Welcome to Maple Counseling. 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.

FOR ADULT CLIENTS

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

CLIENT INFO	**STATUS, Employment and Marital**
Date of Birth: ____/_____/_____ Age: _____ Name: _____ Preferred Name: _____ Preferred Gender Pronouns:_____ Gender: M ☐ F ☐ Other:_____ Address: _____ City: _____ _____ Email: _____ I I would like to receive email updates from MC ☐ **Yes** ☐ **No** Home #: _____ Cell #:_____ Work #:_____ Other #:_____ On what number may we leave a **confidential message**: ☐ Home ☐ Cell ☐ Other	☐ Employed Employer: _____ Address: _____ City: _____Zip: _____ ☐ Self-employed ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled Zip: Does an immediate relative work for the City of Beverly Hills or BHUSD? ☐ **Yes** ☐ **No** I am: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed How many people live in your household? ____

How did you hear about MC?

☐ Referral from relative, friend or MC Client

☐ Therapist, Psychiatrist, Physician or Hospital Staff

☐ Community Agency/ Organization: *(name)*

_____

☐ Another Counseling or Mental Health Treatment Center: *(name)*

_____

☐ Department of Children and Family Services (DCFS)

☐ Other:

_____

☐ Internet Search

☐ Social Media

EMERGENCY CONTACT INFO

Emergency Contact: _____ Phone: _____

_____

Relationship to client: _____

HEALTH AND MEDICAL

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Please list any medical problems:

_____

Please list any current medications:

_____

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 MC before? ☐ **Yes** ☐ **No** If yes, when?

_____

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

Client name: _____

Client ID#: _____

Symptom Assessment

Please give as accurate an account as you can. 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					

Client name: _____

Client ID#: _____

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					

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?**

Client name: _____

Client ID#: _____

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 you or a close relative 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 ever attempted or committed suicide? ☐ **Yes** ☐ **No**

Have you ever attempted 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: _____

_____

_____

Maple Counseling Statistical Information

We gather this data to have overall information about our client population, and to inform our funders about who MC serves. If you "prefer not to state," you may leave any section blank. Thank you.

Beverly Hills Information	**West Hollywood Information**	**Completed Education Level**	**Income Level**
Check all that apply	Check all that apply	Check One	Check One

Client name: _____

Client ID#: _____

☐ Live in Beverly Hills	☐ Live in West Hollywood	☐ Grade school	☐ Less than $10,000
☐ Work in Beverly Hills	☐ Work in West Hollywood	☐ High School	☐ $10,000 to $14,999
☐ Beverly Hills City Employee	☐ West Hollywood City Employee	☐ AA degree	☐ $15,000 to $19,999
Position:	Position:	☐ Bachelor's degree	☐ $20,000 to $29,000
☐ Beverly Hills Student	☐ Fire Department employee	☐ Graduate degree	☐ $30,000 to $49,999
Grade:	☐ Police Department employee		☐ $50,000 to $99,999
☐ Fire Department employee			☐ $100,000 and above
☐ Police Department employee			
☐ BHUSD employee			
	Ethnicity		
Check all that apply			
☐ African, African-American, Black	☐ Asian, Asian-American	☐ Latinx, Hispanic origin	☐ White, Caucasian
☐ Middle Eastern	☐ South Asian	☐ Iranian, Persian	☐ Unwilling to be identified by race
☐ Mixed Race	☐ American Indian or Alaska Native	☐ Pacific Islander, Native Hawaiian	☐ Other: _____
	Religion / Cultural Affiliation		
Check One			
☐ Christian, Protestant, or Catholic	☐ Jewish	☐ Muslim	☐ Atheist
☐ Buddhist	☐ Hindu	☐ Mormon	☐ Agnostic
☐ Sikh	☐ Orthodox (i.e. Greek, Russian)	☐ Other: _____	☐ No religion

Maple Counseling Consent for Treatment

Please read carefully

Psychotherapy is a working collaborative 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. **Maple Counseling has a 24 hour cancellation policy**. If you cancel your appointment with less than 24 hours notice, or you fail to show up for a scheduled appointment, you will be charged for the session. Rescheduling an appointment for another time, even with 24 hours notice, is dependent on the counselor's availability and it may not be possible to have a session in that week. You are encouraged to cancel or request changes as early as possible in advance.
2. Your credit card on file will be charged each week at the time of your session. Should your card on file be declined, we will ask for updated card information. We reserve the right to suspend therapy if services are rendered and not paid for after three sessions. 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.
3. 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.
4. There is a $25.00 service fee for returned checks.

