

Office \_\_\_\_\_

Date of initial visit \_\_\_\_\_

## Client Information

**Please print clearly!!**

Patient name \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ DOB \_\_\_\_\_ Email ( For newsletter) \_\_\_\_\_

Phone Day \_\_\_\_\_ Phone Eve \_\_\_\_\_ Cell \_\_\_\_\_

May we leave a general message with individuals who may answer the phone? Ex “call back Dr. Schwarz” or “I need to cancel and re schedule you” or “your appointment is at...”

Yes \_\_\_\_\_ No \_\_\_\_\_ (If no you must leave another number we can leave a message on)

Best number for messages \_\_\_\_\_

Marital Status \_\_\_\_\_ #of children \_\_\_\_\_ ages: \_\_\_\_\_

If Married for how long have you been married \_\_\_\_\_

Is this your 1<sup>st</sup> Marriage Yes No

Highest grade or degree completed \_\_\_\_\_

Type of employment \_\_\_\_\_

[if patient is a Child Parents names} \_\_\_\_\_

\_\_\_\_\_

## Insurance Information

Type \_\_\_\_\_

Primary insured \_\_\_\_\_ DOB \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Mailing address of insurance company

Street \_\_\_\_\_

City \_\_\_\_\_, State \_\_\_\_\_ Zip \_\_\_\_\_

**I give my authorization and permission for Dr. Schwarz to release information to my insurance company for reimbursement purposes.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**I authorize payments to be sent to Dr. Schwarz for services.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Payment Policy

I understand that I am responsible for payment in full to Dr Robert Schwarz at time of service. They will provide me with a form to submit to my insurance company for reimbursement purposes. If my insurance carrier does not reimburse me I am still responsible for payment at the time of visit for services rendered.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Contacts for emergencies or consultations

When was the last time you had a physical or saw a physician? \_\_\_\_\_

Name of Primary physician \_\_\_\_\_

Address \_\_\_\_\_ Phone number \_\_\_\_\_

\_\_\_\_\_

May we contact him/her for continuity of care?

YES \_\_\_\_\_ NO \_\_\_\_\_

	Name	Relationship	Phone
Emergency contact			

## Referral Source

Referred by \_\_\_\_\_

May we contact them or send a thank you for referral note?

YES \_\_\_\_\_ NO \_\_\_\_\_

Phone \_\_\_\_\_

address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Yellow pages \_\_\_\_\_ Delaware County \_\_\_\_\_ Main Line \_\_\_\_\_

Section Psychologist \_\_\_\_\_ Marriage & family \_\_\_\_\_ Hypnosis \_\_\_\_\_

Superpages.com \_\_\_\_\_ Internet \_\_\_\_\_, Psychology today \_\_\_\_\_

Yoga Life \_\_\_\_\_, New Visions \_\_\_\_\_

800 # in Back of Men are From Mars Women are From Venus Book \_\_\_\_\_

## Substance use

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_

How much alcohol do you drink? \_\_\_\_\_

How much Coffee, tea or caffinated drinks do you drink? \_\_\_\_\_

Do you use street drugs? (Pot, Acid, cocaine etc.?) \_\_\_\_\_ How often? \_\_\_\_\_

Do you use inhalants? ( Whipits, glue, aerosols, etc?) \_\_\_\_\_ How often? \_\_\_\_\_

## Medications

### Current Non-Psychiatric Medications or supplements

Medicine	Dose	How long on this drug	Purpose	How effective is it?	Describe any side effects
1.					
2.					
3.					
4.					

### Current Psychiatric Medications

Medicine	Dose	How long on this drug	Purpose	How effective is it?	Describe any side effects
1.					
2.					
3.					

### Past Psychiatric Medications

**List each drug chronologically, starting with the first medication prescribed.**

Medicine	Dose	How long on this drug	Purpose	How effective was it?	Describe any side effects
1.					
2.					
3.					
4.					

**Summary of Prior Psychotherapy (Please include alternative healers)**

List chronologically, beginning with the first therapist you have ever worked with.

<b>Name of therapist and degree</b>	<b>Date, duration and frequency</b>	<b>Reason for seeking treatment</b>	<b>What type of therapy was it? Was it helpful? Did you have any negative reactions?</b>
1.			
2.			
3.			
4.			

