# Meredith Fielder, LMFT

**Marriage and Family Therapy**

**6224 Airpark Dr. Chattanooga, TN 37421**

**Phone: (423) 668-6184**

##### THERAPY AGREEMENT/INFORMED CONSENT WITH POLICIES AND PROCEDURES

Please read and sign in the places requested, indicating your understanding of my fees and office procedures. I’ll be happy to answer any questions.

**Licensing and Education**

I am a graduate of the Marriage and Family Therapy program at Lee University. I hold a Master’s of Science in Marriage and Family Therapy and have a Marriage and Family Therapy License through the state of Tennessee.

**Information about Location of Practice**

It is important to note that although I am using the GraceBridge church as office space, the church is in no way responsible for any part of our work together. This includes treatment and outcome.

## Philosophy, Benefits and Risks of Therapy

Marriage and Family Therapists (MFTs) are relationship specialists who treat persons involved in interpersonal relationships. We are trained to assess, diagnose and treat individuals, couples, families and groups. The practice of Marriage and Family Therapy as a whole also includes premarital counseling, child counseling, divorce or separation counseling and other relationship counseling. Marriage and Family Therapists are psychotherapists and healing arts practitioners licensed by the State of Tennessee. Therapy sessions are tailored to the individual as well as the relational needs of each client.

The relationship between the therapist and the client is the single most important factor to determine the success of treatment. Feeling comfortable with the therapist provides you with an opportunity to trust the therapist's abilities and allows you to get the most out of treatment. As a client you are invited to question and clarify the nature of the therapeutic relationship as necessary. Feel free to ask any questions about the therapeutic process, the course of treatment or any other question pertaining to the process of psychotherapy. Therapy works best when you are an active participant. You know best why you’re here and what you most want to accomplish.

Therapy gives opportunity for change and is most often beneficial, but change involves risk. You may feel worse before you feel better due to confronting issues that you may have been avoiding up until this point. Your relationships may feel different as you begin to grow and change, and significant others may not respond positively to this. There is no absolute guarantee that any particular psychological treatment will be successful. It is important to be aware of such risks, as they will promote your understanding and realistic expectations of your therapy.

## Availability/Emergencies

If an emergency arises, please be aware that you may not be able to reach me because I am not available 24 hours a day. You may leave a message at my work phone number: (423-668-6184). Indicate in your message that your call is urgent, and I will do my best to contact you as soon as possible. All non-urgent phone calls will be returned during normal workdays within 24 hours. If you are experiencing a life-threatening emergency, go to your closest emergency room or dial 911. If you are reaching me by text message or email, please be advised that these are not HIPAA compliant modes of communication. I advise that you leave out any private information and keep the messages regarding appointment times only.

## Confidentiality, Privileged Communications, and Insurance Usage:

Your presence here, the content of your sessions, and your records are confidential with some important exceptions. I cannot release information to anyone without your specific written permission. If you are engaging in couple’s or family therapy, ALL participants over the age of 18 must give written consent for any records to be released.

However, there are limits to the privilege of confidentiality. These situations include:

1. I am required by law to report suspected abuse or neglect of a child, elderly person, or a disabled person
2. If you intend to commit suicide, I have an ethical and legal responsibility to intervene and protect you from harm. Such interventions may include: soliciting support from significant others, requesting psychiatric evaluation from a county designated team, and or hospitalization as necessary.
3. If you intend to commit homicide, I am required by law to notify the authorities and any potential victims.
4. If I am ordered by a court or judge to release information I must do so.
5. When your insurance company is involved (e.g. in filing a claim, insurance audits, case review or appeals, etc.)
6. In natural disasters whereby protected records may become exposed.
7. When otherwise required by law.

Periodically, I consult with clinical and licensed clinicians (without using identifying information about clients) and these consultations are governed by strict ethical standards for the protection of your privacy.

## CONSENT

## *I have read and do understand the policies described above. In addition, I have discussed such terms and conditions with the therapist, and have had any questions with regard to its terms and conditions answered to my satisfaction. My signature below indicates my full and informed consent to treatment and my intention to be an active participant in my own therapy. I acknowledge that I have been given a copy of my Informed Consent and HIPPA Privacy Act.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of parent/guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/guardian Date

## PAYMENT AGREEMENT

The fee for a 60-minute therapy session is $70.00. The fee for a 90-minute session is $100. At this time, I do not accept insurance. If there is difficulty in paying the fee, you may request to be considered under a sliding scale payment arrangement. Payment is due at each session by cash. There will be additional fees for excessive letter writing or phone calls over 10 minutes. In addition, for all court related cases a fee of $160.00 per hour will be charged where any time is spent speaking with attorneys, writing court reports, traveling to or attending court, or any other time I give to court issues. I do not testify or make judgments of parental fitness for child custody cases under any circumstance.

Sessions missed or not cancelled with 24 hours’ advance notice will be billed to you at the regular fee. Exceptional conditions will be considered.

## *I accept responsibility for payment of fees for services as described above and provided to me by Meredith Fielder. I understand and agree that fees are due at the beginning of session and Meredith Fielder reserves the right to turn unpaid fees over to a collection agency.*

**Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

# Background Information

# Please provide the Child’s information requested below.

# Name Today’s Date

 First M.I. Last

Address

 number street apt.# city state zip

Home Phone ( ) Work Phone ( ) Extension\_\_\_\_\_\_\_\_\_

Cell Phone ( ) Highest Grade Completed:

Birth Date \_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_ Social Security Number\_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Sex: M F

Relationship Status:\_\_Sing.\_\_Dating\_\_Mar.\_\_Sep.\_\_Div.\_\_Wid. How long dating/dated current partner

Employer/School Title Full Time/Part Time?

