Renaldo Strayhorn, Ph.D., LMFT #45042
P.O. BOX 931782, Los Angeles, CA 90093-1782
www.renaldostrayhorn.com – renaldo@renaldostrayhorn.com
Telephone: 818-753-6606

New Client Information

Client Name: _____ Today's Date: _____
(*To be completed by Parent/ Guardian if Client is under 18 years old*)

Client Address:_____

Date of Birth:	Social Security #:	Drivers License #:

Check for preferred call number

_ Home Phone	_ Cell Phone/Pager _ Work Phone

E-mail address:_____

If you were referred here, who referred you?_____

Relationship Status:
Single:____
Married:____
Divorced: ____
Separated: ____
Living Together:____
Widowed:____

Please list all the persons currently living in the home below:	Age

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Client Employer/ School:

_____
(Please include address & phone)

Occupation: _____

How long with your current Employer? _____

New Client Information:

Person(s) to be contacted in Case of Emergency:

Name: _____ Relationship: _____

Home Phone: _____Work Phone: _____

Insurance Information: *[if applicable]*

Health Plan: _____Policy Number: _____

Subscriber Name: _____ Employer: _____

Subscriber Social Security Number: _____

Additional Health Coverage Information: _____

Responsible Party *(if client is a minor or has a conservator):*

Name: _____

Relationship: _____

Address: _____

Date of Birth:	Social Security #:	Driver's License #:

Check for preferred call number

_ Home Phone	_ Cell Phone/Pager	_ Work Phone

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E-mail address:

_____

Employer/ School:

_____
(Please include address & phone)

New Client Information

Client Medical:

Primary Care Physician:_____
(Please include address & phone)

Date of last physical exam: _____

Current & Past Medical Illness & Surgeries:

_____

_____

Please list all current medications, over the counter medications, herbs, and supplements:

Name	*Dosage*	*Frequency*	*Dates Used*

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Client Counseling, Psychotherapy, & Psychiatric History:

Have you ever received treatment for psychological, psychiatric, behavioral, or relationship problems: Yes _____ No _____

If yes, Please describe:

_____

_____

Inpatient (hospital / treatment center):

_____

Outpatient (counseling or other treatment):

_____

Dates of Treatment: _____

Name of Previous Therapist/Psychiatrist: _____

Phone:_____

Address: _____

New Client Information:

Psychiatric Medication Dosage Frequency Dates Used:

Medication:	*Dates Used:*

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Client Alcohol and Drugs:

Have you ever used Drugs (street or Illicit) or Alcohol (*please include experimentation*): Yes _____ No _____

Substances Amount Frequency Dates Used

Substances	*Amount*	*Frequency*	*Dates Used*

Have you ever received Alcohol or Drug Treatment: Yes _____ No _____

If so, when & where:

_____

_____

Have you ever been arrested for being under the influence, possession, or D.U.I's: Yes ____ No ____

Do you drink coffee: Yes ____ No ____ How much: _____

Do you smoke: Yes ____ No ____ How much: _____

New Client Information:

Client Family History: (*Please describe any family history of emotional, behavioral, suicides (or attempts), psychiatric (care or hospitalization), medical, or substance abuse problems with your parents, siblings, spouse / partner, children, or extended family).*

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Presenting Problem(s): Please describe the reason(s) for seeking counseling & when these problem(s) began:

Please indicate how any problems you list are affecting the following areas of your life: [example - relationships, family, jobs, school, friendship, hobbies, financial, physical health, anxiety/worry/stress, mood, eating/not eating, sleep, sexual functioning, concentration, anger control, temper, lack of motivation, energy, other concerns/issues]:

Consent For Treatment, Disclosure Statement, Informed consent, & Agreement for Services :

Client Name: _____
(To be completed by the Parent/ Guardian if client is younger than 18 years)

Financial Agreement:

Many clients have insurance coverage for psychotherapy/ counseling services. As with all health care, the client or designated party is responsible for payment of service. Until your insurance coverage is verified, you will be expected to pay for services at the time service is rendered. Unless otherwise negotiated with Renaldo Strayhorn, Ph.D., LMFT #45042, payment of services is due in full at the time of service, and the standard fee for counseling services is $190.00 per clinical session. For those without health plan/ insurance coverage, payment arrangements should be made prior to your first counseling visit.

Client Initials: _____

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If you have insurance coverage, you are still responsible for payment of the bill. This will include any deductibles or any amounts unpaid by the insurance coverage unless otherwise contractually agreed upon between Renaldo Strayhorn, Ph.D., LMFT #45042, and your Insurance Company.

