BENJAMIN D. GARBER, PH.D.
400 AMHERST STREET, SUITE 407 · NASHUA, NEW HAMPSHIRE 03063
603.879.9100 VOICE · 603.879.9070 FAX

PROVIDING CHILD-CENTERED CLINICAL SERVICES
WWW.HEALTHYPARENT.COM
PAPABEN@HEALTHYPARENT.COM

CONSULTING TO COUNSEL AND THE COURTS
WWW.FAMILYLAWCONSULTING.ORG
BDGARBERPHD@FAMILYLAWCONSULTING.ORG

Family Clinical Intervention
Preliminary Office Forms

Thank you for reaching me and for your interest in pursuing a family clinical intervention in this office. Your time and effort completing this packet will make our work together more effective and time-efficient.

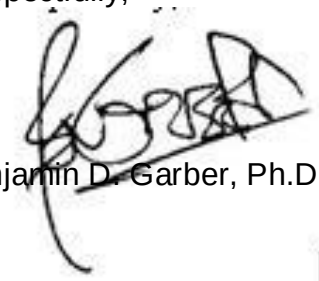
Who should complete this packet? The forms that follow are intended to be completed by adults who are planning to engage in a clinical, family-centered psychological service such as family therapy or couples therapy. These forms are *not* appropriate if you are seeking individual child or adult clinical services, or if you are seeking court-ordered (forensic) services unless I explicitly request otherwise.

If more than one adult will be participating in the service, only one adult needs to complete this packet but **all adults' signatures will be necessary on the last page.**

- Pages 2 through 6 of this packet ask questions about the family's strengths and weaknesses.
- Pages 7 through 14 ask about the family members that you identify on page two. Feel free to provide additional information on the back of any page and/or to provide Dr. Garber with other, relevant documents.
- Finally, pages 15 through 19 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.

Family Clinical Intervention
Preliminary Office Forms

Revised 07.2017

Your time and effort completing this packet in advance of our first meeting will help our work together be more effective and time-efficient. Please provide complete and honest answers. You're welcome to provide additional information on the reverse of any page, and to provide Dr. Garber with copies (not originals) of any additional, relevant documents.

1. Who belongs to this family?

Full Name	**Role (e.g., mother, son, uncle)**	**Is this person willing, able and invited to participate in the intended service?**	
A.			Say more on page 7 →
B.			Say more on page 8 →
C.			Say more on page 9 →
D.			Say more on page 10 →
E.			Say more on page 11 →
F.			Say more on page 12 →
G.			Say more on page 13 →
H.			Say more on page 14 →

The letters A through H in this column are used to refer to family members on pages 7 through 14.
This means that the person you entered as "A" is discussed on page 7.
The person you entered as "B" is discussed on page 8, and so on. Leave blank any page with no corresponding person.

2. **We are seeking psychological services because…**
   (Please describe the concerns and/or specific goals that prompt you to seek out family-based clinical services)

3. Please answer each of the following questions YES or NO. Please elaborate on each YES response on the reverse of this page and provide copies of relevant documents.

Does any person in this family …?

… not speak English?	□ YES	… have a diagnosed mental health condition?	□ YES
… have a serious medical condition or handicap?	□ YES	… have a history of violence toward others?	□ YES
… use or abuse drugs?	□ YES	… have a history of self-destructive or suicidal acts?	□ YES
… have a criminal record?	□ YES	…have serious environmental allergies?	□ YES
…have any other physical, social or emotional condition that might affect his or her ability to participate in the proposed therapy?			□ YES
Are there weapons in this home/these homes?			□ YES

4. **Where we live:** Do all of the people listed above live together at one address? ☐ YES

If NO, then please indicate who lives together at each address:

Address:	Address:
_____	_____
☐ Single Family Home ☐ Apartment ☐ Condominium ☐ Mobile home ☐ Other: _____	Single Family Home ☐ Apartment ☐ Condominium ☐ Mobile home ☐ Other: _____ ☐
Name the people who live in this home full time:	Name the people who live in this home full time:

5. Sometimes family members split their time between homes. If any members of your family split their time between homes, please indicate **who** and **when** they are in each home. If that division of time is dictated by a court order, please provide a copy of that order.:

For example:

When in this home?	When in this home?
Weds school until 8pm *Alt weekends Fri school until Sunday 6 pm*	*All other times*
Who: *6 year old sally*	

When in this home?	When in this home?
Who:	

When in this home?	When in this home?
Who:	

When in this home?	When in this home?
Who:	

When in this home?	When in this home?
Who:	

6. **Emotional and physical safety in the family:** Please indicate whether any of the following are true of any individual or relationship in this family. Please explain any YES response on the reverse.

