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Adult Clinical Intervention
Preliminary Office Forms

Thank you for reaching me and for your interest in pursuing Adult clinical services in this office. Your time and effort completing these preliminary materials will make our work together more effective and time-efficient.

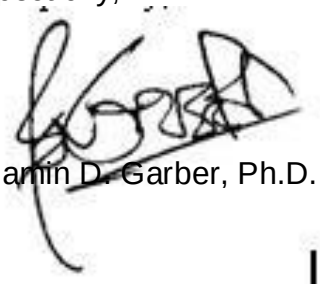
These forms are *not* appropriate if you are seeking family or child therapy, or if you are seeking court-ordered (forensic) services unless I explicitly request otherwise.

Please respond to each item that follows honestly and completely. Feel free to continue any response on the back of the page. I welcome receipt of copies (not originals) of any additional documentation that may be relevant to our work together (e.g., court order, medical record, psychological testing).

- Pages 2 through 6 of this packet ask questions about your strengths and weaknesses.
- Pages 7 through 10 provide a detailed description of the proposed service. **Your signature is requested on the last page.**

Please reach me at any time via email or phone with questions or concerns. In anticipation of our work together, I am,

Respectfully,



Benjamin D. Garber, Ph.D.

Adult Clinical Intervention
Preliminary Office Forms

Revised 07.2017

_____
Please print your name in full

_____ _____
What is your date of birth? What is today's date?

_____ _____
Who is your primary care physician? When did you last have a full physical exam?

1. "I am seeking psychological services because…"
   (Please describe the concerns or specific goals that have prompted you to contact this office. Feel free to continue your response on the reverse.)

2. **Your medical history:** If YES, please describe:

a. Serious illness?	☐ None	
b. Serious injury?	☐ None	
c. Allergies or asthma?	☐ None	
d. Current medications or supplements:	☐ None	
e. Current physical limitations:	☐ None	

3. **Your daily functioning:** If YES, please describe:

a. Sleep: Difficulties sleeping alone, falling asleep, staying asleep or waking? Sleep walking, sleep talking, nightmares or night terrors	☐ None	
b. Appetite: Picky eater, special diet, habits or rituals, Binging, purging, over-eating Weight loss or weight gain	☐ None	
c. Toileting: Wetting, soiling, constipation, diarrhea Fearful, avoidant	☐ None	
d. Self-care: Limitations or resistance dressing, eating, bathing or showering, brushing teeth, maintaining personal hygiene	☐ None	
e. Personal responsibility: Fails to take responsibility for behavior, blames others; irresponsible with money, schedules, possessions	☐ None	

4. **School functioning:** If YES, please describe:

a. The highest grade you've completed so far is:		
b. Grades: Failing, sudden change of grades	☐ None	
c. Homework: Resistant, refusal, procrastination, Disorganized, demands excessive help, completes but refuses to hand-in	☐ None	
d. Behavior: Disruptive, aggressive, demanding Withdrawn, isolates, passive, fearful Suspension, detention, expulsion	☐ None	
e. Attendance: Avoidant, refusal, separation anxiety	☐ None	
f. Special education needs: IEP or 504 (for what needs?) Please provide copy	☐ None	

5. **Your occupational/vocational functioning:** If YES, please describe:

a. Do you presently have a job, internship, mentorship or otherwise function in a work environment?	☐ None	
b. Impaired performance at work	☐ None	
c. Conflict with co-workers and/or the boss	☐ None	
d. Recent job loss, job change	☐ None	

6. **Your relationships:** If YES, please describe:

a. With parents or guardians: Clingy, needy, overly-dependent Resistant, refuses contact Passive, withdrawn; aggressive, demanding	☐ None	
b. With siblings: Clingy, needy, overly-dependent Resistant, refuses contact Passive, withdrawn; aggressive, demanding	☐ None	
c. With other adults outside the home: Clingy, needy, overly-dependent Resistant, refuses contact Passive, withdrawn; aggressive, demanding	☐ None	
d. Teachers, employers, authority figures: Clingy, needy, overly-dependent Resistant, refuses contact Passive, withdrawn; aggressive, demanding	☐ None	
e. In general: Socially inappropriate, fails to respect "personal space;" sexualized; bully; victim; Confused, left out, lonely, loner	☐ None	

7. **Your emotion expression and regulation:** If YES, please describe:

a. Withholds emotion, refuses or unable to express	☐ None	
b. Explosive, abrupt, extreme expressions	☐ None	
c. Inappropriate, bizarre, inconsistent and/or Unpredictable	☐ None	
d. Violent or destructive: Self-harm (e.g., cutting), suicidal, homicidal violent to others, harms pets, siblings intentionally destructive of property	☐ None	

Please be aware that if Dr. Garber believes that any person poses a threat to another person's safety (and in some instances a threat to damage real property) he must alert relevant authorities, e.g., the police.

