Families First Therapy, LLC

Information Sheet

Partner 1 Information:

Legal Name: ______________________ DOB: ______________________
Preferred Name: ______________________ Social Security Number: ______________________
Gender Identity: ______________________ Biological Sex: ______________________
Pronouns: ______________________ Ethnic Identity: ______________________
Sexuality: ______________________ Religious Identity: ______________________
Other Identity: ______________________ Other Identity: ______________________
Primary Language: ______________________ Proficiency of reading / writing in this language: ______________________

Email, text messaging, and other electronic communications are not secure mediums and therefore, confidentiality cannot be assured. Please use discretion when sending information that is sensitive in nature.

Cell Phone ______________________ May I leave a message? YES NO
Marital Status: ______________________ May I text you? YES NO
Email: ______________________ May I email you? YES NO
Home Address: ______________________
Significant Relationship(s): ______________________
Relationship Agreement(s): ______________________

Partner 2 Information:

Legal Name: ______________________ DOB: ______________________
Preferred Name: ______________________ Social Security Number: ______________________
Gender Identity: ______________________ Biological Sex: ______________________
Pronouns: ______________________ Ethnic Identity: ______________________
Sexuality: ______________________ Religious Identity: ______________________
Other Identity: ______________________ Other Identity: ______________________
Primary Language: ______________________ Proficiency of reading / writing in this language: ______________________

Email, text messaging, and other electronic communications are not secure mediums and therefore, confidentiality cannot be assured. Please use discretion when sending information that is sensitive in nature.

Cell Phone ______________________ May I leave a message? YES NO
Marital Status: ______________________ May I text you? YES NO
Email: ______________________ May I email you? YES NO
Home Address: ______________________
Significant Relationship(s): ______________________
Relationship Agreement(s): ______________________

Emergency Contact(s):

______________________ Ok to Contact? YES NO
(Name) (Relationship) (Telephone Num.)

______________________ Ok to Contact? YES NO
(Name) (Relationship) (Telephone Num.)

Families First Therapy, LLC

Partner 1 Intake Questionnaire

Please complete the following questionnaire before your first appointment. This helps me complete an intake assessment and get an overall picture of your current struggles and strengths. While some of these questions may seem like asking a lot of information, most of these questions are required by the norms of the counseling field in order to provide you the best possible service. Thanks!

Reason for seeking counseling: ____

____

____

<u>Presenting Concerns (please check all that apply)</u>

- ☐ Suicidal Thoughts
- ☐ Problems with Child / Children: ____________
- ☐ Defiance / Oppositionality
- ☐ Anxiety / Worries
- ☐ Confusion
- ☐ Depression
- ☐ Difficulty Being Alone
- ☐ Fatigue
- ☐ Guilt / Shame
- ☐ Hearing Voices / Hallucinations
- ☐ Memory / Concentration Problems
- ☐ Mood Swings
- ☐ Motivation Reduced / Absent
- ☐ Obsessive Thoughts
- ☐ Panic (or Anxiety) Attacks
- ☐ Physical Abuse
- ☐ Low Self-Esteem
- ☐ Weight Change
  - ☐ Increase ☐ Decrease
- ☐ Sexual Abuse
- ☐ Sleep Problems
- ☐ Trauma / PTSD
- ☐ Struggles Attaching / Having Relationships
- ☐ Grief and Loss
- ☐ Coming out / GLBTQ Concerns
- ☐ Unusual Thoughts
- ☐ Body Image Concerns
- ☐ Anger / Aggression / Violence
- ☐ Parent / Child Conflict
- ☐ Social Struggles
- ☐ Drug / Alcohol Use Concerns
- ☐ Addiction
- ☐ Eating Habits / Problems
- ☐ Lying Frequently
- ☐ Perfectionism
- ☐ Physically Abusive to Self
- ☐ Other: ____________
- ☐ Other: ____________
- ☐ Shy, Uneasy with Others
- ☐ Passive / Unassertive
- ☐ Unwanted Behavior / Habits
- ☐ Withdrawn
- ☐ Employment / School Issues
- ☐ Legal Problems
- ☐ Living Arrangements
- ☐ Money Management Issues
- ☐ Parenting Issues
- ☐ Relationship / Marital Issues
- ☐ Cutting / Self-Harm
- ☐ Existential / Spiritual Struggles
- ☐ Divorce / Separation
- ☐ Communication Struggles
- ☐ Individual Sexuality Concerns
- ☐ Personal Pleasure Concerns
- ☐ Couple Sexuality Concerns
- ☐ Relationship Pleasure Concern

<u>Prior Behavioral Health Experiences</u>

1. Outpatient Counseling (most recent, to first)

Dates: From – To	Clinic	Therapist	Reason / Results (How was it?)

