Couples Intake

How were you referred? ______________________________

Number of years you have been married to/living with current spouse/partner?______________________

Children with this spouse/partner School/Grade/Where residing?

Name______________________DOB________ ______________________________

Name______________________DOB________ ______________________________

Name______________________DOB________ ______________________________

Who else currently resides in the home?______________________________

To be completed by Spouse/Partner 1:

(email for scheduling & administrative purposes only)

Name______________________ Gender____ DOB________ EMAIL______________________

Address City & Zip______________________________

Phone: Best place to leave message (Circle) CELL WORK HOME ______________________

Occupation, Employer & Address______________________________

Emergency Contact Name, Number (other than partner/spouse)______________________

Previous Marriage(s)?________ Dates & Duration______________________

Children from previous marriages/relationships? School/Grade/Where residing?

Name______________________DOB________ ______________________________

Name______________________DOB________ ______________________________

Name______________________DOB________ ______________________________

Spouse/Partner 1- Medical History & Family Medical History (Check all that apply indicate "S" for Self & "F" for Family)

_____Depression _____Chronic Illness _____Neurological Problems _____Alcohol/Substance Abuse
_____Bipolar Disorder _____Physical Disabilities _____Learning Disabilities _____Attention Deficit Disorder
_____GI/Digestion _____Mental Illness _____Personality Disorders _____Anxiety (OCD, panic)
_____Abuse-physical, sexual, emotional

Name(s) of Previous Counselor(s)______________________________

When & Reason for Previous Counseling______________________________

Current Medications & Who Prescribes?______________________________

Do you drink alcohol___ smoke____ use drugs?___ If yes, which & how often?______________________

Are you adopted?___ If so at what age? ____ Contact w/biological mother?________ biological father?________

Are your parents divorced? _____ How old were you?_____With whom did you reside?______________________

Mother's name, age, residence ______________________________
Father's name, age, residence______________________________
Siblings names, ages, residences______________________________
____

Other significant family members in your life?______________________________
Significant family history/trauma: Relocation, Death, Divorce, Deployment, Conflictual Relationships (Please describe)

____

Religious affiliation as a child? ______________ Religious affiliation as adult?______________________

Highest level of education?______________ Financial/Legal problems?______________________

What goal(s) do you have for therapy?______________________________

(Feel free to use back of page for additional info)

Couples Intake (Continued)

To be completed by Spouse/Partner 2: (for scheduling & administrative purposes only)

Name________________________________ Gender____ DOB________ EMAIL______________________________

Address City & Zip____

Phone: Best place to leave message (circle) CELL WORK HOME ________________________________

Occupation, Employer & Address____

Emergency Contact Name, Number (other than partner/spouse)_________________________________

Previous Marriage(s)?__________ Dates & Duration____

Children from previous marriages/relationships? School/Grade/Where residing?

Name________________________DOB__________ ____

Name________________________DOB__________ ____

Name________________________DOB__________ ____

Spouse/Partner 2- Medical History & Family Medical History (Check all that apply indicate "S" for Self & "F" for Family)

_____Depression _____Chronic Illness _____Neurological Problems _____Alcohol/Substance Abuse
_____Bipolar Disorder _____Physical Disabilities _____Learning Disabilities _____Attention Deficit Disorder
_____GI/Digestion _____Mental Illness _____Personality Disorders _____Anxiety (OCD, panic)
_____Abuse-physical, sexual, emotional

Name(s) of Previous Counselor(s)____

When & Reason for Previous Counseling____

Current Medications & Who Prescribes?____

Do you drink alcohol___ smoke____ use drugs?___ If yes, which & how often?__________________

Are you adopted?___ If so at what age? ____ Contact w/biological mother?_________ biological father?_________

Are your parents divorced? _____ How old were you?_____With whom did you reside?_______________

Mother's name, age, residence ____
Father's name, age, residence____
Siblings names, ages, residences____
____
Other significant family members in your life?_______________________________________
Significant family history/trauma: Relocation, Death, Divorce, Deployment, Conflictual Relationships (Please describe)