**Please List the types of Physical Problems you have had in the last 10 years**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**MARS AND VENUS COUNSELING AND WELLNESS CENTER**  
**Dr. Robert A. Schwarz**

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**CLIENT INFORMED CONSENT AND DISCLOSURE STATEMENT**

Thank you for your interest in working with me as a client, either in person or by telephone, whichever is applicable. People can make better decisions if they have enough information and understand how something works. Therefore, I am providing you with the following information so you can make an informed choice about your decision to engage my services. Although I will share my skills and abilities to support your well-being, my work with you is only a resource. As an intentional and conscious participant in your growth, you will ultimately take all responsibility for and actions related to your health and well-being.

**Counseling Services Offered / Theoretical Approaches**

As a licensed clinical psychologist with over 25 year of practice and hundreds of hours of training beyond graduate school, I integrate a number of therapeutic approaches in my practice within a holistic and psycho-spiritual framework. The approach I use with a given person (couple) is based partly on the nature of the presenting complaint(s) as well as the preferences of the client. The approaches I use include coaching techniques, NLP, Solution Oriented Therapy, structural family therapy, Ericksonian Hypnosis, Cognitive – Behavioral Therapy, John Gray’s Mars and Venus Gender Communication Therapy, kinesiology, and meridian based energetic approaches (“Energy Techniques”).

Energy Techniques is a collective term used to refer to a variety of alternative and complementary treatments based on the use, modification, and manipulation of energy fields that look at imbalances within the person’s energy system as well as the energetic influence of thoughts, beliefs, and emotions on the body. The prevailing premise of the Energy Techniques is that the flow and balance of the body’s electromagnetic and more subtle energies are important for physical, spiritual, and emotional health, and for fostering well-being. Although the Energy Techniques appear to have promising mental, spiritual, and physical benefits, they have yet to be fully researched by the Western academic, medical, and psychological communities. By signing this document you understand that if you choose to use any of these Energy Techniques as part of our work together that the Energy Techniques could be considered experimental and are considered alternative or complementary to the healing arts that are licensed by the Commonwealth of Pennsylvania. If you ever have questions or concerns about the nature of the theories, methods, approaches and/or techniques I use, please feel free to ask me for further resources or references.

**Outcome Expectations**

Please note that it is impossible to guarantee any specific results regarding your

counseling goals using any of the approaches outlined above, and we don't know how you will personally respond to any of the approaches, including the Energy Techniques, if applicable. However, we will work together to achieve the best possible results for you. Counseling and therapy require your active involvement, willingness to be truthful, as well as efforts to acknowledge and/or change your thoughts, feelings and behaviors. You will have to work both in and out of the counseling sessions. There are no instant, painless, or passive cures, no "magic pills." Instead there will be homework assignments, exercises, writing and journals and perhaps other projects. Most likely you will have to work on relationships and make long term efforts. Sometimes change will be easy and swift, but more often it will be slow and deliberate; effort may need to be repeated. As with any intervention, there are benefits and risks associated with counseling and therapy. Risks might include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger frustration, or having difficulties with other people. Being confronted with your difficulties can be very challenging. Some changes may lead to what seems to be worsening circumstances or even losses (for example, counseling can not necessarily keep a marriage intact.). In addition, if we utilize the Energy Techniques or NLP, it's possible that previously vivid or traumatic memories may fade. This could adversely impact your ability to provide legal testimony that carries the same emotional impact as prior to applying these Techniques regarding a traumatic incident.

If we are to work together we will need to specify methods, risks and benefits of treatments, the approximate time commitment involved, costs and other aspects of your particular situation. We will discuss a plan that seems most appropriate to help you reach your goals. Periodically, we will evaluate your progress and if necessary redesign our treatment plan and your goals and the methods used. However, regardless of our work together, you agree to take full responsibility for your self-care in the emotional, mental, physical, and spiritual dimensions of your life.

### **Education and Training**

I received my undergraduate degree at the University of Pennsylvania and my doctorate at Hahnemann University. I am licensed by the Commonwealth of Pennsylvania as a clinical psychologist and have been practicing psychotherapy and coaching for over 25 years. I'm a clinical member of the American Association of Marital & Family Therapy, and a certified diplomate in comprehensive energy psychology by the Association for Comprehensive Energy Psychology. I'm also an approved consultant for the American Society of Clinical Hypnosis. I'm diagnostically trained in Thought Field Therapy, an energy based approach to psychological problems and have been involved in the development of Attractor Field Therapy.