8. **Your addictions and dependencies:** If YES, please describe:

a. Exposure to, experimented with or addicted to tobacco products	☐ None	
b. Exposure to, experimented with or addicted to alcohol products?	☐ None	
c. Exposure to, experimented with or addicted to marijuana products?	☐ None	
d. Exposure to, experimented with or addicted to other “street drugs”?	☐ None	
e. Behavioral addictions: Pornography, video games, gambling Shopping, sex	☐ None	

9. **Your experience of trauma:** If YES, please describe:

a. Exposure to or experience of abuse or neglect of any kind?	☐ None	
b. Grief, loss, death, separation from a loved one?	☐ None	
c. Natural disaster, terrorism, war, motor vehicle accidents, house fire	☐ None	
d. Domestic violence, adult separation divorce	☐ None	

10. **Your mental health history:** If YES, please describe:

a. Diagnosis of any mental health, behavioral health, psychological or psychiatric disorder	☐ None	
b. Ever been in psychotherapy?	☐ None	
c. Ever been hospitalized due to psychiatric, psychological or behavioral health concerns?	☐ None	
d. Blood relatives with psychological, psychiatric or behavioral health disorders	☐ None	

Adult Clinical Interventions:
Adult Informed Consent[1]

- Please read the following description of Dr. Garber's practice completely. Learn more about relevant matters at www.HealthyParent.com and by reaching Dr. Garber directly.

_____

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and reach me via email or telephone to discuss any questions or concerns that might arise. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES: Psychotherapy ("therapy") is a relationship-based intervention in which a skilled professional (therapist) intends to help one or more individuals (clients or patients) to make significant behavioral, emotional, and/or cognitive (thinking) changes. This process requires the active participation of the client.

Psychotherapy can have benefits and risks. Since therapy often addresses unpleasant matters, it can raise uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. The goal, of course, is to decrease your experience of distress and dysfunction so as to improve your functioning, health and happiness. Unfortunately, it is impossible to guarantee the results of any particular therapy.

Providing therapy services to an individual adult typically involves the following steps:

1. Initial interview: I will invite you to participate in one 90-minute interview in order to gather basic history and background. This meeting will conclude with recommendations for next best steps suited to achieve the goals that we discuss. These recommendations may include a combination of services including medication consultation, referral for formal assessment or medical intervention, referral for adjunct therapies (e.g., family therapy, couples' therapy) and a plan for our continuing work together.

2. Preliminary assessment: I commonly consider the first two to four individual 50-minute meetings a period of assessment. The data that we gather together during this period about how we work together, the nature of your concerns and the likely success of various interventions will inform decisions about if and how to continue our work together.

3. We will interrupt or discontinue our work together:
   (a) When we mutually decide that your goals have been met;
   (b) If either of us feels that our work together is no longer effective;
   (c) If a court determines that this service must be discontinued;
   (d) If payment is not current;
   (e) If meeting together poses a threat to any person

MEETINGS: I will recommend how often (e.g., weekly, alternate weeks, monthly) we should meet. Our meetings together will typically be 50-minutes long.

[1] Adapted 07.2017 with permission from APAIT:
https://trustinsurance.com/Portals/0/documents/Informed%20Consent.doc?ver=2015-12-23-134309-760

Our meetings will be scheduled in advance. I am not available to provide emergency or walk-in service. Please be advised that scheduling is available on a first-come, first-served basis. Typically, after school and late day times are in highest demand and may require planning well in advance.

Our meetings will end on time unless there is reason to interrupt a meeting earlier. I reserve the right to pause or discontinue any meeting that I believe has ceased to be constructive.

Our meetings will be safe. Please do not bring weapons of any kind onto the premises for any reason at any time. I will always treat you with respect and dignity and ask that you make the commitment to treat me and my office suite similarly.