Verbally abusive	□ YES	Emotionally neglectful	□ YES
Super-critical and demanding	□ YES	Physically or sexually abusive	□ YES
Emotionally abusive	□ YES	Intimidating, bullying or coercive	□ YES
Psychologically abusive	□ YES	Over-controlling finances or other resources	□ YES
Deprived of food, clothing or shelter	□ YES	Other: _____	

7. **How do the members of the family get along together?** Which two people in the family are most likely to…

… be supportive and loving of one another?	and
… have an argument or fight?	and
… have a long, meaningful conversation together?	and
… know what each other are thinking and feeling?	and

8. **History of trauma and transitions:** Emotionally powerful events like the birth or death of a loved one or a pet, a move to a new home, an arrest, a separation or a divorce can affect families. Please offer a very brief summary of any such events in your family's history.

Date	Event

9. About **PERSON A** identified on page two of this packet:

Full Name	**Age**	**Gender**	**Occupation?** (e.g., Student? Plumber? Nurse?
			How long in this current job? _____ years

10. Please identify the professionals in this person's life:

	name	address	Date of last contact?
Primary physician			
Specialist physician			
Individual therapist			
Prescribing psychiatrist			

11. Please identify any physical, mental, behavioral, psychiatric or psychological health concerns:

Diagnosis	Specify current medication, treatment or intervention:	Service provider

12. Please identify any past or present legal involvement (civil or criminal matters, incarceration, probation or pending court matter).

Date(s)	Nature of legal matter	On-going at present?
		☐ YES
		☐ YES

13. Please identify any substance (e.g., alcohol, marijuana) or behavioral (e.g., video games, gambling shopping) addiction:

Substance or behavior	On-going at present?
	☐ YES
	☐ YES

14. About **PERSON B** identified on page two of this packet:

Full Name	**Age**	**Gender**	**Occupation?** (e.g., Student? Plumber? Nurse?
			How long in this current job? _____ years

15. Please identify the professionals in this person's life:

	name	address	Date of last contact?
Primary physician			
Specialist physician			
Individual therapist			
Prescribing psychiatrist			

16. Please identify any physical, mental, behavioral, psychiatric or psychological health concerns:

Diagnosis	Specify current medication, treatment or intervention:	Service provider

17. Please identify any past or present legal involvement (civil or criminal matters, incarceration, probation or pending court matter).

Date(s)	Nature of legal matter	On-going at present?
		☐ YES
		☐ YES

18. Please identify any substance (e.g., alcohol, marijuana) or behavioral (e.g., video games, gambling, shopping) addiction:

Substance or behavior	On-going at present?
	☐ YES
	☐ YES

19. About **PERSON C** identified on page two of this packet:

Full Name	**Age**	**Gender**	**Occupation?** (e.g., Student? Plumber? Nurse?
			How long in this current job? _____ years

20. Please identify the professionals in this person's life:

	name	address	Date of last contact?
Primary physician			
Specialist physician			
Individual therapist			
Prescribing psychiatrist			

21. Please identify any physical, mental, behavioral, psychiatric or psychological health concerns:

Diagnosis	Specify current medication, treatment or intervention:	Service provider

22. Please identify any past or present legal involvement (civil or criminal matters, incarceration, probation or pending court matter).

Date(s)	Nature of legal matter	On-going at present?
		☐ YES
		☐ YES

23. Please identify any substance (e.g., alcohol, marijuana) or behavioral (e.g., video games, gambling, shopping) addiction:

Substance or behavior	On-going at present?
	☐ YES
	☐ YES

24. About **PERSON D** identified on page two of this packet:

Full Name	**Age**	**Gender**	**Occupation?** (e.g., Student? Plumber? Nurse?
			How long in this current job? _____ years

25. Please identify the professionals in this person's life:

	name	address	Date of last contact?
Primary physician			
Specialist physician			
Individual therapist			
Prescribing psychiatrist			

26. Please identify any physical, mental, behavioral, psychiatric or psychological health concerns:

Diagnosis	Specify current medication, treatment or intervention:	Service provider

27. Please identify any past or present legal involvement (civil or criminal matters, incarceration, probation or pending court matter).

