EMPOWERING
MINDS TOGETHER

5308 Derry Avenue Suite L-201
Agoura Hills, CA 91301
Phone: (747) 222-7923
Email: empoweringmindstogether@gmail.com
Website: https://www.empoweringmindstogether.com/

GROUP THERAPY CONSENT FORM

Fees and Appointments

1. Group sessions ordinarily take place **one or twice time per week**, unless otherwise arranged . If you are unable to attend a group session , please contact your group facilitator to inform them of your absence as soon as possible.

2. Mental Health Services should be affordable. We will work with you to cover as much of the cost as possible by using your benefits . Depending on your specific health plan or sponsored program, you may owe a copy or coinsurance fee.

3. Groups are significantly affected when group members are absent. Therefore, **attendance is strongly encouraged**. Even though you may be absent from time to time, your place in the group is reserved and you are responsible to pay for any missed sessions. **The missed session fee is $60 and is not reimbursable by insurance.**

Confidentiality

4. Communication between you and the group leaders is both privileged and confidential. This means that group facilitators cannot discuss your case orally or in writing, except with the Empowering Minds Together Inc. staff

5. Confidentiality is strongly required among group members.

6. Your group facilitators have an ethical and legal obligation to break confidentiality under the following circumstances:
   - If there is a reason to believe there is an occurrence of child, elder or dependent adult abuse or neglect.
   - If there is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit.
   - If there is a court order for release of your records.

Communication

Because this is a limited private practice, we are often not immediately available by telephone. When we are unavailable, please leave a message on our voicemail. We will make every effort to return your call within 24 to 48 hours, with the exception of weekends and holidays. If I will be unavailable for an extended time, such as for a scheduled vacation, we will provide you with the name of a colleague to contact if necessary.

In the event of a psychiatric emergency, and you are unable to reach us, please call a local Mental Health Hotline or CALL 911 or go to the nearest Emergency Room of your nearest hospital and ask to be evaluated by the psychologist or psychiatrist on call. Mental Health Hotline numbers include (800) 854-7771 (Los Angeles County), and National Suicide Prevention Hotline at 1.800.273.TALK (8255). For less urgent matters or for scheduling issues, please leave a message on our voicemail or by email.

INFORMED CONSENT TO TREATMENT

I have read, understood, and had opportunity to question, and I agree to the above conditions and policies. I agree and consent to participate in mental health care services offered and provided at Empowering Minds Together INC. In addition, I have read, understood, and agree to Empowering Minds Together INC. Privacy Policy form on their website.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

I also permit the use of a copy of this signed authorization in place of the original.

_____

Signature of Client / Legal Representative — Date Signed

_____

Print Name of Client / Legal Representative — Relationship to Client

_____

Signature of Therapist/Psychiatrist — Date Signed

_____

Print Name of Therapist/Psychiatrist — Date Signed

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PERSONAL DATA – please mark with an asterisk (*) your preferred mode of contact

Client Name:	**Home Phone**:
Address:	**Cell Phone**:
	Work Phone:
DOB & Age:	**Email Address**:
SSN:	**Contact Person & Relationship to Client**:
Referral Source:	**Emergency Contact Phone Number:**
Parent or Other Responsible for Billing:	**Relationship to Client**
Address (if different from above):	**Email Address:**

INSURANCE & BENEFIT INFORMATION (if applicable)

Insurance Company:	**Provider Services Phone #**:
Insurance ID #:	**Group #**:
Subscriber Name:	**Client Relationship to Subscriber**:
Subscriber DOB:	**Subscriber Employer**:
Subscriber SSN:	**Policy Effective Date:**
Co-pay/Co-Insurance:	**Deductible (Amount met?):**
# Visits Allowed:	**Preauthorization Required?**

FEES AND PAYMENTS

Registration is for 4 consecutive sessions at a time. Payment is due at the time of intake, unless we agree otherwise. Cash, check, or credit cards are acceptable forms of payment. A credit card is required to be kept on file to hold all scheduled appointment times. The fee for the brief individual intake session is $35 and can be applied towards the group registration cost. The fee is $75 per 90-minute session; $300 is due at intake.