PROFESSIONAL FEES: I charge an hourly rate for all services relevant to our work together, including but not only the time invested in our face-to-face meetings. This may include communications with you and relevant others, correspondence, review of records, provisions of summary materials, travel, and administrative endeavors (e.g., filing, copying).

Payment is requested in full at the time of service. The full fee for the scheduled duration of any meeting will be due even if the meeting is discontinued prematurely. The full fee for the scheduled service will be due if you or any party expected to attend a scheduled meeting fails to arrive, except in case of extreme weather, abrupt illness, or injury.

The hourly fee is determined in part on the nature of the service. This child therapy will be charged at the hourly rate of:

_____/hour

All fees are due in full at the time of service. I withdrew from participation in all managed care and third-party insurance reimbursement panels in 1999. You may be eligible for insurance reimbursement, but I will leave this between you and your insurance carrier. I will not communicate with your insurance carrier, but I would be glad to provide you with documentation in support of any claim that you may wish to make.

If you chose to seek insurance reimbursement, you should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator.

I will resist any effort to involve our work together in litigation. Nevertheless, if you demand that I participate in litigation via court order, subpoena or otherwise, you will become responsible for all associated costs at a higher (forensic) hourly rate due as an advance retainer.

Prompt payment in full of all costs incurred and payment in full of any requested retainer is a necessary precondition for continuation of this service. This means that overdue balances can be cause to discontinue our work.

DIAGNOSIS AND PROCEDURE CODES: My record of our work together will be identified by your LASTNAME, FIRSTNAME.

The procedure or CPT code relevant to this service will usually be 90791 “Initial Interview” and thereafter 90834 “Individual therapy.” I would be glad to discuss any exceptions that may arise at your request.

CONTACTING ME: Please direct your questions and concerns directly to my attention. I do not employ a secretary or receptionist. The most immediate and direct means of communication is via e-mail to papapben@HealthyParent.com. Feel free to reach my answering machine at

603.879.9100. I am not typically available to answer your calls directly, but will usually be able to reply within one business day.

My office is usually open Monday through Friday 8:00 a.m. through 6:00 p.m. EST except during national holidays. In case of extreme weather, I will usually close the office when Nashua (NH) High School North is closed. Please be aware that my work includes out-of-office meetings and travel. I will alert you in advance if I plan to be away for any reason. I will do my best to alert you as far in advance as possible should I become ill or otherwise unexpectedly unavailable.

I am not available to provide emergency or walk-in services. Please be certain to have access to emergency services and to be comfortable dialing 9-1-1 in any such circumstance.

PROFESSIONAL RECORDS: The laws and standards of my profession require that I maintain a physical or digital record of our work together. This record will be archived in conditions and for a period consistent with relevant ethics and laws.

You are free to request a copy of the record of this service at any time. However, because treatment records are easily misunderstood, I will usually recommend that you allow me to provide you with a summary report, instead. You will be responsible for all costs involved copying and delivering the record and/or preparing a summary report. In some I may require your written informed consent allowing me to have a professional copy shop duplicate the record.

I retain the discretion to refuse requests to release records and/or to provide summary reports in any instance in which I believe that complying will cause harm and as the law might otherwise require.

CONFIDENTIALITY: In general, the privacy of all communications between a client or patient and a treating mental health professional is protected by law. This means that I cannot disclose matters that arise in our work together to others, with some important exceptions:

1. I am legally obligated to disclose otherwise confidential information in any instance in which I believe that an individual poses a threat to the well-being of him- or herself, another person and -in some instances- to the integrity of physical structures. In any such instance, I may need to communicate with the police, child protective services or similar agencies.
2. The court can compel disclosure of otherwise confidential information via court order.
3. Regulatory agencies such as the New Hampshire Board of psychologists can access otherwise confidential information.
4. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I will make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential.
5. There may be other legal or ethical conditions which require disclosure of otherwise confidential material. I will alert you to these if and when they become relevant.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have when they arise. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

_____

Adult informed consent: I am 18 years old or older. I have read and understand these pages. I agree to these terms in full.

_____ _____
Please sign your name Today's date

_____ _____
Please print your name Your role in this family
(e.g., mother, son, uncle)

Consent to digital communications: I am 18 years old or older. I agree to allow Dr. Garber to communicate otherwise confidential information about myself and my child to me via digital media.

_____ _____
Please sign your name Today's date

_____
Please print your name

_____ @ _____
Your e-mail address