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CA STATE LIC. #MFC28229

INTAKE AND INFORMED CONSENT

Today's Date _____ I was referred by _____

Name of Client _____ Client is: My self My child

If child, Name of Parents _____

Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Client's age _____ Client's birth date _____

Relationship Status: Married Divorced Separated Long-term Relationship
 In the Process of Separating/Divorcing Remarried Single

Custody status, for child client: Parents married Joint physical/legal
 Sole legal/Joint physical Sole legal/physical
 Other _____

Other family/household members _____

Current prescriptions/medical conditions _____

The reason I am seeking Psychotherapy now is _____

Have participated in psychotherapy before? Yes No

If yes, describe the experience and outcome _____

CONFIDENTIALITY It is the law that therapy be kept confidential, unless: You or your child intend to harm yourself or someone else; you or your child say something that raises even the suspicion of child abuse, elder/dependent adult abuse, or it comes to bear the your child is being abused by someone else. In these circumstances, state law requires me to notify the appropriate authorities. Records produced by me are my sole possession, but, at your written request, you are entitled to a summary of these confidential records. After ten years, these records will be destroyed in a manner that preserves confidentiality.

PAYMENT OF FEES My fee for a 45-50 minute psychotherapy session is \$_____, payable at the time of service. I do not bill insurance companies, but will provide you with a billing statement which you can send to them for reimbursement. If you are unable to keep your appointment, please call and cancel as soon as possible. You will be charged-in-full for appointments that are canceled less than 24 hours in advance. There are a limited number of hours that I am available, and this policy ensures that I can utilize your reserved time. Thank you for your understanding of this policy.

AVAILABILITY My practice is not an emergency-based practice. I am often not immediately available by phone. I am in my office Tuesday through Friday, generally 10:00 AM to 6:00 PM, and on alternating Saturdays, generally 10:00 AM to 3:00 PM. I can be reached at (818)347-1242. I make every effort to return your call within 24 hours, with the exception of weekends, holidays and vacations, when I will leave the phone number of a colleague on my answering machine. If I am unavailable, and you are in crisis, you may need to use other resources including your family physician, medicating psychiatrist, the emergency room at your local hospital, or by dialing 911 in the event of a serious emergency.

Psychotherapy is a relationship-based intervention, the results of which are not guaranteed. Sometimes the process of psychotherapy can be uncomfortable or produce unintended outcomes, such as changes in personal relationships (anger, frustration, separation, etc.). When treating a minor, I may need to discuss sensitive issues such as drugs, sexuality, criticisms of family members, and so on. I will use discretion as to the appropriateness of these topics. If, at any time, you have questions regarding the process, progress, or goals of treatment, don't hesitate to ask me. I welcome your concerns.

Your signature below authorizes me to provide you and/or your minor child with psychotherapy. We have discussed fees, billing, payment, insurance reimbursement, cancellations, confidentiality, the nature of outpatient psychotherapy, and my availability.

Print Name

Signature

Date

Name, if client is a child