MARTHA CARR Psy.D.
Licensed Marriage and Family Therapist
MFT #30697

CONFIDENTIAL CLIENT INFORMATION
Family/Child Form

Date_____

Name of Child_____ Age_____DOB _____

Mother's Name_____Age_____DOB_____

Father's Name_____Age_____DOB_____

Married_____ Separated_____Divorced_____Remarried F: _____(yes/no)
M:_____

(If separate addresses please list both separately, indicate whether father's/mother's)

Street Address_____

City & State_____ Zip Code_____

Home Phone_____e-mail_____(M)

Cell Phone (M)_____

Cell phone (F)_____

Work: (M)_____

Work:(F)_____

Employer (M)_____ Title_____

(F)_____Title_____

Please check here if either of you do NOT wish me to contact you at work: F ☐ M ☐

(If Live Separately) Home address_____

City & State_____ Zip Code_____

Home Phone_____e-mail_____(F)

Other children living in your home? Please give names and ages:

_____ ___ _____ ____ _____ ___

_____ ___ _____ ____ _____ ___

Who referred you to me? _____

May I notify that person to thank them for the referral? (Please circle) Yes No

Pediatrician (Name, address & Phone):
_____

_____

Emergency Contact: Name_____

Phone_____

Who is Financially Responsible for the therapy?_____

Insurance Company_____Phone_____

ID No._____Group Number_____

This signature authorizes your insurance company to pay me directly:

Signature _____

Date_____

INFORMED CONSENT

RESPONSIBILITY FOR PAYMENT

I will make every effort verify your insurance eligibility and benefit coverage. You are responsible for all deductibles, co-pays and payments for sessions that are not covered by your insurance carrier. Please be aware that insurance companies will not pay for missed appointments or late cancellations (less than 24 hours). Under those circumstances you will be responsible for the entire fee (not just co-payments.) Please let me know if you wish to discuss my policies further with you.

DISCLOSURE:

The therapy relationship is a professional and confidential relationship. What is revealed in this setting is protected by professional and ethical standards, such that, with few exceptions, all material is confidential and not released without your written consent. Ethically and legally, however, there are some exceptions or limitations to confidence. They are:

1. If there is a reasonable possibility that you will harm yourself or others. In such a circumstance I have the ethical responsibility to provide for safety which includes the right to inform others. In the case of a minor, I will immediately inform you, the parent(s)/legal guardian, of any life threatening situation.

2. If I have reason to suspect Child, Dependent Adult or Elder Abuse. The State of California requires that I report to either Child or Adult Protective Services any reasonable suspicion of child abuse or evidence of dependent adult or elder abuse. This will result in an investigation of that possibility and, on the basis of that, a determination will be made as to whether the law has been broken and if legal action is warranted.

3. If I am ordered by a court to release information.

4. If you are using insurance to pay for therapy, your "authorization to release information" allows your insurance company to request information regarding your therapy. Please be aware that I will disclose only that which is necessary to release benefits. Insurance companies do require, at minimum, that I provide them with a diagnosis.

CANCELED APPOINTMENTS

I require at least 24 hours notice of cancellation. Without such notice it is my practice to charge you full fee for the missed or canceled appointment. Exceptions to this include true medical emergencies or unavoidable circumstances. Insurance companies will not pay for missed or canceled appointments. I will make every effort to re-schedule you if requested.

In order to create a positive and beneficial therapeutic relationship with my clients, it is my policy to maintain a confidential relationship with them at all times. Your involvement with me regarding your child's therapy will vary according to his or her age and need. I will arrange regular contact with you to let you know of your child's progress and/or to hear any special concerns you may have. Treatment may include individual sessions with the child, family sessions, or sessions with you, the parent(s)/legal guardian, separately.

Your signature indicates you have read, understood and agreed to the above.

Signature_____ date_____

Signature_____ date_____

4001 W. Alameda Ave #205 • Burbank, CA 91505 • (818) 559-7261