Michael Nunes, LCSW
7760 N. Fresno St., Suite 103
Fresno, CA 93720
(559) 940-9911

Client Information Form

Today's date: _____

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification
Your name: _____ Date of birth: _____ Age: ____

Nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

B. Referral: Who referred you?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No
How did this person explain how I might be of help to you? _____

_____

C. Religious and racial/ethnic identification
Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu

❑ Non Denominational Christian ❑ Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____ or other similar way you identify yourself and consider important: _____

D. Your medical care: From whom or where do you get your medical care?
Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

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E. Your current employer

Employer: _____ Address: _____

Work phone: _____ or other means of communication _____

Calls will be discreet, but please indicate any restrictions: _____

F. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

G. Your education and training

Dates From	Dates To	Schools	Special classes?	Adjustment to school	Did you graduate?

H. Employment and military experiences

Dates From	Dates To	Name of employers	Job title or duties	Reason for leaving

I. Family-of-origin history

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Brothers					

I. Family-of-origin history (Continued)

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Sisters					
Stepparents					
Grandparents					
Others					

J. Marital/relationship history

Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Has spouse remarried?
First				
Second				
Third				

K. Significant nonmarital relationships

	Name of other person	Person's age when started	Your age when started	Your age when divorced/widowed	Reasons for ending relationship
First					
Second					
Third					
Current					

L. Children Indicate those from a previous marriage or relationship with "P" in the last column.

Name	Current age	Sex	School	Grade	Adjustment problems?	P?

M. What are the main issues/problems that you are seeking help for?

1.

2.

N. Is there any other information you think I should know?

** This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.*

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Consent to Treatment

I do hereby seek and consent to take part in the treatment by the therapist named above. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), diagnostic information, procedure codes, and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist
Printed Name: Michael Nunes, LCSW Date

❑ Copy accepted by client ❑ Copy kept by therapist

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FORM 13. Form for generic consent to treatment of an adult. From *The Paper Office*. Copyright 2008 by Edward L. Zuckerman. Permission to photocopy this form is granted to purchasers of this book for personal use only (see copyright page for details).

MICHAEL NUNES, L.C.S.W.
7760 N. Fresno St., Suite 103
Fresno, CA 93720

Agreement to Pay for Professional Services

I, the client (or person acting for the client), request that the therapist named below provide professional services to me or to _____ , who is my _____, and I agree to pay this therapist's fee of $110 per session at the time of service. The first session (evaluation) fee is $150, but regular return/ongoing sessions are $110 per session. If I am covered under CuraLinc, Halcyon Behavioral, or Avante Health, I understand that I may have a co-payment and agree to pay those fees if applicable.

* I understand that if I need to cancel an appointment it must be at least **24 hours in advance**, otherwise I will be charged a late cancellation fee of 50 dollars for the first missed session. If additional sessions are missed and not cancelled within 24 hours, I understand that I will be charged $110 dollars per missed session.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

_____ _____
Signature of client (or person acting for client) Date

_____
Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist Date

__ Copy accepted by client __ Copy kept by therapist

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Information About Electronic Health Record Use

I, Michael Nunes, LCSW, currently use an Electronic Health Record (EHR) company to input client data and manage my client records. The company I currently use is nTreatment.com, an internet/cloud based system. nTreatment.com is HIPAA compliant. I currently use this company, but may use a different EHR company in the future. I agree and consent to this provider using nTreatment.com to store and manage my records relating to my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

_____ _____

Signature of therapist Date
Printed Name: Michael Nunes, LCSW

❑ Copy accepted by client ❑ Copy kept by therapist

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