Sarah A. Bryant, MS, LPC

COUNSELING INTAKE FORM

Patient Name:

Date:

Type of counseling I am seeking: Individual ☐ Couple ☐ Group Therapy ☐

PATIENT INFO

Date of Birth: _____ Legal Name: _____ Preferred Name:

Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Preferred Phone #: _____

EMPLOYER & STATUS

Occupation: _____ Industry: _____ Company Name: _____

Company Address: _____ City: _____ State: _____ Zip: _____

Employment Type: Employed ☐ Self-Employed ☐ Unemployed ☐ Other ☐

EMERGENCY CONTACT

Full Name: _____

Phone Number: _____

Relationship to you: _____

HEALTH AND MEDICAL INFO

Primary Care Physician: _____ Phone Number: _____

Psychiatrist: _____ Phone Number: _____

Please list any medical problems: _____

Please list any current medications: _____

AVAILABILITY

Please check all that apply:

Time Available	MON	TUES	WED	THUR	FRI	SAT
8:00 AM						
9:00 AM						
10:00 AM						
11:00 AM						
12:00 PM						
1:00 PM						
2:00 PM						
3:00 PM						
4:00 PM						
5:00 PM						

PERSONAL & FAMILY

What is your ethnicity? _____

What is your marriage status? _____

How many people are in your household? _____

What is the highest education level you've completed? _____

Have you ever been hospitalized for a psychiatric illness? Yes ☐ No ☐

Has a family member ever been hospitalized for a psychiatric illness? Yes ☐ No ☐

Does anyone in your family have a history of mental illness? Yes ☐ No ☐

Have you ever attempted suicide? Yes ☐ No ☐

Has anyone in your family attempted or committed suicide? Yes ☐ No ☐

Do you have substance abuse problems? Yes No

Does anyone in your family have substance abuse problems? Yes ☐ No ☐

Have you ever been arrested? Yes ☐ No ☐

If yes, please explain. _____

How well are you doing at your job? (Please check 1 box that applies below)

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not working	Cannot Function	Serious Problems	Mild Problems	No Problems

How well are you doing in your marital or with your significant other? (Please check 1 box that applies below)

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not working	Cannot Function	Serious Problems	Mild Problems	No Problems

How well are you doing with family relationships? (Please check 1 box that applies below)

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not working	Cannot Function	Serious Problems	Mild Problems	No Problems

How well are you doing in relationships with non-family members? (Please check 1 box that applies below)

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not working	Cannot Function	Serious Problems	Mild Problems	No Problems

How is your current health? (Please check 1 box that applies below)

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not working	Cannot Function	Serious Problems	Mild Problems	No Problems

How is your general happiness and well-being? (Please check 1 box that applies below)

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Not working	Cannot Function	Serious Problems	Mild Problems	No Problems

SYMPTOM ASSESSMENT

I AM EXPERIENCING	NEVER	RARELY	OFTEN	ALWAYS	HOW LONG?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
“Flashbacks” as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					

I AM FEELING	NEVER	RARELY	OFTEN	ALWAYS	HOW LONG?
Decreased interest in pleasurable activities					
Social isolation, loneliness					
Suicidal thoughts					
Bereavement or feelings of loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

I NOTICE	NEVER	RARELY	OFTEN	ALWAYS	HOW LONG?
I am angry, Irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					

I NOTICE	NEVER	RARELY	OFTEN	ALWAYS	HOW LONG?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive thoughts					
Been hearing voices when alone					
Problems with my speech					
Risk taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					

SYMPTOM ASSESSMENT

I USE THE FOLLOWING	NEVER	RARELY	OFTEN	ALWAYS	HOW LONG?
Alcohol					
Nicotine (cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					
Other					
MY EATING INVOLVES	**NEVER**	**RARELY**	**OFTEN**	**ALWAYS**	**HOW LONG?**
Restriction of food consumption					
Bingeing and purging					
Binge eating					
A lot of weight loss or gain					
I HAVE	**NEVER**	**RARELY**	**OFTEN**	**ALWAYS**	**HOW LONG?**
Concern about my sexual function					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					
EMPLOYMENT & SELF CARE	**NEVER**	**RARELY**	**OFTEN**	**ALWAYS**	**HOW LONG?**
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

FINANCIAL AGREEMENT

Rates

Charges for individual counseling are: $120.00 These sessions are 50 minutes in length

These rates are subject to change with the changing market and clients will be notified of any changes in rates. Group therapy rates vary by practitioner.

