Sonal Dhillon, M.A., LMFT

Licensed Marriage & Family Therapist #85497 • 970 Reserve Drive, Suite 170 • Roseville, CA 95678 • (916) 893-0265 • therapywithsonal@gmail.com • www.sonaldhillon.com

Individual/Family Information

Name ____Date of Birth__________________
Gender: Male Female Education completed ___________ Religion (optional)______________
Occupation _______________________________Employer ____________________________
Home Address ____
Email address: _______________ Home Phone # _______________ Cell Phone #_____________

Place an asterisk (*) next to all numbers at which it is okay for me to leave a message.

Spouse/Partner's Name ___________________________________Date of Birth_____________
Gender: Male Female Education completed ___________ Religion (optional)_____________
Occupation _______________________________Employer ____________________________
Home Address (if different from above)____
Email address: _______________ Home Phone # _____________ Cell Phone #_______________

Place an asterisk (*) next to all numbers at which it is okay for me to leave a message.

Number of marriages (including current) for you _______ Your partner ______

Years of current marriage/relationship ____

Please list below all children from this or previous marriages/relationships whether or not they live in your household.

Name(s) *Age* *Gender*

____
____
____
____

Please list below any medication(s) you are currently taking.

Name *Medication* *Dosage*

____
____
____
____

Medical Concerns:

____

Name of Physician:________________________________ Phone: ____________________________________ Date of last physical:______________

Current or Past Service Providers (therapist, psychiatrists, etc):

____

Are you willing to sign a release of information for me to coordinate care with them?: Yes No

Has anyone being seen ever abused alcohol/drugs? Yes No If yes, who and if drugs, which drugs:

____

____

Please list below any physical or emotional health problems that members of your family have suffered now or in the past (Include relevant extended family such as parents).

Name *Physical or Emotional Health Problem*

____

____

____

____

Have you ever participated in counseling or therapy? Yes No

Reason(s)? ____

What led you to end counseling or therapy?____

____

Please check any of the following that have been an issue (past or present) for you:

- ○ Drinking Problem
- ○ Drug Problem
- ○ Depression
- ○ Anxiety
- ○ Disordered Eating
- ○ School Problems
- ○ Legal Problems
- ○ Sexual Problems
- ○ Physical Abuse/Agression
- ○ Parenting Stress
- ○ Trauma
- ○ Anger Problems
- ○ Financial Difficulties
- ○ Suicide attempts
- ○ Family problems
- ○ Chronic Stress
- ○ Controlling or verbal Abuse
- ○ Acting out Children
- ○ In-Law/extended family problems
- ○ Sexual Abuse
- ○ Other: _________

What brought you in today and what are your goals for therapy?

____

____

____

How did you hear about me?

____

In case of emergency contact: _______________________________ Phone:________________________

Relationship to you:____________________

Informed Consent for Treatment and Disclosure of Fees

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask any questions that you may have regarding its contents.

Information about Sonal Dhillon, M.A., LMFT:
Sonal has a Master's Degree in Marriage and Family Therapy from Alliant International University, Sacramento. Sonal is a California Licensed Marriage and Family Therapist (LMFT #85497). If you have any questions about my background or experience, please feel free to ask.

Fees:
The fee for service is $200 per 50-minute individual, family, or couple's therapy session, and is billed in 30minute increments thereafter. Time in court/testimony is $400 per hour. Payment can be made via cash or check. Checks should be made out to Sonal Dhillon.

Fees are payable at the time that services are rendered. If you wish to discuss a written agreement that specifies an alternative payment procedure, please do so prior to session.

Appointment Scheduling and Cancellation Policies:
Sessions are typically scheduled weekly or bi-weekly (sometimes more or less depending on need) at the same time and day if possible. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify me at least 24 hours in advance of your appointment.

If you do not provide me with at least 24 hours notice in advance, you are responsible for full payment for the missed session.

Please initial here to indicate your agreement with the fees, scheduling, and cancellation policies _________

Confidentiality:
All communications made in session will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release (often called a "no-secrets policy").

There are exceptions to confidentiality. Therapists are required to report instances of suspected child or elder abuse. Therapists are also required to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances to provide FBI agents with requested items and prohibits the therapist from disclosing to the client that the FBI sought or obtained the items.

Minors and Confidentiality:
Parents have the legal right to be appraised of the details of their minor (under the age of 18) child's treatment. Parents and other guardians who provide authorization for their child's treatment are encouraged to be involved in their treatment. However, treatment with a minor often progresses best with a good-faith agreement to confidentiality between the parents and their child so that the child can be assured of his or her confidentiality in therapy sessions. Consequently, I may discuss the *treatment progress* of a minor client with the parent or caretaker, but preferably not details that would decrease trust between the minor and me. Minor clients and their parents are urged to discuss any questions or concerns that they have on this topic. Therapist

Availability/ Emergencies:

Telephone consultations between office visits are welcome. However, I will attempt to keep those contacts brief due to my belief that important issues are better addressed within regularly scheduled sessions. Telephone conversations lasting longer than ten minutes will be billed at the regular ½ hour rate. You may leave a message for me at any time in my confidential voicemail at (916) 893-0265. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. **If you have a medical or psychiatric emergency, please call 911 or A.C.C.E.S.S. at 916-787-8860.**

Therapist and Client Responsibilities:

It is my responsibility to provide professional services that will assist you in reaching your goals based upon the information that you provide to me and the specifics of your situation. It is your responsibility to apply the things we discuss and work hard in and out of session. You will likely get out of therapy what you put into it. I will periodically initiate discussions about the progress of treatment. Due to the varying nature and severity of problems and the individuality of each client, I am unable to predict the length of your therapy or guarantee a specific outcome or result.

Termination of Therapy:

The length of your treatment and the timing of the treatment termination depend on the specifics of your treatment plan and the progress you achieve. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either you or I may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents. Signing on the right hand side indicates consent to work with all members of my family under the age of 18 and that this agreement will serve as **"Consent to Treat a Minor Child."** Please ask if you have any questions.

____________________________________ ____

Adult Client Date Minor Client Date

____________________________________ ____

Adult Client Date Therapist Signature Date