Jenny Potzler

1370 N. Brea Blvd, Ste. 210

Fullerton, CA 92835

714/335-1957

FAX 714-441-1761

CLIENT REGISTRATION

Client Information:

Name: _____ Intake date: _____ Time: _____
Address: _____
Date of Birth_____
Social Security #:_____
Source of referral: _____
Phone number: Home: _____ Work phone: _____
Cell phone: _____:
E-mail address:
_____

Do you wish to text to confirm appointments and quick exchanges? Please know that texting and email cannot be guaranteed confidential due to the nature of digital technology but every effort will be made to keep the communication confidential.
Is it permissible to text information related to scheduling appointments which would not identify you or me in a specific manner? Yes____ No_____

In the event of an emergency, whom should I contact?

Name: _____ Phone: _____

Name: _____ Phone:_____

Therapist Contact Information:

Jenny Potzler can be reached at **714-335-1957**, Monday through Friday from 8 am -8 pm. If you have a counseling emergency after hours, you may call me. However, response time will be longer; you may also dial 911.

Email Address: jennypotzler@gmail.com

Email information is for non-emergencies only. It may be used for appointment changes, referrals and non-clinical questions. I check my emails as often as possible, but if you are

cancelling an appointment with less than 24 hours' notice, pleases call my cell phone number.

Web Address: jennypotzler@jennypotzler.com

Informed Consent:

As a Licensed Marriage Family Therapist, I am governed by certain laws and regulations and by the code of ethics for my profession. The ethics code requires that I make you aware of certain office policies which may affect you. Please take a moment to read the following information.

Your Rights as a Client

- You have the right to ask questions about any procedure used during therapy.
- You have the right to decide at any time not to receive therapy from Jenny Potzler. If you wish, she will provide you with the names of other qualified professionals whose services you might prefer.
- You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued.
- Therapy is a commitment of your time, financial resources and emotional energy. Often times, especially in the beginning, emotions can become very intense and painful before they remit. In most cases, weekly therapy is the most effective and advantageous for the client and facilitates the most positive outcome. If this is not advisable, I will inform you of my opinion and we will discuss other options available to you.
- If I feel that I am unable to provide you with the level of care or expertise your situation demands, I will give you referrals to appropriate professionals.

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ADULT PERSONAL HISTORY

Please provide the following information and bring to your first session. Note: this information is protected and is confidential.

Client's name: _____ Today's date: _____

Gender: __ F__ M_____Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: ____ Zip: _____

Phone (home): _____ (work): _____ ext: _____

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

__ Anger management ___ Anxiety ___ Coping ___ Depression

__ Eating disorder ___ Fear/phobias ___ Mental confusion _____

Sexual concerns

__ Sleeping problems ___ Addictive behaviors _____ Alcohol/drugs

__ Other mental health concerns (specify): _____

Family Information

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
Mother						
Father						
Spouse						
Children						

Significant others (brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.) _____

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___

Marital Status (more than one answer may apply)

__ Single ___ Divorce in process ___ Unmarried, living together

Length of time: _____ Length of time: _____

__ Legally married ___ Separated ___ Divorced

Length of time: _____ Length of time: _____ Length of time: _____

__ Widowed ___ Annulment

Length of time: _____ Length of time: _____ Total number of marriages: __

_____

Assessment of current relationship (if applicable): ___ Good _____ Fair _____ Poor

Do you have children? ____

Names and ages of children

Parental Information

__ Parents legally married ___ Mother remarried:
Number of times: _____

__ Parents have even been separated ___ Father remarried:
Number of times: _____

__ Parents ever divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

Development

Are there special, unusual, or traumatic circumstances that affected your development? _ _____ Yes __ No

If Yes, please describe: _____

Has there been history of child abuse? ___ Yes _____ No

If Yes, which type(s)? _____ Sexual ___ Physical __ _____Verbal

If Yes, the abuse was as a: ___ Victim __ _____ Perpetrator

Other childhood issues: ___ Neglect ___ Inadequate nutrition __ _____ Other (please specify): _____

Comments re: childhood development: _____

_____

Social Relationships

Check how you generally get along with other people: (check all that apply)