Date(s)	Nature of legal matter	On-going at present?
		☐ YES
		☐ YES

28. Please identify any substance (e.g., alcohol, marijuana) or behavioral (e.g., video games, gambling, shopping) addiction:

Substance or behavior	On-going at present?
	☐ YES
	☐ YES

29. About **PERSON E** identified on page two of this packet:

Full Name	**Age**	**Gender**	**Occupation?** (e.g., Student? Plumber? Nurse?
			How long in this current job? _____ years

30. Please identify the professionals in this person's life:

	name	address	Date of last contact?
Primary physician			
Specialist physician			
Individual therapist			
Prescribing psychiatrist			

31. Please identify any physical, mental, behavioral, psychiatric or psychological health concerns:

Diagnosis	Specify current medication, treatment or intervention:	Service provider

32. Please identify any past or present legal involvement (civil or criminal matters, incarceration, probation or pending court matter).

Date(s)	Nature of legal matter	On-going at present?
		☐ YES
		☐ YES

33. Please identify any substance (e.g., alcohol, marijuana) or behavioral (e.g., video games, gambling, shppping) addiction:

Substance or behavior	On-going at present?
	☐ YES
	☐ YES

34. About **PERSON F** identified on page two of this packet:

Full Name	**Age**	**Gender**	**Occupation?** (e.g., Student? Plumber? Nurse?
			How long in this current job? _____ years

35. Please identify the professionals in this person's life:

	name	address	Date of last contact?
Primary physician			
Specialist physician			
Individual therapist			
Prescribing psychiatrist			

36. Please identify any physical, mental, behavioral, psychiatric or psychological health concerns:

Diagnosis	Specify current medication, treatment or intervention:	Service provider

37. Please identify any past or present legal involvement (civil or criminal matters, incarceration, probation or pending court matter).

Date(s)	Nature of legal matter	On-going at present?
		☐ YES
		☐ YES

38. Please identify any substance (e.g., alcohol, marijuana) or behavioral (e.g., video games, gambling, shopping) addiction:

Substance or behavior	On-going at present?
	☐ YES
	☐ YES

39. About **PERSON G** identified on page two of this packet:

Full Name	**Age**	**Gender**	**Occupation?** (e.g., Student? Plumber? Nurse?
			How long in this current job? _____ years

40. Please identify the professionals in this person's life:

	name	address	Date of last contact?
Primary physician			
Specialist physician			
Individual therapist			
Prescribing psychiatrist			

41. Please identify any physical, mental, behavioral, psychiatric or psychological health concerns:

Diagnosis	Specify current medication, treatment or intervention:	Service provider

42. Please identify any past or present legal involvement (civil or criminal matters, incarceration, probation or pending court matter.

Date(s)	Nature of legal matter	On-going at present?
		☐ YES
		☐ YES

43. Please identify any substance (e.g., alcohol, marijuana) or behavioral (e.g., video games, gambling, shopping) addiction:

Substance or behavior	On-going at present?
	☐ YES
	☐ YES

44. About **PERSON H** identified on page two of this packet:

Full Name	**Age**	**Gender**	**Occupation?** (e.g., Student? Plumber? Nurse?
			How long in this current job? _____ years

45. Please identify the professionals in this person's life:

	name	address	Date of last contact?
Primary physician			
Specialist physician			
Individual therapist			
Prescribing psychiatrist			

46. Please identify any physical, mental, behavioral, psychiatric or psychological health concerns:

Diagnosis	Specify current medication, treatment or intervention:	Service provider

47. Please identify any past or present legal involvement (civil or criminal matters, incarceration, probation or pending court matter).

Date(s)	Nature of legal matter	On-going at present?
		☐ YES
		☐ YES

48. Please identify any substance (e.g., alcohol, marijuana) or behavioral (e.g., video games, gambling, shopping) addiction:

Substance or behavior	On-going at present?
	☐ YES
	☐ YES

Family Clinical Interventions:
Adult Informed Consent/Youth Informed Assent[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.

- Each adult intending to participate in the proposed family clinical service must sign and date this document on the last page. Young adults (typically teenagers) can be invited to read and sign as well at the adults' discretion, but their signatures are not necessary.