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.

III. Training and Clinical Supervision

1. Maple Counseling is a training center for Master's and Doctoral level counseling and psychology graduate students, Trainees and Associates. All counselors at Maple Counseling are pre-licensed, working 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. Recordings are for training and supervision purposes, and are viewed only by clinical supervisors and Maple counselors in a supervision setting. All recordings are erased in a timely manner. No recording of any portion of a session may be made other than by the counselor for this specific purpose of training and supervision. You must agree to be taped to receive counseling services at Maple Counseling.
3. Counselors are generally on a time limited contract with Maple Counseling. Therefore, it is possible that your counselor may leave Maple Counseling 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 Counseling 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.

Although your counselor has a Maple Counseling email address, email communication is only for the purpose of scheduling sessions. Therapy is not conducted via email, and you are asked to phone your counselor if you need to reach them between sessions.

V. Child Care Release

Maple Counseling 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.

Maple Counseling 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 Maple Counseling of your therapeutic needs, Maple Counseling's ability to address those needs, or other circumstances that lead Maple Counseling to conclude in its sole and absolute discretion that your counseling needs would be better served at an another counseling facility. Under such circumstances, Maple Counseling will suggest an appropriate counselor or counseling agency.

Your signature below indicates that you have read and understand this information and have received a copy of this consent form. You give permission to Maple Counseling to provide counseling services with the terms described, and understand that this contract is binding for all future sessions you may have with this entity.

Print Name: _____ Date: _____

Signature of Client _____

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 Maple Counseling. 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 LINK TO THE HIPAA NOTICE OF PRIVACY PRACTICES, located on Maple Counseling's website.

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:_____

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, tablet or phone, internet connection and a webcam with microphone to video conference is required. TeleCounseling should only be conducted using a HIPAA compliant online company.
Maple Counseling only provides TeleCounseling to clients who are physically located within the state of California.
Per California law, your counselor is required to confirm the address of your physical location at the start of each session.

As with any clinical 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 counselor, and Maple Counseling 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 counselor will call the patient back at the phone number provided on this form.
- The counselor 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 counselor judgment. Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate clinical decision making by the counselor.

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 Maple Counseling 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 Maple Counseling has the right to withhold or withdraw 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 psychotherapy in the state of California also apply to TeleCounseling.

- I understand that the counselor will not record any of our TeleCounseling sessions without my written consent.
- I understand that the counselor 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 responsible for using this technology in a secure and private location, so that others cannot hear my conversation. I will inform the counselor if any other person can hear or see any part of our session before the session begins.
- I understand that TeleCounseling sessions must be conducted safely, and I agree not to drive a vehicle or be engaged in other activity while participating in a session.
- I will not record any TeleCounseling sessions without written consent from the counselor.
- I agree to be sober at the time of my session, and refrain from use of alcohol or other substances during session.
- 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 understand that the company that Maple Counseling has chosen to conduct the online appointment (see Guidelines) is an independent company specializing in HIPAA compliant telemedicine. Maple Counseling 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 have read and understand all of the clinic policies of Maple Counseling, and that they apply to all TeleCounseling sessions 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 payment system established by Maple Counseling.
- 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 24 hours in advance, there will be a charge for a missed appointment for the time my counselor 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 counselor and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of TeleCounseling in my mental health care and authorize the counselor and Maple Counseling 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: _____

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:

As part of a programmatic partnership between Maple Counseling and The Jewish Federation of Greater Los Angeles, we ask you to please fill in the following information:

Do you identify as Jewish?

- ☐ YES
- ☐ NO
- ☐ PREFER NOT TO ANSWER

Were you referred to us for services by a Jewish organization?

- ☐ YES; *If so, which organization?* _____
- ☐ NO
- ☐ PREFER NOT TO ANSWER

Thank you!