Gwen Burson, LMFT
Intake Paperwork

Name:_____ Age:_____ Date of Birth:_____ Soc. Sec. #_____

Address:_____ City: _____ Zip:_____

Second Client or Responsible Party (if not client)

Name:_____ **A**ge:_____ Date of Birth:_____ Soc. Sec. #_____

Address:_____ City:_____ Zip:_____

Phone Numbers: (Please check the box if you are hesitant to receive calls at this location.)

Home: ☐_____ Work: ☐_____ Cell or pager #: ☐_____

Who can we call in an emergency? _____ Phone:_____
Name Relationship

Marital Status: Please check all that apply: ( ) Never married ( ) First marriage ( ) Separated
( ) Divorced ( ) Remarried ( ) Widowed ( ) Shared Living Arrangement

Household Members:_____
(List names, ages, relationship)

Educational Status: Years completed:_____ Degree/fields of study:_____

Current Occupation/Employer:_____

Former Occupations: _____

Religious Preference:_____

Name of church:_____ Attend church functions ( ) times per month.

Previous Therapy Experience: _____
Name of therapist, dates, problem

Psychiatric Hospitalizations:_____

Current Medical Doctor:_____ Phone:_____

Current Medications:_____

Medical Insurance_____ ID #_____ Group #_____

Name of Primary Insured:_____ Social Security#_____

Referring person or agency: _____
May we thank the person who referred you? Yes ( ) No ( )

Sources of Stress:

Goals for Counseling:

Gwen Burson, MFT
11344 Coloma Rd., Suite 250
Gold River, CA 95670
(916) 501-6706

Below I have outlined important information concerning policies, services and fees.

A. Conduct of Therapy

1. Confidentiality is of the utmost importance and your privacy will be respected and protected. Your personal life will not be discussed with anyone without your permission unless the law requires it (e.g. child abuse, elder abuse, mental health legal defense) or if you are a danger to yourself, or to someone else.
2. Specific goals of therapy will be developed by mutual agreement of the client and therapist, and will be reviewed periodically.
3. The client and the therapist are expected to begin and end appointments on time. Sessions last approximately 50 minutes.
4. Neither client nor therapist will terminate therapy without prior discussion with the other and an attempt to reach a mutual decision on the matter.
5. If it is necessary to bring young children to your appointment, please make arrangements for them to be supervised.

B. Cancellation Policy

In order to have adequate time to reschedule a client in the session reserved for you, 24 hours notice of a cancellation is needed. Otherwise, you will be charged for the professional time reserved. Missed appointments cannot be billed to insurance.

C. Billing Policy

Sometimes there is confusion with billing, particularly when insurance is utilized as part of the payment. It is important for you to understand your insurance coverage including the deductible, mental health coverage and co-payment policy. Full payment is expected at the time of service even if insurance is being used, unless there has been a previous arrangement with your therapist and insurance carrier.

$_____ Fee to be paid at each session.
$_____ Co-payment to be paid at each session:
with pre-arrangement with insurance carrier.

I have read the above and agree to these terms unless amended by mutual agreement.

Client:_____ **Date**:_____

Therapist**:**_____ Date:**:**_____