Dr. Mark Maxwell
Marriage and Family Therapist
LMFT #80504

Office Use only

Client Name:_____

Case Number: _____

Personal Information

Date_____

Name: (Client 1) _____

Date of Birth: _____ Age: _____

Occupation: _____

Primary contact Number: _____ email: _____

Address:_____

Sex: Male Female Transgender Active Military: Yes No

Ethnicity: _____ Married: Yes No Years: _____

Children's name/age: _____

Church Affiliation (if applicable): _____

Medications currently taking: _____

Emergency Contact Name: _____ Number: _____

Name: (Client 2) _____

Date of Birth: _____ Age: _____ Relation to client 1:_____

Occupation: _____

Primary contact Number: _____ email: _____

Address: (if different) _____

Sex: Male Female Transgender Active Military: Yes No

Ethnicity: _____ Married: Yes No Years: _____

Children's name/age: _____

Church Affiliation (if applicable): _____

Medications currently taking: _____

Emergency Contact Name: _____ Number: _____

Referred by: _____ May we thank this person? Yes No

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Client Name:_____

Case Number: _____

Personal Info Continued

Name: (Client 3) _____

Date of Birth: _____ Age: _____ Relation to client 1:_____

Occupation: _____

Primary contact Number: _____ email: _____

Address: (if different) _____

Sex: Male Female Transgender Active Military: Yes No

Ethnicity: _____ Married: Yes No Years: _____

Children's name/age: _____

Church Affiliation (if applicable): _____

Medications currently taking: _____

Emergency Contact Name: _____ Number: _____

Name: (Client 4) _____

Date of Birth: _____ Age: _____ Relation to client 1:_____

Occupation: _____

Primary contact Number: _____ email: _____

Address: (if different) _____

Sex: Male Female Transgender Active Military: Yes No

Ethnicity: _____ Married: Yes No Years: _____

Children's name/age: _____

Church Affiliation (if applicable): _____

Medications currently taking: _____

Emergency Contact Name: _____ Number: _____

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Personal Info Continued

Name: (Client 5) _____

Date of Birth: _____ Age: _____ Relation to client 1:_____

Occupation: _____

Primary contact Number: _____ email: _____

Address: (if different) _____

Sex: Male Female Transgender Ethnicity: _____

Medications currently taking: _____

Name: (Client 6) _____

Date of Birth: _____ Age: _____ Relation to client 1:_____

Occupation: _____

Primary contact Number: _____ email: _____

Address: (if different) _____

Sex: Male Female Transgender Ethnicity: _____

Medications currently taking: _____

Please briefly describe the reason you are seeking therapy:

_____

_____

Have you or someone in your family ever received a mental health diagnosis:

No **Yes –** Please describe:_____

_____

Do you or any family members have previous arrests or incarcerations?

No **Yes** – Please describe: _____

_____

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Qualifications

Mark Maxwell earned a PsyD in Couple and Family Therapy from Alliant International University, California School of Professional Psychology in 2013 and an MA degree in Community Counseling from Louisiana State University in 2007. Mark is licensed as a Marriage and Family Therapist (#80504) with the California Board of Behavioral Sciences. Mark has received advanced training in Emotionally Focused Couple Therapy under Dr. Lisa Palmer-Olsen (M.F.T. #37577).

INFORMED CONSENT

The following information is provided to acquaint you with the policies and procedures of this office and to better assist you in your efforts towards personal growth.

I. The Therapy Relationship

(INITIALS)

1. The primary goal and responsibility for the therapist is your overall health and well being, as well as the mental, physical, and spiritual aspects of your life. In order to thoroughly explore the thoughts, emotions, attitudes and behaviors that you bring to the counseling experience, a relationship must be created that strives for mutual respect, understanding, and trust. It is the goal to provide a safe environment of acceptance, warmth, and respect where this relationship can be built and the goals achieved that were set out in the beginning of the process.

2. In working together, your honesty and effort are essential the success of therapy. This means you are responsible for setting and keeping scheduled appointments and paying your fees on time. You must take an active role in helping to plan your goals in the sessions and following through with those goals, always maintaining a cooperative effort. If you choose to seek another professional counselor and enter into another arrangement, you must notify Dr. Maxwell so that he, with your permission, can either coordinate with the professional or terminate your sessions. You are expected to inform Dr. Maxwell of any other professional services you may be using, especially those related to the counseling process.

3. You should be aware that counseling poses potential risks. In the course of working together, additional problems may surface of which you were not initially aware. If this occurs, you should feel free to share these new concerns. Changes in relationship patterns may occur with others or may produce unpredicted responses from others. In couple therapy, there is no guarantee of success in therapy or that your relationship may dissolve. Clients understand and agree that divorce or dissolution of a marriage or relationship is a part of the risk in therapy, especially when the relationship is in distress when beginning therapy.

