

*Katherine M. Hertlein, Ph.D.*  
Licensed Marriage and Family Therapist  
3243 E. Warm Springs Rd. Suite 108  
Las Vegas, NV 89120 Phone: 702-895-3210

**Confidential Client Information Form**

**DIRECTIONS:** This information is for me to get an initial idea about the nature of your concerns. This information, like anything else you provide to me, will be kept confidential. Please fill out this form as completely as possible. If you have any questions, feel free to ask me.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Mobile Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

At which number should I call you?     Home     Cell     Work

How discrete should I be?     Very     Somewhat     Not at all

Date of Birth: \_\_\_\_\_

Ethnicity:     Hispanic     African-American     Asian-American  
 Native American     Caucasian     Other (specify): \_\_\_\_\_

Faith/Spirituality Affiliation: \_\_\_\_\_

Do you want to incorporate your spirituality/faith into treatment?     Yes     No     Unsure

Occupation: \_\_\_\_\_

Household Income (please check one):

- |  |   |
|--|---|
| <input type="checkbox"/> Under \$20,000      | <input type="checkbox"/> \$50,000 – \$74,999  |
| <input type="checkbox"/> \$20,000 – \$34,999 | <input type="checkbox"/> \$75,000 – \$100,000 |
| <input type="checkbox"/> \$35,000 – \$49,999 | <input type="checkbox"/> Over \$100,000       |

Current Relationship Status (please check one):

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> single    | <input type="checkbox"/> divorced               |
| <input type="checkbox"/> engaged   | <input type="checkbox"/> remarried              |
| <input type="checkbox"/> married   | <input type="checkbox"/> committed relationship |
| <input type="checkbox"/> separated | <input type="checkbox"/> widowed                |

Who lives in your house?

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender:  M  F

Relationship: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender:  M  F

Relationship: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender:  M  F

Relationship: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender:  M  F

Relationship: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender:  M  F

Relationship: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender:  M  F

Relationship: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender:  M  F

Relationship: \_\_\_\_\_

Tell me why you are coming to see me. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long has this been going on? \_\_\_\_\_

\_\_\_\_\_

How important would you say it is for you to reach your goals?

0 1 2 3 4 5 6 7 8 9 10  
Not at all important Extremely important

How confident would you say you are that if you decided to reach your goals, you could do it?

0 1 2 3 4 5 6 7 8 9 10  
Not at all confident Extremely confident

Have you seen a mental health professional in the past, either related to this problem or for something unrelated?  Yes  No

If YES, what was the name of the therapist and for what problem? \_\_\_\_\_

\_\_\_\_\_

Are you taking any medications?  No  Yes (complete details below)

Medication	Dosage	Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please check any of the following that apply to the person seeking treatment (If you are a parent seeking treatment for a minor, please complete this for the minor):

<input type="checkbox"/> Headaches	<input type="checkbox"/> Excessive sweating	<input type="checkbox"/> Low self-esteem	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Stomach trouble	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Obsessive thinking
<input type="checkbox"/> Bowel disturbance	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Physical complaints	<input type="checkbox"/> Tremors
<input type="checkbox"/> Breathing problems	<input type="checkbox"/> Conflict	<input type="checkbox"/> Sexual problems	<input type="checkbox"/> Thoughts of harming self
<input type="checkbox"/> Anger control	<input type="checkbox"/> Stress	<input type="checkbox"/> Relationship problems	<input type="checkbox"/> Thoughts of harming others
<input type="checkbox"/> Nightmares/Terrors	<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Indecisiveness	<input type="checkbox"/> Trauma/assault
<input type="checkbox"/> Feeling tense	<input type="checkbox"/> Fears/phobias	<input type="checkbox"/> No appetite	<input type="checkbox"/> Abuse (emotion/physical/sex)
<input type="checkbox"/> Depressed	<input type="checkbox"/> Grief/loss	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Memory problems
<input type="checkbox"/> Unable to relax	<input type="checkbox"/> Problems with eating	<input type="checkbox"/> Allergies	<input type="checkbox"/> Financial problems
<input type="checkbox"/> Can't make friends	<input type="checkbox"/> Career issues	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Can't keep a job

Is there any **family history** of drug/alcohol abuse?  No  Yes (complete details below)

Family Member	Substance	Duration of Use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any **personal history** of drug/alcohol abuse? No

Yes (complete details below)

Substance

Duration of Use

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Is there anything else that you think I need to know? \_\_\_\_\_

