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 top of the staircase (there are some chairs if you'd like to sit down).

PLEASE DO NOT KNOCK ON OR WAIT OUTSIDE MY DOOR. I may have other clients in my office when you arrive.

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).

The *Notice of Privacy Practices* is for your records. You do not need to bring that to your first session.

I encourage you to reflect on your goals for counseling. 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

I attend: *(Circle one)* Church | Synagogue | Temple | Other_____ | Not Applicable

Where: _____ _____
Name *City*

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:

Initials	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 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? _____

May I thank them for the referral? Yes No *(circle one)*

_____ _____
Signature *Date*

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

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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, method 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 get 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. With respect to child abuse, I am not permitted to investigate if the information is true or not. I am considered a "mandatory reporter" and must report *any* information.

   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.

   See the "Notice of Privacy Practices" for further explanation of how the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule applies to counseling.

4. Email communication: If you've provided your email address and checked "yes" in the "Messages OK?" box I may use your email for direct communication. Your confidentiality rights described in #3 above apply to email communication. However, email has certain risks that are not present with speaking in person or phone calls. The risks of e-mail are that it could fail to be received and that confidentiality could be breached. E-mail could fail to be received if it is sent to the wrong e-mail address or if the recipient just does not notice it. Others who

have access to the account or the computer, hackers, or Internet service providers could breach confidentiality in transit or at either end. To mitigate the risks, I use encryption and passwords to protect confidentiality on my end. Nevertheless, if you wish to avoid these risks, please let me know by selecting "No" under the "Messages OK" box on the "Client Information" sheet.

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

6. If you request in writing, 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.

7. 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, the National Suicide Prevention hotline at 800-273-TALK (8255), or 911.

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 as we will have to end at the scheduled time, 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. Please make the check **payable to *Rob Curwen***.

2. ***Via phone***: My standard fee for therapy via the phone is $105 per 50-minute session. Payment in full is expected at the time of scheduling the appointment and can be paid with *Visa* or *MasterCard*. A link to a secure website will be provided. Alternatively, payment information can be provided via phone.

3. 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. If the services

require me to be out of the office, a minimum 8-hour day, including travel time, is due at the time of scheduling the services.

4. A receipt with all essential information required for insurance reimbursement is provided per request. Depending on your policy, you may or may not be entitled to partial or full reimbursement.

5. 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.

6. 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. In accordance with HIPPA regulations, a copy of the "Notice of Privacy Practices" has been made available to me. 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 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 me. As such, I 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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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that is designed to protect the privacy of client information, provide for the electronic and physical security of health and client medical information, and simplify billing and other electronic transactions by standardizing codes and procedures. A piece of this law is known as the HIPAA Privacy Rule. The HIPAA Privacy Rule creates a minimum federal standard for the use and disclosure of Protected Health Information (PHI) by health care organizations. One of the requirements of the Privacy Rule is that I give to you a Notice of Privacy Practices (NPP) that describes your rights and protections regarding your health care records (PHI). You may request a copy (paper or electronic) of this notice at any time. This document describes how your PHI, as a client of Rob Curwen, may be used and disclosed.

Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material known as "Psychotherapy Notes" which is not available to outside sources and in some cases, not to the client.

HIPAA provides privacy protections about your personal health information (PHI) which could personally identify you. PHI consists of three components: treatment, payment, and health care operations.

A: Commitment to Privacy

I know how important your PHI is and I am committed to respecting and protecting it. In conducting sessions, I will create notes regarding you and your treatment. I am required by law to maintain the confidentiality of all PHI that identifies you.

The terms of this notice apply to all records containing your PHI that are created or retained by me. I reserve the right to revise or amend this notice at any time. Any revision or amendment to this notice will be effective for all your past records that I have created or maintained as well as any records that may be created or maintained in the future.

B. Uses and Disclosures of Mental Health Information (PHI)

Treatment: I may discuss certain aspects of our sessions in supervision. I may use or disclose your PHI to a physician or other healthcare provider where you are also going for treatment in order to coordinate care.

Payment: I may use and disclose your PHI in the billing process to obtain payment for the services provided to you.

Mental Health Care Operations: I may use and disclose your protected PHI for mental health care operations, which will include internal administration such as record keeping, billing, appointment setting and reminders, voicemail messages to you and mailings to your home address.

Your Authorization: In addition to my use of your PHI for treatment, payment or operations, you may also give me written authorization to use your PHI or to disclose it to anyone for any purpose. If you give me an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give me a written authorization, I cannot use or disclose your PHI for any reason except those defined in this notice.

Required by Law: I may use or disclose your PHI when I am required to do so by law. This would include responding if a court of law issues a legitimate court order (signed by a judge), reporting child abuse and/or neglect to the authorities authorized by law to receive such reports, and disclosure of your PHI to the extent necessary to avert a serious threat to your own safety and health and/or the safety and health of others.

C. Use and Disclosure Requiring Your Written Authorization

I will not use or disclose your confidential information for any purpose other than the purposes described in the notice, without your written permission. For example, I would not supply confidential information to a family member, a research organization or to a prospective employer without your signed consent / request.

D. Individual Rights

1. Access

You have the right to look at or get copies of your PHI in the designated medical record, with limited exceptions (i.e., where assessments designate the use by clinicians only, psychotherapy notes and information compiled in anticipation of litigation, etc.) as long as the PHI is maintained in the record. The charge for requested copies is 50 cents per page, $90 per hour for time to locate and copy the PHI and the required postage should you want the copies mailed to you.

In recognition of the importance of the confidentiality of conversations between the counselor and the client in treatment settings, HIPAA permits keeping "psychotherapy notes" separate from the overall "designated medical record." "Psychotherapy notes" are not the same as your "progress notes" which provide general information about your care and progress each time you have an appointment.

2. Right to Request Additional Restrictions

You may request restrictions on my use and disclosure of protected PHI for treatment, payment, or mental health care operations in addition to those explained in the notice. All requests for such restrictions must be made to me in writing. While I will consider all requests for additional restrictions carefully, I am not required to always agree with the additional requested restriction.

3. Right to Receive Confidential Communications

You may request and I will accommodate any reasonable request that you receive protected PHI by an alternative means of communication.

4. Disclosure Accounting

I will inform you if I disclose your PHI. You have the right to receive a list of instances in which I have disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities.

5. Right to Amend Your Records

You have the right to request that I amend your PHI. Your request must be in writing and it must explain why the information should be amended. I may deny your request under some circumstances.

Questions and Complaints

If you are ever concerned that I may have violated your privacy rights, or you disagree with a decision I have made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have me communicate with you by alternative means or at alternative locations, you may complain to me using the contact information listed at the beginning of this notice. You also may submit a written complaint to the U. S. Department of Health and Human Services (address provided upon your request).

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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 may 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**_____