4. Physical health can be an important factor in the well being of an individual. It is recommended that you receive a physical examination if you have not done so within the

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last year. It is also expected that you provide me with a list of any medications you are currently taking and the name of your physician.

5. You can always reach Dr. Maxwell at 619-204-9513 between the hours of 9am to 9 pm, or at maxmft@me.com. Please contact Dr. Maxwell only for issues related to appointments unless you are in a crisis or emergency. You may also text Dr. Maxwell at the above number but only for appointment related issues. Dr. Maxwell cannot respond clinically to texts and or emails. It is preferable if you are in crisis or emergency to call Dr. Maxwell or the crisis hotline (see below). For ethical and confidentiality reasons, it is Dr. Maxwell's policy not to communicate or contact through social network internet sites (Facebook, Twitter, LinkedIn etc). Please do not try to contact or connect with Mark on any social network site.

II. Your Rights as a Client

(INITIALS)

1. You have the right to ask questions about any procedures used during therapy.
2. You have the right to decide at any time not to receive therapy from Dr. Maxwell. If you wish, he will provide you with the names of other qualified professionals whose services you might prefer.
3. You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued.

III. Confidentiality

(INITIALS)

1. Within certain limits, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your permission. At times therapy will involve the participation of more than one family member and/or significant persons. While Dr. Maxwell will attempt to follow your wishes, he does not guarantee confidentiality will be kept among all the participants in the therapy.
2. There are certain situations in which Dr. Maxwell is required by law to reveal information obtained during therapy to other persons or agencies without your permission. These situations include:
   a. If you threaten bodily harm or death to another person, Dr. Maxwell is required by law to inform the intended victim and appropriate law enforcement agencies.
   b. If you threaten bodily harm or death to yourself, Dr. Maxwell will inform the appropriate law enforcement agencies and others (such as a spouse, friend, or an inpatient psychiatric institution) who could aid in prohibiting you from carrying out your threats.
   c. If you reveal information related to the abuse or neglect of a child, dependent adult, or elderly person, Dr. Maxwell is required by law to report this to the appropriate authorities.

3. Dr. Maxwell may review all therapy sessions with, Dr. Lisa Palmer-Olsen, (M.F.T. #37577) for training and purposes in EFT. Dr. Palmer-Olsen is bound by the same limitations and principles of confidentiality as stated above.

IV. Therapy Services and Fees

(INITIALS)

1. A therapy hour is fifty minutes to an hour. You are encouraged to schedule appointments

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as you feel will be of need to you. The current rate for one session is $125 or the rate agreed upon by you and Dr. Maxwell. If you are unable to attend your scheduled appointment, you must call 24 hours in advance. If you cancel within 24 hours (or the same day), you will be charged for half the rate of your session up and until three hours of the appointment. If you do not show for your appointment without canceling, or cancel within three hours of your appointment, you will be charged for the full rate of your session. Additionally, if your personal check is returned for insufficient funds you will be charged a $25 fee.

2. Payments are required at the time of your appointment, unless other arrangements have been made in advance. If at any point in the course of treatment you are unable to pay for your fee, please communicate this to your therapist and your fee will be negotiated.

3. Dr. Mark Maxwell can be reached at 619-204-9513, Monday through Friday 9am to 9pm. If you have a counseling emergency after hours, please call the 24 Hour Emergency Crisis Line at 1-800-479-3339.

4. Email communication is for **non-emergencies only**. It may be used for appointment changes, referrals and non-clinical questions. I check my emails as often as possible, but if you are canceling an appointment with less than 24 hours notice, please call my cell phone number. Please direct emails to: maxmft@me.com. Please note that I cannot respond clinically to emails.

V. **If you are the guardian of a minor or are a minor, please read the following:**

(INITIALS)

By signing below, I give my consent for Dr. Maxwell to conduct therapy sessions with the minor listed below. I have also been informed of the limitations to confidentiality in terms of the treatment of the minor. I understand that special care and sensitivity may be required in releasing information to me about certain topics such as substance use and sexual activity. I accept Dr. Maxwell's judgment in regards to releasing information related to the treatment of this minor. In addition, I understand that at anytime if Dr. Maxwell believes this minor is in danger of hurting him or herself, I will be notified immediately.

