Trinity L. Bockus, M.A., LMFT

Licensed Marriage & Family Therapist
MFC 48408

11B Williamsburg Lane
Chico CA 95926

Ph: 916-995-2883 Fax: 530-898-0255

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Referred by: _____

Please indicate if messages can be left or mail sent:

Home Phone: ☐ yes ☒ no Work Phone: ☐ yes ☒no Cell Phone: ☐ yes ☒ no Home Address: ☐ yes ☒ no

In case of emergency, please contact: _____ Phone: _____ Relationship:_____

Your Date of Birth: _____ Age: _____ Social Security #: _____-_____-_____

Marital Status (circle): S M W Se D # Years Married: _____ Spouse Name: _____

Children (names & ages): _____

Place of Employment: _____ Occupation: _____

Breifly describe why you are seeking therapy at this time:

_____

_____

_____

Primary Care Physician: _____ Phone: _____

Do I have permission to coordinate care with your Primary Care Physician? ☐ yes ☒ no

Date of last physical examination: _____

Treating Psychiatrist: _____ Phone: _____

Current Medications:	Dosage	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Therapist: _____ Dates of Service: from_____ to _____

Issues addressed in therapy:

_____

_____

_____

Do you currently have any medical conditions that you are being treated for? ☐ yes ☒no
Please explain:

_____

_____

_____

If you have ever been hospitalized, please list when and for what reason. (please include pregnancy & abortion)

_____

_____

_____

Have you ever experienced any trauma in your life? ☐yes ☐no If so, please briefly explain:

_____

_____

_____

List 5 things about yourself that you like:

_____

_____

_____

List 5 things about yourself that you would like to change:

_____

_____

_____

What are your major strengths?: _____

_____

_____

Have any anniversaries of important or stressful events in your life occurred recently or are any due to occur soon?

_____

_____

_____

List any major problems or stressful events that other family members or close friends are currently dealing with:

_____

_____

What solutions or efforts have you tried to solve the problems that bring you here?

_____

_____

Do you have any religious affiliation? _____ If so, what denomination?: _____

Are you ☐practicing or ☐non-practicing in your faith?

Do you want to have your faith integrated into therapeutic treatment? ☐yes ☐no

Family History

Relationship	Living?	Deceased?	Age	If living, location

Mother:

_____

Father:

_____

Brothers:

_____

_____

_____

Sisters:

_____

_____

_____

Is there any family history of mental illness? ☐yes ☐no

Are there issues with your family of origin that you believe are influencing the quality of your life today?

If so, please describe:

_____

_____

_____

_____

Do you drink alcohol? ☐yes ☐ no

If so, how much beer, wine or hard liquor do you consume each week on average? _____

Have you ever felt the need to cut down on your drinking? ☐yes ☐no

Have you ever felt annoyed by criticism of your drinking? ☐yes ☐no

Have you ever felt guilty about your drinking? ☐yes ☐no

Have you ever had a DUI (Driving Under the Influence) arrest? ☐yes ☐no Date: _____

Do you smoke cigarettes? ☐yes ☐no How many packs per day? _____

Do you use recreational drugs? ☐yes ☐no If yes, what substances do you use, and how often? _____

_____

Do you have any compulsive behaviors that you would like to address in therapy?

_____

_____

_____

Office Policies & Confidentiality

My fee for service is $105.00 per 50 minute session for individual therapy and $115.00 for Couples/Families per 50 minute session. Except for brief messages or e-mails, I charge for report writing, phone therapy, email responses or other professional services at a rate of $95.00 per hour in 15 minute intervals. Payment is required at the time of each session. If you are having difficulty paying your bill, then we can talk about a payment schedule. I also accept Visa and MasterCard.

Many health insurance policies cover the services of a professional family therapist. Nevertheless, the reimbursement varies considerably from company to company and from policy to policy. Also, most policies have annual deductibles, co-payments, or other limits on benefits. Read your policy carefully and be aware of what is or is not covered. It is your responsibility to initiate the authorization from our insurance company. You may also wish to call your employer's personnel department if you have questions about your benefits. If I do not take your insurance, and you have a PPO instead of an HMO, I can provide a monthly bill for you to turn into your insurance company for reimbursement.

You are responsible for payment of services in full at time of service.
Any reimbursement from your insurance company is your responsibility. Initials _____

I ask for a 24-hour cancellation notification prior to appointment unless There is an emergency. Failure to do this will result in billing for the entire missed appointment fee. Initials _____

Psychological services are best provided in an atmosphere of trust. You expect me to be honest with you about your problems and progress. I expect you to be honest with me about your expectations for services, your compliance with medication, and any other factors that may be barriers to treatment.

Because trust is so important, all services are confidential. Everything you say to me remains within the office walls. Nevertheless, I am required by law to make exceptions in narrow circumstances such as when there is a suspicion of child or elder abuse, immediate danger to another person or self, or other rare circumstances.

I will take all necessary precautions to protect your privacy. My records are considered confidential and are not available for anyone to view without proper releases of information signed. No information will be disclosed without your written consent. The only exception to this is if I receive a valid and accurately prepared court ordered subpoena. If you are using insurance or an Employee Assistance Plan to help with the payment of therapy services, I am required to disclose information regarding your diagnosis, dates of service, and progress in treatment.

I understand the above statement of policy.

_____
Printed Name

_____
Signature Date

I am in receipt of the "Notice of Privacy Practices".

_____
Signature Date

Release of Information for Billing Purposes

If you request that I complete insurance forms, you authorize me to make disclosure of your diagnostic information and dates of therapy sessions. Upon revocation of this authorization, further release of information shall cease immediately. This release of information for the purposes of a claim for benefit payment(s) expires upon termination of coverage under the insurance policy or benefit plan or the final determination of the claim, if later.

Executed this _____day of _____, 20____

_____ _____

(Patient signature) (Witness signature)

_____

(Parent, Guardian IF REQUIRED)

Insurance Information

Please bring in your insurance card or a copy of the front and back with you to your first session:

Insurance Company: _____ Insurance Plan Name: _____

Primary Insured's Name: _____ Date of Birth: _____

Patient's Relationship to Insured: _____

Primary Insured's Employer's Name: _____

Is there another Health Benefit Plan? ☐yes ☐no If yes, what _____

For Office Use Only

Authorization # : _____ # of visits Authorized: _____ Copay: _____

Dates of Service: _____ to _____