__ Affectionate ___ Aggressive ___ Avoidant ___ Fight/argue often ___ Follower __ Friendly ___ Leader ___ Outgoing ___ Shy/withdrawn ___ Submissive

__ Other (specify): _____

Sexual orientation: _____

Comments: __

Sexual dysfunctions? _____ Yes _____ No

If yes, describe: _____

Any current or history of being a sexual perpetrator? ___ Yes _____ No

If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? _____ Yes _____ No

If yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? ___ Not ___ Little ___ Moderate ___ Much

Are you affiliated with a spiritual or religious group? __ Yes _____ No

If Yes, describe: _____

Were you raised within a spiritual or religious group? ___ Yes _____ No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? _____ Yes _____ No

If Yes, describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? _____ Yes _____ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: ____

Are you presently on probation or parole? ___ Yes _____ No

If Yes, please describe: _____

Past History

Traffic violations: ___ Yes __ No DWI, DUI, etc.:___ Yes __ No

Criminal involvement: _____ Yes _____ No Civil involvement: ___ Yes __ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education

Fill in all that apply: Years of education: ____ Currently enrolled in school? _____ Yes _____ No

__ High school grad/GED

__ Vocational: Number of years: __ Graduated: ____ Yes _____ No Major: ___

__ College: Number of years: __ Graduated: ____ Yes _____ No Major: ___

__ Graduate: Number of years: __ Graduated: ____ Yes _____ No Major: ___

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Employment

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

Currently: ___ FT __ PT __ Temp __ Laid-off _____ Disabled _____ Retired

__ Social Security _____ Student __ Other (describe): _

Military

Military experience? _____ Yes _____ NoCombat experience? ___ Yes _____ No

Where: _____

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

__ AIDS
__ Alcoholism
__ Abdominal pain
__ Abortion
__ Allergies
__ Anemia
__ Appendicitis
__ Arthritis
__ Asthma
__ Bronchitis
__ Bed wetting
__ Cancer
__ Chest pain
__ Chronic pain
__ Colds/Coughs
__ Constipation
__ Chicken Pox
__ Dental problems
__ Diabetes
__ Diarrhea
___ Dizziness
___ Drug abuse
___ Epilepsy
___ Ear infections
___ Eating problems
___ Fainting
___ Fatigue
___ Frequent urination
___ Headaches
___ Hearing problems
___ Hepatitis
___ High blood pressure
___ Kidney problems
___ Measles
___ Mononucleosis
___ Mumps
___ Menstrual pain
___ Miscarriages
___ Neurological disorders
___ Nausea
___ Nose bleeds
___ Pneumonia
___ Rheumatic Fever
___ Sexually transmitted diseases
___ Sleeping disorders
___ Sore throat
___ Scarlet Fever
___ Sinusitis
___ Small Pox
___ Stroke
___ Sexual problems
___ Tonsillitis
___ Tuberculosis
___ Toothache
___ Thyroid problems
___ Vision problems
___ Vomiting
___ Whooping cough
___ Other (describe): _____
_____

List any current health concerns: _____

List any recent health or physical changes: _____

_____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	___ / week	_____	___ No __ Low __ Med __ High
Lunch	___ / week	_____	___ No __ Low __ Med __ High
Dinner	___ / week	_____	___ No __ Low __ Med __ High
Snacks	___ / week	_____	___ No __ Low __ Med __ High

Comments: Some days I have no appetite.

Current prescribed medications		Dose	Dates	Purpose Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds		Dose	Dates	Purpose Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? ___ Yes _____ No

If Yes, describe: _____

Name of personal physician_____

Physician's address _____

Physician's phone_____

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last dental exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgery	_____	_____	_____
Upcoming surgery	_____	_____	_____

Family history of medical problems: _____

Pleases check if there have been any recent changes in the following:

__ Sleep patterns ___ Eating patterns ___ Behavior ___ Energy level

__ Physical activity level ___ General disposition ___ Weight ___ Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								
PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Over the counter								
Prescription drugs								
Other drugs								