____

Religious affiliation as a child? _______________ Religious affiliation as adult?______________________

Highest level of education?__________________ Financial/Legal problems?_______________________

What goal(s) do you have for therapy?____

____

(Feel free to use back of page for additional info)

Laurie L. Rosen, LCSW • Licensed Clinical Social Worker
Red Maple Court • 10617 Jones Street, Suite 201A • Fairfax, Virginia 22030
703-239-2600 • laurielrosenlcsw@gmail.com • www.laurielrosenlcsw.com

Payment Contract

-This Payment Contract between Laurie L. Rosen, LCSW & ________________________________(name of "Responsible Party") establishes that the above "Responsible Party" agrees to make all payments in full by **cash or check**, payable to Laurie L. Rosen, LCSW, due at the time session.
-If patient misses or cancels a session with less than 24 hours advance notice, "Responsible Party" agrees to pay half the session fee ($75) for that missed session, which is not to be submitted to health insurance for reimbursement.
-"Responsible party" understands this mental health provider is out-of-network with all health insurance carriers.
-"Responsible Party" agrees to submit their own claims if seeking reimbursement.
-"Responsible party" agrees to pay any amounts charged in an attempt to collect fees via attorney or collection agency, which may be used for a balance delinquent past 30 days, unless arrangements for a payment plan have been made.
- "Responsible Party" understands treatment may be terminated until such time that all delinquent fees have been paid.

Fee for psychotherapy session (TBD w/ therapist)________________________________

________________________________ ________________________________
Signature ***Date***

Notice of Privacy Practices & Informed Consent (Both partners please initial below)

_____/______I have received a copy of or have been instructed as to where I can access the Notice of Privacy Practices (NPP), informing me about how my Protected Health Information (PHI) may be used and disclosed, and how I can get access to this information. It is my responsibility to request a copy if I so desire.
_____/______I understand that much of the work of therapy will be to resolve issues, and will depend on my honesty and willingness to do the things I need to do to move forward, even if it is painful and difficult. I understand that "homework" such as reading, written exercises, and changing behaviors may be prescribed as part of my treatment. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling.
_____/______I understand that whatever I say in a session is strictly confidential and will not be released to anyone without my consent EXCEPT in cases of: abuse, being at risk for harming myself or others, couples therapy, utilizing collection agencies for unpaid balances, and obtaining payment from health insurance companies. Without using my name, I understand my therapist may share information about my case when consulting with colleagues for purposes of treatment planning. I agree to the above statements and hereby agree to enter into a therapeutic relationship with Laurie L. Rosen, LCSW.
_____/______I understand that 30 days from my last session without any follow-up appointment or communication, my case will be considered closed and the therapeutic relationship terminated. However, I may call for an appointment to resume therapy anytime contingent upon scheduling availability.

ADDITIONAL FEES: I understand there are additional fees to be paid should I request documentation about my treatment (ex: correspondence, reports, or forms). I agree NOT to petition this therapist to appear in court as a witness for custody hearings, trials, or other domestic issues. I understand any attempt to petition this therapist to court would nullify the confidentiality of my records and may be more damaging to my case. In the event a petition is served to this therapist, it will include payment of $300/hr with a minimum of 4 hours ($1200) for my services. This includes but is not limited to: wait time, time for meals, transportation, time to testify, depositions). I understand compensation for court appearances are paid in full to my therapist prior to the court date.

DATE________________________________

________________________________ ________________________________
Signature Partner 1 ***Signature Partner 2***

As your therapist, I will bring the best that I know from my study and experience, insight and wisdom. I will keep a holistic perspective in our work together because I believe that the mind, body, and spirit all work together to form the wholly healthy person. You can expect truth from me even when you may not want to hear it. I will provide a safe place where you will experience compassion and empathy on your journey. Thank you for the privilege to share in your life, learning, and growth. ***Laurie***