Informed Consent

Andrea Gurney
Clinical Psychologist

Welcome to my practice. The following information is provided to inform potential clients of important information about my services and our work together. As a client in psychotherapy, you have certain rights that are important for you to know about; there are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you. Please feel free to ask for more information if anything is unclear.

Confidentiality & Exceptions: Initial: _____
Trust is crucial to our work together. Thus, all therapy sessions are confidential and may not be revealed to anyone without your written and verbal consent, except where disclosure is mandated by law. Legal exceptions to confidentiality are in place to protect your safety and the safety of others. This includes: when there is reasonable suspicion of child, elder, or dependent adult abuse or neglect; when a client presents a danger to self, to others, or to property; and when a court of law issues a legitimate subpoena.

I practice a no-secrets policy when working with couples, which means that confidentiality does not apply between the couple. Any information given will not be held in confidence in couples sessions, unless mutually agreed upon under rare circumstances involving personal safety.

Phone Messages & Emergencies: Initial: _____
My confidential business line, (805) 565-6057, is available to you 24 hours a day and I check it regularly on weekdays. I make every effort to return calls within 1 business day. In the event of an emergency and I am not available, please call 911 or go to your local Emergency Room.

Please know that if we spend more than ten minutes on the phone, I will bill you at a prorated basis for that time.

Cancellations: Initial: _____
When you schedule a session, this time is reserved solely for you. For this reason, I require 24 hours notice of cancellation or you will be charged the full fee for the session. I understand that occasionally circumstances beyond your control may arise which would prevent you from keeping your appointment; if this occurs, please do your best to give 24 hours notice.

Fees/Payments/Insurance: Initial: _____
My fee is $225 per 50 minute session. Longer sessions are prorated at the same rate. You are expected to pay at each session unless other arrangements have been made. I accept cash or checks made payable to Andrea Gurney.

I do not take insurance and therefore all professional services are rendered and charged directly to you, the client. I am happy to provide you with a monthly statement of services, which can be submitted to your insurance company for reimbursement if you so choose. It is, however, your responsibility to verify the specifics of your coverage.

Emails and Texting: Initial: _____
Many clients enjoy the convenience and ease of texting and/or emailing as a form of communication with me. This is fine as long as you understand that neither is 100% secure in terms of confidentiality. You can email me at drg@andreagurney.com and I will make every effort to reply as soon as possible.

Record Keeping: Initial: _____

I keep brief records noting that you have been here and what topics/interventions we discussed. Records are kept in a secure location that is not accessed by anyone else. If you prefer that I keep no records, you must give me a written request to this effect for your file and I will only note that you attended therapy in the record.

Treatment Length: Initial: _____

The decision to end therapy normally belongs to the client, with three exceptions. If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract. If I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. If you threaten, harass, or do violence to myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

Litigation Limitations: Initial: _____

Due to the sensitive nature of the therapeutic process, it is agreed that should there be any legal proceedings (such as, but not limited to, custody disputes, divorce, lawsuits, etc.), neither you (client) nor your attorney or anyone else acting on your behalf, will call me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Explanation of Dual Relationships: Initial: _____

Your relationship with me is strictly professional in nature. A therapist is not allowed to invite you into a business venture, ask for personal favors, or have a social relationship with you; this would be a "dual relationship" and is unethical. In the event I see you outside of the office, I will be discreet and maintain your confidentiality. I typically follow your lead, and thus it is your choice to acknowledge the encounter or not.

I look forward to working with you. Please bring this form to the first session so I may keep it in your file.

- □ I have thoroughly read and understand this informed consent document.
- □ I understand that I am financially responsible to Andrea Gurney, Ph.D.
- □ I authorize Andrea Gurney, PhD to proved psychological services.

_____ _____

Client/Parent/Guardian's Signature Date

_____ _____

Client/Parent/Guardian's Signature Date

_____ _____

Client's Signature if a Minor Date

Client History Form

Andrea Gurney
Clinical Psychologist

Name: _____
Date:_____

Current Symptom Checklist *(check all symptoms currently present):*

☐ depressed mood	☐ binging/purging	☐ guilt
☐ appetite disturbance	☐ laxative/ diuretic abuse	☐ elevated mood
☐ sleep disturbance	☐ generalized anxiety	☐ hyperactivity
☐ elimination disturbance	☐ panic attacks	☐ dissociative states
☐ fatigue/low energy	☐ phobias	☐ somatic complaints
☐ irritability	☐ specific anxiety	☐ self harm behavior
☐ poor concentration	☐ parenting problems	☐ weight gain/ loss
☐ self harm thoughts	☐ marital issues	☐ medical condition
☐ mood swings	☐ aggressive behaviors	☐ emotional trauma
☐ agitation	☐ paranoid thoughts	☐ physical trauma
☐ emotionality	☐ sexual problems	☐ sexual trauma
☐ obsessions/compulsions	☐ social isolation	☐ substance concerns
☐ grief	☐ feelings of worthlessness	☐ fear
☐ hopelessness	☐ self-doubt	☐ other _____

Emotional/Psychiatric History

Prior ***out***patient psychotherapy? ☐No ☐ Yes
Name of most recent therapist: _____ Reason for therapy:_____
Dates: _____ Helpful? ☐No ☐ Yes

