William Arndt, MA, LMFT, LCADC
Licensed Marriage and Family Therapist
Licensed Alcohol and Drug Counselor

ADOLESCENT FORM

Thank you for choosing to come in today. Let me take a minute to provide you with some professional and personal information about myself. I am a Licensed Marriage and Family Therapist (#1142) and Licensed Clinical Alcohol and Drug Counselor (#399) in the state of Nevada. My Master of Arts is in Marriage and Family Therapy from Regis University and I completed my undergraduate work at the University of Nevada Las Vegas, where I majored in Psychology. I provide mental health and substance abuse counseling for individuals, families, couples and adolescents. Please complete the following forms; the information you provide below will be helpful in determining the best course of action for your current needs.

Parent Guardian Information

Name_____ Date_____

Gender_____ Date of Birth_____ Age_____ Marital Status_____

Address_____

City_____ State_____ Zip_____ Phone_____

Email_____

Religion/Faith_____ Referred By_____

Emergency Contact_____ Number_____ Relationship_____

Occupation_____ Employer_____

Adolescent Information

Name_____ Date_____

Gender_____ Date of Birth_____ Age_____

Address_____

City_____ State_____ Zip_____ Phone_____

Email_____

Religion/Faith_____ Referred By_____

Emergency Contact_____ Number_____ Relationship_____

Grade_____ School_____

Background Information

Immediate Family Members

Name	Relationship	Age	Living In Home

Have you had any treatment with a psychiatrist, psychologist or therapist in the past? _____Yes _____No

Was it Helpful? _____Yes _____No

Briefly explain why you are seeking counseling today: _____

_____

Please describe any complaints associated with the problem: _____

When did the problem start? _____ How long do you think it will take to resolve these problems? _____

Current Medications: _____

Are you currently at risk of harming yourself or someone else? _____Yes _____No _____Unsure

Have you attempted to harm yourself in the past? (Please list dates) _____

Following is a list of common obstacles that often lead people to seek counseling. Please check all that apply:

___Anxiety	___Communication	___Self Esteem	___Depression
___Addiction	___Grief	___Eating Problems	___Insomnia
___Alcohol	___Drugs	___Weight	___Stress
___Smoking	___Gambling	___Work Problems	___Shyness
___Relationships	___Sexuality	___Panic Attacks	___Guilt
___Phobia (Please List)	___Abuse	___Trauma	___Anger
___Suicide Attempts	___Suicidal Thoughts	___Self-Harm (Cutting)	___Pain
___Low Motivation	___Sexual Problems	___Social Withdrawal	___School

Is there a family history of?

___Alcoholism	___Drug Use	___Depression	___Anxiety
___Suicide	___Attempted Suicide	___Medical Problems	___Psychosis

In the past 2 weeks have you engaged in any of the following?

___Alcohol	Frequency_____	Favorite Movie / Play_____
___Marijuana	Frequency_____	Favorite Book _____
___Drugs	Frequency_____	Favorite Television Show _____
___Pornography	Frequency_____	Meaningful Song_____

Explain how you cope with stress: _____

What do you like to do with your free time? _____

Is there anything else that you feel is important for me to know? _____

_____

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Client Rights

1. You have the right to receive information concerning the methods of therapy employed, the techniques used, the duration of therapy and the fee structure for services provided. If services are not appropriate, referrals to other qualified professionals will be provided.
2. You have the right to refuse or terminate treatment at any time.
3. You have the right to seek a second opinion, if needed I can provide you with the names of other qualified professionals.
4. You have the right to know that in a professional psychotherapeutic relationship sexual intimacy between therapist and client is never appropriate.
5. Therapy is a professional relationship. It is extremely important that you and I both believe the relationship is the right fit to provide you with the greatest benefit possible. Because I value and appreciate your commitment to therapy, if at any time, I believe you would greater benefit from seeking the services of another professional, I will inform you immediately and provide referrals.

_____Initials

Confidentiality

The therapeutic relationship is confidential and protected by ethical standards of practice and Nevada statutes. Any information obtained in the therapeutic setting cannot be released without your prior written consent except in the following situations according to Nevada State Regulations:

a. Cases of suspected child or elder abuse or neglect.
b. Cases of potential harm to self or others or a need for immediate hospitalization – medical/mental health concerns
c. Cases of legal claims or defense required by state of federal law or court ordered by a judge.
d. Cases under investigation by a board of examiners as part of an investigation or hearing.
e. If you are under the age of 18 in the State of Nevada, parents have access to information regarding their child's medical records.

It is my policy to maintain confidentiality throughout the therapeutic process; therefore, I will not acknowledge clients in a public area unless first approached by client.

_____Initials

Fees and Cancellation Policy

Sessions are 50 minutes long. The charge per session is $150.00 and is due at the time of service. Please give a 24-hour cancellation notice to avoid a fee for the missed appointment and to allow others to receive help in your place. *I understand that William Arndt is not a 24-hour crisis intervention provider. If I am faced with a mental health emergency I agree to call 911 or go to my local emergency room.*

_____Initials

Insurance Billing

The following categories describe the ways that your health information may be used and disclosed:

a. I may use and disclose your health information for determining coverage, billing, collections, claims management and reimbursement. Health information may be released to an insurance company, third party payer or other entity involved in the payment of your medical bill and may include copies or excerpts of your medical record that are necessary for payment of your account. Your health plan may be notified about a treatment you are going to receive to obtain prior approval or determining whether your plan will cover the treatment.
b. I may disclose your health information to business associates with whom I contract to provide services on my behalf. For example, I may contract with another entity to provide transcription or billing services.

_____Initials

Electronic Communication

Though I do my best to protect your confidentiality of electronic messages, please note that I cannot guarantee confidentiality under circumstances that include use of Internet, cellular phone or text message.

I authorize William Arndt to send Email messages regarding appointments _____Initials
I authorize William Arndt to send text messages regarding appointments _____Initials

I have read and fully understand the nature and limits of the above statements and agree to participate in counseling under these conditions.