PLEASE NOTE: If you are coming to see me for couples counseling, each of you must independently complete and sign your own copy of this form.

Name: _____Birthdate: _____Age: _____

Address: _____City/State: _____ Zip:_____

Primary Phone: _____ Secondary Phone: _____

Emergency Contact: _____Cell: _____ Home: _____

Briefly describe your reason for coming to see me: _____

_____

_____

How did you hear about me? _____

What is your religious affiliation? _____ None ❑

Education/Degrees: _____

Occupation: _____How Long? _____

Place of Employment:_____How Long? _____

If not employed, how long has it been since you worked? _____

What kind of job did you have? _____

What caused you to stop working? _____

Relationship Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Living Together

Current and Past Significant Relationships

To Whom	Length of Relationship	Ending Date of Relationship	Children together

Briefly describe your current relationship:_____

_____

_____

Age of current spouse/partner: _____Religion: _____

Education/degrees?_____Occupation: _____

Is he/she currently employed? ❑ Yes ❑ No How Long?_____

Has your partner had previous significant relationships? ❑ Yes ❑ No Number of times: _____

How long since his/her last one?_____

Number of children from previous relationship: _____Ages of children: _____

With whom are you currently living?

Name	Relationship	Age	Use of Alcohol/ Drugs?	How do you get along?

Extended Family: Parents, Siblings, And Others Close To You

Name	Relationship	Age	Occupation	Challenges: i.e. Alcohol, History Mental Illness

How was it to grow up in your family?_____

_____

_____

_____

Medical Information

When were you last examined by a physician?_____ Name of Doctor:_____

List any health problems for which you currently receive treatment: _____

_____

List any past health problems including accidents: _____

_____

List any medications you currently take: _____

Women only:

How many pregnancies have you had?_____Are you pregnant now? ❑ Yes ❑ No

Any miscarriages or abortions? ❑ Yes ❑ No How many? _____

Men and women:

Are you sexually active? ❑ Yes ❑ No Beginning at what age?____

Do you use birth control methods? ❑ Yes ❑ No If yes, what? _____

Have you ever had concern about eating habits? ❑ Yes ❑ No

Psychological/Emotional Information

Have you ever sought help or been treated for psychological or emotional reasons? ❑ Yes ❑ No

If so, when and where?_____

Was it helpful? _____

Have you ever thought about suicide? ❑ Yes ❑ No If so, did you have a plan? ❑ Yes ❑ No

Have you ever attempted suicide? ❑ Yes ❑ No If so, how many times? _____

Alcohol/drug use history

Do you feel you have a drug or alcohol problem? ❑ Yes ❑ No

Have you ever had any previous treatment for drug / alcohol abuse? ❑ Yes ❑ No

If so, when and where?_____

List all drugs, including alcohol, that you currently use, or have used in the last year (indicate frequency and amount): _____

_____

_____

Legal

Please list and describe any arrests or legal problems (including driving violations): _____

Circle any problem that pertains to you at the present:

Anger	Education	Sexual Problems	Work
Drug Use	Loneliness	Bowel Troubles	Relationship
Fatigue	Ambition	Stomach Problems	Divorce
Finances	My Appearance	Suicidal Thoughts	Future
Friends	Concentration	Nightmares	Temper
My thoughts	Parenthood	Health Problems	Age
Nervousness	Relaxation	Making Decisions	Stress
Self-esteem	Sexual Orientation	Physical Abuse	Anxiety
Separation	Energy	Inferiority	Appetite
Sexual Abuse	Children	Career Choices	Weight
Shyness	Legal Matters	Self Control	Memory
Sleep	Under / Over-eating	Alcohol Use	Overeating
Unhappiness	Depression	Headaches	Fears

Other: _____

Circle everything that has happened to you in the past three years:

