OLIVE BRANCH PSYCHOTHERAPY

Dr. Stephen R. Parrish DMFT, LCPC
1601 2nd Ave. North - Suite 514 (Columbus Center) Great Falls, Montana 59401: 406-217-2338

PRE-MARRIAGE INITIAL INTAKE

Welcome to Olive Branch Psychotherapy. I look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help me to better understand your situation as well as potential solutions in helping you and your partner.

Please note - the information is confidential, for my use only, and will not be released to anyone without your written permission.

PERSONAL INFORMATION FOR PARTNER 1

First Name: _____ Last Name: _____ Middle Initial: _____

_____ _____ _____ _____
Street Address City State Zip Code

Date of Birth: ____/____/_____ Age: _____ SSN: ____/____/_____ Sex: Male _____ Female _____

Highest Level of Education Completed: _____ Religious Affiliation: _____

Please check mark if it is ok to leave a message.

Home Phone: _____ ___Yes / No___ Work Phone: _____ ___Yes / No ___

Cell Phone _____ ___Yes / No ___ Email: _____ ___Yes / No ___

Employer: _____ Length of Employment: _____ Occupation: _____

Name of Person Responsible for Payment: _____

How did you learn about this office? _____

Emergency Contact: _____ *Contact Number:* _____ *Relationship:*_____

OLIVE BRANCH PSYCHOTHERAPY

Dr. Stephen R. Parrish DMFT, LCPC

1601 2nd Ave. North - Suite 514 (Columbus Center) Great Falls, Montana 59401: 406-217-2338

MEDICAL AND MENTAL HEALTH HISTORY / INFORMATION

Are you being treated by a physician for any medical conditions?: _____

Are you currently taking medication? ___Yes / No ___; Medication name/dose: _____

_____

Have you ever seen a Psychiatrist or any other mental health provider? ___Yes / No ___; If yes, when? _____

Focus of treatment: _____

_____ Helpful? ___Yes / No ___

ALCOHOL / SUBSTANCE USE SURVEY

How often do you have a drink containing alcohol? ____ Never ____ 1/month ____ 2-4/month ____ 2-4/week ____ 4/week +

How many drinks containing alcohol do you consume on a day you are drinking? 1 - 2 - 3 - 4 - 5 - 6 - 7 - or more

Do you use marijuana or other “street drugs”? ___Yes / No ___; what type/quantity/frequency of use: _____

_____

_____

If you prefer not to answer in writing and choose to discuss this privately with the therapist, check here: _____

RISK ASSESSMENT

Is there any family history of mental illness or substance abuse? If so, please list relationship & diagnosis: _____

_____

Please list family/friends/support groups which are helpful to you: _____

_____

_____

Have you experienced a personal history of emotional, physical, and/or sexual abuse? _____

_____

_____

Has a family member or close friend ever committed suicide? ___Yes / No ___; relationship: _____

_____

Have you been having any thoughts of harming yourself or others?:

___Yes / No ___; If so, Self _____ Other(s) _____

Are there any guns or weapons in your house (specify whose & what type) _____

_____

Have you ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation, parole)? If so, please stat under what circumstances: _____

_____

OLIVE BRANCH PSYCHOTHERAPY

Dr. Stephen R. Parrish DMFT, LCPC

1601 2nd Ave. North - Suite 514 (Columbus Center) Great Falls, Montana 59401: 406-217-2338

PERSONAL INFORMATION FOR PARTNER 2

First Name: _____ Last Name: _____ Middle Initial: _____

_____ _____ _____ _____

Street Address City State Zip Code

Date of Birth: ____/____/_____ Age: _____ SSN: ____/____/_____ Sex: Male _____ Female _____

Highest Level of Education Completed: _____ Religious Affiliation: _____

Please check mark if it is ok to leave a message.

