

Dr. Thomas Lucking, Ph.D., Licensed Marriage & Family Therapist

Initial Intake Form and Informed Consent

408.409.4167 doctorthomaslucking@gmail.com www.ThomasLucking.com

		Client #1	Client #2
Full name			
Date of birth			
Age			
Sex (circle)		Male Female	Male Female
Marital Status (Circle)		Single Married Divorced Separated Widowed	Single Married Divorced Separated Widowed
Phone	Home		
	Work		
	Cell		
Email (optional)			
Home Address			
Employer	Company		
	Phone		
Health Insurance Co.			
Primary Person for Insurance			
Referred by: (name of person or website)			

Emergency Contact:	Name		
	Phone		
	Relationship		
Physician	Name		
	Phone		

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Children	Name	Age	At home? (yes or no)

CLIENT #1 Medications	Medication	Reason for Taking	Dosage	Prescribing Doctor
CLIENT #2 Medications				

PRIOR OR CURRENT COUNSELOR (No contact will be made without your express permission)		Therapist	Individual or Couple	Duration (months & # of sessions)	Indicate Year and whether current
	Client				
	Spouse / Partner				

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Please indicate if you would like to address the following areas during therapy. This is NOT a commitment to do so but rather an initial indication of interest.

	Client #1			Client #2		
	Yes	No	Maybe	Yes	No	Maybe
FOUNDATIONAL						
Anger management						
Family of origin						
Heal Relationship Wounds						
Communication						
Problem-solving						
Intimacy (non-sexual)						
Support of Each Other						
Relationship Vision						
TOPICAL						
Parenting						
Financial						
Spiritual						
Sleep						
Sexual Intimacy						
Jealousy and affairs						
Roles, chores						
Time management						
In-laws						
Blended family issues						
Substance abuse						
Domestic violence						
Depression						
Worry / Anxiety						
Forgiveness						
Honesty / Trust						

Please write in other areas....

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Services and Fees

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Psychotherapy - Psychotherapy for individuals, couples, families, or groups. Location for session is one of Dr. Lucking's two offices, an alternate location, video, or phone.

Service	Fee	CPT insurance codes ^
Individual Psychotherapy 45-55 minute session	\$250	90834 98037
Individual Psychotherapy 20-30 minute session	\$125	98032
Couples or Family Psychotherapy 45-55 minute session	\$250	90846 90847
Group Psychotherapy 65-75 minute session	\$125	90853

Daily Care Psychotherapy - A higher level of care and support is available for (a) individual, couple, or family crisis (b) addiction and recovery (c) coping skills (d) more severe mental health challenges such as complex grief, trauma, and mood disorders (e) time-bound growth and goals that require regular accountability and support (f) developing new habits.

Service	Fee	CPT insurance codes ^
Online Log and/or Mobile Therapy Responses between sessions within 24 hours except Saturdays, Sundays, and holidays*^	\$125	

Couples Care Intensives – Deep immersions to accelerate growth and healing. Two types of intensives are listed below. Contact Dr. Lucking for specific fees based on your needs.

Service	
Deep Dive Intensive 1-5 dives across 1-3 days. ⁺ Location of your choice. Includes assessments and all materials.	Solid Follow-Through Intensive Daily phone check-ins and mobile therapy activities across 5-7 days. Includes mobile app access.

Administrative Time - Time outside of session may be necessary for Dr. Lucking to prepare reports, complete assessments, write contracts, or other administrative support for psychotherapy.

Service	Fee	CPT insurance codes ^
Administrative Time 45-55 minute session	\$250	
Administrative Time 20-30 minute session	\$125	

^ Services and fees without CPT insurance codes will not have a code on superbills or not be listed on superbills

*Response times are goals not guarantees, if crisis or emergency please call 911. Holidays include personal time off.