_____

Substance of preference

1. _____ 3. _____
2. _____ 4. _____

Substance Abuse Questions

Describe when and where you typically use substances: _____

_____

Describe any changes in your use patterns: _____

_____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

_____

Reason(s) for use:

__ Addicted ___ Build confidence ___ Escape ___ Self-medication

__ Socialization ___ Taste ___ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

__ Yes __ No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? __ _____ Yes ___ No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe):_____

_____

Does your body temperature change when you drink? ___ Yes _____ No

If Yes, describe: _____

Have drugs or alcohol created a problem for your job? _ Yes _____ No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	_____	_____	__	__ _____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	_____	_____	__	__ _____

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	_____	_____	___	___
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	_____	_____	___	___

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

__ Aggression
__ Alcohol dependence
__ Anger
__ Antisocial behavior
__ Anxiety
__ Avoiding people
__ Chest pain
__ Cyber addiction
__ Depression
__ Disorientation
__ Distractibility
__ Dizziness
__ Drug dependence
__ Eating disorder
___ Elevated mood
___ Fatigue
___ Gambling
___ Hallucinations
___ Heart palpitations
___ High blood pressure
___ Hopelessness
___ Impulsivity
___ Irritability
___ Judgment errors
___ Loneliness
___ Memory impairment
___ Mood shifts
___ Panic attacks
___ Phobias/fears
___ Recurring thoughts
___ Sexual addiction
___ Sexual difficulties
___ Sick often
___ Sleeping problems
___ Speech problems
___ Suicidal thoughts
___ Thoughts disorganized
___ Trembling
___ Withdrawing
___ Worrying
___ Other (specify): _____

Briefly discuss how the above symptoms impair your ability to function effectively: ____

Any additional information that would assist us in understanding your concerns or problems: _____

What are your goals for therapy? _____

Do you feel suicidal at this time? ____ Yes ____ No

If Yes, explain: _____

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Limits of Confidentiality

The contents of a counseling, intake, or assessment session are considered to be confidential. 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:

There are certain situations in which Jenny Potzler is required by law to reveal information obtained during therapy to other persons or agencies without your permission. These situations include:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional may notify legal authorities and make reasonable attempts to notify the family of the client, a close friend or spouse or an inpatient psychiatric institution) who could aid in prohibiting you from carrying out your threats.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

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.

Court Orders

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

If you are the guardian of a minor or are a minor, please read the following:

By signing below, I give my consent for Jenny Potzler to conduct therapy sessions with the minor listed below. I have also been informed of the limitations to confidentiality in terms of the information given to Jenny Potzler about certain topics such as substance use and sexual activity. I accept Jenny Potzler's judgment in regard to releasing information related to the treatment of this minor. In addition, I understand that at any time if Jenny Potzler believes this minor is in danger of hurting him or herself, I will be notified immediately.

Signature: _____Date: _____

Other Provisions

When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and the name of the clinic.

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

In some cases notes and reports are dictated/typed within the clinic or by outside sources specializing (and held accountable) for such procedures.

When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. The information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjoint family or couples sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.

In the event in which I must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where I may reach you by phone and how you would like me to identify myself. For example, you might request that when I phone you at home or work, I do not say the nature of the call, but rather my first name only.

If this information is not provided to me (below), I will adhere to the following procedure when making phone calls: First I will ask to speak to the client (or guardian)

without identifying myself. If the person answering the phone asks for more identifying information I will say that it is a personal call. If I reach an answering machine or voice mail I will follow the same guidelines.

Please check where you may be reached by phone. Include phone numbers and how you would like me to identify myself when phoning you.

____ HOME Phone number: _____
How should I identify myself? _____

____ WORK Phone number: _____
How should I identify myself? _____

____ OTHER Phone number: _____
How should I identify myself? _____

Limitation on Confidentiality in Couple or Family Therapy

This written policy is intended to inform you, the participants in family therapy or couple therapy, that when I agree to work with a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (the treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. You should see these sessions as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since these sessions can and should be considered a part of the family or couple therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit - that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the patient (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

We, the members of the _____ couple/family (or other unit being seen), acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Jenny H. Potzler, MFT, and that we enter couple/family therapy in agreement with this policy.