2. Intensive Treatment (including residential treatment, treatment foster care, and hospitalizations)

Dates: From – To	Clinic	Therapist	Reason / Results (How was it?)

Medical History (current and in the past)

Medical Conditions in the last year: ____________________

Chronic Illnesses: ____________________

Surgeries: ____________________

Head Injuries (TBI diagnosed or otherwise):____________________

Disabilities (physical or developmental): ____________________

Allergies: ____________________

Advanced Directives (if applicable): ____________________

Medication	Dose/Frequency	Start Date	End Date	Reason for RX	Prescribed By

Drug and Alcohol Use History:

Past Use	Type	Quantity	Frequency	Date Started (If applicable)	Date Ended (If applicable)
Alcohol					
Tobacco					
Non-Prescribed Drugs					

Have there been any undesirable results of your drug or alcohol use? YES NO
(struggles at school / job, physical health problems, relationship problems, legal problems)

Have you ever been concerned about your drug or alcohol use? YES NO

Have others expressed concern about your drug or alcohol use? YES NO

Have your loved ones struggled with problems related to drug or alcohol use? YES NO

Have you ever attended a 12-step support group (AA, NA, Al-Anon, etc.)? YES NO

Are you currently attending a 12-step support group? YES NO

Describe your daily caffeine consumption (tea, coffee, energy drinks, chocolate, soda): ____________________

____

Education and Employment (if applicable):

1. Education History

Highest level of education to date: ____________________

Current School / Field of Study: ____________________

2. Employment History

Are you currently employed? YES NO Job Title: ____________________

Do you have any concerns about employment? YES NO :____________________

3. Military Experience

Have you been in any branch of the military? YES NO Branch ____________ Position ____________

Reason for Discharge: ____________________

Families First Therapy, LLC

Partner 2 Intake Questionnaire

Please complete the following questionnaire before your first appointment. This helps me complete an intake assessment and get an overall picture of your current struggles and strengths. While some of these questions may seem like asking a lot of information, most of these questions are required by the norms of the counseling field in order to provide you the best possible service. Thanks!

Reason for seeking counseling: ____

____

____

Presenting Concerns (please check all that apply)

- ☐ Suicidal Thoughts
- ☐ Problems with Child / Children: ____________________
- ☐ Defiance / Oppositionality
- ☐ Anxiety / Worries
- ☐ Confusion
- ☐ Depression
- ☐ Difficulty Being Alone
- ☐ Fatigue
- ☐ Guilt / Shame
- ☐ Hearing Voices / Hallucinations
- ☐ Memory / Concentration Problems
- ☐ Mood Swings
- ☐ Motivation Reduced / Absent
- ☐ Obsessive Thoughts
- ☐ Panic (or Anxiety) Attacks
- ☐ Physical Abuse
- ☐ Low Self-Esteem
- ☐ Weight Change
  - ☐ Increase ☐ Decrease
- ☐ Sexual Abuse
- ☐ Sleep Problems
- ☐ Trauma / PTSD
- ☐ Struggles Attaching / Having Relationships
- ☐ Grief and Loss
- ☐ Coming out / GLBTQ Concerns
- ☐ Unusual Thoughts
- ☐ Body Image Concerns
- ☐ Anger / Aggression / Violence
- ☐ Parent / Child Conflict
- ☐ Social Struggles
- ☐ Drug / Alcohol Use Concerns
- ☐ Addiction
- ☐ Eating Habits / Problems
- ☐ Lying Frequently
- ☐ Perfectionism
- ☐ Physically Abusive to Self
- ☐ Other: ____________________
- ☐ Other: ____________________
- ☐ Shy, Uneasy with Others
- ☐ Passive / Unassertive
- ☐ Unwanted Behavior / Habits
- ☐ Withdrawn
- ☐ Employment / School Issues
- ☐ Legal Problems
- ☐ Living Arrangements
- ☐ Money Management Issues
- ☐ Parenting Issues
- ☐ Relationship / Marital Issues
- ☐ Cutting / Self-Harm
- ☐ Existential / Spiritual Struggles
- ☐ Divorce / Separation
- ☐ Communication Struggles
- ☐ Individual Sexuality Concerns
- ☐ Personal Pleasure Concerns
- ☐ Couple Sexuality Concerns
- ☐ Relationship Pleasure Concern