^Responses in effect for a maximum of 7 days between sessions

⁺See website for explanation of a 'dive' <https://www.thomaslucking.com/couples-care-intensives/>

Fees are payable by cash, check, PayPal, Venmo, or credit card. Checks preferred for intensives.

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CANCELLATION POLICY

24 HOUR CANCELLATION POLICY: Your therapy time is reserved for you and you will be charged for full payment if you do not cancel 24 hours before your scheduled appointment.

INSURANCE

Dr. Lucking is on some insurance panels. In these cases he will bill your insurance company directly. If he is not in your insurance network he will, upon your request, provide you with a statement of receipt to submit to your insurance company for reimbursement.

CONFIDENTIALITY

Therapy sessions are strictly confidential except:

- When Dr. Lucking has reasonable suspicion of abuse of an elderly or dependent adult or a child,
- Instances of danger or threat of suicide or harm to oneself or to others,
- Instances of knowingly downloading, streaming, or accessing any medium in which a child is engaged in an act of obscene sexual conduct or any other form of child pornography,
- Certain legal situations, such as a court order, a court-ordered evaluation, or if you place your mental status at issue in litigation, and
- When Dr. Lucking receives information from one member of a couple outside of the presence of the other member of the couple. In rare cases, he may disclose information to the other member of the couple at his discretion.

THERAPY

SCHEDULE: Initially, sessions will be at a regular time at least once per week or every other week. When you feel ready, sessions will shift to an as-needed basis.

BENEFITS / NO GUARANTEE: Participating in therapy can help you learn new and important things about yourself as well as better ways of handling feelings or problems. While there are no guarantees, coming to therapy should help you feel better and produce beneficial results. You have the right to end therapy at any time.

PROVIDER: Your therapy will be provided by Dr. Thomas Lucking who is licensed as a Marriage and Family Therapist by the State Of California, holds a Doctoral degree in Psychology, a Master's degree in Counseling Psychology, and a Master's degree in Divinity.

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FEEDBACK Dr. Lucking promotes feedback in the therapeutic and transformational work of psychotherapy and coaching. As a result he welcomes two types of feedback:

- **WELL-BEING:** how are you doing in 3 different areas of your life?
- **SESSION:** how did your last session go? Did you feel heard, validated, and cared for in a way that helps your growth, healing, and movement towards your goals?

Before and/or after any session you are welcome to submit feedback using either or both of the two forms.

Well-being and Session feedback forms can be found at <https://www.thomaslucking.com/feedback/>

ELECTRONIC COMMUNICATIONS You understand that the confidentiality of Electronic Communications (E.C.) cannot be guaranteed. E.C. may include, but are not limited to, email, text messages, and voicemail. E.C. are inherently vulnerable and insecure and may result in the unintentional harmful disclosure of personal information. You acknowledge that you implicitly consent to Dr. Lucking sending E.C. to you by: a) your inclusion of your email address on Dr. Lucking's forms, b) providing your email to Dr. Lucking in session, or c) your sending an email, text message, or other E.C. to Dr. Lucking. You acknowledge that Dr. Lucking may not read or respond to E.C. until the next scheduled appointment and that you will not use E.C. for emergencies.

EMERGENCY PROCEDURES In a crisis, if you cannot reach Dr. Lucking and you are in imminent danger, please call one of the following emergency numbers: 911; Emergency Psychiatric Services at 408-885-6100; Suicide and Crisis Services at 855.278.4204; or go immediately to your local emergency hospital.

AGREEMENT You are encouraged to take the time to read through this carefully before your first appointment.

I have read and understood all the information on this form. By signing below, I agree to the above conditions, and to avail myself (and/or the named minor) to the professional services of Dr. Thomas Lucking, Ph.D., Marriage and Family Therapist, and consent accordingly to the use of individual, couples, family, and or group psychotherapy, and/or psychological testing.

	Print Name	Sign	Date
CLIENT #1			
CLIENT #2			
PARENT(s) OR GUARDIAN:			