In addition to a general practice in adult and child psychotherapy, I specialize in family & marital problems, trauma related problems, and mind-body problems. I also specialize in hypnosis and energy psychology and I'm certified by the Mars & Venus Counseling Center and have been personally trained by John Gray. In addition, I provide coaching to executives, managers, business owners, and athletes to improve their performance and/or advance their businesses.

**Acknowledgment and Consent to Receive Services**

By signing this document and any attachments hereto, you agree that I have disclosed to you sufficient information to enable you to decide to undergo or forgo any of the approaches and other services I offer. You understand that you are freely choosing to take advantage of my services and would otherwise have the option of using conventional health care services exclusively, provided by another professional health care provider of your choosing. You understand that your consent to the nature of our sessions is given voluntarily, without coercion, and may be withdrawn at any time in the future. Further you understand if you choose to use the Energy Techniques as part of our work together that the Energy Techniques are a relatively new healing approach and the extent of their effectiveness, as well as their risks and benefits are not fully known and you agree to assume and accept full responsibility for any and all risks associated with using the Energy Techniques. You represent that you're competent and able to understand the nature and consequences of our proposed sessions. You have read and understand the above disclosure about the services offered by me and my training and education and you have discussed with me the nature of the services to be provided. .

By signing in the space provided below, you knowingly, voluntarily, and intelligently assume these risks and agree to release, indemnify, hold harmless and defend Robert Schwarz, and his representatives, agents, consultants, and employees from and against any and all claims or liability, of whatsoever kind or nature, which you, or your representatives, may have for any loss, damage, or injury, including without limitation, physical, emotional, mental, financial, or personal, arising out of or in connection with your sessions.

You acknowledge that we have discussed and you understand and agree to my standard Office Policies and Procedures regarding confidentiality, fees, billing, cancellations, insurance reimbursement, dual relationships, complaint procedures, etc. which is attached hereto and incorporated herein by reference. Please sign both copies of this Client Informed Consent and Disclosure Statement. A copy for your records will be returned to you. I will retain a copy for my confidential records.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist's Signature

\_\_\_\_\_  
Date

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**MARS AND VENUS COUNSELING AND WELLNESS CENTER**  
**Dr. Robert A. Schwarz**

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**OFFICE POLICIES AND PROCEDURS STATEMENT**

**Confidentiality**

I regard the information you share with me with the greatest respect, so I want us to be clear as possible about how it will be handled. There are two circumstances in which I cannot guarantee confidentiality, legally and or ethically. 1) When I believe you intend to harm yourself or another person; and 2) when I believe a child or elder person has been or will be abused or neglected. In addition to the foregoing, I may be required by a court of law to provide confidential information in the event of some kind of a court proceeding. Otherwise, I will not tell anyone anything about your treatment, diagnosis, history, or even that you are a client without your full knowledge and usually a signed Release of Information Form.

The only other exception to the above is that your diagnosis and billing information will be released to your insurance company if you seek reimbursement. I cannot guarantee the further confidentiality of this information once it is sent to the insurance company. If your therapy is being paid for by a third party such as an insurance company from an automobile accident they may require specific information about your symptoms and progress to continue paying for your treatment. If this happens you will be informed of this event ahead of time and we can discuss your options at that point.

**Confidentiality with Couples Work**

If I am working with you in the context of couples or relationship work, I will not share details of our private sessions with your partner. This is information that is also protected by confidentiality. If there is something I believe your partner should know, I will ask permission to share it and encourage you to share it yourself. If you are actively having an affair or withholding information from your partner that I believe is important, I will encourage you to share it. If you are not able to share it, I will excuse myself as your therapist as I will not be part of keeping a detrimental secret from your partner. Even in this case your confidentiality will be protected.

**Length of Sessions and Cancellations**

I provide my services in a professional manner consistent with accepted ethical standards. There are several session length options. Sessions are either 50 minutes, 80 minutes or 100 minutes. We will mutually agree on the schedule for our sessions together. If you are unable to keep an appointment, please call to cancel or reschedule at least 24 hours in advance. This time is set aside just for you. If you are unable to give such advance notice you will be billed in full for the session missed. In instances of extreme emergency such as car accident while driving to a session, an extreme accident by a

family member that day, last minute cancellation by a baby sitter, or major accident on the road you are traveling on to get to my office which significantly delays traffic, the fee will be waived. (If you are coming for couples work and your sitter cancels I prefer that one of you still make the session as opposed to last minute canceling.) I am not able to wave to fee for late cancellations due to inconvenience, error in scheduling on your part, last minute meetings at work etc. I would love to have that flexibility but unfortunately late cancellations do not allow me enough time to fill your slot.

