Mary Ewing Rixford, M. A., LMFT, LPC
6750 Hillcrest Plaza Dr. Suite 304
Dallas, Texas 75230-1447
(972) 788-0990
www.singlecandle.com

Name:____

Address:____

City & State:_______________________________ Zip Code:___________________

Home phone number:_________________   Work/Cell phone number:________________

Date of birth:_________ Who referred you for Counseling?_______________________

E-Mail Address: ______________________@______________________

_____   Please initial here if I may contact the person who referred you.

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What brings you to counseling?

How long have you considered counseling?

What finally helped you decide to come?

Has life been satisfying to you? _____ Yes _____ No   (Please explain)

Who or what have you lost of major significance in the past five years?

Please list your goals for counseling:

Are issues related to God, faith or spirituality important to consider in your counseling?
_____Yes _____ No (if yes, please describe on the back of this page)

Describe your current occupation (job, volunteer work, school, etc.):

Is your occupation satisfying to you? ______ Yes ____ No
(Please explain)

Are you satisfied with your current social life? _____ Yes _____ No (Please explain)

Have you had counseling or psychiatric care in the past? _____ Yes _____ No (If yes, please list the names of those with whom you were in treatment, the dates and length of treatment)

Type of treatment:

Are you currently being treated for any medical conditions? _____ Yes _____ No. If yes, (please describe and give the names of your physicians)

Please list the type and dose of all medically prescribed medication you are currently taking:

Please check which of the following substances you use and, after each you have checked, describe your pattern of use (number of times a day/week/month and amount):

_____ Alcohol

______Tobacco

______ Caffeine

______ Non-medically prescribed drugs (marijuana, cocaine, amphetamines, etc.)

______ Pain pills

______ Tranquilizers

______ Herbal remedies (list type)

______ Others (please describe)

RELATIONSHIP INFORMATION:

(Please check the one that applies to you):

_____ Single _____ Engaged _____ Long-term committed relationship
_____ Married _____ Separated _____ Divorced _____ Widowed

How long have you been in this relationship status?

If in a relationship, what is your partner's first name?

Please list the first names and ages of any children currently living in your home:

Children living away from home:

Names and ages of other persons currently living in your home:

Please list any other relationships of significance in your life and the length of this relationship:

FAMILY OF ORIGIN:

Describe your relationship with your mother (if she is deceased, please tell how she died and how old you were when she died):

Describe your relationship with your father (if he is deceased, please tell how he died and how old you were when he died):

Please list first names of your brothers and/or sisters. After each name, briefly describe your relationship with this sibling (if he or she is deceased, please tell how he/she died and how old you were when he/she died):

____

____

____

What is your birth order?

_____ Only child _____ Oldest Child _____ Middle child ______Youngest child

IMPORTANT FAMILY HISTORY:

Many factors have a strong effect on family life. Please check which of the following events occurred in your family. After each you have checked, please briefly describe who was involved in the event.

_____ Physical Abuse

_____ Sexual abuse

_____ Verbal Abuse

_____ Emotional abuse

_____ Neglect or abandonment

_____ Suicide

_____ Homicide

_____ Drug or alcohol abuse

_____ Domestic violence

Please list other events you believe had an important effect on your family or you:

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COUNSELING INFORMATION & CONSENT

Welcome to counseling. I hope your counseling experience is helpful and meaningful. As a way of getting our working relationship started, I will introduce myself, tell you about my philosophy of how counseling/therapy works and provide you with some important facts that will help you make informed choices about your counseling.

I have been working in the mental health field for more than thirty years. My work has included psychotherapy with individuals, couples, families and groups. For approximately fifteen years, I was privileged to supervise and train new Professional Counselors, Marriage and Family Therapists, crisis counselors, grief counselors and Pastoral Counselors. I am licensed as a Marriage and Family Therapist (LMFT) and a Professional Counselor (LPC). I am also certified as an Eye Movement Desensitization and Re-processing International Association (EMDRIA) therapist. Please ask me about any of these credentials and I will provide you with information about how to reach the licensing boards or certifying organizations. If you want more information about my experience, I will be happy to provide you with my Curriculum Vita or you may go to my web site, www.singlecandle.com..

