



Clinical Psychologist

Informed Consent

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 \$275 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@andregurney.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 provide psychological services.

Client/Parent/Guardian’s Signature

Date

Client/Parent/Guardian’s Signature

Date

Client’s Signature if a Minor

Date

Client History Form



Clinical Psychologist

Name: _____

Date: _____

Current Symptom Checklist (check all symptoms currently present):

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

Emotional/Psychiatric History

Prior **out**patient psychotherapy? No Yes

Name of most recent therapist: _____

Reason for

therapy: _____

Helpful? No Yes

Dates: _____

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
- engaged for _____ months/yrs divorce in process _____ prior marriages
- 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 _____ times mother remarried _____ times father remarried
- separated from each other someone 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:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> diabetes | <input type="checkbox"/> heart disease | <input type="checkbox"/> stroke |
| <input type="checkbox"/> high blood pressure problems | <input type="checkbox"/> dementia/Alzheimer's disease | <input type="checkbox"/> thyroid |
| <input type="checkbox"/> birth defects | <input type="checkbox"/> cancer | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> emotional problems | <input type="checkbox"/> behavior problems | <input type="checkbox"/> drug abuse |
| <input type="checkbox"/> alcoholism | <input type="checkbox"/> other: | |

Socio-Economic History

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

- | | |
|--|---|
| <input type="checkbox"/> supportive network | <input type="checkbox"/> few friends |
| <input type="checkbox"/> substance-use based friends | <input type="checkbox"/> distance from family of origin |

Employment:

- | | | |
|--|---|--|
| <input type="checkbox"/> employed and satisfied | <input type="checkbox"/> coworker conflicts | <input type="checkbox"/> disabled |
| <input type="checkbox"/> employed but dissatisfied | <input type="checkbox"/> supervisor conflicts | <input type="checkbox"/> unstable work history |
| <input type="checkbox"/> unemployed | | |

Legal history:

- | | |
|--|--|
| <input type="checkbox"/> no legal problems | <input type="checkbox"/> lawsuits pending |
| <input type="checkbox"/> arrest(s) not substance-related | <input type="checkbox"/> arrest(s) substance-related |

Military History:

- | | |
|---|---|
| <input type="checkbox"/> never in military | <input type="checkbox"/> served in military – no incident |
| <input type="checkbox"/> served in military with incident _____ years in military | |

Cultural/Spiritual/Recreational History

- | | | |
|---|-----------------------------|------------------------------|
| Currently active in community/recreational/spiritual activities? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Formerly active in community/recreational/spiritual activities? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Currently engaged in hobbies? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Currently participate in cultural/spiritual/religious activities? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

If yes to above, please describe:

Additional Information/ Notes

Client Signature

Date



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



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