### **Fees/Methods of Payment**

My standard fees are: \$170 for a 50 minute session, \$250 for an 80 minute session. I do keep 5 sliding scale slots available each week for those who simply cannot afford my fees. If you are in need of a sliding scale slot we will negotiate your fee at our first session. My goal is to be able to provide affordable counseling for anyone who is motivated to help themselves. Lack of finances should not deter someone who wants assistance. In return for your fee, I agree to provide counseling services for you. Payment is required at the beginning or end of each session. Cash or personal checks are acceptable for payment. Credit cards are accepted for phone counseling or if absolutely needed for payment for office visits. (We prefer not to use credit cards but will when necessary) You may also pre-pay for sessions if you wish.

### **Billing/Insurance Reimbursement**

If you wish to seek reimbursement for my services from your health insurance company, I will be happy to complete any forms related to your reimbursement provided by you or the insurance company. Payment in full is expected at time of visit. Except in certain circumstances, I do not receive third party payment. I will not file insurance claims for you but will provide the necessary documentation.

Some insurance companies will reimburse clients for my counseling services and some will not. Generally companies that allow you to see an out of network practitioner for mental health services will provide reimbursement. Those that do, usually require that you meet your out of network deductible before reimbursement is allowed and then they will reimburse you a portion of the fee. However, please remember that you are responsible and not your insurance company for paying the fees agreed upon

Health insurance companies often require that I provide a diagnosis of your mental health condition and indicate that you have an “illness” before they will agree to reimburse you. I will inform you of the diagnosis I plan to render before I document it on the forms you will submit to your insurance carrier. Any diagnosis made will become a part of your permanent insurance records.

## **Explanation of Dual Relationships**

Although our sessions may be very intimate psychologically, it is important for you to know that we have a professional relationship rather than a social one. Our contact will be limited to sessions you will arrange with me. In the rare occasion we may bump into each other out of the office I will maintain your confidentiality. If you wish to extend a brief hello that is fine. Or, if you wish not to acknowledge the encounter that is fine as well. There have even been times when clients wish to introduce me to friends as their therapist so they can give a call later to set up an appointment. That is fine too. You will learn a great deal about me as we work together during your counseling experience. However, it is important for you to remember that you are experiencing me in my professional role. Ethical principles do not allow for dual relationships. This means that we cannot have a role as therapist/client and have another role such as you being my plumber or lawyer. It is unethical for therapists to have intimate personal relationships with clients. Sometimes patients/clients develop strong feelings about their therapist. There is nothing wrong with these feelings. In that event, they should be discussed as part of treatment. Under no circumstances is it ethical or helpful for them to be acted upon.

## **Complaint Procedures**

If you are dissatisfied with any aspect of our work together, please inform me immediately. This will make our work together more efficient and effective. If you think that you have been treated unfairly or unethically, by me and we cannot resolve this problem, you have the option to contact the Pennsylvania Psychological Association at (717) 232-3817 for clarification of clients' rights. If you have any questions, please feel free to ask. Please sign and date both copies of my Office Policies and Procedures Statement. A copy for your records will be returned to you. I will retain a copy for my confidential records.

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Client's Signature

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Date

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Therapist's Signature

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Date

# Expectations of Therapy

Name \_\_\_\_\_ Date \_\_\_\_\_

If you have never been to a therapist before you may be not completely clear about what you expect or want from a therapist. If you have been to therapy before, you may have some specific ideas about what you want from therapy.

This brief questionnaire is designed to help you clarify your thoughts as well as to help us understand what you expect so we can tailor therapy to your needs or clarify unreasonable expectations.