Client Initials: _____

Since many insurance companies will pay only a portion of treatment, a co-payment *may* be required and sometimes a deductible must be satisfied and is your responsibility. Any and all payment will be expected at the time of service.

Client Initials: _____

Clients whose costs are covered by insurance should be aware that coverage always requires a diagnosis. Some insurance companies require even greater information in order to complete treatment reports after a certain amount of counseling sessions.

Client Initials: _____

It is assumed that by requesting the completion of an insurance form you are granting permission to fill out the necessary information concerning diagnosis and treatment. Questions regarding your insurance company's policies on confidentiality must be addressed directly to your insurance company.

Client Initials: _____

Consent For Treatment, Disclosure Statement, Informed consent, & Agreement for Services :

Your fee per appointment is $ *190*_____
Your fees will be paid through the following means: _____
In full, before the start of the appointment.

Client Initials: _____

Release of Information:
By signing this form, I authorize the release of information for claims, certification/ case management/ quality improvement, and other purposes related to benefits of my health plan [Releases of information to providers, family, etc., requires a separate form].

Client Initials: _____

Returned Electronic Checks & Unpaid Balances:
Any returned electronic checks due to insufficient funds will be charged an additional *$50.00* fee. There will be a *10% service charge* applied monthly to *all unpaid* balances. No further appointments will be scheduled until any and all returned checks and balances are paid in full.

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Client Initials: _____

Canceled or Missed Appointments:
A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with less than 48 hours notice, the client will be billed *$100.00* for all Late canceled or missed appointments.

Client Initials: _____

Session Time:
Counseling sessions are fifty (45) minutes in length. Sessions lasting longer than sixty (60) minutes will be *prorated to the nearest quarter of an hour*, unless arrangements have been agreed upon by both counselor and client prior to the conclusion of session.

Client Initials: _____

Consent For Treatment, Disclosure Statement, Informed consent, & Agreement for Services

Telephone Contact:
Telephone contact is sometimes necessary to confirm appointments, change appointments, or convey brief information. For telephone contact lasting longer than 15 minutes you will be charged at your regular session rate. Messages are checked weekdays from 6PM to 9PM. Telephone calls are usually returned within 48 hours. If it is urgent please indicate so in your message, and the call will be returned within 24 hours. If urgent, you are more than welcome to call again in case you call has been inadvertently missed.***In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.***

Client Initials: _____

Secrets Policy:
It is the policy of Renaldo Strayhorn, Ph.D., LMFT #45042, to not hold secrets between couples, family members, or significant others involved in the counseling process even if such information is revealed without the presence of others or over the telephone. This will be discussed upon commencement of the start of treatment.

Client Initials: _____

Confidentiality:
All information between Renaldo Strayhorn,Ph.D., LMFT#45042 and client is held strictly confidential unless:
The client authorizes release of information with his/her signature.

The client presents as a danger to self.
The client presents a danger to others.
Child abuse and/or neglect are suspected
Elder and/ or dependent adult abuse and/or neglect are suspected (this included financial elder abuse). In the *latter four instances*, Renaldo Strayhorn, Ph.D., LMFT #45042 may be required by law to break client confidentiality to protect client, inform any potential victims, and/ or contact legal authorities so that protective measures can be taken.

Client Initials: _____

Consent For Treatment, Disclosure Statement, Informed consent, & Agreement for Services:

Consent for Treatment:

I further authorize and request that Renaldo Strayhorn, Ph.D., LMFT #45042 provide psychotherapy/ counseling services consisting of assessments, evaluations, diagnostic procedures, and treatments which now or during the course of my care as a client are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of counseling is designed to be helpful, it may at times be difficult and uncomfortable. The nature of psychotherapy/ counseling services to be provided can vary from client to client, and in some cases it might be necessary to make referrals to other practitioners for more extensive psychological testing, medication evaluation, or medical and / or psychiatric treatment. Mostly, however, problems tend to arise in the context of relationships, and those problems can be diminished through evaluation of the problem cooperatively by the therapist and the client(s). Treatment orientation may include but is not limited to various modalities within analytical, therapeutic, counseling, mental health practices. Many of these treatment orientations examine the client(s) psyche, thoughts, feelings, and behaviors that may be involved in the presenting problem as well as give assistance to both the therapist and the client(s) in diminishing the presenting problems.

Client Initials: _____

Termination of Therapy:

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your treatment, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals. Many clients frequently abruptly stop therapy. This analyst/therapist honors your decision and recognized your choice in termination; however, it is aspirational to have a

closure that is collaborative with the therapist/client dyad.