Home Phone: _____ ___Yes / No___ Work Phone: _____ ___Yes / No ___

Cell Phone _____ ___Yes / No ___ Email: _____ ___Yes / No ___

Employer: _____ Length of Employment: _____ Occupation: _____

Name of Person Responsible for Payment: _____

How did you learn about this office? _____

Emergency Contact: _____ *Contact Number:* _____ *Relationship:*_____

MEDICAL AND MENTAL HEALTH HISTORY / INFORMATION

Are you being treated by a physician for any medical conditions?: _____

Are you currently taking medication? ___Yes / No ___; Medication name/dose: _____

_____

Have you ever seen a Psychiatrist or any other mental health provider? ___Yes / No ___; If yes, when? _____

Focus of treatment: _____

_____ Helpful? ___Yes / No ___

ALCOHOL / SUBSTANCE USE SURVEY

How often do you have a drink containing alcohol? ____ Never ____ 1/month ____ 2-4/month ____ 2-4/week ____ 4/week +

How many drinks containing alcohol do you consume on a day you are drinking? 1 - 2 - 3 - 4 - 5 - 6 - 7 - or more

Do you use marijuana or other “street drugs”? ___Yes / No ___; what type/quantity/frequency of use: _____

_____

_____

If you prefer not to answer in writing and choose to discuss this privately with the therapist, check here: _____

OLIVE BRANCH PSYCHOTHERAPY

Dr. Stephen R. Parrish DMFT, LCPC

1601 2nd Ave. North - Suite 514 (Columbus Center) Great Falls, Montana 59401: 406-217-2338

RISK ASSESSMENT

Is there any family history of mental illness or substance abuse? If so, please list relationship & diagnosis: _____

_____

Please list family/friends/support groups which are helpful to you: _____

_____

_____

Have you experienced a personal history of emotional, physical, and/or sexual abuse? _____

_____

_____

Has a family member or close friend ever committed suicide? ___Yes / No ___; relationship: _____

_____

_____

Have you been having any thoughts of harming yourself or others?:

___Yes / No ___; If so, Self _____ Other(s) _____

Are there any guns or weapons in your house (specify whose & what type) _____

_____

_____

Have you ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation, parole)? If so, please stat under what circumstances: _____

_____

_____

OLIVE BRANCH PSYCHOTHERAPY

Dr. Stephen R. Parrish DMFT, LCPC

1601 2nd Ave. North - Suite 514 (Columbus Center) Great Falls, Montana 59401: 406-217-2338

Couple's Relationship / Family Information

How long have you been in this relationship together? _____

How long have you been engaged? _____ When is your wedding date? _____

Have either one of you previously been married? _____

Do clients have children together? ___Yes / No ___; If so, please provide names and ages: _____

_____

Do either of you have children from a previous partner? If so, please state which client and list names and ages of the children: _____

Do you have any pets in the home? If so, what type? _____

List any other individuals living in either of your homes: _____

PRE-MARITAL GOALS

Goals are very important in counseling. They provide me with a focus and direction that will help us to help you. Please list the goal(s) that you hope to address and achieve in counseling. Please be as specific as possible.

PARTNER 1: _____

PARTNER 2: _____

Please rate the following topics from 1-6 (with 1 being most needed) indicating in what area you feel you need the most assistance as a couple:

___ Finances ___ Distribution of Household Responsibilities ___ Children/Parenting ___ Intimacy/Sex

___ Role of Friends/Extended Family ____ The role of Spirituality/Religion in your lives

What would you say that your greatest strengths are as a couple?_____

_____

By signing below, I confirm that the information I have provided is true and correct. I understand that I must be committed to attend sessions on a consistent basis in order to receive the greatest benefit from therapy. Although I may stop therapy at any time, I agree to inform my therapist of my decision prior to my last visit. If my therapist believes that I can receive more effective treatment elsewhere, I will be given referrals. I understand that I may not attend a session if I am under the influence of alcohol or drugs, or if I am in possession of a dangerous weapon. My signature below indicates my desire and consent to receive mental health services from *Olive Branch Psychotherapy* (OBP). I understand that I have the right to agree to, or to refuse mental health services provided by OBP. By signing below, I am indicating my desire to receive Mental Health services from Dr. Stephen R. Parrish DMFT, LCPC.

