Rob Curwen, *MS MFT*
301 Mallory Station Rd.
Franklin, TN 37067
615-519-9945
connectingmatters.com

Instructions

Please fill out and bring these forms to your first session. When you arrive, enter the front door of the building. I will meet you at the chairs at the top of the staircase.

The "No Secrets Policy" is only for clients participating in couples counseling. Clients coming for individual counseling do not need to read or sign this form (even if you are married).

I encourage you to reflect on what your goals for counseling are. You may want to write a list of the reasons you've decided to begin counseling and what you hope to accomplish. We will talk about your hopes and goals for our time together in the first session.

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Client Information

Messages OK? *Yes* *No*

Full Name:_____ Home Phone:_____ ☐ ☐

Date of Birth (DOB):_____ Work Phone:_____ ☐ ☐

Age:_____ Sex:_____ Cell Phone:_____ ☐ ☐

Occupation:_____ Employer:_____

Email Address:_____ ☐ ☐

Street Address:_____

City:_____ State:_____ Zip:_____

Marital Status (*circle one*): Single Married Remarried Separated Divorced Widowed Cohabitating

Partner's Name:_____ Wedding Date:_____

Age:_____ Work Phone:_____ ☐ ☐

DOB:_____ Cell Phone:_____ ☐ ☐

Occupation:_____ Employer:_____

Email Address:_____ ☐ ☐

List all children (living with you or not) and any other people living with you:

Name(s)	Relation	DOB	Living with You?	Occupation

Over →

Do you or your partner have a history that includes any of the following?
(Circle any that apply)

Fertility struggles Abortion Adoption Child death

Health Information

When was your last physical? _____
List major medical problems, surgeries, recent hospitalizations, and/or health conditions

_____

_____

List medications or recreational drugs you are currently taking:

Intls.	Name of medication	Dosage	To treat:

Please list any addictions or *possible* addictions:_____

_____

Person to contact in case of an emergency:_____

Phone number:_____ Relationship:_____
(this person would only be contacted in an emergency)

Have you (or your partner) ever been involved in any other type of counseling? Yes No

If yes, when:_____ Where: _____

Reasons:_____

Have you (or your partner) ever been diagnosed with a mental illness? Yes No (*circle one*)

If yes, list diagnosis:_____

Date of diagnosis:_____ Hospitalized because of it?_____

Are you (or your partner) currently having thoughts of killing or seriously injuring yourself?

Yes No *(circle one)*

How did you hear about me? _____

Is it OK for me to thank them for the referral? Yes No *(circle one)*

_____ _____
Signature *Date*

_____ _____
Partner's Signature *Date*
(if couple's counseling)

(09/08)

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Professional Disclosure Statement

Counseling with families, couples, and individuals

Welcome! This paperwork has been prepared for you to inform you of my qualifications and what you can expect from me as a therapist. Please read this form carefully and sign in the appropriate places. Feel free to ask questions or discuss this information with me at any time.

Philosophy and Approach to Therapy:

My philosophy of therapy is holistic, meaning that I believe that people are made up of many parts – body, soul, (mind, emotions, will) and spirit. I am a Christian. I believe God made us to be defined by and through the relationships we're in -first through Christ, then through others. We can't know ourselves outside the context of our relationships. Healing occurs through repairing relationships and altering our interactions within those relationships.

My approach to therapy is from a systemic perspective. I believe that people work in relationship systems and each person in the relationship is important to the balance of the whole. When relationships become out of balance, it is a result of many different factors or patterns, which can be examined in the therapy sessions. I place a strong emphasis on healthy communication, problem solving and emotional connections. I counsel families, couples, and individuals.

Code of Ethics & Supervision:

As a marriage and family therapist, I am bound to the American Association for Marriage and Family Therapy ("AAMFT") Code of Ethics and the laws of the state of Tennessee. I have completed my M.S. degree. I have a temporary Tennessee Marital and Family Therapy license (#762) and I am currently supervised by an AAMFT approved supervisor who is also a licensed marriage and family therapist. My supervisor's name and number is Kenny Sanderfer, (615) 500-2849.

Formal Education and Training:

- Master of Science in Marriage and Family Therapy from *Fuller Theological Seminary*
- PREPARE/ENRICH Certified Counselor
- Dave Ramsey Certified Counselor
- California Certified Public Accountant (*inactive*)

Professional Boundaries:

I will not acknowledge the existence of the relationship outside of the therapy session unless initiated by the client. The therapeutic relationship is a professional relationship and therefore will not be a social or business relationship at any time. Such a relationship, in my view, would be detrimental to our purposes of therapy.

Risks in Counseling:

Counseling may be tremendously beneficial, while at the same time there are some risks. The risks may include the experience of intense and unwanted feelings, including sadness, fear, anger, guilt, or anxiety. It is important to remember that these feelings may be natural and normal and are an important part of the counseling process. Other risks of counseling may include: recalling unpleasant life events, facing unpleasant thoughts and beliefs, increased awareness of feelings, values and experiences, alteration of an individual's thinking, and calling into question some or many of your beliefs and values. For couples counseling, although the goal is to improve communication and increase closeness, there is no guarantee of those results. I am available to discuss any of your assumptions, problems, or possible side effects of our work together.