Client Initials: _____

Consent For Treatment, Disclosure Statement, Informed consent, & Agreement for Services :

Education & Clinical Experiences:

Renaldo Strayhorn, Ph.D., LMFT #45042, holds the following degrees from accredited institutions: Master of Arts in Clinical Psychology from Antioch University, Los Angeles. Additionally, he received his Ph.D., in Clinical Psychology, emphasis in Jungian Depth Psychology from Pacifica Graduate Institute.

I understand that Renaldo Strayhorn, Ph.D., LMFT is a Marriage and Family Therapist licensed by the State of California Department of Consumer Affairs, Board of Behavioral Sciences (MFC 45042) to provide therapy to individuals, couples, children, families, and groups in accordance with the provisions of Division 2 Chapter 13 of the Business & Professions Code.

I have read the above and I agree to accept treatment. Further, I agree to all conditions set forth and understand my responsibility.

_____ _____
Client Signature Date

_____ _____
Renaldo Strayhorn, Ph.D., LMFT #45042, Date

Assignment of Release of Benefits:

I hereby authorize my insurance benefits to be paid directly to *Renaldo Strayhorn, Ph.D., LMFT #45042,* the treatment provider, and acknowledge that I am financially responsible for the non-covered services.

I authorize *Renaldo Strayhorn, Ph.D., LMFT #45042,* to release any information required to my insurance company in regards to processing my claims and for quality assurance as necessary.

I acknowledge that *Renaldo Strayhorn, Ph.D., LMFT #45042,* may file claims for treatment services through an *insurance claims clearinghouse* or *insurance claims billing service*, and I also authorize the release of any information required

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in regards to processing my claims.

_____ _____
Insured and/or client signature Date

_____ _____
Insured and/or client signature Date

_____ _____
Renaldo Strayhorn, Ph.D., LMFT #45042, Date

Missed or Canceled Appointments Agreement:

Please read the following policy regarding missed and canceled appointments:

1. It is my responsibility to notify Renaldo Strayhorn, Ph.D., LMFT #45042, *at least 48 hours prior to the scheduled appointment if I am unable to keep the scheduled appointment.*

2. I understand that *I will be charged $100.00* in the event that I miss an appointment or fail to provide a 48 hour cancellation notice at (*818) 753-6606. My signature below indicates that I have read, understand, and agree to the above policy regarding missed and less than fourty-eight hour notice for canceling appointments.*

_____ _____
Client /Responsible Party Date

_____ _____
Renaldo Strayhorn, Ph.D., LMFT #45042 Date

Client Rights:

Renaldo Strayhorn, Ph.D., LMFT #45042, is a private Licensed Marriage & Family Therapist providing comprehensive psychotherapy /counseling services to individuals, couples, families, adolescents, and groups.

Your rights as a client are to:

• Be treated with respect and honesty throughout your relationship with your

therapist in a safe environment free from sexual, physical, and emotional abuse.

• Be provided with quality counseling services without bias to race, nationality, ethnicity, creed, gender, age, sexual preference, or socio-economic status.

• Be provided with quality counseling services as fits the best interest of your difficulties, or you will be referred in a timely manner.

• Request and receive full information about your therapist's professional capabilities including licensure, education, training, experience, as well as specializations and limitations.

• Know that counseling will be conducted in a lawful and ethical manner regardless if you are participating in individual, couple, family, child, or group counseling sessions. Counseling consists of face-to-face contact between the counselor and the person(s) in treatment focusing on the presenting problem(s) and the associated feelings, thoughts, and behaviors; assessing possible causes of the problem(s) and previous attempts to cope with it; and the possible alternative courses of action and their consequences.

• Refuse to answer any questions or disclose any information you choose not to reveal.

• Request and receive information from your therapist about your progress.

• Refuse a particular type of treatment, or end treatment without obligation or harassment.

• Know that you are expected to benefit from counseling, but there is no guarantee that you will. Maximum benefits from counseling can occur with regular attendance; however, you may temporarily experience counseling, at times, to be difficult and/ or uncomfortable. Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

• Know that all information and records obtained during the course of counseling are held strictly confidential, and they will not be released without your written consent unless:
a. The client authorizes release of information with his/her signature.
b. The client presents a physical danger to self.
c. The client presents a danger to others
d. Child abuse and/ or neglect are suspected.

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e. Elder abuse and/ or neglect are suspected.
f. Dependent adult abuse and/ or neglect are suspected.

• In the latter four instances, Renaldo Strayhorn, Ph.D., LMFT #45042, is required by law to inform the potential victims and legal authorities so that protective measures can be taken.

**BY SIGNING I ACKNOWLEDGE THAT I HAVE READ AND & UNDERSTOOD THIS POLICY.

_____ _____
Client Signature Date

_____ _____
Renaldo Strayhorn, Ph.D., LMFT #45042 Date