Rae A. Littlewood, Ph.D.
Licensed Clinical Psychologist - NM License #1167

CLIENT INFORMATION

Please have the partner who is financially responsible for treatment complete this section.

Today's Date: _____

Name: _____ DOB: _____/_____/_____ Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone #: _____ Alternate Phone #: _____

Email Address: _____

Sex (Circle one): Female Male Referred By: _____

Arrangement for Payment (check one): _____ Bill to Insurance

_____ Self-pay rate $175/1-hour session

PRIMARY INSURANCE POLICY - **Please have your card ready to copy.**

Insurance Company: _____ Co-pay: _____

Insured's Name: _____

Policy ID: _____ Group Number: _____

SECONDARY INSURANCE POLICY - **Please have your card ready to copy.**

Insurance Company_____

Policy ID: _____ Group Number: _____

DESCRIPTION, POLICIES, AND CONSENT FOR COUPLES THERAPY

Rae A. Littlewood, PhD, LLC

This document contains important information about my professional services and business policies. Please read it carefully and ask me any questions that arise. Your signature indicates that you understand and accept the terms of treatment.

My approach to couples therapy is called INTEGRATIVE BEHAVIORAL COUPLES THERAPY (IBCT). This treatment is based on the idea that couples with relationship problems have developed behavioral patterns that erode relationship quality. The essential elements of treatment are altering interaction patterns through, for example, things like how to communicate in less destructive ways, how to interrupt and alter negative thoughts about a partner, or how to express or experience emotion in a more positive way. IBCT also includes a focus on teaching couples to accept and better understand their partner's actions and ways to manage and accept irreconcilable differences.

The initial phase of treatment is assessment and feedback. Typically, I will meet with the couple for the initial session and then have an individual session with each partner to learn more about their individual background. The fourth session is a feedback session for the couple to discuss my observations and the focus and goals of treatment.

Couple's therapy works best when the focus of my work is on your relationship. When working with you, it is expressly understood that my patient is both your relationship and each of you as individuals. In order to maintain fidelity to both of you and to your relationship, there are important agreements for us to make.

1. *Any information conveyed to me by either of you may be shared by me with the other member of the couple.* At times, there arise instances where one partner in a couple wants to tell me something without the other knowing it. Please do not expect me to keep secrets where doing so jeopardizes the therapeutic work or my relationship with either of you or your relationship. Please be aware that information you chose to share with me that is particularly pertinent to both of you may come out in therapy. This pertains to all verbal, written and phone conversations and messages.

2. If I meet with one or both of you in individual sessions, we will likely share the contents of that meeting with the partner at the next couple's session.

3. The purpose of treatment is to provide the couple with assistance in addressing problems within the relationship and/or family. My ethical standards require that I do not engage in multiple relationships with clients. This means that, as your therapist, I will not conduct evaluations or provide opinion on forensic matters pertaining to your relationship, your family, or your fitness for custody.

4. The continued participation by each person is voluntary. Either participant may suspend or terminate the therapy at her or his individual request.

PROFESSIONAL FEE INFORMATION

SESSION FEES: The standard fee for an initial diagnostic interview is $225.00. The standard fee for ongoing psychological services or assessment is $200.00 for a 60-minute session. New Mexico Gross Receipts tax is included in these rates.

INSURANCE: Dr. Littlewood accepts Presbyterian, BCBS, New Mexico Health Connections, TriCare, and Medicare. If you intend to use your insurance, it is your responsibility to confirm that you have coverage for behavioral health services and to understand your benefits. You are responsible for payment of your deductible and/or co-payment. You are responsible for any amount that is not covered by your insurance company, whether that is a co-payment, the result of an unmet deductible, or lack of benefits.

SELF-PAY: For patients who are uninsured or do not wish to bill insurance for services, the fee for a couples session is $175.00.

PAYMENT: Payment is due at the time services are rendered. Accepted methods of payment are cash, check, or credit card. Checks should be made payable to Rae A. Littlewood, PhD. If you have a health plan with which I am contracted, I will bill them directly, and am reimbursed by them directly. Depending on your coverage, you may be responsible for a deductible and/or co-payment. It is your responsibility to inform me of any changes to your insurance coverage. Failure to do so may result in your liability for the total account balance. If you pay by check and the bank refuses it, a charge of $25.00 will be assessed in addition to the original amount of the check. If your account has not been paid for more than 90 days and terms of payment have not been arranged with me, your account may be sent to a Collection Agency and its cost added to the amount you owe.