Dated: _____ Signature: _____

Dated: _____ Signature: _____

Dated: _____ Signature: _____

I have read and understand the information that has been presented to me. In addition, I agree to participate in the therapy process in accordance with the terms that have been explained.

Dated: _____Signature: _____

Jenny Potzler

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FINANCIAL POLICY

Jenny Potzler, M.F.T., is committed to providing caring and professional mental health care to all of her clients. As part of the delivery of mental health services she has established a financial policy which provides payment policies and options to all consumers. The financial policy is designed to clarify the payment policies as determined by Jenny Potzler.

The person obligated to pay for the client is required to sign this form. Your insurance policy, if any, is a contract between you and the insurance company. I am not part of the contract with you and your insurance company.

My policy for payment is as follows:

- **My fee per hour is $135 for 60 min if paid at time of service.**
- **You may request a 90 min. session for $202.50**

  I do not bill your insurance provider for you but will provide you with a "super-bill" with all the necessary information needed. I will give this to you at the end of each session. You can submit these "super-bills" to your insurance provider as you determine-after every session or monthly or what is most convenient for you.
- Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service
- **Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the Payment Contract for Services.** The appointment time we have agreed upon is set aside for YOU. If you cancel prior to 24 hours that hour goes unused. Emergencies do occur and in the event that you must cancel an appt. you will not be charged for a missed appointment ***if you are able to reschedule another appointment time in that same week.***
- Payment methods include checks and cash or credit card
- **Preferred method of payment (please circle one): credit card check cash**

CREDIT CARD INFORMATION

The undersigned hereby authorizes Jenny Potzler to charge my credit card (provided below) for the amount of any balance remaining at the end of each billing period. If payment by check is the preferred method agreed upon, the following card will only be charged if there is an outstanding balance of more than 30 days after issuance of an invoice.

A current credit card number must be on file at all times, regardless of your preferred method of payment. Your card will not be charged if you choose to pay by check at the time your payment is due. If credit is your preferred method of payment, your card will be charged at the end of each session for services rendered. All paid invoices are emailed to the card holder at time of charge.

Credit Card to remain on file is:

1. Please circle: MasterCard Visa

2. Card Number: -

_____

3. Expiration Date:

_____

4. Security Code:

_____

5. Name as appears on the card:

_____

6. Billing Address with zip code:

_____

_____

_____

7. Signature of card holder:

_____

Payment by Check

All payments by check must be submitted by the 10th of the month following receipt of an invoice. All invoices are for services rendered the previous month and payment will be considered late if not received by the due date posted. All invoices are mailed at time of billing cycle.

The Undersigned understands and agrees to be bound to such agreements as outlined in this document. Please provide your signature below. If there is more than one adult participating in treatment, both must sign below.

*Signature:*_____*Date*_____

*Print Name*_____

Signature:

_____*Date*_____

Print Name:

_____

Questions regarding the financial policies can be answered by your therapist.

Release of Information Consent

Jenny Potzler, LMFT

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I,_____ authorize_____ _____ to:
____ (Send) ___ (Receive) the following ___ (to) _____
(from) the following agencies or people:

Name: _____
Address: _____ City: _____ State: ____ Zip: _____

Name: _____
Address: _____ City: _____ State: ____ Zip: _____

- ____ Academic testing results
- ____ Behavior programs
- ____ Case notes
- ____ Intelligence testing results
- ____ Medical reports
- ____ Personality profiles
- ____ Progress reports
- ____ Psychological reports
- ____ Psychological testing results
- ____ Service plans
- ____ Summary reports
- ____ Vocational testing results
- ____ Entire record
- ____ Other (specify) _____

_____

_____

The above information will be used for the following purposes:

- ____ Planning appropriate treatment or program
- ____ Continuing appropriate treatment or program
- ____ Determining eligibility for benefits or program
- ____ Case review
- ____ Updating files
- ____ Other (specify) _____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Client's signature: _____ Date: ____/____/_____

Parent/guardian signature: _____ Date: ____/____/_____

Witness (if client is unable to sign): _____ Date: ____/____/_____

Person informing client of rights: _____ Date: ____/____/_____