

**Life Source, Inc. - Roseville, CA - One Intake Form Per Person**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First "Nickname" Middle Initial  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ *If it is okay to call you at work, please list phone number*—Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Gender: Male Female

Marital Status: \_\_\_ Single \_\_\_ Widowed \_\_\_ Divorced \_\_\_ Separated \_\_\_ Married (Spouse's Name: \_\_\_\_\_)

Married, widowed, separated or divorced—How Long? \_\_\_\_\_

Living Arrangement: Live Alone? \_\_\_\_\_ Live With (If other than spouse) \_\_\_\_\_ Relationship \_\_\_\_\_

If you were previously married, list your prior marriages beginning with the first and number of years:

\_\_\_\_\_  
\_\_\_\_\_

**EMPLOYER** \_\_\_\_\_ City \_\_\_\_\_ Position/Occupation \_\_\_\_\_

**Children/Step Children/Names/Ages:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Education:** Highest Degree Completed: \_\_\_\_\_ Degree(s) Earned: \_\_\_\_\_  
Other Education/Training/Certification: \_\_\_\_\_

**If high school age or younger/current grade** \_\_\_\_\_ Parents(s) or Guardian(s): \_\_\_\_\_

**Religion:** Denomination \_\_\_\_\_ Church/Synagogue \_\_\_\_\_ City \_\_\_\_\_  
Attend How Often? \_\_\_\_\_ Positions or responsibilities \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

List any significant health problems:

List any medications you are presently taking & dosage:

**Emergency Information:** Nearest Relative/Friend: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

**How did you hear about LIFE SOURCE, INC.?**

- \_\_\_ Referred by Friend/Relative
- \_\_\_ Internet Search
- \_\_\_ Telephone Directory Ad
- \_\_\_ Physician Referral by Dr. \_\_\_\_\_ City \_\_\_\_\_
- \_\_\_ Referred by Pastor/Church Leader \_\_\_\_\_ Church/City \_\_\_\_\_
- \_\_\_ Other \_\_\_\_\_

Have you been in therapy before? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when? \_\_\_\_\_

Purpose of therapy and was treatment successful:  
\_\_\_\_\_  
\_\_\_\_\_

**Purpose of Seeking Therapy:** Therapy begins with a clarification of the reason for seeking therapy and the goals you would like to accomplish. Reason for seeking help at this time . . .

\_\_\_\_\_  
\_\_\_\_\_

**Goals I/We would like to accomplish during therapy . . .**  
\_\_\_\_\_  
\_\_\_\_\_

**Your Therapist . . . Dr. Orville E. Easterly - Licensed Marriage & Family Therapist**

Dr. Easterly is a California licensed Marriage and Family Therapist MFC27132 with over 30 years of counseling experience as a psychotherapist and minister. His Master of Divinity degree included course work in psychological care. His Doctor of Ministry degree project was in marriage and family counseling.

***OUR POLICY IS PAYMENT IN FULL ON THE DAY OF EACH SESSION.***

**Fees for Services – Dr. Orville E. Easterly**

45 min. Standard Session	<b>\$115</b>
Intake Session/ <b>60</b> Min. Session	<b>\$155</b>
Extended Session <b>90</b> minutes	<b>\$230</b>
Pre-Op Interview/Report	<b>\$195</b>
Telephone Consultation	<b>\$40</b> (per 15 minutes or any portion thereof)

\*Fees vary for special services such as psychological testing, report writing and review, summation of notes, mediation, reports, consulting with other professionals, or legal services.

**Cancellations/Missed Appointments.** Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of **48 hours (2 day) notice is required** for rescheduling or canceling an appointment. The full fee will be charged for late cancellation or missed appointment without such notification. *We will do our best to reach someone on the waiting list to fill your reserved time and then you will not be charged.*

Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_

*If client is a minor, please complete:  
I hereby grant permission for my child (print name) \_\_\_\_\_ to receive counseling.*

Signature Parent/Legal Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

## Life Source, Inc. -- Roseville, CA

### Office Policies & General Information Agreement for Services

*In keeping with state and federal legal and ethical mandates, **please read this information and sign** prior to your first session. Please let us know if you have any questions.*

**CONFIDENTIALITY:** *All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law.*

***When Disclosure Is Required By Law:*** Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a patient presents a danger to self, to others, to property, or is gravely disabled.

***When Disclosure May Be Required:*** Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony from your therapist. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Your therapist will use his/her clinical judgment when revealing such information. Your therapist will not release records to any outside party unless he/she is authorized to do so by all adult family members who were part of the treatment.

***Emergencies & Confidentiality:*** If there is an emergency during your treatment, or in the future after termination where your therapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, your therapist will do whatever he/she can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, your therapist may also contact the person whose name you have provided on the intake sheet.

***Health Insurance & Confidentiality of Records:*** Disclosure of confidential information may be required by your health insurance carrier in order to process the claims. If more information is needed by your carrier other than the usual diagnostic code, your therapist will consult with you before responding. Your therapist or Life Source, Inc. has no control or knowledge over what insurance companies do with the information that he/she submits or who has access to this information. You must be aware that submitting a mental health claim form for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance. The risk stems from the fact that mental health information is entered into big insurance companies' computers and soon will also be reported to a congress approved National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to be sold, stolen or accessed by enforcement agencies, which put you in a vulnerable position.