_____

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. Your informed consent to engage in the proposed service is necessary before we can meet. 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 clients and, in the case of a family therapy, it requires the active support and participation of other family members.

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 the clients' distress and dysfunction so as to improve functioning, health and happiness. Unfortunately, it is impossible to guarantee the results of any particular therapy.

Our first few sessions will involve an evaluation of your needs and the needs of the others who are likely to participate in this family-centered intervention. By the end of the evaluation, I will provide preliminary impressions of what our work will include and a treatment plan that we might follow. You should evaluate this information along with your own opinions of whether you feel comfortable working with me and whether the plan is appropriate to your needs and means. Therapy involves a large commitment of time, money, and energy, so you should be careful to assure that your needs are being met at all times. If you have questions about procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

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

MEETINGS: As a family-centered matter, we will commonly meet together with others from the family group. I will recommend who should attend each meeting based on our goals and treatment plan.

Our meetings together will typically be either 50- or 90-minutes long. When two or more family members are present, 90-minutes is commonly more productive.

Our meetings will commence when all persons expected to attend are present. I reserve the right to postpone or cancel a meeting if a person expected to attend is absent.

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, my office suite, and the other members of your family and participants in this therapy similarly.

The charge for this service will be based on an hourly rate that I will specify. 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.

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 ahead.

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, provision of summary materials, travel, and administrative endeavors (e.g., filing, copying).

The hourly fee is determined in part on the nature of the service. The proposed clinical family psychotherapy 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 any person demands that I participate in litigation via court order, subpoena or otherwise, that person will become responsible for all associated costs at a higher (forensic) hourly rate due as an advance retainer commensurate with anticipated costs..

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.

It is important to be clear in advance about who will pay for this service. I have no preference whether the adults involved split the costs incurred or how. Please communicate with the other adults in your family so as to clarify this matter in advance of meeting together.

DIAGNOSIS AND PROCEDURE CODES: Because this is a family-centered intervention, my record will be held as LASTNAME, FAMILY. I will not identify an individual as the patient or client. I will not diagnose any individual unless doing so is directly relevant and useful in support of the goals of this therapy.

The procedure or CPT code relevant to this service will usually be 90791 “Initial Interview” and thereafter 90847 “Family 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 often 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 records of our work together. This record will be archived in conditions and for a period consistent with relevant ethics and laws.

Because this is a family-centered intervention, I will require the informed consent of all participating adults in order to release a copy of this record. Your request alone may not be sufficient.

Because treatment records are easily misunderstood, I will usually request that parties who request a copy of the record of treatment allow me to provide them instead with a summary report. You will be responsible for all costs involved copying and delivering and/or preparing a summary report. In some instances, all parties’ written informed consent allowing me to have a professional copy shop duplicate the record may be required.

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.

MINORS: Individuals who are less than eighteen years old are entitled to different rights as participants in psychotherapy.

Minors may not have access to records of their treatment without their parents’ or legal guardians’ written consent.

Minors may be able to restrict communication of otherwise confidential matters with others, including but not only their parents or legal guardians.

I expect that minors will be treated with respect at all times. This may include seeking their informed assent and opinions, when appropriate. Even when parents or legal guardians retain decision making authority, I will often invite minors to voice any relevant thoughts, feelings or opinions.

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:

As a family-centered intervention, **anything that I learn from any participant in this therapy can be shared with any other participant in this therapy at my discretion**. This means that I will not keep secrets with you from other family members. Of course, matters that are discussed among adults who share a responsibility to a minor child may reasonably be kept from that minor child.

Should you or the family become involved in legal proceedings, you may have the right to prevent me from providing any information about your treatment to the court. I am not, however, free to decline the court's order to disclose information.

If I believe that an identified individual's safety is threatened, I may be required to alert first responders including but not only the police. If a client/patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

I may occasionally find it helpful to consult other professionals. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential.

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 understand that digital communications are not secure. I agree to allow Dr. Garber to communicate otherwise confidential information about myself and my family to me via digital media.

_____ _____
Please sign your name Today's date

_____
Please print your name

_____ @ _____
Your e-mail address

Youth informed Assent:

I am less than 18 years old. I want to know about this family therapy. I have read and understand these pages and I agree to participate.

_____ _____
Please sign your name Today's date

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