Prior ***in***patient treatment for a psychiatric, emotional, or substance use issue? ☐No ☐ Yes
Name of most recent facility: _____ Dates: _____ Helpful? ☐No ☐ Yes

Has any family member had inpatient treatment for a psychiatric, emotional, or substance use issue? ☐No ☐ Yes
If yes, who/why:_____

Additional Information:
_____
_____
_____
_____

Relationships

Intimate relationship:
☐ currently in a serious relationship _____ years in current relationship
☐ never been in a serious relationship
☐ not currently in a relationship

Marital status:

☐ single, never married	☐ separated for _____ years	☐ ____prior marriages
(self)		
☐ engaged for _____ months/yrs	☐ divorce in process	☐ ____prior marriages
partner		
☐ married for _____ months/yrs	☐ divorced for _____ years	☐ live-in for _____ months/yrs

Relationship Satisfaction:

☐ very satisfied with relationship ☐ somewhat satisfied with relationship
☐ satisfied with relationship ☐ dissatisfied with relationship ☐ very dissatisfied

Briefly describe any significant issues in ***intimate*** relationships:

_____
_____
_____
_____

Sexual history:

☐ heterosexual orientation	☐ currently sexually active	☐history of unsafe sex
☐ homosexual orientation	☐ currently sexually satisfied	☐history of promiscuity
☐ bisexual orientation	☐ currently sexually dissatisfied	

Living Situation *(Spouse, Partner, Roommate, Children, Alone, etc)*:_____

Children's Names/Ages:

_____
_____
_____

Parents:

Father living? Y/N Name: _____Age:____ Occupation:_____
Education:_____
Mother living? Y/N Name:_____Age:_____ Occupation:_____
Education:_____

Parent's current marital status:

☐ married to each other	☐ mother remarried ___times	☐father remarried ___times
☐ separated from each other	☐ mother involved w/ someone	☐father involved w/ someone
☐ divorced for _____ months/yrs	☐ mother widowed	☐ father widowed

Medical History:

Describe your physical health: ☐ excellent ☐ good ☐fair ☐poor

Physician Name: _____ Phone:_____ Last Exam:_____

Psychiatrist Name *(if any):* _____Phone:_____ Last Exam:_____

Medications currently being taken (*give dosage and reason)*:

_____
_____
_____

List any known allergies:
_____

Describe any serious accidents or hospitalizations you have had:
Date: _____ Age:_____
Reason:_____
Date: _____ Age:_____
Reason:_____

Additional Medical Information:
_____
_____
_____
_____

Is there a history of any of the following in the family:

☐ diabetes	☐ heart disease	☐ stroke
☐ high blood pressure	☐ dementia/Alzheimer's disease	☐ thyroid problems
☐ birth defects	☐ cancer	☐ tuberculosis
☐ emotional problems	☐ behavior problems	☐ drug abuse
☐ alcoholism	☐ other:	

_____

Socio-Economic History

Social support system *(check all that apply)*:

☐ supportive network	☐ few friends
☐ substance-use based friends	☐ distance from family of origin

Employment:

☐ employed and satisfied	☐ coworker conflicts	☐ disabled
☐ employed but dissatisfied	☐ supervisor conflicts	☐unstable work history
☐ unemployed		

Legal history:

☐ no legal problems	☐ lawsuits pending
☐ arrest(s) not substance-related	☐ arrest(s) substance-related

Military History:

☐ never in military	☐ served in military – no incident
☐ served in military with incident	_____ years in military

Cultural/Spiritual/Recreational History

Currently active in community/recreational/spiritual activities?	☐ No	☐ Yes
Formerly active in community/recreational/spiritual activities?	☐ No	☐ Yes
Currently engaged in hobbies?	☐ No	☐ Yes
Currently participate in cultural/spiritual/religious activities?	☐ No	☐ Yes

If yes to above, please describe:
_____
_____
_____
_____

Additional Information/ Notes

_____
_____

_____
_____
_____
_____
_____
_____

_____
_____
Client Signature Date

Andrea Gurney
Clinical Psychologist

New Client Intake Form

Today's Date: _____

Personal Information

Name: _____

Date of birth: ___/___/___ Age:____ Social Security #: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Preferred Method of Communication: ☐ Phone Call ☐ Text ☐ Email ☐ Any

Employer: _____Occupation: _____

Emergency Contact: _____ Relationship: _____Phone: -_____

Current or Chronic Health Problem(s): _____

Current Medication(s): _____

Medical Doctor: _____ Date of Last Exam: _____

Previous Psychotherapy

Therapist:_____ Dates: _____

Therapist: _____ Dates: _____

What Brings You [Briefly describe why you are seeking therapy; what is the present situation?]

_____
_____
_____
_____

_____ _____

Client Signature Date

Andrea Gurney

Clinical Psychologist

Release of Information

I, _____, hereby authorize my therapist, Andrea Gurney, PhD, to exchange confidential information regarding my treatment with:

_____

_____

_____

I understand that I have a right to receive a copy of this authorization. A photocopy of this authorization will be as effective and valid as the original. I also understand that any cancellation or modification of this authorization must be in writing.

This authorization shall remain in effect for 180 days unless rescinded in writing.

I furthermore release all parties stated here within from any legal liability resulting from release of this information.

_____ _____

Client Signature Date

_____ _____

Andrea Gurney, Ph.D. Date