Insurance

Primary Insurance Name:

Subscriber's Name:

Contract number:

Relationship to Subscriber:

Subscriber's date of birth:

Do you have a Secondary Insurance?

Payment

I understand that payment is due at the time of treatment. I agree to pay reasonable attorney fee's and all cost of collections, includeing court costs, if this matter is referred to an attorney.

Cancellation Policy

I understand that there will be a $50.00 fee for any cancellations provided less than 24 hours before my appointment. No show appointments will be responsible for the full session of $120.00.

Thank you for valuing our services by agreeing with these terms.

Patient Signature: _____ Date: _____

Telecounseling Consent

TeleCounseling is providing therapy/counseling services using interactive audio and visual (video) electronic systems where the provider and the patient are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

Requirements

A computer, laptop, or mobile phone with a webcam and microphone to video conference using a HIPAA compliant online company specializing in telemedicine. As with any medical procedure, there may be potential risks associated with the use of TeleCounseling. These risks include, but may not be limited to:

- Therapy conducted online uses technology and problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. Any problems with internet availability or connectivity are outside the control of the practitioner, and makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, the practitioner will call the patient back at the phone number provided on this form.
- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by the psychiatrist or therapist.
- The provider may not be able to provide treatment to the patient using interactive electronic equipment, or provide for or arrange for emergency care that the patient may require, in cases of connection failure.
- Delays in evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Although highly unlikely, security protocols can fail, causing a breach of privacy of confidential medical information.
- A lack of access to all of the information that might be available in a face to face visit, but not in a TeleCounseling session, may result in errors in provider judgment.

My Rights

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to Telecounseling.
- I understand that the technology used by the provider is encrypted to prevent the unauthorized access to my private medical information.
- I have the right to withhold or withdraw my consent to the use of TeleCounseling during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
- I understand that the provider has the right to withhold or withdraw his or her consent for the use of Telecounseling during the course of my care at any time.
- I understand that all the rules and regulations which apply to the therapy in-person also apply to TeleCounseling.
- I understand that the provider will not record any of our TeleCounseling sessions without written consent.
- I understand that the provider will not allow any other individual to listen to, view, or record my Telecounseling session without my express written permission.

My Responsibilities

- I agree to take full responsibility for the security of any communications or treatment information involved with my own computer and with my own physical location.
- I understand that I am solely responsible for maintaining the strict confidentiality of my user ID and password and I will not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location, so that others cannot hear my conversation.

- I understand that the company that the doctor has chosen to conduct the online appointment is an independent company specializing in HIPAA compliant telemedicine. My doctor has no responsibility for that company's operations or security of my protected health information. In addition, the company might send me emails or communication, such as appointment reminders. I understand that the provider is not responsible for this communication. If I am receiving any unwanted communication from the company, I will call/contact the company directly and address my concerns with them.
- I will not record any Telecounseling sessions without written consent from the provider. I will inform the provider if any other person can hear or see any part of our session before the session begins.
- I have read and understand all of the clinic policies , and that they apply to all telemedicine as well as in-person visits.
- I consent to paying fees that are the same as an in-office visit for the type and length of service provided, through the billing department.
- I understand that a TeleCounseling appointment is scheduled the same as an in-office appointment would be, and should I not be available for the appointment, or cancel it less than xxx business days in advance, there will be a charge for a missed appointment for the time my practitioner has reserved for the scheduled appointment.

Patient Consent to the Use of TeleCounseling

I have read and understand the information provided in the preceding pages regarding TeleCounseling. I have discussed this information with my provider and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of TeleCounseling in my medical care and authorize the provider to use TeleCounseling in the course of my diagnosis and treatment.

