Center For Family Counseling

Brian W. Towers, LMFT LLC

Welcome Letter

Welcome to the Center for Family Counseling. Enclosed in the packet you will find a General Information Form (one for each person attending counseling), a Billing and Treatment Agreement, and directions to the office. Please review and complete this information and bring it with you to your first session.

Whether you have attended counseling before or if this is your first time, you will find my style to be relaxed and conversational. However, this does not mean that therapy will not be challenging at times. Often we desire changes in our lives or relationships but discover that change can be difficult to achieve and maintain. In therapy we will work together to establish goals and create a "roadmap" to achieve your desired goals.

I use various methods and techniques during therapy that are primarily grounded in systems and cognitive-behavioral theories. These theories recognize the importance of families, their interactions, and your understanding of the events in your life. However, it is important to understand that the effort made by the families, couples, or individuals attending therapy will have an important impact on the overall success of the therapeutic process.

I am sometimes away on vacation, seminars, or training and will make every effort to inform you of these absences in advance. I can be reached via voicemail at (540) 361-1556 ext. 703 or by e-mail at bwtowers@comcast.net or brian@centerforfamilycounseling.com during most times, and will make arrangements for contact should I be away for an extended period of time. I look forward to working with you to help achieve the desired changes in your life.

Best regards,

Brian W. Towers, LMFT
License: 0717001213

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General Information Form

(Fill Out One For Each Person Attending Counseling)

Contact Information

First Name: _____ Last Name: _____

Address: _____ Date of Birth: / /

_____ Gender: ☐ M ☐ F

City: _____ State: _____ ZIP: _____

Phone (H):	( )	E-Mail:	
Phone (W):	( )	Employer:	
Phone (C):	( )	Referred By:	

Demographic Information

Race:
☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Am Indian ☐ Other _____

Education (check highest grade attending/attended):
☐ Elem/Mid School ☐ High School ☐ Trade School ☐ College ☐ Grad School

Current Marital Status:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Significant Relationship

Annual Financial Status (for the family as a whole, if attending Marital/Family therapy):
☐ 0 – 30K ☐ 30 – 45K ☐ 45 – 60K ☐ 60 - 75K ☐ 75 – 100K ☐ 100K+

Health Status:
☐ Good ☐ Fair ☐ Poor If poor, explain:_____

Religious/Spiritual Status:
☐ Highly ☐ Moderately ☐ Slightly ☐ Not Religious ☐ Anti-Religion

Religious Preference:
☐ Protestant ☐ Catholic ☐ Agnostic ☐ Atheist ☐ None ☐ Other

Adoption Status (if adopted, please circle known or unknown to indicate client's knowledge):
☐ Not Adopted ☐ Adopted (known / unknown) If so, at what age:_____

Parent's Marriage Status:
☐ Very Happy ☐ Happy ☐ Unhappy ☐ Very Unhappy ☐ Divorced/Separated

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General Information Form (cont'd)

Current Rx:	Name	Dosage (mg)

Primary Care Physician: _____

Prev. Therapist: _____

Psychiatrist: _____

Last Physical: (XX yrs, XX mos) _____

How did you hear about us?

Previous Counseling? ☐ Yes ☐ No	How Long Did You Attend (Sessions)?

How would you describe it?
☐ Very Helpful ☐ Helpful ☐ Neutral ☐ Unhelpful ☐ Very Unhelpful

Family Members (Currently Residing in the Home):

Name	Age	Gender	Relationship

What do you hope to accomplish in counseling today?

Number of sessions you believe it will take to resolve the problems that brought you:
☐ 1 - 5 ☐ 5 - 10 ☐ 10 - 15 ☐ 15 - 20 ☐ 20+ ☐ I have no idea.

This is the right place for me.	Therapy will be successful.
☐ Yes ☐ No ☐ I have no idea.	☐ Yes ☐ No ☐ I have no idea.

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Billing and Treatment Agreement

(To be filled out by the person responsible for treatment and billing)

I understand that therapy sessions are 50 minutes in duration, and that the Center for Family Counseling charges **$90 per session**. I also understand that this $25 fee will be charged for missed appointments or for cancellations not made at least 24 hours in advance of my appointment. I also understand that payment is expected at each visit unless prior arrangements have been made. In the event that a collection agency is retained to collect my account, I agree that I will be responsible for any and all collection fees.