I believe human beings are wondrously made with thoughts, feelings, and actions, bodies and spirits that can either help or stop them from meeting life's challenges. I define mental health as the ability to be honest with oneself and others, to take responsibility for self and the tasks of life, to have a sense of humor and to engage in meaningful, satisfying relationships, work and social activities. I am willing to explore with you how your thoughts, emotions, behaviors, physiology and or spirit may be helping or harming your ability to achieve mental health. If there are any areas you do not wish to explore, please tell me and we will not discuss those areas. **YOU ARE IN CHARGE OF YOUR THERAPY. IT IS OKAY TO SAY "NO" TO ANY SUGGESTION AND TO ASK ME "WHY" I AM DOING WHAT I AM DOING.** I am prepared to explore issues related to God, faith or spirituality from your perspective, but only if you request it. I am trained to reflect from *your* faith view, not my own.

I believe that a counseling relationship is collaborative. What "collaborative" means to me is that you and I meet as human beings with different experiences, knowledge and expertise. You are the expert on your life and have many resources within you that will help you meet your goals in therapy. I bring my own life experiences; my training and information about human psychology, behavior and theology that may assist you meet your goals in therapy. You and I will decide on mutually acceptable goals for therapy and work together to achieve them. We are both responsible for "the work" of therapy.

I am able to provide outpatient psychotherapy services. In other words, I am able to work with people who can be responsible for their part of the working relationship, take care of themselves between sessions and stay safe from harming themselves or others. I will make recommendations and refer to other professionals who can provide more intense therapy any person I perceive cannot take responsibility for her-/himself or who cannot remain safe between sessions. I believe your part of the working relationship is to set goals, make decisions about how you will live your life and solve your problems and take actions on your new decisions. You are also responsible for telling me what is helpful AND what is not helpful. I am responsible for assessing your needs in therapy, applying what I have learned to best address these needs, encouraging you to take the power within you to make your life work and for making recommendations of other resources to help you achieve your goals.

I do not believe I can help persons if certain conditions occur on a consistent basis. If these conditions occur, I will be unwilling to continue working with you and will make recommendations for other sources of help. The first condition is if you are prescribed medication by a physician and are not taking it as prescribed by that doctor, I will terminate professional responsibility for your care and make appropriate referrals. I am also unwilling to continue work with you if you are using drugs or alcohol in a way that I believe is harmful to you or others or that is impairing your progress in therapy. I am willing to work with you if I perceive you are taking responsibility for stopping harmful drug or alcohol use. If you arrive for a session under the influence of a non-medically prescribed, mind altering substance, I will not conduct a session with you on that day and will charge you for the session. If you choose to consistently not follow my recommendations that I deem essential for the maintenance of your mental health, I will notify you of my unwillingness to continue as your therapist and make appropriate referrals. I will not be able to help you if you are unwilling to keep yourself from self-harm or consistently act in violent ways toward persons or property. I will terminate our relationship if you consistently act in a disruptive, harassing or abusive manner to me, those around me in my place of business or toward any of my family or friends. If you consistently miss scheduled appointments, we will discuss your continued commitment to therapy and I may recommend termination or referral to other sources of help.

After you have read this information, please ask me any questions you may have. Keep asking questions until you are satisfied you understand the answers.

IMPORTANT INFORMATION ABOUT CONFIDENTIALITY

Many people believe that everything that is said in therapy is always kept confidential by their therapist. I am committed to keeping what you tell me private and confidential. However, some laws and careful professional practices may require me to tell others what you have said to me. Please carefully read and initial each of the following statements about some of the situations in which I cannot promise to protect your confidentiality. Changes in the laws and other circumstances out of my control may add situations to the list below that may affect your privacy. Please ask questions about what you read and only initial or sign when you are satisfied you understand the answers.

______ I understand that my therapist is required by law to report suspected or actual incidents of abuse or neglect of children, the elderly or others unable to care for themselves.

_____ I understand that the law permits my therapist to notify law enforcement officials or medical professionals if she believes I am dangerously close to harming myself or others.