Prior Behavioral Health Experiences

1. Outpatient Counseling (most recent, to first)

Dates: From – To	Clinic	Therapist	Reason / Results (How was it?)

2. Intensive Treatment (including residential treatment, treatment foster care, and hospitalizations)

Dates: From – To	Clinic	Therapist	Reason / Results (How was it?)

Medical History (current and in the past)

Medical Conditions in the last year: ______

Chronic Illnesses: ______

Surgeries: ______

Head Injuries (TBI diagnosed or otherwise): ______

Disabilities (physical or developmental): ______

Allergies: ______

Advanced Directives (if applicable): ______

Medication	Dose/Frequency	Start Date	End Date	Reason for RX	Prescribed By

Drug and Alcohol Use History:

Past Use	Type	Quantity	Frequency	Date Started (If applicable)	Date Ended (If applicable)
Alcohol					
Tobacco					
Non-Prescribed Drugs					

Have there been any undesirable results of your drug or alcohol use? YES NO
(struggles at school / job, physical health problems, relationship problems, legal problems)

Have you ever been concerned about your drug or alcohol use? YES NO

Have others expressed concern about your drug or alcohol use? YES NO

Have your loved ones struggled with problems related to drug or alcohol use? YES NO

Have you ever attended a 12-step support group (AA, NA, Al-Anon, etc.)? YES NO

Are you currently attending a 12-step support group? YES NO

Describe your daily caffeine consumption (tea, coffee, energy drinks, chocolate, soda): ______

______

Education and Employment (if applicable):

1. Education History

Highest level of education to date: ______

Current School / Field of Study: ______

2. Employment History

Are you currently employed? YES NO Job Title: ______

Do you have any concerns about employment? YES NO :______

3. Military Experience

Have you been in any branch of the military? YES NO Branch ______ Position ______

Reason for Discharge: ______

Families First Therapy, LLC

CONSENT TO TREATMENT

It is the policy of Families First Therapy LLC that clients have the right to say whether or not they wish to receive Outpatient services. Each client has impartial access to treatment, regardless of race, religion, gender identity, ethnicity, age, sexual preference or disability, within the range and diagnostic criteria for which Families First Therapy LLC provides treatment.

The undersigned acknowledges that Families First Therapy LLC makes no guarantees to the undersigned or the client as to the results or likelihood of success of Families First Therapy LLC services.

The undersigned acknowledges that if a client becomes dangerous to him/herself or to others, the staff will exercise the necessary precautions in order to protect the client or others.

The undersigned acknowledges receiving a copy of information about Families First Therapy including policies and procedures, Informed Consent, HIPPA compliance protocols, and Notice of Privacy Practices.

The undersigned releases Families First Therapy LLC staff from any liability for the loss or damage of personal property and/or money while receiving services at Families First Therapy LLC or at the client's home.

These services are completely voluntary:

☐ **Yes; I Consent** to receive outpatient services from Families First Therapy LLC for myself or on the behalf of the client.

☐ **No; I Do Not Consent** to receive outpatient services from Families First Therapy LLC for myself or on the behalf of the client. Referrals for outside services or alternative services can be supplied upon request.

My signature below attests to the fact that I have read this form, understand its content and request that the above information be released as specified.

____ ____________________
PARTNER 1 SIGNATURE DATE

____ ____________________
PARTNER 2 SIGNATURE DATE

I have discussed the notice of privacy practices, informed consent, consent to treatment, consent to policies, consent to payment policies, consent to Relationship therapy, consent to cancellation policy, and client rights and responsibilities with the couple. My observations of their behavior and responses give me reason to believe that they are fully competent to give informed and willing consent. My signature below attests to this statement.