**Family Information**

**Mother’s Name** Birth Date Age SSN

Home Address

 number street apt.# city state zip

Home Phone ( ) Cell Phone ( )

Work Phone ( ) Extension

Employer Job Title

**Father’s Name** Birth Date Age SSN

Home Address

 number street apt.# city state zip

Home Phone ( ) Cell Phone ( )

Work Phone ( ) Extension

Employer Job Title

**Step-Mother’s Name (if applicable)**:

**Step-Father’s Name (if applicable)**:

**Who has legal custody of the youth?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Legal Guardian’s Name** Birth Date Age SSN

Home Address

 number street apt.# city state zip

Home Phone ( ) Cell Phone ( )

Work Phone ( ) Extension

Employer Job Title

**Please list youth’s immediate family including parents and siblings (excluding those already listed):**

**Name Age Relationship to Youth**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who all lives in the household with this youth?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for referral/chief complaint**

**Briefly describe the problems and reasons that brought you here:**

**How are these problems affecting your child’s and family’s life? (home, social, education/occupational, health, etc.)**

**How long have these problems existed?**

**Has there been a time when symptoms have worsened?**

**Briefly describe any events, precipitating factors, stressors, and or incidents leading to need for services:**

**Briefly list the goals you have for your youth’s treatment here; that is, what you would like to achieve and/or see happen by coming here for care:**

**How did you find information about my services?**

**Medical and Mental Health History**

|  |
| --- |
| **Name of Primary Care Physician**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please list below any past or present treatment for medical conditions, including behavioral/mood, developmental problems, diseases, illness, major accidents, injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and/or obesity. |
| **Relevant Medical Conditions** |
| **Medical/Mental** | **Age Diagnosed** | **Treating Physician** | **Medication Prescribed w/ Dose & Frequency** |
|  | *1.* | *1.* | *1.* |
|  |  |  |  |
| *2.* | *2.* | *2.* | *2.* |
|  |  |  |  |
| *3.* | *3.* | *3.* | *3.* |
|  |  |  |  |
| 4. | 4. | 4. | 4. |
|  |  |  |  |

**Previous mental health treatment/therapy services**

# Type of Services Provider Dates of Service

**Family mental health treatment/therapy history:**

## Legal Issues

## Past or current legal involvement, including custody, visitation, divorce-related disputes, arrests, or pending court actions? *[ ]* Yes *[ ]*  No If yes, please explain:

**Past or current legal involvement of family members:**

**Substance Use: Previous and Current**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Drug Type****(Circle those that apply)** | **Age of First Use** | **Age of Last Use** | **Amount** | **Frequency** | **Results of Use** |
| Prescription Drugs- other than as prescribed |  |  |  |  |  |
| Over the Counter Drugs- not as directed  |  |  |  |  |  |
| Nicotine- cigarettes, dip |  |  |  |  |  |
| Alcohol |  |  |  |  |  |
| Marijuana/Hashish-other hallucinogens |  |  |  |  |  |
| Barbiturates- other sedatives hypnotics |  |  |  |  |  |
| Benzodiazapine- other tranquilizers |  |  |  |  |  |
| Cocaine/Crack- other stimulants |  |  |  |  |  |
| Methamphetamine- other amphetamine |  |  |  |  |  |
| Opiates- heroin, non-rx-methadon, morphine |  |  |  |  |  |
| Inhalants |  |  |  |  |  |
| Phencyclidine (PCP) |  |  |  |  |  |
| Other/Drug Unknown |  |  |  |  |  |

**Family history of substance use:**

**Psychosocial History**

**Family history (Current living Situation, family constellation, family of origin, family dynamics, violence/abuse, strengths)**:

**Developmental history (Pregnancy, birth, milestones, strengths, areas of difficulty):**

**Educational history (Highest grade completed, strengths/weaknesses, learning issues/interventions, conflicts w/ classmates/teachers, suspensions, retentions, truancies, school changes):**

**Social support/relationships (Current social support network, conflicts w/ peers, intimate relationships, developmentally appropriate relationships, etc.):**

**Traumatic events/significant life events (Separations, divorce, moves, deaths, losses, neglect, sexual/physical/emotional abuse, rape, major accidents, burglaries, etc.):**

**Culture and role of religion in client’s life (Cultural group identification/identify, acculturation**

**issues; Role of spirituality in emotional problems and interventions):**

## In Case of an Emergency:

## In the unlikely event of an emergency while in therapy with Meredith Fielder, I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission to Meredith Fielder to contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by phone at\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

## Parent/Guardian Signature \_\_\_\_ Date

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##### CONSENT FOR MENTAL HEALTH SERVICES FOR A MINOR CHILD

I, (parent/guardian) give permission for

 (name of minor) to be provided services by

Meredith Fielder, which consist of all or part of the following:

Interviews(s)

Observations

History from referral source

Assessment of Emotional Status

Individual and/or Family Therapy Sessions

Consultation with Relevant Professionals

My signature below certifies that I am the legal custodian of the above-named minor.

##  Parent/Guardian Date

 **Witness Date**

 CLIENT’S COPY TO KEEP

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