

Sylvia L. Flanagan, MA, MFT (MFC 43147)
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(619) 318-1901

CONSENT FOR COUNSELING

NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:
DATE OF BIRTH:		
HOME PHONE: ()	MAY I CALL/LEAVE MSG? Y N (circle one)	
CELL PHONE: ()	MAY I CALL/LEAVE MSG? Y N (circle one)	
EMAIL:		
REFERRED BY:		

I understand that my counselor is a California Licensed Marriage & Family therapist. I further understand that all information disclosed within sessions is confidential and will not be discussed outside sessions.

However, California law does either mandate and/or allow disclosure of certain information under specific circumstances. While no information will be disclosed outside this relationship without my written consent for such relates, the following exceptions to confidentiality exist under law:

1. Where there is reasonable suspicion of physical abuse, sexual abuse, or neglect of a child under the age of 18;
2. Where there is reasonable suspicion of physical abuse, fiduciary abuse or neglect of the elderly or dependent adult;
3. Where the client presents a serious danger of violence to another;
4. Where the client is likely to harm himself/herself seriously unless protective measures are taken;
5. A judge in a court of law subpoenas your records.

I understand that if the counselor is not, for any reason, the appropriate person to meet my counseling needs, I will be given referrals to other resources more appropriate to my needs and goals.

I understand that fees for services are \$___ per one-hour session and payable at the time of each session unless otherwise arranged in advance. All fees are payable to Sylvia Flanagan, MFT. Signature on this form assigns insurance payments to provider.

NOTE: Payment is required for any session cancelled by the client without a full 24 hours notice.

Please briefly answer the following questions:

ARE YOU MARRIED/PARTNERED OR SINGLE?
DO YOU HAVE ANY CHILDREN? IF SO, HOW MANY?
DO YOU HAVE A GOOD SUPPORT SYSTEM?
WHAT ARE YOUR STRENGTHS?
WHAT ARE YOUR LIMITATIONS?
DO YOU THINK YOU MIGHT HAVE A PROBLEM WITH ALCOHOL OR DRUGS?
DO YOU HAVE ANY MEDICAL CONDITIONS?

Please provide the name, address and phone number of the nearest relative or friend who may be contacted in the event of an emergency:

NAME:	ADDRESS:
STATE & ZIP:	PHONE:

Please list all medication(s) you are currently taking and have recently ceased taking:

Currently Taking	Ceased Taking

If you have previously seen a counselor, therapist, psychologist or psychiatrist, please list when and for what reasons:

Please provide a brief statement regarding the situation that leads you to seek therapy at this time:

Client Signature

Date