Debra Orbuch Grayson, M.S., LMFT
1409 Willow Street, Suite #400
Minneapolis, MN 55403
Office: (612) 419-5638

Registration Information

Please print and complete these documents and bring them with you to our first session. Feel free to contact me directly if you have any questions or concerns. Thank you.

Part One: Personal Background Information

Name:_____ Date of Birth_____ Age_____

Address:_____City_____State_____Zip_____

Telephone (h)_____ (w)_____ (c)_____

Email:_____

Please list the members of your family and their ages and **dates of birth:**

_____ _____

_____ _____

Were you referred by someone?_____

Part Two: Counseling History/Reasons for Seeking Help

Have you or anyone in your family ever been in therapy before? ___ yes ___ no

If yes, briefly describe the reason(s), when, with whom and for how long:

_____

If yes, was it a positive experience? ___ yes ___ no

What did you like about it/not like about it?

_____

_____

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Have you or anyone in your family ever attempted suicide? ___yes ___ no

If yes, please describe the situation:

_____

Do you have any chronic illnesses, or medical conditions? ___ yes ___ no

If yes, please describe:_____

Are you presently taking any medication? ___ yes ___ no
If **yes**, please list your medications and what you are taking them for as well as the prescribing physician:

_____

Briefly describe your reason(s) for seeking help at this time:

_____

_____

What do you wish to accomplish through the process of therapy?

_____

_____

Please rate your support system (family, friends, religious, community, or other on a scale of 1-5, 5 being the strongest)

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Payment Agreement/Consent for Treatment

Name_____

Address_____

City_____ State_____Zip_____

Preferred Phone Number_____Circle: Home Work Cell

Insurance Carrier and policy #_____

Birth Dates:_____

Fees are **$150.00 per hour**, and all fees are payable at the time of service. 24 hour cancellation notice is required to avoid payment for missed sessions.

I/we understand that if I/we are delinquent in meeting the terms of this agreement that my service may be terminated.

You have the right to expect complete confidentiality with the exception of mandatory reporting as follows: mental health professionals are required by law to report physical harm or sexual abuse of a minor or vulnerable adult. We are also required by law to report the threat of harm to self or to a third party.

Please sign below to indicated your informed consent to the above conditions of our therapeutic relationship.

_____ _____
Signature Date

_____ _____
Signature Date

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INFORMED CONSENT CHECKLIST FOR TELETHERAPY SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferences (e.g. limits to patient confidentiality) that differ form in-person sessions.
- Confidentiality still applies to teletherapy services, and your therapist will not be recording the session without the permission from the other person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions and the therapist will explain how to use it.
- It is important to be in a quiet, private space that it free of distractions (including cell phone or other devices) during the session.
- It is important to be on time. If you need to cancel or change your tele-appointment, you agree to notify your therapist within 24 hours by phone or email.
- Sometimes back-up plans are necessary if there are technical difficulties. In the event of technical difficulties your therapist will call you by phone.
- In the event of a crisis, you agree to call one emergency contact and utilize crisis services if needed.
- Teletherapy services will be part of our work together but in person sessions will be resumed when both client and therapist feel comfortable doing so.

Therapist Name: Debra Orbuch Grayson M.S., LMFT

Client name: _____

Client Signature: _____

Date: _____