_____	_____	_____
Partner 1 Name - Printed	Signature of Partner 1	Date
_____	_____	_____
Partner 2 Name - Printed	Signature of Partner 2	Date

OLIVE BRANCH PSYCHOTHERAPY

Dr. Stephen R. Parrish DMFT, LCPC

1601 2nd Ave. North - Suite 514 (Columbus Center) Great Falls, Montana 59401: 406-217-2338

Client Services Agreement

PAYMENT INFORMATION:

I understand that I (the client) am fully responsible for the payment of all fees for services provided and that OBP will not bill my insurance company for premarital counseling. I understand that it is OBP's policy that the fee for any session is payable at the beginning of the session. OBP accepts cash, checks or credit cards as forms of payment. All sessions are 45 - 50-minutes in length. The fee for an initial intake session is $160.00. The remaining 5 sessions are $130 each.

I understand that OBP offers a reduced fee for prepayment of the 6-session premarital program. If paid on the day of each session, the total fee paid would be $810. However, if I elect to prepay for the program, I will pay only $700. total (saving $110).

CANCELLATIONS AND MISSED APPOINTMENT AND POLICY

I understand that unless a verifiable emergency exists, I must cancel or re-schedule my appointment 24 hours in advance. Same-day cancellations will incur a $50 fee applied to my account and my failure to attend a scheduled appointment without cancellation (a "no-show") will incur a $100 fee to my account. I can expect an invoice to be mailed directly to me if I do not show up or timely cancel a scheduled appointment. The voicemail system at OBP records the day and time of all messages left. If I cancel appointments on a consistent basis or miss appointments twice in a row without reasonable cause, OBP reserves the right to refer me elsewhere for services. I understand that this policy is not meant to be punitive, but instead is to request consideration for the professionals who are providing me a valuable service. My appointment time is reserved for me at the exclusion of others who may be waiting to see the therapist. Since OBP's practice is fee for service, my late cancellation or failure to show for an appointment may result in a loss of income for the therapist.

RETURNED CHECKS

Any check not honored by your bank for any reason will result in a $35 returned check fee. Returned checks, in some cases, may or may not be processed by the bank twice before deemed insufficient. Returned checks must be paid by cash, money order or credit card. Failure to pay any returned check and fees may result in criminal prosecution.

My signature below indicates that I have read, understand, and agree to the statements made above regarding Treatment, Payment & Insurance Reimbursement, and Cancellations and Missed Appointment and Returned Check Policy.

_____ _____

Partner 1 Name (please print): PARTNER 2 Name (please print):

_____ _____

PARTNER 1 Signature: PARTNER 2 Signature

Date: _____/_____/_____ Date: _____/_____/_____

OLIVE BRANCH PSYCHOTHERAPY

Dr. Stephen R. Parrish DMFT, LCPC

1601 2nd Ave. North - Suite 514 (Columbus Center) Great Falls, Montana 59401: 406-217-2338

Limits of Confidentiality

I understand that the contents of a counseling, intake, or assessment session are protected under the confidentiality laws of the State of Montana. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this office not to release any information about a client without a signed release of information. Noted exceptions are as follows:

- Signed authorization to release information to a specific individual or organization.
- Therapist determination that you may harm yourself or someone else
- Disclosure of abuse, neglect, or exploitation of a child, the elderly, or disabled
- Disclosure of professional misconduct of another mental health professional
- Court order or requirement by law to disclose information
- Prenatal exposure to controlled substances
- In the event of a client's death (the spouse or parents of a deceased client have a right to access their child's or spouse's records)
- Minors/Guardianship (parents or legal guardians of non-emancipated minor clients have the right to access the client's records)
- Insurance Companies (only information required for billing purposes)

By my signature below, I agree that I understand my right to confidentiality and the above noted exceptions.

_____ _____

Partner 1 Name (please print): PARTNER 2 Name (please print):

_____ _____

PARTNER 1 Signature: PARTNER 2 Signature

Date: _____/_____/_____ Date: _____/_____/_____