CLIENT INTAKE INFORMATION

Confidential Use Only

Legal Name:_____Birthdate: _____

Gender:_____ Relationship Status:_____Ethnicity: _____

Occupation:_____Employer/School: _____

Home Address: _____

Home Phone:_____Permission to leave message: Yes ☐ No ☐

Cell Phone:_____Permission to leave message: Yes ☐ No ☐

Email Address:_____Permission to leave message: Yes ☐ No ☐

Emergency Contact Name & Phone_____Relationship:_____

Emergency Contact Name & Phone_____Relationship:_____

Name of Primary Physician:_____Physician Phone: _____

Coordinating care with your physician may be necessary. Do I have permission to contact your physician to collaborate for your well-being, should the need arise? Yes☐ No☐

List any current medications and dosage: _____

_____

Have you been in therapy or counseling before? Yes☐ No☐

Name of previous therapist(s), if applicable: _____

How were you referred: _____

What matters would you like to work on in therapy: _____

_____

_____

_____

_____

Policies and Procedures

Appointments

It is a privilege to support you during this time. Therapy is a process that is taken seriously, and I will do my best in providing you with the support that you need. Additionally, I will assist you by connecting you to other resources that may contribute to your wellness. As we begin our therapeutic relationship, I will honor our appointment times to the best of my ability by keeping any changes to a minimum. Similarly, I request that I receive a minimum of 24-hour notice prior to a cancellation. Missed sessions and late cancellations will be charged the full fee.

Office Location and Policy

Fee Policy

All fees will be determined prior to the start of treatment. Phone sessions will have a prorated fee of $____ per every ____ minutes. Payments may be made using cash, check, or credit card. A fee of $_____ is applied to credit card charges. Payments must be made in full and cannot be carried over. The standard fees for session apply as follow:

		$
		$
		$
		$

From time to time, I raise my fees; the increase is usually less than _____%. I will provide at least_____ months notice of any fee increase.

Insurance

Client Agreement

I agree to pay for all services I receive. Payments will be made using cash, check, or credit card. Additionally, I understand that I will be fully liable for the full fee of any incomplete sessions, missed sessions and sessions cancelled with less than 24-hour notice. I am aware that if I arrive late to a session, the session will conclude based on my original appointment time and I will be financially liable for the full rate of the session.

Client(s) Signature:_____Date: _____

Therapist Signature:_____Date: _____

Consent for Evaluation and Treatment

The Therapy Process

Participating in therapy can result in benefits to you by allowing you to better understand yourself and your personal goals, values and sense of self. Therapy may also allow you to better understand your personal relationships and find resolutions related to issues that encouraged you to seek therapy. Working towards these benefits will require effort on your part that may result in your experiencing considerable discomfort. At times, change may be easy and swift, but more often it will be slow and frustrating. The process of recalling unpleasant events and resolving them through therapy can bring on feelings of frustration, anger and possible depression or anxiety. When working with a partner or family member, the situation may be further complicated because of the ongoing relationships outside of the session.

Please notify me if you do not feel that you are benefiting from working with me as your therapist. Be assured that your best interest is always in mind and you will be provided with appropriate referrals to select another therapist. This will be done without any form of retaliation and full compliance in regards to your subsequent therapeutic relationship. Similarly, I reserve the right to refer you if I do not feel that I am able to support you using the therapeutic orientations that I follow. This referral will occur with a thorough discussion of your treatment goals and your current progress.

- Suicidal and/or homicidal ideations
- Abuse of a child
- Abuse of an elderly or dependent individual

Additionally, you have the right to know the content of your records at any time and I have the right to provide you with either the complete records or a summary of their content.

Your Rights

You have the right to a confidential relationship with me as your therapist. All information discussed in session will be kept confidential and released only after obtaining your written consent outside of the three mandates:

Upon request, I can release any part of your records on file with me to anyone that you specify. Please note that I will use my clinical judgment in releasing this information, especially in cases where it may harm you in any way. Moreover, you have the right to ask questions about the procedures used in the course of therapy. Additionally, you will be informed on my clinical orientation and what to expect during the intake session.

Consent for Evaluation and Treatment

I,_____, authorize and request _____, to carry out therapeutic interventions, counseling services and referrals for thepurpose of my care in individual/couples counseling.

The purpose of interventions and treatments will be disclosed to me and are subject to my agreement. I fully understand the therapeutic relationship I am entering with my therapist and the credentials my therapist has to conduct treatment.

Printed Name of Client or Guardian _____

Client or Guardian Signature to Authorize _____

Therapist's Signature_____Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at _____

If you have any questions about my Notice of Privacy Practices, please contact me:

I acknowledge receipt of the Notice of Privacy Practices of _____

Printed Name: _____

Signature:_____Date: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patient's acknowledgement of his or her receipt of my Notice of Privacy Practices, including _____

_____

However, because of _____

I was unable to obtain my patient's acknowledgement .

Signature of Provider:_____Date: _____

Informed Consent for TeleMental Health Services

The following information is provided to clients who are seeking Telehealth psychotherapy. This document covers your rights, risks and benefits associated with receiving services, my policies, and your authorization. Please read this document carefully, note any questions you would like to discuss, and sign.

Telehealth means the remote delivering of health care services via technology-assisted media. This involves the use of electronic communications to enable _____ to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video chatting is the preferred method of service delivery.

I understand that I have the following rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed to me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to, reporting child, elder, dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. _____ utilizes secure, encrypted audio/video transmission software todeliver telehealth.
4. I understand that if my therapist believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse.

Initials: _____

5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my therapist, I may be directed to “face-to-face” psychotherapy.
6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that my expressed consent is required to forward my personally identifiable information to a third party.
8. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.
9. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

I,_____, voluntarily agree to receive Telehealth psychotherapy and authorize _____ to provide such care, treatment, or services as are considerednecessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services. By signing this Informed Consent, I, _____ acknowledge that I have both read and understand the terms and information contained herein. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

_____ _____

Signature of Client Date