____ ____________________
STEPHEN RATCLIFF, MA, LPCC, NCC, CST DATE

Cell (505) 504-5449 www.steveratcliff.com steve@familiesfirsttherapy.org

Families First Therapy, LLC

CONSENT TO POLICIES

Thank you for choosing Families First Therapy as your therapy provider. Please review carefully the consent to disclosure to insurance companies (if applicable) and receipt of notice of privacy practices below. If you agree to each item, please have both people initial next to each statement indicating your agreement and sign at the bottom.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

_______ _______I acknowledge that I have been provided a Notice of Privacy Practices that fully explains the uses and disclosures that Families First Therapy will make with respect to my individually identifiable health information. I understand that I have the right to review said notice before signing this consent. Additional copies of this notice are posted on the website www.familiesfirsttherapy.org and also in the office lobby. I also understand that Families First Therapy reserves the right to change its notice and the practices detailed therein prospectively, and will notify me of any changes.

RECEIPT AND CONSENT TO INFORMED CONSENT AND ADDITIONAL POLICIES

_______ _______I acknowledge that I have been provided and reviewed a copy of Informed Consent, additional privacy policies and cancellation and no show policy. I understand these policies and agree to abide by the boundaries and stipulations therein.

_______ _______I understand the limits of confidentiality in communication by electronic means. I will use discretion when electronically communicating information to this therapist.

My signature below attests to the fact that I have read this form, understand its content, and agree to these conditions.

PARTNER 1 SIGNATURE	DATE
PARTNER 2 SIGNATURE	DATE
STEPHEN RATCLIFF, MA, LPCC, NCC, CST	DATE

Cell (505) 504-5449 www.steveratcliff.com steve@familiesfirsttherapy.org

Families First Therapy, LLC

Please review carefully the boundaries and expectations outlined below. Please have both people initial next to each statement indicating your agreement and sign at the bottom. These are considered a necessary condition for treatment.

CONSENT TO PAYMENT POLICIES

PAYMENT POLICIES

_______ _______ We understand that all Copays, Deductible payments, Self-pay, or Sliding-scale fees are due at the time or service. If my insurance company denies paying for my services or indicates a deductible payment or different copay amount than indicates on my insurance card, then these payments are due five business days after I am invoiced.

_______ _______ We understand that if I don't have insurance, I will be expected to pay the noted fee (or sliding scale fee) for these services at each appointment. Any payments may be made via cash, check, or credit card.

_______ _______ We understand that the full-scale fees for services are as follows: Intake Assessment **$200**, After hours Therapy **$200** per 55 minutes, Counseling / Therapy Appointments **$175** per 55 minutes, Couples Therapy Appointments **$175** per 55 minutes, and a one-time **$30** fee for the Gottman Relationship Checkup Assessment Measures for couples psychotherapy clients.

_______ _______ We understand that any balances not paid within 30 calendar days may be turned over to collections with an additional 2% late fee added. I understand that if my bill must be turned over to collections due to not paying my balance after 30 calendar days, I am responsible for the collections fees (typically 40% of the total bill).

_______ _______ We understand that if payment for the services I receive is not made, the therapist may stop my treatment.

_______ _______ We understand that if I pay by check or credit card and the payment is later recouped (e.g. the check bounces), a fee of **$50 per incident** will be incurred. I understand that this balance must be paid by alternative means in 5 days.

ADDITIONAL SERVICES

_______ _______ We understand that any out of session communication (telephone call or other medium) lasting more than 5 minutes will result in a fee of **$25** per 15 minutes. There will be no fee for contacts lasting less than 5 minutes.

_______ _______ We understand that other services such as record preparation, report writing, and other documentation are charged at the rate of **$25** per 15 minutes.

_______ _______ We understand that if I choose to subpoena Stephen Ratcliff, all legal services including preparation time, testimony time, transportation time, and commute time will incur a fee of **$500** per hour due prior to testimony date.

CONSENT TO CANCELLATION POLICY

_______ _______ We understand that if I am unable to attend my scheduled therapy appointment, I must first notify Families First Therapy by email or at 505-504-5449 by text or voicemail 24 hours in advance of my appointment.

_______ _______ We understand that If I do not call to cancel or reschedule my appointment, this will be considered a **no-show**. Additionally, arriving later than 20 minutes for my scheduled therapy appointment time constitutes a no-show. No-shows to appointments are not covered by my health insurance and will result in a subsequent fee of **$25**.

