

LINDA E. CARLOS, LMFT

Individual Psychotherapy
Marriage & Family Counseling

Elk Grove & Gold River



Please fill out the following intake information as completely as possible.

Thank you.

Elk Grove ___ Gold River ___ Date: _____

Client: _____ Parent/Spouse Name: _____

Birth date: _____ Age: _____ Birth date: _____ Age: _____

Single Married Date _____ Divorced Date _____ Widowed Date _____

Address: _____ City: _____ Zip: _____

E-mail: _____

Cell/Home Phone: _____ Work Phone: _____

Employer: _____ Spouse's Employer: _____

Children: Full Name Age Living at home? (Y/N)

1. _____

2. _____

3. _____

Emergency Contact (Name/Phone): _____

How did you find me? Were you referred to me?

Previous Counseling: (Who? When? How long? Outcome?)

If you attend church: Name: _____ Pastor: _____

Doctor: _____ Phone: _____

Medical Problems: _____

Current Medications: _____ Amounts: _____

_____ Amounts: _____

_____ Amounts: _____

Any side effects/reactions: _____

Reason for Seeking Counseling: _____

Elk Grove Office:

8841 Williamson Drive, Ste 40

Elk Grove, CA 95624

916.685.5258

Gold River Office:

11344 Coloma Rd # 350

Gold River, CA 95670



Informed Consent Form

*Welcome! Please read the following regarding my policies. Your understanding of this part of our professional relationship is important. Ask me any questions you have at the beginning of our session. Sign this only when you feel you understand it and have all your questions answered.
It is my desire that the overall therapy experience is helpful to you.*

Confidentiality

Our relationship is both professional and confidential. I will keep written and/or electronic notes and records of our sessions. They will remain confidential unless you request the release of information to another professional. I have release forms for this purpose. There are a few exceptions to confidentiality.

Limits of Confidentiality:

1. I will assume you have given permission (if applicable) to release information to my billing company, and b) for them to share information that is requested on your forms for reimbursement.
2. If I have reason to believe that you are a danger to yourself, it is my duty and desire to intervene. This may mean contacting a family member or friend and calling the police. The purpose of this would be to provide safety for you until the crisis passes and you are able to more clearly see options for yourself
3. If I have reason to believe that you are a physical danger to someone else, I also have a duty and desire to intervene. This may mean me warning the person who is at risk and calling the police.
4. I am mandated by law to report known or suspected child abuse, elder abuse, or dependent adult abuse. If a report needs to be made because of something you share with me, I will let you know and we can discuss the report.
5. If I receive a subpoena to appear in court or to provide records of treatment to the court, your right to confidentiality is voided. I will make every attempt within the law to protect your privacy.
6. In addition, the Notice of Privacy Practices provides information about how I may use and disclose protected health information about you.

❖ ***Please initial here that you have read and understand the limits to confidentiality and the Notice of Privacy Practices.***

❖ ***Initials:*** _____

Scheduling and Payment Policies (see Pricing & Packaging for complete details)

My fee for a 50-minute counseling session is \$160. Sessions generally start promptly and I usually schedule a 50 minute hour so that I can complete notes of a session and make a transition from one appointment to the next. I desire to work together to maintain the time limits and use your time wisely.

In addition, when I utilize EMDR (Eye Movement Desensitization and Reprocessing) the session is 50-80 minutes. The fees for these sessions start at \$180 for a 50 minute session..

Your appointments will be scheduled according to availability while making careful effort to accommodate your schedule. Please note that **both of us** are reserving time with me in your name. It is best to give your therapy times the priority you deserve and arrange your schedule around them. This also allows me to plan my time and my finances responsibly.

If you need to cancel or reschedule an appointment, my policy is that you will be charged the full counseling fee for an appointment canceled less than 24 hours in advance.

If you cannot make your appointment, you must notify me as soon as possible so that the time may be offered to others waiting to be scheduled. Please text me: 916-879-5896. Add me to your contacts.

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Exceptions include sudden illness of you or a child and emergencies. Work schedule changes are not an exception.

❖ ***Please initial here that you have read and understand the Scheduling and 24 hr. Cancellation policy/charges.***

❖ ***Initials:*** _____

Fees are due and payable at the beginning of each session unless other arrangements have been agreed upon in advance. In order to maximize the use of the therapy hour, please consider the following about your choice of payment:

- if paying by cash, bring in the correct amount of cash for your session;
- if paying by check, make it out to Linda Carlos prior to your appointment;
- if paying by credit card (Visa, MasterCard, American Express), provide current credit card information to me on the intake payment form. I can charge your card through PayPal on my phone or you can make payment on my web page (<http://creeksidetherapists.com/linda-e-carlos-m-a-mft>).
- if wanting to submit to insurance for reimbursement, my billers can prepare an invoice for you.

If you need telephone time with me between sessions, please leave a message on my voice mail (916-685-5258, vm11) or e-mail (lindacarlos@creeksidetherapists.com). I will return your call. If you need more than 5 minutes, please let me know as we will most likely need to schedule a time. My regular fee applies to telephone appointments.

Since I have voice mail and do not carry a beeper, I am not available for emergencies of an immediate nature. In choosing to work with me, it is important that you fully understand this. If you do not have a friend or family member available in an emergency, you can:

- Call 911;
- Call the Sutter Center for Psychiatry Call Center at 386-3000;
- Call the Suicide Prevention Hotline at 368-3111.

❖ ***I acknowledge that I have read and understand the Payment policies, Between session availability, and Emergency procedures.***

❖ ***Initials:*** _____

Creekside Counseling Associates & Gold River Christian Counseling Associates Information

All Associates who practice at this location are independent practitioners in private practices or employees of independent practitioners in private practices. Management practices and treatment issues are the separate responsibility of each individual practitioner.

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❖ ***I have thoroughly read the above contract and understand each of the practices, policies & procedures outlined above of Linda Carlos, LMFT, signified by my signature below.***

❖ ***Signature*** \_\_\_\_\_ ***Date*** \_\_\_\_\_

❖ ***Signature*** \_\_\_\_\_ ***Date*** \_\_\_\_\_