***Confidentiality of e-mail, cell phone, & fax communication:*** It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong number. Please notify your therapist and this office in writing if you decide to avoid or limit in any way the use of any or all of the above mentioned communication devices.

***Confidentiality & Litigation Limitation:*** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. *Please initial this paragraph \_\_\_\_\_*

***Consultation & Confidentiality:*** Your therapist consults regularly with other professionals regarding his/her patients; however, patient's name or other identifying information is never mentioned. The patient's identity remains completely anonymous, and confidentiality is fully maintained.

**Confidentiality & Your Right to Review Records:** Both law and the standards of my profession require that I keep appropriate treatment records. As a patient, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when your therapist assesses that releasing such information might be harmful in any way. In such a case, your therapist will provide the records to an appropriate and legitimate mental health professional of your choice. Often single charts include individual, couple, and family sessions. In which cases, all persons noted in the chart must sign a release of information or the chart must be audited, edited, and/or transcribed. This work requires your therapist's time and that of his support staff. The time involved will be charged at your therapist's normal and customary rate for research and writing. Therapy records are kept for 6 years from the last activity in your file.

**Minors in Therapy/Confidentiality:** If you are under eighteen years of age, please be aware that the law may give your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. It is the policy of Life Source, Inc. to request a written agreement from your parents or guardians indicating that they consent to give up access to such information and/or to your records. If they agree, your therapist will provide them only with general information about our work together subject to your approval, or, if your therapist feels it is important for them to know in order to make sure that you and people around you are safe. If your therapist thinks it is appropriate, he/she will involve them if your therapist feels that there is a high risk that you will seriously harm yourself or another/others. Before giving them any verbal or written information, your therapist will discuss the matter with you, if possible. Your therapist will do the best he/she can to resolve any difference that you and your therapist may have about what your therapist is prepared to discuss.

*\* Considering all of the above exclusions, if it is still appropriate, upon your request, your therapist will release information to any agency/person you specify unless your therapist assesses that releasing such information might be harmful in any way.*

**Dual Relationships:** Your therapist makes every effort to avoid entering into a dual relationship with a patient. However, all dual relationships are not unethical or avoidable and some can be clinically beneficial. Therapy never includes a dual relationship that impairs your therapist's objectivity, clinical judgment and therapeutic effectiveness or that can be exploitative in nature.

**TELEPHONE & EMERGENCY PROCEDURES:** Monday through Friday the office staff begins answering the phone at 9:00 a.m. On **Monday, Tuesday, Wednesday** and **Thursday** evenings phones are usually answered until 8:00 p.m. We are closed on major holidays. During business hours, we do our best to return your call promptly. On weekends the office voice mail is checked about once on Saturday and once on Sunday. In the case of an emergency, please call **911** or the local mental health center (**916/787-8860**) for assistance. Your therapist and the staff of Life Source, Inc. are not equipped to deal with emergencies that may require medical or hospital intervention.

**MEDIATION & ARBITRATION:** All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of your therapist and/or Life Source, Inc. and you. The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Placer County, California in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Life Source, Inc. can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum for the costs of arbitration and for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

**THE PROCESS OF THERAPY/EVALUATION:** Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits; however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Your therapist will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation.

During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions or perceptions or propose different ways of looking at,

thinking about, or handling situations which can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, your therapist is likely to draw on various psychological approaches depending, in part, on the problem that is being treated and his assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, family systems, developmental (adult, child, family), or psycho-educational.

**Discussion of Treatment Plan:** Within a reasonable period of time after the initiation of treatment, your therapist will discuss with you (patient) his/her working understanding of the problem, treatment plan, therapeutic objectives and his/her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, your therapist's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that your therapist does not provide, he has an ethical obligation to assist you in obtaining those treatments.

**Termination:** As set forth above, after the first couple of meetings, your therapist will assess if he can be of benefit to you. Your therapist does not accept patients who, in his/her opinion, he cannot help. In such a case, he will give you a number of referrals that you can contact. If at any point during psychotherapy your therapist assesses that he/she is not effective in helping you reach the therapeutic goals he/she is obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, he/she will give you a number of referrals that may be of help to you. If you request it and authorize it in writing, your therapist will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, your therapist will assist you in finding someone qualified, and if he/she has your written consent, he/she will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, your therapist will offer to provide you with the names of other qualified professionals whose services you might prefer.

***I have read the "Office Policies and General Information Agreement for Services" carefully; I understand them and agree to comply with them.***

Client/Guardian (Print Name) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

**Credit Card Authorization** - *Optional*:

**For your convenience, you may keep a credit card authorization on file to pay for your sessions.**

I, (please print name) \_\_\_\_\_,  
Client Name/Responsible Party

authorize Life Source, Inc. to charge my credit card for future sessions/services.

**Please check:**     Visa         MasterCard         Discover         American Express

Credit Card # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name on Card (please print): \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

Authorized Cardholder Signature \_\_\_\_\_ Date \_\_\_\_\_