Initial_____

I understand that **my therapist does not participate in any insurance provider plans**. This means that I am personally responsible for the agreed-upon fees for treatment, which may not be reimbursable through my insurance company. If I choose to seek out-of-network reimbursement from my insurance company, I understand that I must contact my insurance carrier prior to my first session to understand my carrier's specific policies.

Initial_____

I understand that confidentiality means that what is discussed within a therapy session will not be revealed without my **written and express** permission. However, I understand that therapists in the Commonwealth of Virginia are mandated reporters in the following cases:

- If I am a danger to myself or others
- If there is evidence of child abuse, elder abuse, or anyone else who is otherwise mentally incapacitated

I further understand that in certain cases that the Commonwealth of Virginia or its agents can subpoena private health records to be submitted to the courts.

Initial_____

I understand that I have the right to ask any questions about my treatment and may end my treatment at any time. However, I agree to make every effort to discuss my concerns about my progress or treatment before terminating therapy. I further understand that information in my treatment file is considered private health information and is subject to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand that I can request a copy of the act to review in the office or that I can download information on the Internet from http://www.hhs.gov/ocr/hipaa/ if I have questions about my private health information.

Initial_____

If I am consenting to the treatment of a minor, I understand that the therapist must tell me if my child is in danger, but to facilitate trust and a good, working therapeutic relationship, the therapist will give my child(ren) the same confidentiality afforded to others. The therapist will work with my child to share information that would be important to my child's healing or welfare. However, if I desire more than generalized information, I understand that I may need to seek out another therapist for my child.

If for minor child(ren), please list names, gender, and ages below:

Name	Gender	Age
_____	_____	___
_____	_____	___
_____	_____	___

I have read and agreed with the above and agree to enter into therapy or have my child(ren) enter into therapy with the Center for Family Counseling.

Signed:_____ Date:_____
(Adult, parent, or legal guardian)

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Payment Arrangements

(To be filled out by the person responsible for payment)

The Center for Family Counseling offers several payment options. Please indicate in the space below which method you would **typically** like to make payment for therapeutic services:

☐ Cash (please bring exact change, if possible)
☐ Check (please make out to **Brian W. Towers, LMFT LLC**)
☐ Credit Card (please complete the section below)

Center for Family Counseling

Credit / Debit Card Authorization Form

This will authorize the Center for Family Counseling, hereinafter called "CFC," to initiate credit entries and adjustments for any credit entries in error, if necessary, to the credit or debit card below for the amount listed below. This authorization will remain in effect until either services are terminated with CFC or until CFC receives written notice requesting a change.

This activity will authorize the credit card company indicated below to credit and / or debit the same credit or debit card account.

BILLING INFORMATION

VISA ○ MasterCard ○

Member Name (Print):

Expiration Date:

___ ___ / ___ ___

Card Number:

__ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

CVV Code:

Member Street Name:

Member Zip Code:

Amount:
$

Authorized Signature:

Date of Authorization:

___ ___/___ ___/___ ___

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Directions to the Center for Family Counseling

307 Lafayette Blvd., Suite 202 Fredericksburg, VA 22401

From Route 3:

- Eastbound Route 3 – turn left on Lafayette Blvd; Westbound Route 3 – turn right on Lafayette Blvd.
- 307 Lafayette Boulevard is on the left, just past Charles Street intersection.
- The Center for Family Counseling can be found in Suite 202 (Second Floor)

From Route 1/Rt. 3:

- Northbound, turn right on Princess Anne Street; Southbound, turn left on Princess Anne Street.
- Make right on Lafayette Blvd.
- 307 Lafayette Boulevard will be on the right, before Charles Street intersection.
- The Center for Family Counseling can be found on the Second Floor

Limited parking can be found by the building. Please do not park in spaces marked 'Sheriff's Office' or 'Reserved', but all other spaces are acceptable. Street parking can be found all along Wolfe Street and Princess Anne Street. There is a parking garage at Wolfe Street and Caroline Street (pay).