CREDIT CARD AUTHORIZATION. Your signature authorizes Empowering Minds Together INC. to charge your credit card for late cancellations, missed appointments, and outstanding balances (over 60 days):

Payment method MASTERCARD VISA AMERICAN EXPRESS DISCOVER

Credit card number _____

Print name as it appears on credit card _____

Zip code_____ Security code_____ Expiration date _____/_____

Email address for receipts _____

Authorization signature _____ Date_____

. **CERTIFICATION AND AUTHORIZATION** (if applicable)

I certify that the above information is correct. I authorize the release of any medical information necessary to process this claim. I request that payments be made directly to Empowering Minds Together INC. on my behalf. Therefore my signature will be on file to file with my insurance company.

Signature of Patient (or Parent): _____Date: _____

GROUP THERAPY - ADOLESCENT INFORMATION FORM

Child's Name:	Date of Birth:	Age:	Sex:

Race/Ethnicity:

☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African/American ☐ Hispanic/ Latino ☐ Hawaiian/ Pacific Islander ☐ White/ Caucasian ☐ Other: _____

School:	Grade:
Legal Guardian(s):	Relation to Child:

Person Filling Out This Form:

☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Self ☐ Other: _____

Biological Parents' Marital Status:

☐ Married ☐ Never married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Describe the problem that you are looking to address in group therapy.

Current Symptoms include (check all that apply):

- ☐ I have no problems or concern bringing me here
- ☐ Aggression, violence
- ☐ Anger problems
- ☐ Attention problems
- ☐ Career concerns, goals, and choices
- ☐ Parenting issues (your own child)
- ☐ Custody of Children
- ☐ Delusions (false ideas)/ Hallucinations
- ☐ Dependence
- ☐ Depression
- ☐ Divorce, separation
- ☐ Drug use
- ☐ Eating/appetite problems
- ☐ Fatigue/Low energy
- ☐ Fears, phobias
- ☐ Financial problems
- ☐ Grief
- ☐ Health, medical concerns
- ☐ interpersonal conflicts
- ☐ Irritability
- ☐ Legal matters problems
- ☐ Loneliness
- ☐ Memory problems
- ☐ Mood swings
- ☐ Nervousness, tension
- ☐ Obsessions/ compulsions
- ☐ Pain, chronic
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Relationship problems
- ☐ School problems
- ☐ Self-esteem
- ☐ Sexual problems
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems
- ☐ Smoking and tobacco use
- ☐ Spiritual, religious, moral, ethical issues
- ☐ Stress
- ☐ Suicidal thoughts
- ☐ Temper problems
- ☐ Thought disorganization and confusion
- ☐ Withdrawal, isolating
- ☐ Work problems
- ☐ Other concerns or issues: _____ _____ _____

How long have these difficulties been present?

What are your specific **goals and expectations** for this group?

MENTAL HEALTH AND MEDICAL HISTORY

Describe any stressors that might be affecting your life right now (i.e. school, relationships, death, divorce, trauma):

_____

_____

Have you ever been diagnosed with any behavioral, educational, medical, neurological, or psychiatric disorder, such as Attention Deficit/Hyperactivity Disorder (ADHD), Learning Disorder (LD), Anxiety or Depression? If YES, please specify:

_____

_____

Mental Health History: *Have you received a previous evaluation or intervention?* ☐ *YES* ☐ *NO*

Previous Mental Health Treatment or Evaluation:			
Date(s)	Therapist/Facility	Reason for seeking treatment/evaluation	Outcome/ Was treatment helpful?

Psychiatrist name (if applicable):	
Psychiatrist Address	
Psychiatrist phone#	

CURRENT MEDICATIONS					
Medication	Dosage/ Times per Day	Reason for prescription	How long on medication?	Who Prescribed?	Is medication helpful?

SUPPORT SYSTEM

List the significant people in your life and specify your relationship (i.e., father, mother, sibling, friend, cousin, etc.)

_____

_____

_____

_____