Death of a spouse/partner	Relationship Problems	Changes in relationship status
Death of another family member	Family Problems (Children, in-laws)	Loss of Job
Major illness or injury–yourself	Financial Problems	Move to another city or state
Major illness or injury–family member	Legal Problems	Other: _____

Please list any additional information that you feel may be helpful for me to know about you:

Jeri L Kramer, Psy.D. 602-690-7763
Website: www.jerikramer.com Email: jeri@jerikramer.com

Office Policy and Financial Responsibility Statement

I UNDERSTAND THAT:

- Therapy sessions are **50 minutes** in length and are billed at **$145.00 per session.** Extended sessions are billed proportionately. Payment of cash, check or credit card is due at each visit.
- Sessions of late arrivals will end on time and be billed the full fee.
- The rate of $145.00 will also apply to time spent on providing special services, such as telephone sessions, phone calls, case consultations, and time spent discussing treatment with other authorized professionals.
- Jeri Kramer does not communicate with clients via text messages or social media platforms. Communication outside of therapy sessions is best done via her encrypted email account or phone.
- With the exception of Blue Cross Blue Shield, Jeri Kramer does not participate with third party payers, such as managed care organizations and insurance companies. By signing this form, I am agreeing to pay the entire bill at the time of service. If requested, I may receive a "super-bill" as a receipt to submit to a third party payer.
- **I must give 24-hour notice of appointment cancellation or I will be billed in full. MONDAY appointments must be cancelled by Friday at 5:00pm.**

initial _____

I understand that I am financially responsible for any and all charges incurred for the treatment of the above-named. I have read the above office policy regarding length of sessions, late arrivals, charges, missed appointments, etc. **I understand and agree to the stated terms.**

_____ _____

Signature of Client (or Parent of Minor child) Date

Jeri L Kramer, Psy.D. 602-690-7763
Website: www.jerikramer.com Email: jeri@jerikramer.com

Limitation on Confidentiality when Providing Therapy to Couples

There are slightly different expectations and limits about confidentiality in couples therapy than there are in individual therapy. When I agree to treat a couple I consider that couple to be the patient. For instance, if there is a request for the treatment records of the couple, I will need the authorization of both members before I release confidential information. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the couple, not just an individual.

During the course of my work with a couple I often see each individual alone for one or more sessions. These sessions are a part of the work that I am doing with the couple, unless otherwise indicated. If you are involved in one or more of these sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple, I would also seek the authorization of the other individual before releasing confidential information to a third party.

Regarding sharing the content of these individual sessions with the other member of the couple, I will not disclose specific information from individual sessions to the other party, but I will share my impressions and generalizations in the interest of promoting greater insight and understanding for each.

By signing below, I acknowledge that I have read this policy understand it, that I have had an opportunity to discuss its contents with Jeri L. Kramer, PsyD, LPC and that I enter couple's therapy in agreement with this policy.

Signature: _____ Date: _____

Jeri L Kramer, Psy.D. 602-690-7763
Website: www.jerikramer.com Email: jeri@jerikramer.com

Consent for Evaluation and Treatment

Your signature below indicates that you have received a copy of the INFORMED CONSENT from my website (www.jerikramer.com), and that you agree to abide by these terms during our professional relationship.

Name of client

Signature of client (or guardian if client is a minor)

Date

Jeri L Kramer, Psy.D. 602-690-7763
Website: www.jerikramer.com Email: jeri@jerikramer.com

Addendum to Informed Consent For for Clients Requesting Teletherapy Services

I consent to engage in teletherapy with Jeri Kramer, PsyD. I understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually. I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general Informed Consent that I received prior to our first session.

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

4. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if Dr. Kramer believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area.

5. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

6. I understand that I am responsible for a) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions; b) the information security on my computer; and c) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

_____

Name of client

_____

Signature of client (or guardian if client is a minor)

_____

Date

Jeri L Kramer, Psy.D. 602-690-7763
Website: www.jerikramer.com Email: jeri@jerikramer.com