay each week for my group session. I understand that after four annual valid cancellations that I agree to pay for my place in the group whether I attend or not

Outside Contact

- To keep the relationships in the group therapeutic, not social. Interactions that occur between or among members outside of the group are group business and need to be brought back into the group

Termination

- To let the group participate when I think the time has come to terminate
- 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 (printed name) _____ (signature) _____

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Patient Information and Informed Consent for TeleCounseling Service

TeleCounseling is providing therapy/counseling services using interactive audio and visual (video) electronic systems where the provider and the patient are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

Requirements

A computer and a webcam with microphone to video conference using a HIPAA compliant online company specializing in telemedicine. As with any medical procedure, there may be potential risks associated with the use of TeleCounseling. These risks include, but may not be limited to:

- Therapy conducted online is technical in nature and problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. Any problems with internet availability or connectivity are outside the control of the doctor, and the doctor makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, the doctor will call the patient back at the phone number provided on this form.
- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by the psychiatrist or therapist.
- The provider may not be able to provide treatment to the patient using interactive electronic equipment, or provide for or arrange for emergency care that the patient may require, in cases of connection failure.
- Delays in evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Although highly unlikely, security protocols can fail, causing a breach of privacy of confidential medical information.
- A lack of access to all of the information that might be available in a face to face visit, but not in a TeleCounseling session, may result in errors in provider judgment.

My Rights

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to TeleCounseling.
- I understand that the technology used by the provider is encrypted to prevent the unauthorized access to my private medical information.
- I have the right to withhold or withdraw my consent to the use of TeleCounseling during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
- I understand that the provider has the right to withhold or withdraw his or her consent for the use of TeleCounseling during the course of my care at any time.
- I understand that all the rules and regulations which apply to the practice of medicine in the state of California also apply to TeleCounseling.
- I understand that the provider will not record any of our TeleCounseling sessions without written consent.

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- I understand that the provider will not allow any other individual to listen to, view, or record my TeleCounseling session without my express written permission.

My Responsibilities

- I agree to take full responsibility for the security of any communications or treatment information involved with my own computer and with my own physical location.
- I understand that I am solely responsible for maintaining the strict confidentiality of my user ID and password and I will not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location, so that others cannot hear my conversation.
- I understand that the company that the doctor has chosen to conduct the online appointment (see Guidelines) is an independent company specializing in HIPAA compliant telemedicine. My doctor has no responsibility for that company's operations or security of my protected health information. In addition, the company might send me emails or communication, such as appointment reminders. I understand that the provider is not responsible for this communication. If I am receiving any unwanted communication from the company, I will call/contact the company directly and address my concerns with them.
- I will not record any TeleCounseling sessions without written consent from the provider. I will inform the provider if any other person can hear or see any part of our session before the session begins.
- I have read and understand all of the clinic policies of The Maple Counseling Center, and that they apply to all telemedicine as well as all in-person visits.
- I consent to paying fees that are the same as an in-office visit for the type and length of service provided, through the billing department at The Maple Counseling Center.
- I understand that a TeleCounseling appointment is scheduled the same as an in-office appointment would be, and should I not be available for the appointment, or cancel it less than two full business days in advance, there will be a charge for a missed appointment for the time my practitioner has reserved for the scheduled appointment.

Patient Consent to the Use of TeleCounseling

I have read and understand the information provided in the preceding pages regarding TeleCounseling. I have discussed this information with my provider and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of TeleCounseling in my medical care and authorize the provider to use TeleCounseling in the course of my diagnosis and treatment.

Patient Name: First: _____ MI: ___ Last: _____

Date of Birth: _____/_____/_____

Signature of Client or Parent/Guardian: _____

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The Maple Counseling Center

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: