

Craig Harris, LCSW

Licensed Clinical Social Worker LCS 21912
1665 Creekside Dr., Suite #106
Folsom, CA 95630
(916) 895-5639

• General Information

Client	Date of Birth	Male / Female
Address	Telephone (Cell)	(Work)
City	State	Zip

• If minor, please list legal guardian / parent

Name	Telephone
------	-----------

• Insurance Carrier Information

Insurance Company	Policy Number	Group Number
Address	Insured's Social Security Number	
Insured Name	Relationship to Client	

• Other Information

Occupation and Employer	Religion
-------------------------	----------

• Academic Information

Current School Name	Current or Highest Grade Completed
---------------------	------------------------------------

• Marital Status

Never	Married	Divorced	Separated	Widow(er)	Number of Marriages
-------	---------	----------	-----------	-----------	---------------------

• Family Members

Name	Age	Relationship	In the home
Name	Age	Relationship	In the home
Name	Age	Relationship	In the home
Name	Age	Relationship	In the home

• Medical Information

Primary Care Physician	Phone	Date of Last Physical
------------------------	-------	-----------------------

Medication (prescribed by whom, medication name, dosage)

Medical Conditions and/or Allergies

Alcohol Use (frequency / amount)

Drug Use (non-prescribed street or over the counter)

• Therapy Information

What would you like to discuss

How long has this been going on

Have you had previous therapy	By Whom	When
-------------------------------	---------	------

Person to contact in case of an emergency	Phone
---	-------

Referred By

May I thank them for the referral

Craig Harris, LCSW

Licensed Clinical Social Worker LCS 21912
1665 Creekside Dr., Suite #106
Folsom, CA 95630
(916) 895-5639

Thank You for Selecting Me as Your Therapist

Therapy is a process that may lead to problem solving, resolving grief and loss issues, and reaching personal goals. You may experience changes that have benefits and risks, and such changes can effect how you relate to others. Moreover, changes in relationships may occur. Sometimes throughout the process, you may feel worse before you feel better. I trust that you will let me know when you are having unmanageable painful feelings and call 911 or go to the hospital should you be in crisis away from our sessions. I look forward to working with you.

Office Address

1665 Creekside Dr., Suite #106, Folsom, CA 95630 (916) 895-5639

Confidentiality Statement

The law and ethics of psychotherapy protect your right to privacy. Information about you will not be released without your prior permission, except for the following:

1. Suspicion of child, dependent adult, or elder neglect or abuse.
2. Reasonable belief that you are a danger to yourself or others.
3. Insurance company requires a report of your diagnosis, therapy needs, and goals, for authorization of benefits.

Permission for Treatment

I, _____, give my permission to Craig Harris, LCSW, to see my son / daughter, _____, for treatment of counseling. This authorization is effective immediately and shall remain in effect until the termination of therapy, unless otherwise revoked by the undersigned.

Cancellations

For cancellations, please call me 24 hours in advance of your scheduled appointment. Otherwise, you will be charged for the session unless you have an obvious emergency. Your insurance company does not cover late cancellations or missed appointments and you will therefore be responsible for the fee of \$150.

Fees

My standard fee is \$150.00 per 50-60-minute session. Phone consultations lasting longer than 10 minutes will be charged at a rate of \$15.00 per 10-minute increment. I am ethically bound to offer a sliding scale for individuals and or families who are limited financially. I will also accept contract rates with insurance providers that may be less than my standard fee. Furthermore, I will offer referrals so that your counseling needs may be met by another, more affordable professional. If your insurance company requires co-payment, I am legally bound to collect this from you. You will be responsible for any fees incurred due to returned checks.

"I agree that I am responsible for payment of services not covered by insurance. I understand and agree to the above conditions and hereby request psychotherapy services."

Signature of Client Date

Craig Harris, LCSW Date

Signature of Parent / Legal Guardian Date

Signature of Parent / Legal Guardian Date

Craig Harris, LCSW

Licensed Clinical Social Worker LCS 21912
1665 Creekside Dr., Suite #106
Folsom, CA 95630
(916) 895-5639

Telemedicine Informed Consent Form

I _____ [name of patient] hereby consent to engaging in telemedicine with Craig Harris, LCSW as part of my psychotherapy. I understand that “telemedicine” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California.

I understand that I have the following rights with respect to telemedicine:

- (1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- (2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

- (3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g., face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

- (4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
- (5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all my questions have been answered to my satisfaction.

Electronic Signature of patient/parent/guardian

Craig Harris, LCSW

Craig Harris, LCSW

Licensed Clinical Social Worker LCS 21912
1665 Creekside Dr., Suite #106
Folsom, CA 95630
(916) 895-5639

Symptom Checklist

Please check the items that are currently causing you difficulty in your life:

- | | |
|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sex |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Codependency | <input type="checkbox"/> Work-Related Stress |
| <input type="checkbox"/> Parenting Issues | <input type="checkbox"/> Legal Issues |
| <input type="checkbox"/> Separation/Divorce | <input type="checkbox"/> Affair |
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Internet Addiction |
| <input type="checkbox"/> Sexual Orientation | <input type="checkbox"/> Eating/Weight Issue |
| <input type="checkbox"/> Relationship Problems with: | <input type="checkbox"/> Drugs: |
| <input type="checkbox"/> Significant Other/Spouse | <input type="checkbox"/> Prescription |
| <input type="checkbox"/> Children | <input type="checkbox"/> Illegal substances Parents |
| <input type="checkbox"/> Siblings | |
| <input type="checkbox"/> Friends | |
| <input type="checkbox"/> Co-workers | |