VI. **Emotionally Focused Therapy:** (If you are not coming for couples therapy you may skip this section)

(INITIALS)

EFT is a short term (10-20 sessions) structured approach to couples therapy formulated by Susan Johnson and Les Greenberg in the early 80's. The strategies and techniques of **EFT** are also used with families. A substantial body of research outlining the effectiveness of **EFT** now exists. This research demonstrates that couples significantly improve over the course of treatment and continue to get better at two year follow up. Please refer to the EFT website for further information about the treatment model and present outcome research. www.iceeft.com. The amount of session you may require is also contingent upon past stressors, trauma and previous relationship injuries, resulting in a need for more sessions and/or conjoint individual therapy. This will be assessed with Dr. Maxwell.

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The Goals of EFT are:

1. 1. To expand and re-organize key emotional responses
2. 2. To create a shift in partner's interactional patterns
3. 3. To foster the creation of a SECURE bond between partners/families

VII. Live Observation and Release of Information:

(INITIALS)

Dr. Maxwell may request to record therapy sessions. The purpose to record sessions is to be more effectively trained as a therapist and provide the best possible therapy treatment or for simple review purposes. Recorded sessions would only be observed by Dr. Maxwell or an EFT trainer. All recorded sessions are kept in on a password protected computer and are inaccessible to anyone other than Dr. Mark Maxwell. Any use of a recorded session beyond the use stated above would require your written consent and approval.

I understand that any supervisor or trainer who observes my therapy session is under the same confidentiality requirements as my therapist. Furthermore, I understand that if by chance any supervisor, therapist or trainer who knows me socially, he/she will not observe, seek, or be given any information about my case. I also understand that the purpose of allowing observation of my therapy sessions is to enhance the effectiveness of the therapy treatment I am receiving with Dr. Maxwell. I understand that I may withdraw this consent at any time and that I will be notified if any live observation or taping is going to occur before my arrival.

Furthermore, I understand that while being treated, my primary therapist will remain Dr. Maxwell and that in case of emergency or problems during the week, I will contact Dr. Maxwell or the emergency/crisis phone numbers listed in the Informed Consent.

Client Signature:_____
Date:_____

Client Signature:_____
Date:_____

Therapist Signature:_____
Date:_____

This release is valid for the duration of treatment under Dr. Mark Maxwell

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Fee Acknowledgment and Agreement

All clients must have a credit card on file, regardless of the chosen payment method for services.

The undersigned, by providing his/her signature in the space below agrees to accept the therapy services provided by Dr. Mark Maxwell in accordance with and pursuant to the terms and conditions set forth herin.

The fee for your initial evaluation has been set at _____. Subsequent treatment provided by the above mentioned name(s) will be billed at a rate of: _____ per 50 minute session. If your session goes longer than an hour or if you are participating in intensive therapy, your fee for this service will be negotiated with your therapist and the amount agreed upon will be owed by you or charged to your card at the end of each therapy session.

All fees are expected to be paid at the end of your therapy session.

All outstanding balances remaining unpaid more than 30 days will be charged directly to your credit card. If the credit card does not authorize payment, you are subject to interest accrued at a rate equal to 10% per month of such outstanding balance.

The undersigned hereby authorizes Dr. Mark Maxwell to charge my credit card (provided below) for the amount of any balance remaining at the end of each therapy session or after a balance has been unpaid for 30 days.

I am also authorizing Dr. Mark Maxwell to charge my card when I do not show up for my scheduled appointment or if I cancel in less than 24 hours notice. The charge for a "no show or late cancelation" on the same day within three hours of appointment is the same as a full session fee agreed upon in this document. The charge for a cancelation within 24 hours but not within three hours of appointment is half of the full session fee agreed upon in this document.

If payment by check is the preferred method agreed upon, the following card will only be charged if there is an outstanding balance more than 30 days after your last session or if you have a returned check. Your card will be charged $25 for a returned check.

Credit and debit card payments are subject to a convenience charge. A charge of $3 will be added to credit card charges and $1 will be added to debit card charges.

Dr. Mark Maxwell reserves the right to refuse services to any client/patient on the account of any delinquent or unpaid fees for services performed without any liability or further obligation to the undersigned.

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Dr. Mark Maxwell does not participate in any insurance and therefore you are entirely responsible for the payment of your therapy.

CREDIT CARD INFORMATION

The credit card to remain on file is:

1. Please circle: MasterCard Visa
2. Card Number: _____
3. Expiration Date: _____
4. Security Code: _____
5. Name as it appears on the card: _____
6. Full billing address with zip code: _____

_____

7. Signature of card holder: _____
8. Preferred method of payment (please circle one): Credit Card Check Cash

The Undersigned understands and agrees to be bound to such agreements as outlined in this document. Please provide your signature below. If there is more than one adult participating in treatment, both must sign below.

SIGNATURE: _____

PRINT NAME: _____

SIGNATURE: _____

PRINT NAME: _____

DATE: _____