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## **Consent to Treatment**

### **Your Rights**

As a client, your rights are guaranteed by the rules of good professional practice and by law. You have the right to:

- mental health care and treatment
- to be advised about treatment choices and possible treatment concerns
- to refuse treatment
- to privacy

Information about treatment is confidential and not released to anyone without written consent. There are limits to privacy. The ethical standards of therapists, and in some instances, state laws, require therapists to report to responsible persons when clients indicate any of the following:

- abuse or neglect of a child, or if I suspect abuse or neglect
- abuse or neglect of an elderly person, or if I suspect abuse or neglect
- threat to harm themselves
- threat to harm someone else

Other limits to your privacy include:

- the court can obtain your clinical record with a Court Order
- Ex-spouses have the right to review their child's record unless those rights have been terminated by the Court
- HMOs that authorize and pay for treatment have the right to review your records.

### **Office Practices and Policies**

Therapy is a building block process. Each session builds on or complements previous sessions. Successful treatment depends on your attendance at each scheduled session.

**Payment policies:** A typical session lasts 50 minutes. Occasionally it may be better to go on with a session, rather than stop or postpone work on a particular issue. When this extension is more than 10 minutes, I will tell you, because **sessions that run over 60 minutes will be billed a second hourly session fee**. Clients can also choose to schedule extended sessions. A session and a half is 75 minutes (not 90 minutes). A double session is 100 minutes (not 120 minutes).

The hourly rate for one 50-minute session is **\$125**. Payment of any session fees must be received at the time of service. Please pay for each session at its end. I accept cash and checks only. I do not accept debit or credit cards. You have a responsibility to pay for any services you receive before you terminate services. Fees accrued due to cancellations and phone sessions must be received on or before the next scheduled appointment and further appointments will not be scheduled until a zero balance is obtained.

**Cancellation policy:** If you are sick or unable to attend your scheduled session, please notify me as soon as possible so I can adjust my schedule and reschedule you for another time. It is important that I have current phone numbers in case I need to cancel an appointment with you. Clients who cancel less than 24 hours prior to their scheduled appointment will be charged the full session fee.

**Phone call policy:** There is no charge for calls about appointments or similar business. Occasionally, however, telephone consultations may be suitable or even needed at times in your therapy. Therefore, any phone call lasting over 10 minutes will be charged a full session fee.

**Court-related services policy:** I do not participate in any court-related services for clients, including depositions, hearings, consultations with lawyers, or attendance at courtroom proceedings. I ask that you respect the integrity of the therapeutic process and refrain from asking for my participation. Any court related services will incur a fee of **\$400 per hour**.

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I give permission to Katherine M. Hertlein to evaluate and provide treatment. I have read the office practices and policies and have had any questions answered about these policies. I understand and agree to the policies described above. I further understand that any psychotherapy has risks and benefits, but that these cannot be fully described here in anticipation of a potential for treatment.

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Client Signature

Date

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Client Signature

Date

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Witness/Therapist Signature

Date

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<b>Electronic Communication Policy</b>
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E-mail offers an easy and convenient way for therapist and client to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember: there are important differences. E-mail is not the same as calling my office; there is no person at the other end of the call – just a computer. You can't tell for certain when your message will be read, or even if I am in the office or on vacation. Nonetheless, I believe that the ease of communication e-mail can afford a benefit to client care. Below are some guidelines for contacting me using e-mail.

- E-mail is never, ever, appropriate for urgent or emergency problems! Please use the telephone or go to the Emergency Department for emergencies.
- E-mail is great for asking those little questions that do not require a lot of discussion. Appropriate uses of e-mail also include referral and appointment scheduling requests.
- E-mails should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- **E-mail is not confidential.** It is like sending a postcard through the mail. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail if he or she chooses.
- E-mail may become a part of the medical record when we use it; a copy may be printed and put in your chart.
- E-mail is not a substitute for seeing me. If you think that you might need to be seen, please call and book an appointment!
- Either party can revoke permission to use the e-mail system at any time.

Please check the following boxes if you DO want to communicate via email:

- I DO want to communicate with Dr. Katherine Hertlein electronically. I have read the above information and understand the limitations of security on information transmitted. I understand that Dr. Hertlein may not be able to communicate with me electronically about my specific condition if there are concerns regarding confidentiality.
- It is permissible for Dr. Hertlein to contact me via email regarding scheduling.

Please check the following box if you DO NOT wish to communicate via email.

- It is NOT permissible for Dr. Hertlein to contact me via email.

Client Name: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

E-mail Address: \_\_\_\_\_