_______ _______ We understand that reoccurring no-shows / same day cancellations (2 instances in 12 months) may result in the termination of services. I understand that if I miss my scheduled appointment, it is my responsibility to call to set up another appointment. I understand that if I don't respond to contact attempts from Families First Therapy, this will interpreted as communication that I no longer wish to receive services.

_______ _______ We understand that if extenuating circumstances arise and I cancel in advance of my appointment but not with 24 hours' notice, Families First Therapy may choose to waive this fee on a case-by-case basis.

_______ _______ We understand that if I miss my scheduled appointment, it is my responsibility to call to set up subsequent appointments. Failure to cancel with 24-hour prior notice *may* result in me losing my preferred time slot. If I am failing to maintain contact, Families First Therapy may take this as communication that I am terminating services.

My signature below attests to the fact that I have read this form, understand its content, and agree to these conditions.

_____________________________________ _______________
PARTNER 1 SIGNATURE DATE

_____________________________________ _______________
PARTNER 2 SIGNATURE DATE

_____________________________________ _______________
STEPHEN RATCLIFF, MA, LPCC, NCC, CST DATE

Families First Therapy, LLC

CLIENTS RIGHTS AND RESPONSIBILITIES

<u>Client's Rights</u>

1. The right to efficient and equal service, regardless of race, gender, religion, ethnic background, education, social class, physical or mental disability, sexual orientation, gender identity, or economic status.
2. The right of considerate, courteous and respectful care from all Families First Therapy, LLC staff.
3. The right to informed consent and full discussion of risks and benefits prior to any invasive procedure, except in an emergency. Alternative to the proposed procedure must be discussed with the client.
4. The right to receive information in an understandable manner.
5. The right to obtain a referral for bi-lingual services or to have an interpreter present in session if needed.
6. The right to the names, titles, and professions of Families First Therapy, LLC staff with whom the client speaks and from whom services or information are received.
7. The right to refuse examination, discussion, and/or procedures to the extent permitted by law and to be informed of the health and legal consequences of this refusal.
8. The right of access to the client's own personal health record.
9. The right to confidentiality and privacy of the client's personal mental health records as provided by the law. The details of the clients life and treatment are shared only with the client's parent's or guardian's permission and the client's explicit consent.
10. The right to expect reasonable continuity of care within the scope of services of Families First Therapy, LLC.
11. The right to examine and receive a full explanation of any charges made by Families First Therapy, LLC regardless of the source of payment.
12. The right of respect for the client's civil rights and religious opinions.
13. The right to be represented by a family member of guardian if the client is unable to fully participate in treatment decisions.

<u>Client's Responsibilities</u>

1. Provide accurate and complete information relevant to your treatment at Families First Therapy, LLC.
2. Ask questions if you do not understand any aspect of your treatment.
3. Report safety concerns immediately to your therapist.
4. Avoid drugs, alcoholic beverages or toxic substances while in attendance of your therapy session.
5. Accept the consequences if you do not follow the care, service, or treatment plan provided to you.
6. Respect the property of other people and of Families First Therapy, LLC.
7. Be considerate of other clients.
8. Sign a written acknowledgement that you have received the applicable Notice of Privacy Practices.
9. Provide accurate information needed for processing your insurance coverage.
10. Be responsible for payment of all services, either through your third party payers (insurance company) or by personally making payment for any service that are not covered by your insurance policy(s) including second opinions or consultations.

By signing below, I acknowledge my client's rights and responsibilities listed herein.

______________________________	______________
PARTNER 1 SIGNATURE	DATE
______________________________	______________
PARTNER 2 SIGNATURE	DATE
______________________________	______________
STEPHEN RATCLIFF, MA, LPCC, NCC, CST	DATE

Cell (505) 504-5449 www.steveratcliff.com steve@familiesfirsttherapy.org

Families First Therapy, LLC

INFORMED CONSENT FOR RELATIONSHIP COUNSELING

General Information

Please review the following boundaries and information carefully and thoroughly. Please feel free to ask any questions!

