Active Enhancement

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Licensed Marriage and Family Therapist #T0637 Oregon
Licensed Professional Counselor #C2022 Oregon

Family Consent/Information Form

Submit by Email

Print Form

This is an electronically fillable form. You can type directly into each field.

Please fill this form out as a family if possible. Do your best to answer all questions. This information will be used in your first session as a starting point for discussion. When finished completing the form, you can return to the top right hand corner of this page and click on the 'Submit it by Email' button. You will sign and date the form at the beginning of your first appointment. You can also print it for your records.

Family Name: Today's Date:

Parent(s) Name(s):

Home Address:

City, State, Zipcode:

Phone #: Work/Cell #s

Email Adresses:

Are your Email Adresses Confidential? Yes No

Relationship Status (check all that apply):

Married Romantic Relationship Living Together Living Apart

Separated Divorced

How long have you been together:

List names and ages of children (if applicable):

Are there any children from a previous marriage or relationship? Yes No

If 'Yes" please explain:

Please describe what brings your family to counseling at this time:

What does your family hope to accomplish through counseling:

What has your family already done to cope with difficulties:

Have family members had previous psychiatric counseling/therapy: ◯ **Yes** ◯ **No**

Check all that apply:

☐ **Individual Counseling** ☐ **Couples' Counseling** ☐ **Group Counseling** ☐ **Family Counseling**

If yes, when and where did family members receive counseling and what were the issues:

List any medications or prescriptions that family members are taking and for what health issue:

List any major health issues that familiy members may be experiencing now or in the recent past:

Are any family members currently under the care of a physician? ◯ **Yes** ◯ **No**

If 'Yes' for what condition?

What are your biggest strengths as a family and what do you do for fun or to relax?

Do family members exercise? ◯ **Yes** ◯ **No**

If 'Yes' please describe type and frequency of exercise:

Describe family eating habits and diet:

Do family members smoke cigarettes? ◯ **Yes** ◯ **No**

Consume alcohol? ◯ **Yes** ◯ **No** **How many drinks/day**

Put person's initials next to number **How many drinks per/wk**

Use non-prescribed/recreational drugs? ◯ **Yes** ◯ **No**

Interactions between client and therapist are confidential. Unless I have specific permission from you, I will not discuss the content of our sessions with any outside parties. There are four exceptions to confidentiality that Oregon State law requires mental health professionals to report.

1. Incidences of child or elder abuse.
2. Intent to commit suicide.
3. Threats to do harm to self or another person.
4. Court Order.

Additionally, in the event of a billing dispute, names, dates and lengths will be disclosed to a collection agency and/or attorney.

The community that we live in can often feel small and the possibility that we may see one another outside of therapy is always present. Your confidentiality is first and foremost in such situations and therefore, I leave it up to you if you would like to verbally or non-verbally recognize our encounter. I will follow your lead in such situations as I understand that everyone has a different comfort level when it comes to the privacy of their therapy.

If I am not able to make an appointment, I will cancel the appointment by telephone with at least a 24-hour notice.
If I miss a scheduled appointment without giving 24-hour notice, I agree to pay the full session fee.
Fees are:

$110.00 per 50 minute session for families.

*The $110.00 rate also applies if I see an individual member of the family alone or the parent(s)/guardian.

All Fees are due at the time of service and can be paid by check, cash or credit card (visa or mastercard)

I allow limited contact between sessions for informational purposes or emergencies. Any contact by either phone or email that is longer than 10 minutes will be billed at the rates above in half hour increments.

Insurance companies may or may not cover therapy. Clients are required to pay Active Enhancement, LLC directly and then apply for insurance reimbursement through their provider. If additional information is needed for you to file this claim, I will be happy to supply that information in a timely manner if you provide clear instructions by email.

The door access to my office building is unlocked during regular business hours only. If you find the door locked for your appointment, the code to gain access is 9262*. Please have a seat in the waiting room as I am most often with other clients until your specific time. The screen between the therapy room and waiting room is meant to protect your privacy while waiting, but cannot be guaranteed to do so.

I have read and understand all aspects of this form and agree to the terms and conditions. By signing below, I am consenting to therapy and releasing Active Enhancement, LLC/Kenny Wolford, M.A., M.F.T. from any and all liability resulting from therapy. I am the party responsible for payment of services and will pay in full at time of each therapy session. My signature below also confirms that I have received a copy of the "HIPAA Notice of Privacy Practices" and a "Professional Disclosure Statement" at the beginning of the first therapy session. I also understand that I can view and download copies of both of the above at Kenny's website: www.activeenhancement.com under the 'client forms' tab.

Printed Legal Name: _____ **Date:** _____

Signature _____ **Date:** _____

Printed Legal Name: _____ **Date:** _____

Signature _____ **Date:** _____

*Please return to page 1 of this form and click on the 'submit by email' tab as well as print a copy for your records.