Patient Signature: _____ Date: _____

CONSENT FOR TREATMENT

Psychotherapy is a working cooperative relationship between you and your counselor. Each member of this cooperative relationship has certain responsibilities. Your counselor will contribute their knowledge, expertise, and clinical skills. You, as the client, have the responsibility to bring an attitude of collaboration and a commitment to the therapeutic process. While there are no guarantees regarding the outcome of the treatment, your commitment may increase the likelihood of a satisfactory experience.

Fees and Appointments

Appointments are xxx minutes in length, and take place on a xxxxxx basis. Your counselor holds your specific hour for you each week. If you are unable to keep an appointment, please cancel as soon as possible. You will be responsible for payment of missed sessions. If you are able to reschedule your appointment within xxx working days, it will not count as a cancellation. We reserve the right to suspend therapy if services are rendered and not paid for after xxx sessions. During your initial appointment you will be assigned a fee for your weekly sessions based on your ability to pay. Please discuss any concerns regarding your financial status with your counselor, especially if your financial situation should change or improve.

Confidentiality

Communication between you and your counselor is confidential. This means that your counselor will not discuss your case orally or in writing without your expressed written permission (please see the following section on “Training and Supervision”).

Your counselor has an ethical and legal obligation to break confidentiality under the following circumstances:

a. If there is a reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect.
b. If there is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit.
c. If you disclose that you knowingly develop, duplicate, print, download, stream, or access through any electronic or digital media or exchanges, a film, photograph, video in which a child is engaged in an act of obscene sexual conduct.
d. If you introduce your emotional condition into a legal proceeding.
e. If there is a court order for release of your records.

Availability and After Hours Emergencies

Counselors check for voice mail messages during normal business hours. Messages left outside of normal hours of operation will be picked up the next business day. If you have an emergency that needs immediate attention you may need to seek assistance at the nearest emergency services department.

Child Care Release

We do not provide childcare and are not responsible for children or adolescents left unsupervised in the waiting room. Minors must be picked up following their appointments on time. If you must leave your child in the waiting room during a session, it is your responsibility to provide appropriate supervision for that child. Children under the age of 10 may not be left without supervision in the waiting room.

Additional Rights and Responsibilities

In addition to your right to confidentiality, you have the right to end your counseling at any time, for whatever reason and

without any obligation, with the exception of payment of fees for services already provided. You have the right to question any aspect of your treatment with your counselor.

You also have the right to expect that your counselor will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you.

We reserve the right to discontinue counseling at any time including, but not limited to, a violation by you of this Consent for Treatment, a change or reevaluation of your therapeutic needs,

Our ability to address those needs, or other circumstances that lead us to conclude in its sole and absolute discretion that your counseling needs would be better served at an another counseling facility. Under such circumstances, we will suggest an appropriate counselor(s) or counseling agency.

Your signature below indicates that you have read and understand this information and have received a copy of this consent form and give permission to us to provide counseling services and that this contract is binding for all future sessions you may have with this entity.

Patient Signature: _____ Date: _____

HEALTH RELEASE CONSENT

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

In the course of providing services to you, we may create, receive, and store individually identifiable information, including information that relates to health care and payment for health care ("Personal Information"). It is often necessary to use and disclose this Personal Information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a HIPAA Notice of Privacy Practices that describes these uses and disclosures. As described in our Notice of Privacy Practices, the use and disclosure of your Personal Information for treatment purposes not only includes care and services provided here, but also disclosures of your Personal Information as may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your Personal Information for purposes of payment may include, for example, the submission of this information to a billing agent for processing claims or obtaining payment and/or submission of claims to insurers.

When you sign this consent document, you expressly agree that we can and will use and disclose your personal Information to treat you, to obtain payment for our services, and to operate our practice. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You also acknowledge, by your signature below, that you have received a copy of our HIPAA Notice of Privacy Practices.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES.

Patient Signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: _____ Name: _____ Date: _____