- I utilize Gottman method, attachment-focused, emotion-focused and other supplementary couples therapy methods. I seek to create a tailored treatment approach that builds on your relationship's strengths and addresses your unique situation and struggles.
- Once we have started Couples therapy, I will be unable to offer individual therapy for any of the relationship members. This is due to a conflict of interest. I would be happy to offer a referral if desired.
- In relationship therapy, the relationship is the client rather than any of the relationship's members.

Expectations of the Process

- I will never advocate for you to stay together at all costs or to divorce. These decisions are yours to make and my job is to support you in making your relationship decisions rather than dictate a certain path for you.
- While I seek to support you in your relationship goals, I cannot guarantee any outcome from treatment.
- The continued participation by all members of the relationship is voluntary. Any participant may suspend or terminate the therapy at his or her individual request at any time.

Unique limitations regarding Confidentiality

Due to couples work involving two people, the following information is important to clarify at the beginning of therapy.

- In order for counseling information or records to be released, all members of the relationship must provide their written authorization. If all members of the relationship who participated in this therapy (as identified below) do not provide consent, then records cannot be released.
- Because there are two or more individuals who are the focus of treatment, privilege cannot be guaranteed. This means that confidentiality is somewhat more limited compared to individual therapy where information disclosed is considered privileged. Thus, anything involved with relationship counseling may not be privileged communication.
- I receive occasional professional consultation to help me improve my provision of services. Neither your name nor any identifying information about you and your relationship are revealed during these consultations.
- Because the process of relationship counseling involves a high amount of vulnerability in the efforts to build a closer emotional bond in the relationship, it is understood that all partners will not use the information disclosed during the therapy process against any other partner in a judicial setting of any kind, be it civil, criminal, or circuit. Likewise, neither party shall for any reason attempt to subpoena my testimony or my records to be presented in a deposition or court hearing of any kind for any reason, such as a divorce or custody case.
- Because of the limitations due to my scope of practice, I am unable to make any kind of formal recommendation or state any opinion regarding child custody (Custody recommendations are only permitted by a psychologist custody evaluator).

No Secrets Boundary

My allegiance is to your relationship and not to any of the partners of your relationship as individuals. I find this is particularly important in creating a space where all partners can feel safe. Therefore, I adhere to a strict "No Secrets" policy. This means that I will not hold secrets for any partner. This policy is intended to allow me to continue to treat the relationship by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the relationship being treated.

I affirm that I have read, fully understand, and agree with the Informed Consent for Relationship Counseling. I also affirm that a representative of Families First Therapy, LLC has answered all of my questions about these policies.

PARTNER 1 SIGNATURE ____________________ DATE ____________

PARTNER 2 SIGNATURE ____________________ DATE ____________

STEPHEN RATCLIFF, MA, LPCC, NCC, CST ____________________ DATE ____________

Cell (505) 504-5449 www.steveratcliff.com steve@familiesfirsttherapy.org

Families First Therapy, LLC

RELATIONSHIP COUNSELING PAYMENT AGREEMENT

Partner 1 Name: ____

Partner 2 Name:____

I ______________________________________(responsible party) agree to pay $___175.00___ per session, **for relationship psychotherapy services** received through Families First Therapy, LLC.

I also agree to, and understand, the following conditions:

- Sessions are defined as one hour in length. Extended fees may be incurred for longer sessions.
- The client, or responsible party, will be held responsible for all fees charged.
- Sliding scale fees are to be determined using the client's household income and the number of people in the household. All sliding scale arrangements must be made in advance of the session.
- Fees are due at the time of each session and will be accepted in the form of cash, check, credit card, or money order.
- Fees will only be refunded in the event that the service is not delivered.
- Non-payment of fees could result in the discontinuation of services to the client.
- Clients will be billed for any unpaid services via an invoice by mail. Any unpaid balances may be turned over to collections after 30 days.
- Insurance will NOT be billed for these services; consequently, none of the fees for services will be applied to an insurance plan's annual deductible.
- Because no diagnosis will be rendered and an individual is not being treated, insurance cannot be billed for these services.
- A $25 discount will be applied per session for any payments made in cash or check by clients at the time of service.

____ ______________

PARTNER 1 SIGNATURE DATE

____ ______________

PARTNER 2 SIGNATURE DATE

____ ______________

Stephen Ratcliff, MA, LPCC, NCC, CST DATE

Cell (505) 504-5449 www.steveratcliff.com steve@familiesfirsttherapy.org