MISSED SESSIONS: If you must cancel an appointment, please provide at least 24 hours notice, by Friday if you have a Monday appointment. The fee for a missed session that is not canceled with 24 hours notice is $75. Insurance does not cover charges for missed appointments.

INFORMED CONSENT

I have chosen to receive psychological services from Rae A. Littlewood, PhD., a clinical psychologist and partner of Behavior Therapy Associates LLC. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychological treatment is a cooperative effort between me and my therapist, I will work with my therapist to the best of my ability to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed that is upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that the ability of my therapist to provide useful feedback and guidance to me is dependent upon the accuracy of the information I provide about myself.

My rights include:

- The right to be informed of the steps and activities involved in receiving services

- The right to confidentiality under federal and state laws relating to the receipt of services
- The right to humane care and protection from harm, abuse, or neglect
- The right to make an informed decision whether to accept or refuse treatment
- The right to contact and consult with counsel at my expense
- The right to select practitioners of my choice at my expense

I understand that records and information collected about me will be held or released in accordance with state and federal laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults and all cases in which there exists a danger to self and/or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that my therapist may contact me to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.

I understand that my therapist will be required to provide basic clinical information, including diagnoses, to my insurance company in order to receive payment for services, and that my therapist has no control over how my insurance company handles my private information and that my therapist cannot be held liable for the actions of the insurance company.

If you have questions about fees, payment plans, insurance, or other financial concerns, please discuss these with me. Please be sure, as well, to read the **Notice of Privacy Practices** available in the waiting area.

Your signature below verifies that you have read, understand, and agree with the information provided**.** This also verifies that you have read and understand the Notice of Privacy Practices and have been offered a copy for your records. Your signature also authorizes the release of any medical or other information necessary to process this claim with your insurance company.

I HAVE READ THE ABOVE. I UNDERSTAND AND AGREE TO ABIDE BY THE STATED POLICIES.

CLIENT SIGNATURES:

_____ DATE:_____

_____ DATE:_____

COUPLES INTAKE INFORMATION

(each partner completes their own intake information)

Name:_____

Education (highest grade/degree *completed*): _____

Occupation: _____ Employer: _____

Marital Status: _____

Children's Names & Ages: _____

_____

Who lives in your home with you?

_____

Briefly describe the problem or concern that you would like to address in therapy:

_____

_____

_____

If you have attended individual or couples therapy with a mental health professional, please describe your experience below:

When & with whom?_____

What issues did you work on?_____

Why did you stop?_____

Primary Care Physician (family doctor): _____

Telephone: _____ Fax: _____

List any other doctors you are seeing: _____

Please list CURRENT health conditions, problems, and allergies:

_____

_____

Please list PAST health problems, including major operations and hospitalizations:

_____

_____

Please list ALL medications and doses (including homeopathic) you are currently taking:

_____

_____

Please list all non-prescribed substances you use, the amount you currently use and the frequency:

Substance	Amount/day	#days/week
Alcohol	_____	_____
Caffeine	_____	_____
Tobacco	_____	_____
Recreational/Illicit Drugs	_____	_____

Type of drugs used: _____

Have you ever had problems with alcohol or drugs or been in treatment for substance abuse or dependence? NO YES If YES, please describe: _____

_____

Have you ever experienced any of the following as a child or an adult?

Sexual Abuse:	NO	YES	Physical Abuse:	NO	YES
Emotional Abuse:	NO	YES	Victim of Crime:	NO	YES
Eating Disorder:	NO	YES	Suicide Attempt:	NO	YES
Self-Harm:	NO	YES			

Please describe any current, past, or future legal problems or concerns: _____

_____

Please describe any problems with your finances, job, or school: _____

_____

Please describe your hobbies, special interests, and talents: _____

_____

Please describe any family history of mental health concerns: _____

_____

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_____