Your rights as a client:

1. You are entitled to information about any procedure, methods of therapy, techniques, and possible duration of therapy. If you desire, I will explain my usual approach as well as qualifications.

2. You have the right to decide not to receive therapeutic assistance from me or to see a second opinion from another therapist. I will provide you with the names of other qualified professionals whose services you might prefer.

3. You have the right to expect confidentiality within the limits described as follows. There are certain situations in which I am required by law to reveal information obtained during therapy without your permission. These situations are: (a) if you threaten bodily harm or death to yourself or another person; (b) if a court of law issues a legitimate court order (signed by a judge); (c) if you reveal information relating to physical abuse, sexual abuse, or neglect of a child.

   Also, I may discuss certain aspects of our sessions in supervision. Supervisors are licensed marriage and family therapists. Everything discussed in supervision is confidential within the boundaries discussed above.

   In addition, for couples and families, I maintain a "no secrets policy." I believe that secrets hinder the intimacy building process. Therefore, anything one partner tells me outside the presence of the other partner may be discussed with either partner based on my professional judgment. I explain this in more detail in the "No Secrets Policy" page.

4. You have the right to end therapy at any time without any moral, legal, or financial obligation other than those already accrued.

5. If you request in writing, any records can be released to any person or agency you designate (note that consent from all clients in the treatment group is needed for a release of records). Also, you may authorize me, in writing, to consult with another professional about your therapy.

6. I may not always be immediately available to you. If you are having thoughts of suicide and are unable to speak with me, please contact the crisis hotline at 615-244-7444 or the National Suicide Prevention hotline at 800-273-TALK (8255).

Appointment Issues:

In order to serve you in the best way possible and meet your needs for therapy services, the following is my policy on missed and canceled appointments.

1. I expect 24-hour notice from you if you need to change your appointment time. If I am not given this notice, I will expect payment for that hour of time at our agreed upon rate. For clients in couple's counseling, unless we have planned otherwise, both partners must be present at the appointment time for the session to continue.

2. If you are late for a session, the time of your session may be shortened, but you will be required to pay for a full session.

3. For individuals who haven't called and are late for an appointment, I will wait for up to 15 minutes, and then assume you are not coming. The regular fee will still be expected for the time I reserved for you. If an emergency occurs that causes this, we can discuss the exception.

Financial Consideration

1. My standard fee for therapy is **$90** per **50-minute session**. If we agree to longer or shorter sessions, you will be charged accordingly. Payment in full is expected at the end of each session.

2. There may be a charge for other services, including consultation with other professionals, preparation of reports or correspondence, any necessary court appearances, and phone calls lasting over 10 minutes. The fee will be agreed on by both of us before the performance of these services.

3. Therapists have a right to seek legal recourse to recoup unpaid balances. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.

4. When diagnostic testing is appropriate and recommended, some psychological assessment needs may be referred to another mental health professional who will determine his or her own fee.

Consent to Treatment:

I affirm that prior to becoming a client of Rob Curwen, he gave me sufficient information to understand the nature of therapy and the nature of confidentiality. I consent to participate in evaluation and treatment and I understand that I may refuse services at any time. I am also aware that the therapist will periodically consult with clinical supervisors, as required, on client issues. I have read the above and both understand and agree to the financial consideration as and the appointment policy. My signature below affirms my informed and voluntary consent to receive therapy. With the understanding of the above information and conditions, I agree to participate in therapy.

Signature _____ Date _____

Signature _____ Date _____

If under 18, signature of a parent or guardian is required:

If you are requesting counseling as the guardian or parent of a child or a dependent adult, the same general principles as above will apply. However, as your child's counselor it is important that your child be able to completely trust his counselor. As such, we keep confidential what the child says in the same way I keep confidential what an adult says. As the parent or guardian you have the right and responsibility to question and understand the nature of our progress with your child, and I must use my discretion as to what is an appropriate disclosure. In general, I will not release specific information that the child provides to me; however, I feel it is appropriate to discuss your child's progress in broader terms and value your participation in his counseling experience. Your signature below indicates your consent to treat your child:

Signature _____ Date _____

Therapist's Signature _____ Date _____

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"No Secrets" Policy with Couples or Families

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit).

During the course of my work with a couple or a family, I may see or speak separately with a smaller part of the treatment unit (e.g., an individual or two siblings). These discussions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such discussions with me, please understand that generally these discussions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since those discussions can and should be considered a part of the treatment of the couple or family, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual discussion (or a discussion with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure**.** Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual discussion may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the _____ (couple/family) being seen, acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Rob Curwen (the therapist), and that we enter couple/family therapy in agreement with this policy.

Dated: _____ **Signature**_____

Dated: _____ **Signature**_____

Dated: _____ **Signature**_____

Dated: _____ **Signature**_____