______ My initial here gives my therapist permission to notify the following persons in cases of emergency or if she believes I am dangerously close to hurting myself or others. I understand that my therapist may choose to tell the following persons in order to get me the best help possible.

	Name	Address	Phone
1.	___________________________	_________________________________	_______________________
2.	___________________________	_________________________________	_______________________

_______I understand my therapist is concerned about the life and safety of all persons and that she may choose to notify any person she perceives I am dangerously close to harming (in addition to notifying law enforcement officials) in order to safeguard my safety and the safety of others.

_______I understand my therapist may be required to turn over my mental health records to an attorney or a judge if I am involved in a legal case such as child custody, civil litigation or criminal proceedings (please refer to the attach Policy for Legal Matters).

_______I understand that if I choose to use insurance to pay for therapy I am waving my rights to confidentiality to the extent requested by the insurance company.

FEES AND APPOINTMENTS

______ I understand I am responsible for paying a fee of __________ for each 45 – 50 minute therapy session and that I will pay, by check or cash, at the time of service rather than accumulating a balance.

_____ I understand I will be charged and expected to pay for missed (no show) or late cancelled (with less than 24 hours notice) appointments and that my insurance will not pay for missed or late canceled appointments.

THERAPIST_CONSULTATION

_____ I understand my therapist may consult with other professionals concerning my case in order to assure high quality service to me. I understand that she will protect my identity and confidentiality (within the limits listed above) when consulting with other professionals on my behalf.

My signature below means I have read this form, been given opportunity to ask questions and have received answers to my questions that I understand. My signature also means I am making a voluntary, informed choice to enter a counseling/therapy relationship with Mary Ewing Rixford.

Signature _____________________ Date:_______________

Policy Concerning Legal Matters

Please be notified, I am not a legal consultant or representative. I do not do custody evaluations or make recommendations regarding custody agreements. I do provide counseling, consultation, and psychotherapy to individuals, couples, and families who are making changes in their lives or dealing with difficulty in a life situation. Because I am mandated to protect the confidentiality of all my clients and their children, I shall not testify nor provide summary of sessions for the purpose of custody issues. I shall not discuss the content of any session with any legal representative. If, however, I am subpoenaed to do so or ordered to do so by a presiding judge, the fee to the party demanding such services will be $200.00 per hour for all activity related to and providing such a service including travel time, etc. Reasonable reimbursement for travel expenses is required. A retaining fee of $1500.00 must be prepaid.

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INFORMATION ABOUT YOUR FEE

Your fee is based on a sliding scale according to your net annual family income. The scale ranges from $50.00 to $125.00 for a 45 to 50 minute session. The fee is calculated by multiplying your net annual income by 1.5. For example, an income of $50,000.00 would qualify for a $75.00 fee. An income of $32,000.00 or less would qualify for the minimum fee of $50.00. I expect payment (in exact cash or personal check) at the time of service. I do not believe it is helpful to your counseling experience to add the stress of accumulating a balance for therapy.

If you use your insurance, your fee is still determined on this sliding scale. Your insurance company will not be charged more than you would be charged if you were paying out of pocket for therapy (unless a fee is predetermined due to a contract with that insurance company). Please ask questions about your fee before coming to your first appointment or at the beginning of your initial session. If you choose to use insurance to pay for service, I require you to pay my fee in full and I will provide you with the necessary documents to file, for yourself, with your insurance company. If you choose to use insurance, please read how your confidentiality may be affected and discuss these effects with me before releasing me to give information to your insurance company.

I believe all persons deserve affordable counseling services and that many cannot pay the current market standard fee nor do all persons have insurance benefits. Many with insurance choose to not use it due to the current lack of adequate protection for the confidentiality of mental health records. As a result, in appropriate circumstances, I am willing to discuss alternatives for affording counseling. Please discuss these options with me before deciding you cannot afford therapy.

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FINANCIAL INFORMATION & AGREEMENT

How do you plan to pay for therapy? ________ Self Pay _________ Filing insurance

How much money have you budgeted for therapy?

What is your family's net annual income?

