BOB BERTOLINO, PH.D.

Licensed Marital and Family Therapist (LMFT) – State of Missouri – #300097
Licensed Professional Counselor (LPC) – State of Missouri – #2447
National Certified Counselor (NCC) – #40464
Certified Rehabilitation Counselor (CRC) – #102075
National Board Certified Fellow in Hypnotherapy (NBCFCH) - #3400
American Association for Marriage and Family Therapy (AAMFT) – Clinical Member – #62859

Client Information Form

Date: ________________________________ File #: __________________________

Name: ____

Date of Birth: __________________________ Age: _________ Gender: ___________

Address: ____
Street

____
City State Zip Code

Primary Phone: ____

Occupation: ________________________ Employer: __________________________

Referred by: ___________________________ Phone: __________________________

Relationship Status

________ Single ________ Married ________Engaged ________Cohabiting

________ Separated ________ Divorced ________ Remarried ________ Widowed

Name of Significant Other: ____

Family Relationships

Who lives in your household?

Name Age Gender Relationship

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Reason for Seeking Therapy

What event, if any, led you to seek therapy at this time? _________________________

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Briefly describe the concern(s) that led you to therapy _________________________

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Please share any other information you think might be helpful for your therapist to know about you or the concern(s) that brought you to therapy ___________________________

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What would you like to have change or be different as a result of coming to therapy?

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On a scale of 1 to 10, with 1 being least hopeful and 10 being most hopeful, how hopeful are you that therapy can help with the resolution or management of your concern(s)? (Circle number below)

1 2 3 4 5 6 7 8 9 10

Therapy History

Have you seen a counselor/therapist before? Yes No

If yes, what were the approximate dates? _______________________________________

Name of Counselor/Therapist/: ____

For what concern(s) did you seek therapy in the past? ______________________________

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What was most and least helpful about therapy? ____________________________________

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Basic Health

Name of Physician: ____

Prominent Medical Concerns: ____

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Medications currently prescribed: ____

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____ ______________________________
Client Signature Date

Consent for Services

Welcome. My name is Dr. Bob Bertolino. I am a Licensed Marital and Family Therapist (LMFT) and Licensed Professional Counselor (LPC) in the state of Missouri. I am also a National Certified Counselor, a Certified Rehabilitation Counselor, a National Board Certified Fellow in Hypnotherapy, and a Clinical Member of the American Association for Marriage and Family Therapy. I provide individual, couples, and family therapy, clinical hypnosis, and consultation. I appreciate the opportunity to work with you.

Confidentiality and Limits

I adhere to HIPAA regulations, state laws, and professional ethical standards regarding your privilege of confidentiality. All information disclosed in sessions is confidential and is not revealed to any entity without your written consent (requiring a release of information [ROI]). The only exceptions to this rule are required by Federal and Missouri laws and include:

1) By legitimate order of the court;

2) In the event of a medical emergency;

3) Suspected or reported child abuse or neglect or elder abuse or neglect. I am legally mandated to report any such information to the Division of Social Services (DSS)—Children's Division or the Missouri Department of Health and Senior Services (DHSS);

4) In the event that there is a threat of harm to self or others; and,

5) The release of any medical or any other information necessary to process an insurance claim.

If you would like us to contact a referral source, family member, or other service provider, I will ask you to give your permission in writing. Per state law, clinical files are maintained for 7 years.

Fees

My fee for psychotherapy is $125 per hour to be collected at the end of each session. Payments may be made via cash, check, or major credit/debit cards. Please be advised that I do not accept insurance at this time. You may request that an invoice be prepared for you to submit to your insurance provider. In such cases, determinations for reimbursement exist solely with the insurance provider. The fee for time spent outside of the therapy session (i.e., preparing reports, contacting physicians, attorneys, etc.) is $150 per hour.

Phone Policy

Phone consultations may be requested. Phone consultations are used for clients who would like therapeutic advice for problem solving ideas. Phone consultations are $31.25 per 15 minutes. Clients will not be charged for basic client questions such as scheduling or cancelling appointments, informational questions about therapy, or follow up. Please call at least 24 hours in advance to cancel and or reschedule your appointment. You may be charged for appointments not kept or cancelled without 24 hours' notice. Appointments that can be rescheduled within a week will not be charged.

Emergencies

Unless advised, I will return your calls within 1 business day. In the event of an emergency, please call 911, proceed to your closest emergency room, or call Behavioral Health Response (BHR) at (314) 469-6644, (800) 811-4760, or TTY (314) 469-3638. BHR provides confidential telephone counseling to people in mental health crises, offer mobile outreach services, and community referral services. Please note that BHR does not provide medical treatment.

COVID-19 Statement

Given the current situation with the coronavirus (COVID-19) pandemic, I am offering sessions remotely via Teletherapy. Teletherapy offers a way to provide therapeutic services when in-person sessions are not possible. Teletherapy involves the use of doxy.me, a via a third-party platform that can be used with an electronic device such as a computer, tablet, or smart phone. I take necessary precautions in order to reduce risk and ensure client privacy and follow all guidelines related to privacy and confidentiality. Doxy is free to all clients.

Contact

Please identify your preferred method(s) of contact by checking all the boxes that apply:

Phone ☐ #: ____

Text ☐ #: ____

Email ☐ Email Address: ____

Your signature indicates that you understand and accept the above described policies. Your signature also gives authorization for services to persons listed below who under the age of 18 listed and for whom you are permitted to provide consent. Please sign and date your signature.

Name (Printed): ____

Signature: ____ Date: ______________

Name (Printed): ____

Signature: ____ Date: ______________

Name (Printed): ____

Signature: ____ Date: ______________