Melissa Danielson, M.Ed., M.S., MFT

9480 S. Eastern Ave. Suite 258

Henderson, NV 89123

Application for Care

I utilize a whole-person approach to the counseling process. My approach takes into consideration several areas of your life and your family’s life in an effort to assess how you are managing these areas. In order for me to provide you with the highest level of professional care, please complete every field below and sign or initial where required.

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name

 (Last) (First) (M.I.)

Circle: Male Female Date of Birth SSN#

Address

 (City) (State) (Zip)

Home Phone # Cellular Phone #

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

I want Melissa’s monthly emailed newsletter providing resources and tips? Yes [ ]  or No [ ]

Responsible Party (if a minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian SSN# Date of Birth

Current marital status: (parent’s status if minor) [ ]  Single [ ]  Engaged [ ]  Married [ ]  Separated

 [ ]  Partner [ ]  Remarried [ ]  Divorced [ ]  Widowed

Primary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_

Employer Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name and Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ASSIGNMENT and RELEASE

I, the undersigned, have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and assign benefits directly to Melissa Danielson, LMFT, that are otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the counselor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions and/or cash pay.

Signature Date

*SPIRITUAL:*

Religious affiliation:

Name of church/synagogue you currently attend:

#### PHYSICAL

How often do you go to the doctor?

Date of last physical:

Please list any chronic/serious illness and date of onset:

Current medications:

 Name Dosage Reason

Are you currently sexually active? [ ]  Yes [ ]  No. If yes, does this involve high-risk behaviors such as multiple partners, unprotected sex, etc?

Do you exercise regularly? [ ]  Yes [ ]  No

At present, I would assess my physical condition as being:

[ ]  poor [ ]  fair [ ]  average [ ]  good [ ]  excellent

*COUNSELING/PSYCHOTHERAPY/FAMILY THERAPY:*

Have you previously received counseling or some other form of mental health or family therapy?

[ ]  Yes [ ]  No

(please understand that previous counselors/therapists will not be contacted without your consent)

Presenting Problem Therapist Place Date

Reason for termination:

Who referred you to Melissa Danielson, M.S., LMFT? [ ] Patient [ ] Google Search [ ] Doctor/Provider

[ ] Website [ ] Facebook [ ] PsychologyToday.com [ ] Insurance Provider [ ] Other

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In a few words, how might you describe your main concern at present?

What do you hope to gain by coming here?

Are you currently feeling overwhelmed by difficulties in your life? [ ]  Yes [ ]  No

I would assess my current mental/emotional condition as:

[ ]  poor [ ]  fair [ ]  average [ ]  good [ ]  excellent

# LATE CANCELLATION/NO SHOW POLICY

IMPORTANT, PLEASE READ CAREFULLY: Our scheduled meeting times are valuable and important to keep. Please give at least 24 hours notice if you must cancel or miss an appointment to avoid being charged our standard $150.00 session fee. This fee will be charged to your account immediately and cannot be billed to your insurer.

Appointments may be cancelled and/or rescheduled with at least 24 hours notice at no charge by calling 702-339-5663. Please leave a detailed message if you are unable to reach a live representative at the time you call.

By initialing below you are indicating you understand and agree to our Late Cancellation/No Show Policy.

Initial Here:\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date:\_\_\_\_\_\_\_\_\_ 3 digit code: \_\_\_\_\_\_Zip Code: \_\_\_\_\_\_\_\_

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Informed Consent & Limits of Confidentiality

1. Appointments, cancellations, and changes for scheduled appointments can be made by calling 702-339-5663. You may leave a message if you do not reach a live representative. We do not accept text messages. Please limit communication outside of your scheduled sessions to setting, changing or cancelling appointments. We are not able to answer treatment related questions over the phone or via email, please reserve such discussions for your scheduled appointment times. In the case of an emergency, call 911.
2. Fees for services per 45-minute session are $150.00. Fees are payable at the time of service. Psychological tests, psychiatric evaluations, letters and books are at your option to purchase when recommended.
3. In an attempt to improve my services, I may give you a client satisfaction survey in order to gain valuable feedback on what I am doing right, and what skills I need to improve on. You do not need to put your name on the evaluation so please be as honest as possible.

No information about you or your treatment will be divulged to any person outside of counseling without your written consent, with the following exceptions: 1. when required by your insurance to authorize or as a condition of payment; 2. in the event that there is a clear and imminent threat of harm towards yourself or against another person; 3. if there is intent to commit criminal activity or awareness or suspicion of such toward a minor or an elder; 4. in the event of a court order requiring the personal testimony of the counselor, under legal consultation, in response to a client’s raising the issue of mental health in a lawsuit or when minors have limited rights of confidentiality. 5. When required by an employee of Danielson Therapy for the purposes of billing, scheduling, courtesy reminder calls, etc. Employees are bound by confidentiality laws and do not use your information for anything outside of performing their duties. In couple or family counseling, individual confidentiality is rarely in the best interest of all parties, and by signing below you agree to forgo individual confidentialities that are judged counterproductive to the goals of treatment. I will not acknowledge you should we meet in public without your acknowledgement first, except as would be appropriate in another non-counseling relationship. Finally, the therapeutic relationship generally precludes simultaneous dual relationships.

***I have read and understand the nature and limits of the counseling I have elected and voluntarily agree to participate under these conditions.***

Printed Name of Client

Signature of Client Date