

KAREN GLESS, Ph.D.
MARRIAGE AND FAMILY THERAPIST
3660 CLAIREMONT DR., SUITE 9, SAN DIEGO, CALIFORNIA 92117
(858) 273-2980
General Intake Information

All information is treated with professional confidentiality

NAME _____ DATE _____
first middle last

ADDRESS _____ RES. PHONE _____

CITY _____ STATE _____ ZIP _____ BUS. PHONE _____

FAX _____ E-MAIL _____ CELL _____

DATE OF BIRTH _____ AGE _____

DRIVER'S LICENCE NUMBER _____

MARITAL STATUS: M S D W YEARS MARRIED _____

YOUR EDUCATION LEVEL _____

CHILDREN: NAMES & AGES _____

FAMILY PHYSICIAN _____
name address phone

OCCUPATION _____

EMPLOYER _____
Company name address phone

REFERRAL SOURCE:
Physician or Psychotherapist _____
Friend/Family member _____
Internet _____
Phone book _____
Other _____

IN CASE OF EMERGENCY, CONTACT _____
name address phone

Do you have insurance? Yes () No ()

Company name _____ Policy number _____

Insured's name _____

Please write a brief statement of your current problem: _____

Do you have any specific goals with regard to your treatment? _____

Do you have any particular concerns/fears with regard to treatment? _____

Have you had any prior treatment? _____

If so with whom? _____
name address phone

Length of care _____

Check the following questions for YES or NO

YES NO

Are you now, or have you been under the care of a doctor during the past year?

If so, for what reason? _____

Doctor's name? _____
name address phone

Have you been a patient in a hospital in the past two years? _____

If so for what reason? _____

Have you taken any kind of medicine or drugs, during the past year?

If so please list. _____

Do you drink alcohol? If so, how much do you consume in a week? _____

Do you use illegal drugs? If so, please describe your use _____

Please include any other information that you believe is relevant to your treatment. _____

Signature _____ Date _____

KAREN GLESS, PH.D.
Marriage and Family Therapist Lic# MFC21423
3660 Clairemont Drive, Suite 9
San Diego, California 92117
(858) 273-2980

INFORMED CONSENT AND AUTHORIZATION FOR PSYCHOLOGICAL TREATMENT

I understand that Karen Gless, Ph.D., will provide me with psychological services. These services may consist of interviews, treatment sessions, the administration of various psychological tests, the review of various documents and records from my background, and interviews with other individuals who are familiar with me. Everything that is said during the course of my treatment is protected under my rights to confidentiality and will not be conducted or released without my expressed and written authorization.

A limited exception to confidentiality may exist in the case of third-party payors (insurance companies, employee assistance plans, victims assistance programs, health maintenance organizations) and will be limited to reporting my diagnosis and treatment needs in order to satisfy billing requirements. I also understand that in the case of delinquent accounts, a collection agency may be employed to seek payment; however, information released to them will consist solely of session dates and account balances.

Therapy sessions will typically occur once a week and will last for fifty minutes unless other arrangements have been made. If I have to cancel a session, I will do so 24 hours before my appointment; otherwise, I will be responsible financially for the missed session. I can contact Karen Gless, Ph.D., for urgent and non-urgent purposes at (858) 273-2980. If I am unable to reach her in an emergency, I will call the San Diego County crisis-team hotline at (619) 557-0500.

I understand that Dr. Gless charges \$150.00 per hour for the first session. Then, for subsequent sessions she charges \$150.00 per hour for couples therapy sessions and \$110.00 per hour for individual therapy sessions. If I have health insurance covering psychological treatment, I understand that I am responsible for any deductible and co-payment charges required by the insurance carrier.

I understand that at times Karen Gless, Ph.D., may use various professional test scoring services and other professional services and that she may consult with other professionals as part of ongoing professional education, research and workshop presentations. At all times Karen Gless, Ph.D., will protect my privacy by not revealing my name or other unique identifying characteristics. Also, I understand that Karen Gless, Ph.D., has a policy of destroying patient records after 10 years. If, however, Karen Gless, Ph.D., is incapacitated by illness, injury or death, I understand that my records will be temporarily transferred to Dr. Robert Simmonds, Ph.D., at (858) 483-6070, and that he will assume responsibility for my care in Dr. Karen Gless's absence.

The information disclosed by you during the course of your therapy is generally confidential. However, there are exceptions to confidentiality including, but not limited to, reporting child, elder, and dependent adult abuse, expressed threats of violence towards an ascertainable victim, and in case you make your mental or emotional state an issue in a legal proceeding.

If I am receiving couples therapy, I also understand that Karen Gless, Ph.D., has a "no secrets" policy for couples therapy. This means that any information shared with Karen Gless, Ph.D., by one member of the couple outside the presence of the other member of the couple may be disclosed to the other member of the couple at the discretion of Karen Gless, Ph.D. In other words, the therapist will not allow herself to be put in the position of holding the secrets of a patient participating in conjoint therapy.

I understand that there may be alternative treatment methods for my condition and that I can discuss these alternatives with Karen Gless, Ph.D., at any time. I also understand that I may choose to terminate treatment at any time with the understanding that a final session focused on termination issues is advisable and requested. I am aware that there are risks associated with psychotherapy and these may include lack of improvement, disruptions in my life that can occur as a result of therapeutic changes, and emotional pain associated with the exploration of personal issues.

I have read (or have had read to me) the information in this authorization and consent and I have asked questions about anything I have not understood. By signing this form, I freely acknowledge my willingness to undergo the psychological treatment to be performed by Karen Gless, Ph.D., and release her of any liability that might directly or indirectly result from the release or exchange of any information covered by this form.

I have been provided with a copy of this form. Initials_____

Name (please print)_____

Signature _____

Date_____