**Please circle the appropriate numbers to show how strongly do you agree with the following statements**

**Strongly disagree      Slightly disagree      neutral      slightly agree      strongly agree**

**1                                  2                                  3                                  4                                  5**

I want my therapist to understand and validate my feelings.	1	2	3	4	5
I want therapy to be highly structured.	1	2	3	4	5
I want therapy to be very loose and spontaneous depending upon what is on my mind at the time.	1	2	3	4	5
I want my therapist to tell me specific interventions to do to solve my problems.	1	2	3	4	5
I want my therapist to be gentle and supportive.	1	2	3	4	5
I want therapy to include looking at how my thoughts and beliefs may create negative patterns in my life.	1	2	3	4	5
I want therapy to include looking at spiritual or existential issues.	1	2	3	4	5
I want my therapist to focus mostly on listening and allowing me to vent my problems or solve problems for myself.	1	2	3	4	5
I want therapy to include specific exercises and readings when appropriate to augment my treatment.	1	2	3	4	5
I want my therapist to be able to confront me when I resist or may be sabotaging myself.	1	2	3	4	5

I have very specific issues to work on in therapy.	1	2	3	4	5
I do not have specific goals but want general guidance and assistance.	1	2	3	4	5
It is the therapist's Job to make me better.	1	2	3	4	5

(Optional) If you prefer to use your own words feel free to write out what you want from your therapist? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Expectation for length of treatment in number of sessions

Under 5      5-10      10-20      20+      prefer to come in on as needed basis

Please circle any specific tools or techniques you would be open to using to help resolve your issues.

Self - examination training      energy work      role-playing      hypnosis

Are finances a substantial burden for you at this time? If yes, please describe your situation.

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

Is there anything else you want your therapist to know about you or your situation?

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

## Individual Therapy Questionnaire

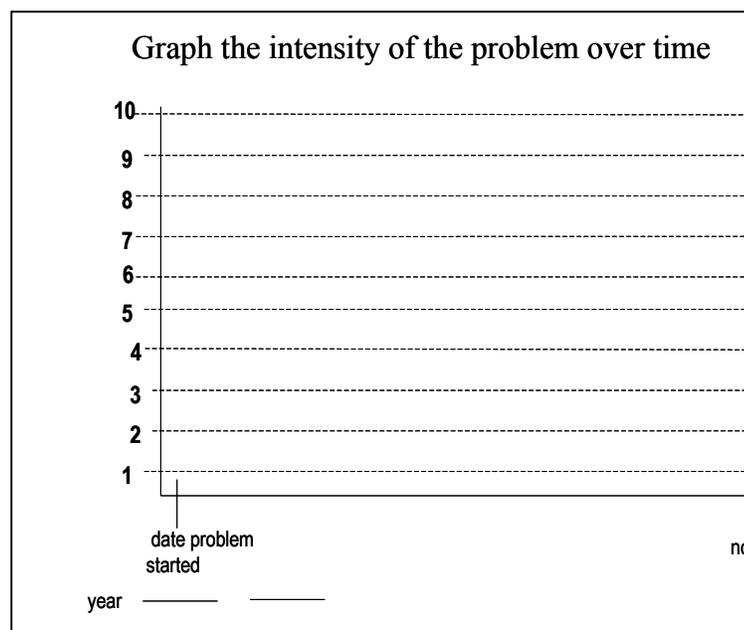
You make a big difference in the outcome of your therapy. Please give yourself the gift of taking the time to answer these questions. Approach this task with the following thoughts in mind. 1) You are providing valuable information to your therapist to understand you better and to help you have a better life. 2) You are taking the time to become more aware of your own process in order for you to help you get what you want. 3) Be honest and non judgmental. Feel free to use extra paper if you wish. The questionnaire is designed to help you organize your thoughts to get the most out of our time together. Feel free to adjust any question that you want to make it fit for you. You can also choose to leave anything out that you cannot answer.

What is (are) the reason(s) that you are coming for therapy or counseling?

Please describe the history of the problem. When did it start ? Has it gotten significantly worse?  
Does anything seem to make it worse or better?

On a scale of 1-10 where 1= the problem is gone and 10 is the problem is as bad as it could be please show on the graph on the right how hw problem has changed over time. (You can rate in weeks, months or years )

What outcomes would you like to achieve as a function of the work we do together?



Take some time and broaden your view of your life. Please comment on your satisfaction or dissatisfaction in other areas of your life

Work/Career,

Friends,

Relationships

Physical health/exercise,

Play/Fun,

Spirituality,

Life Dreams or Goals

What things/activities bring you pleasure or joy?

What do you do that connects you with your (best) self?

What characteristics do you consider as your strengths?

Brief Family Relationship History

Pick five words or phrases that describe your mother (or mother figure):

Pick Five words or Phrases that describe your father (or father figure)

What was the relationship of your parents like? What was the atmosphere of the house like ?

What conclusions decisions did you make in either childhood or adolescence about what you wanted out of marriage or relationships?

Anything else you would like to say.