List any financial obligations you believe have a significant impact on your family's budget and, therefore, will influence the fee we set:

****

PLEASE FILL OUT THIS SECTION IF YOU PLAN TO PAY FOR THERAPY YOURSELF

Your name: ____

Address: ____

City:________________________ State:_________ Zip:____________

Home phone number: _________________ Work Phone number:__________________________

Is someone else going to help you pay for therapy? ___ Yes ___No (if yes, please fill in the following):

Name:____

Address:____

City:________________________ State:_________ Zip:____________

Home phone number:________________ Work/Cell phone number:____________________________

What is this person's relationship to you?

My signature below means I understand my fee is ______________which I agree to pay in cash or by check at each therapy session. It also means I have been told how this fee is determined and I have received clear answers to any questions I have asked. My signature also means I am responsible for paying the full, negotiated fee for any appointment I schedule but do not show for (i.e., a "no show") or fail to cancel at least 24 hours before the scheduled appointment (i.e., a "late cancel"). My signature also acknowledges that I know that if someone else is responsible for payment of my therapy fees that Mary Ewing Rixford, M.A, LMFT, LPC may contact this responsible party listed above concerning billing or overdue balances.

Signature: _________________________________ Date: _____________

PLEASE READ AND FILL OUT THIS SECTION IF YOU WILL BE FILING INSURANCE

Important information about filing insurance for mental health treatment

Your insurance company may handle mental health benefits differently than medical benefits. I strongly recommend you call your insurance company to ask questions about mental health benefits before you decide to use insurance for psychotherapy. Many insurance plans will only pay for individual psychotherapy, not couple's or family therapy. If you are seeing me in a couple or a family I will not tell the insurance company I am doing individual therapy. As a result, you may be refused reimbursement for treatment. Most insurance companies require a mental illness diagnosis be made in order to receive payment for therapy. I will not make a mental illness diagnosis unless I believe it is warranted. As a result, you may be refused reimbursement for treatment. Currently, laws protecting the confidentiality and privacy of mental health records are inconsistent and inadequate. As a result, information given to your insurance company may not be kept confidential by them. This information could be released to third parties whom you may not want to have the information (i.e., employers or other insurance companies). A mental illness diagnosis or use of insurance for mental health treatment may affect future insurance coverage (i.e., life insurance premiums might be raised or future benefits denied). Please note: When you ask me to give information to your insurance company, you must give me permission to give them any information about your therapy that they request. The company could ask to see all forms you have completed and all my notes concerning your treatment. Some insurance companies can request to observe a therapy session. *IF YOU USE YOUR INSURANCE, I CANNOT PROTECT YOUR CONFIDENTIALITY.*

Please initial each of the following:

_______*I wish to file insurance for my mental health treatment.*

_______*I give Mary Ewing Rixford permission to release to my insurance company any information they request in order to handle or determine my claim.*

_______*I understand that Mary Ewing Rixford cannot fully protect my confidentiality if I choose to file for insurance reimbursement for her services.*

My signature below means I have read all information provided in this form, understand the possible consequences of filing for insurance reimbursement and have been given clear answers to the questions I have asked. My signature also means I agree to pay the fee at the time of service and will take responsibility for seeking reimbursement from my insurance company (with documents provided by Mary Ewing Rixford). My signature also means I am responsible for paying the full fee for any appointment I schedule but do not show for (i.e., a "no show") or fail to cancel at least 24 hours before the scheduled appointment (i.e., a "late cancel"). I understand my insurance company will not pay for missed appointments.

Signature ____________________________ Date: __________________

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Authorization for Release of Information

I, ____________________________________, authorize Mary Ewing Rixford to release her records regarding my treatment, history, information, etc., to:

Name: ____

Address: ____

Phone: ____

I also give her permission to consult and discuss my treatment with the party listed above and give permission to the party named above to discuss my treatment with Mary Ewing Rixford.

I release Mary Ewing Rixford and the party named above from any liability for injuries or damages resulting from the release of the above-mentioned information.

____

Patient's Signature

____

Date

____

Parent or Guardian Signature if Patient is a Minor

____

Date