Debra M. Lobatz, MA MFT

162 S. Rancho Santa Fe Rd. Suite B-50, Encinitas, CA. 92024

(760) 634-3188

Name: ________________________________ **Date of Birth:** ______________ **Today's date:**___________________

Address:____________________________________ **City:**___________________________ **Zip:**_________________

Home Phone: _____________________ **Cell Phone:**____________________ **email:** _________________________

BEST PHONE NUMBER TO LEAVE A CONFIDENTIAL MESSAGE: ____

Spouse/Legal Guardian: ____________________________ **Phone #s:** ____

Address: _______________________________ **City:**_____________________ **Zip:** ______________________________

Emergency Contact: _________________________________ Best Contact Number: _____________________________

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT:

Name: __________________________**Date of Birth:** ___________________ **email:** ______________________________

Address:___________________________ **City:** ______________________________ **Zip:** _________________________

Occupation: _______________________ **Work Phone:** __________________ **Cell Phone:**_________________________

PLEASE READ AND SIGN BOTH ITEMS BELOW:

CONSENT TO TREATMENT:

I agree to participate in therapy with Debra Lobatz, Marriage and Family Therapist. I accept responsibility for the cost of professional services. I understand that the agreed upon fee is due and payable at each session, and that the usual and customary **fee may be charged for appointments cancelled with less than 24 hours notice**.

Signed: ____ **Date:** ___________________________________

Parent/Guardian (if minor)

CONFIDENTIALITY:

I 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 release, the following exceptions to confidentiality exist under law:

1. Where there is reasonable suspicion of physical or sexual abuse, or neglect of a child under the age of 18;
2. Where there is reasonable suspicion of financial, physical abuse or neglect of the elderly;
3. Where the client presents a serious danger of violence to another or,
4. Where the client is likely to harm himself/herself seriously unless protective measures are taken.

Signed: ____ **Date:** ____________________________________

Parent/Guardian (if minor)

CURRENT TREATMENT:

Physician/therapist: ____ Phone: ________________________________

Address: ____________________________ City: ____________________ State: _________ Zip: _______________

Reason for treatment: ____

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Referred by:

____

MAY I SEND AN ACKNOWLEDGEMENT TO REFERRAL SOURCE? (Circle one) YES NO

Medications currently taking	Medications taken in recent past

If you have previously seen a counselor, therapist, psychologist or psychiatrist, please list when and why; what was useful, what was not:

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

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OTHER CONCERNS/QUESTIONS: