Psychotherapy and Counseling Intake Forms

50 Ready-To-Use Forms

BY ANGELA M. DOEL, MS
& LAWRENCE E. SHAPIRO, PH.D.

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and
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Between Sessions Resources, Inc.
Coral Gables, FL

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Cover by Mike Canavan

Disclaimer: This book is intended to be used as an adjunct to psychotherapy. If you are experiencing serious symptoms or problems in your life, seek the help of an experienced mental health professional.

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About the Authors

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Lawrence E. Shapiro, PhD, is a prolific author of self-help books and the inventor of more than 100 therapeutic games. Dr. Shapiro is known for his practical approach to helping others. He has written workbooks, storybooks, card games, board games, and smartphone apps. His work has been translated into twenty-seven languages.

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Introduction

Perhaps you are just starting out as a therapist, and you are interested in establishing an effective intake process. Maybe you're a seasoned counselor and you want to ensure your intake paperwork is up to date.

The intake process is one of the most important parts of the therapeutic process, as it lays the foundation for successful working relationships with your clients. You must ensure you get all the information you need to make informed decisions about how to assess and treat clients. In addition, your clients must be provided with all the necessary information, so they have a clear understanding of confidentiality, your services, and their rights.

The purpose of the intake session is for you to create an accurate picture of a client's therapeutic needs. In other words, this session allows you to review all there is to know – as if that's possible in one session! – about a new client. One way in which you do that is through the use of forms – which include informed consent, release of information, questionnaires, intakes, and so on.

During the intake session, you might ask questions about current problems, therapy and treatment history, personal relationships, and therapy goals. Along with basic client information, you must address:

- topics such as payment, ethical concerns, and the therapeutic relationship
- informed consent and release of information
- confidentiality and client rights and responsibilities
- any documents they filled out before the session
- the potential need for a crisis plan

Because so much happens during the initial intake session, it is often longer than the typical 50-minute session. Being clear and concise is particularly important. Having all the paperwork ready is essential. Before you sit down with your client or turn on your webcam for the intake session, make sure you:

- have all the necessary paperwork ready
- review the pre-session questionnaire so you have a sense of your client's background and presenting problems
- write down questions you need to ask during the intake session

Once you are conducting the intake session with your client, the most important skill you can practice is good listening. This workbook makes it easier for you to focus on establishing the therapeutic relationship with your new client – instead of scrambling for the necessary paperwork. This workbook includes every form you need to conduct the most effective intake sessions with new clients. Visit BetweenSessions.com for 100+ additional practice management forms.

Section 1. Intake Forms

CLIENT INTAKE FORM

Please answer the following questions to the best of your abilities. This information is held to the same standards of confidentiality as our therapy sessions. This questionnaire will take approximately 30 minutes to complete.

Name: _____
(Last) (First) (Middle initial)

Name of parent or guardian (if minor): _____

Birth date: _____/_____/_____ Age: _____

Gender: ____Male ____Female ____Other: _____

Marital status: ___Single ___Partnered ___Married ___Separated ___Divorced ___Widowed

Number of children: _____ Ages: _____

Home address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ May we leave a message? Yes / No

Cell/other: _____ May we leave a message? Yes / No

Email: _____ May we email you?* Yes / No
**NOTE: Emails may not be confidential.*

Referred by: _____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes / No

Reason for change: _____

Have you had any mental health services in the past? Yes / No

Reason for change: _____

Are you currently taking any psychiatric prescription medication? Yes / No

If yes, please list: _____

Have you been prescribed psychiatric prescription medication in the past? Yes / No

If yes, please list: _____

General Health Information

How would you describe your physical health at the present time?

____Poor ____Unsatisfactory ____Satisfactory ____ Good ____ Very good

Please list any persistent physical symptoms or health concerns (e.g., chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.):

_____

_____

_____

Are you on any medication for physical/medical issues? Yes / No

If yes, please list: _____

Are you having any problems with your quality of sleep? Yes / No

If yes, check those that apply:

____ Sleep too much ____ Sleep too little ____ Poor quality ____ Disturbing dreams

____ Other: _____

How many times per week do you exercise? _____ days _____ minutes / hours

Are there any changes or difficulties with your eating habits? Yes / No

If yes, check those that apply:

____Eating less ____Eating more ____Bingeing ____Restricting ____Other: _____

Have you experienced a weight change in the last two months? Yes / No

If yes, describe: _____

Do you consume alcohol regularly? Yes / No

In one month, how many times do you have four or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use?

___Daily ___Weekly ___Monthly ___Rarely ___Never

Have you felt depressed recently? Yes / No

If yes, for how long? _____

Have you had any suicidal thoughts recently? Yes / No

If yes, how often? ___Frequently ___ Sometimes ___ Rarely

Have you ever had suicidal thoughts in the past? Yes / No

If yes, how long ago? _____

How often did you have these thoughts? ___Frequently ___ Sometimes ___ Rarely

Are you currently in a romantic relationship? Yes / No

If yes, how long have you been in this relationship? _____

On a scale from 1 to 10 (10 being great, 1 being poor), how would you rate the quality of your relationship? _____

In the last year, have you experienced any major life changes (employment, relocation, relationship, illness, loss of loved one, etc.)? Describe.

_____

_____

_____

Check off the issues below that apply to you:

___ Extreme depressed mood	___ Mood swings	___ Extreme anxiety
___ Panic attacks	___ Phobias	___ Sleep disturbance
___ Hallucinations	___ Memory problems	___ Body complaints
___ Alcohol/substance abuse	___ Body complaints	___ Eating disorder
___ Repetitive thoughts	___ Anxiety	___ Time loss
___ Repetitive behaviors	___ Homicidal thoughts	___ Indecision
___ Suicide attempts	___ Trouble planning	___ Lack of focus
___ Difficulty with relationships	___ Confusion	___ Anger issues

Occupational Information

Are you currently employed? Yes / No

If yes, who is your employer? _____

What is your position? _____

Are you happy in your current position? Yes / No

Are you fulfilled in your current position? Yes / No

Does your work make you stressed? Yes / No

If yes, what are your work-related stressors? _____

Religious/Spiritual Information

Do you practice or observe a religion? Yes / No

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? Yes / No

Family Mental Health History

Please provide information about your family history. Circle yes or no. If yes, please indicate the family member/relationship affected.

Depression Yes / No _____

Anxiety Disorders Yes / No _____

Bipolar Disorder Yes / No _____

Panic Attacks Yes / No _____

Alcohol Abuse Yes / No _____

Drug Abuse Yes / No _____

Eating Disorder Yes / No _____

Learning Disability Yes / No _____

Trauma Yes / No _____

Domestic Violence Yes / No _____

Obesity Yes / No _____

OCD Yes / No _____

Schizophrenia Yes / No _____

Other _____

List your strengths.

_____

_____

_____

List areas you would like to develop or improve.

_____

_____

_____

What do you like most about yourself?

_____

_____

_____

What are some ways you cope with life obstacles and stress?

_____

_____

_____

What are your goals for therapy? What would you like to accomplish during your sessions?

_____

_____

_____

Is there anything else you would like to share?

_____

_____

_____

_____

LIFE HISTORY QUESTIONNAIRE

Name: _____ Date: _____

The information you provide will help in the planning of your counseling and assist you and your therapist in clarifying your therapy goals. Please be as open and honest as possible. This questionnaire will be kept in your private confidential file.

What to Do

Please check all the items below that you currently experience or have experienced in the past. Feel free to add any others at the bottom under "Other Concerns or Issues." You may add details as needed to clarify at the end of this questionnaire.

- ☐ Abortion
- ☐ Abuse – emotional
- ☐ Abuse – neglect
- ☐ Abuse – sexual
- ☐ Adoption
- ☐ Aggression
- ☐ Alcohol Use
- ☐ Ambition
- ☐ Anger
- ☐ Anxiety
- ☐ Arguing
- ☐ Attention problems
- ☐ Career Concerns
- ☐ Childhood issues
- ☐ Children – care of
- ☐ Children – custody
- ☐ Children – management
- ☐ Choices you have made
- ☐ Chronic Pain
- ☐ Codependence
- ☐ Compulsive Gambling
- ☐ Compulsive Spending
- ☐ Confusion
- ☐ Constant Conflicts
- ☐ Crying
- ☐ Grieving, Mourning
- ☐ Guilt
- ☐ Headaches
- ☐ Health Problems
- ☐ Hearing Voices
- ☐ Hostility
- ☐ Hyperactivity
- ☐ Impulsive Spending
- ☐ Impulsiveness
- ☐ Incest
- ☐ Indecision
- ☐ Inferiority
- ☐ Infertility
- ☐ Inhibition
- ☐ Interpersonal Conflict
- ☐ Irresponsibility
- ☐ Irritability
- ☐ Judgment Problems
- ☐ Laziness
- ☐ Legal Problems
- ☐ Loneliness
- ☐ Loss of Control
- ☐ Loss
- ☐ Loss of Interest in Activities
- ☐ Loss of Interest in Sex
- ☐ Physical Problems
- ☐ PMS
- ☐ Poor Self-Care
- ☐ Pornography Use
- ☐ Procrastination
- ☐ Relationship Problems
- ☐ Relaxation
- ☐ Remarriage
- ☐ Risk-Taking
- ☐ Sadness
- ☐ School Problems
- ☐ Self Harm – burning
- ☐ Self Harm – cutting
- ☐ Self Harm – other: _____
- ☐ Self Harm – scratching
- ☐ Self Harm – hair pulling
- ☐ Self-Centeredness
- ☐ Self-Control Problems
- ☐ Self-Esteem Issues
- ☐ Self-Neglect, Poor Self-Care
- ☐ Sepration
- ☐ Sexual Addiction
- ☐ Sexual Conflicts
- ☐ Sexual Desire Differences
- ☐ Shyness

☐ Death of a loved one
☐ Debt
☐ Decision-Making Problems
☐ Dependence
☐ Depression
☐ Distractibility
☐ Divorce
☐ Domestic Violence
☐ Drug Abuse – over the counter
☐ Drug Abuse – prescription
☐ Drug Abuse – street drugs
☐ Drug Abuse – alcohol
☐ Education Issues
☐ Employment – lack of
☐ Employment – overdoing
☐ Employment Problems
☐ Employment – termination
☐ Emptiness
☐ Exhaustion
☐ Failure
☐ Fatigue
☐ Fears
☐ Feelings of Helplessness
☐ Feelings of Hopelessness
☐ Financial Troubles
☐ Friendship Problems
☐ Gambling
☐ Gender Identity Issues
☐ Goals Being Unmet
☐ Low Energy
☐ Low Frustration Tolerance
☐ Low Income
☐ Low Mood
☐ Marital Conflict
☐ Marital Distance
☐ Marital Infidelity/Affairs
☐ Medical Concerns
☐ Memory Problems
☐ Menopause
☐ Menstrual Problems
☐ Mixed Feelings
☐ Mood Swings
☐ Motivation
☐ Mourning
☐ Nail-Biting
☐ Nervousness
☐ Nightmares
☐ Obsessions, Compulsions
☐ Outbursts
☐ Oversensitive to Criticism
☐ Oversensitive to Rejection
☐ Overweight
☐ Panic or Anxiety Attacks
☐ Parenting Issues
☐ Perfectionism
☐ Pessimism
☐ Phobias
☐ Smoking
☐ Spirituality
☐ Step-Parenting
☐ Stress
☐ Stress-Management Problems
☐ Suspiciousness
☐ Temper Problems
☐ Tension
☐ Thought Disorganization
☐ Threats of Violence
☐ Tiredness
☐ Tobacco Use
☐ Unhappiness
☐ Violence
☐ Violence – victim of crime
☐ Weight and Diet Issues
☐ Withdrawal – isolating
☐ Work Problems
☐ Worry
☐ Other concerns or issues:
_____
_____
_____
_____

Where did you attend high school? _____

Did you attend college or professional school? When, where, degree earned? _____

_____

_____

Any plans to further your education? □ Yes □ No

If so, when and what? _____

What is your ethic background?

□ African / African American

□ Asian American / Chinese / Filipino / Japanese / Korean / Vietnamese

□ East Indian / Pakistani

□ Latino / Hispanic / Mexican American / Puerto Rican / Cuban

□ Middle Eastern

□ Native American / Alaskan Native

□ Polynesian / Micronesian

□ White/Caucasian

□ Other (specify): _____

How much do you identify with your ethnic heritage? (Check one):

□ Not at all □ A little □ Somewhat □ Moderately □ Strongly

Religious/Spiritual preference: _____

Do you consider yourself a religious person? □ Yes □ No or a spiritual person? □ Yes □ No

Comment: _____

Faith: Group/Denomination in which you were raised: _____

Current Congregation: _____

How active are you? □ Inactive □ Slightly □ Moderate □ Very

Does your family speak a language other than English at home?

□ Not at all □ Very little □ Sometimes □ Frequently □ Always

If "Sometimes" to "Always", what language is spoken? _____

Were you and both your biological parents born in the United States? □ Yes □ No □ Unsure

If no, who was foreign-born, where and what was the approximate age of immigration to the USA?_____

_____

Have you seen another therapist before? □ Yes □ No

If yes, who did you see? _____

Have you ever been hospitalized for psychological/emotional difficulties? □ Yes □ No

If yes, please note dates of hospitalization. _____

Are you or have you been on any medication for your psychological problems? □ Yes □ No

If yes, please note the type of medication, the dosage, and the dates you used this medication.

_____

_____

_____

_____

Briefly describe the problem that brought you here.

_____

_____

_____

_____

Problem Intensity: How would you rate the intensity of the problem or concern that brought you in? (Circle the appropriate number):

1 2 3 4 5 6

Not intense Moderately intense Extremely intense

Approximately how long have you had the current problem (in months or years)? _____

In what ways have you attempted to cope with this problem?

_____

_____

_____

_____

What do you hope to accomplish by coming to therapy? Be as specific as possible.

_____

_____

_____

_____

Have you been married/partnered before? ☐ Yes ☐ No

If yes, when and for how long? _____

Please list the names of your children or dependents.

Names of Children	Date of Birth	Age	Lives with You?

List others who may live with you including their ages and occupations.

_____

_____

_____

Please check any past, present, or impending problems in your family.

☐ Deaths	☐ Frequent Locations	☐ Serious Illness
☐ Psychiatric Disorders	☐ Physical/Sexual Abuse	☐ Legal Problems
☐ Eating Disorders	☐ Financial Problems	☐ Unemployment
☐ Divorce	☐ Attempted/Completed Suicide	☐ Other: _____

Please specify family member(s) with special problems, and approximate year of occurrence (e.g., mother, serious illness, 1998).

_____

_____

_____

_____

Would you like anyone else involved in counseling with you? (family members, friends, etc.)

_____

_____

_____

_____

Is there a concern about violence in your life today (either from you or toward you)? Explain.

_____

_____

_____

_____

Have you personally experienced family abuse?

☐ None ☐ Unsure ☐ Emotional ☐ Physical ☐ Sexual

Have you personally experienced legal problems? ☐ Yes ☐ No

Did you experience learning problems in elementary or high school?

☐ None ☐ A little ☐ Some ☐ Substantial ☐ Lots, constant struggle

In general, how happy or adjusted were you growing up? (Check one):

☐ Not at all ☐ A little ☐ About average ☐ Substantial ☐ Completely

How much is your family a source of emotional support for you now?

☐ None ☐ A little ☐ Somewhat ☐ Substantial ☐ Very strong

How much conflict in values do you currently experience with your parents?

☐ Very little or none ☐ Some ☐ Moderate ☐ Strong ☐ Extreme

Who in your family do you currently feel closest to? _____

_____

Most distant from? _____

In most conflict with? _____

Are you currently in the process of separation or divorce? Explain.

_____

_____

_____

_____

Length of time apart? _____

How committed are you to making your marriage/relationship work?

_____

_____

_____

_____

What changes are you willing to make for the sake of your marriage/relationship?

_____

_____

_____

_____

Describe any concerns regarding sexual or emotional intimacy with your spouse/partner.

_____

_____

_____

_____

Please list any other information that you believe will be helpful for your therapist to know.

_____

_____

_____

_____

How is your physical health at present?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

List any persistent physical symptoms or health concerns (e.g., chronic pain, diabetes, headaches, etc.)

_____

_____

_____

_____

Are you presently taking any prescribed or non-prescribed medication? ☐ Yes ☐ No

If yes, explain.

_____

_____

_____

_____

Are you having any problems with your sleep habits? ☐ Yes ☐ No

If yes, check where applicable: ☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep ☐ Disturbing dreams ☐ Other: _____

How many times per week do you exercise? _____ About how long each time? _____

Are you having any difficulty with appetite or eating habits? ☐ Yes ☐ No

If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Bingeing ☐ Poor appetite

☐ Making myself vomit ☐ Significant weight change (last two months)

Do you regularly drink alcohol? ☐ Yes ☐ No

In a typical month, how often do you have four or more drinks in a 24-hour period? _____

Do you consider your alcohol consumption a problem? ☐ Yes ☐ No ☐ Unsure

How often do you engage in recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Do you consider this drug use a problem? ☐ Yes ☐ No ☐ Unsure

Do you have any problems or worries about sexual functioning? ☐ Yes ☐ No

If yes, check where applicable:

☐ Lack of desire ☐ Performance problem ☐ Difficulty maintaining arousal

☐ Worried about sexually transmitted disease ☐ Sexual impulsiveness

☐ Other: _____

Have you ever experienced sexual assault, unwanted sex, or uncomfortable touching?
☐ Yes ☐ No

Explain.

_____

Have you had suicidal thoughts in the last few months?

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Have you had them in the past?

☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

Have you ever intentionally inflicted any harm upon yourself? ☐ Yes ☐ No ☐ Unsure

In the past, how would you rate the quality of your friendships?

☐ Very poor ☐ Unsatisfactory ☐ About average ☐ Good ☐ Excellent

Approximately how many significant intimate relationships (e.g., lasting 6 months or more) have you been involved in? _____

Are you in one now? ☐ Yes ☐ No ☐ I think so

Besides family members, approximately how many people can you really count on right now for friendship or emotional support? _____

List them below:

_____

_____

_____

_____

Please enter any additional information about your life history here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PSYCHOSOCIAL HISTORY

Name: _____ DOB: _____

Family History

Is your father living? Yes / No Father's age: _____
Where does your father live? _____

Father's occupation: _____

Describe your relationship with your father.

_____

_____

_____

_____

Is your mother living? Yes / No Mother's age: _____
Where does your mother live? _____

Mother's occupation: _____

Describe your relationship with your mother.

_____

_____

_____

_____

What was it like growing up?

_____

_____

_____

_____

Describe your parents' relationship with each other when you were a child.

_____

_____

_____

_____

What is it like now?

_____

_____

_____

_____

Do/did you have stepparents? Yes / No

Describe your relationship with stepparent(s).

_____

_____

_____

_____

List the names and ages of your siblings and note if they are deceased.

_____

_____

_____

_____

Are you the oldest, middle, or youngest child? _____

Are/were there major cultural or religious influences in your family? Describe.

_____

_____

_____

_____

Describe your family growing up.

_____

_____

_____

_____

_____

_____

_____

_____

Describe your childhood.

_____

_____

_____

_____

_____

_____

_____

Describe your current religious or spiritual beliefs/practices.

_____

_____

_____

_____

Marital status: _____ How long? _____

Number of marriages/long-term partners: _____

Do you have children? Yes / No If yes, write down their names and ages.

_____

_____

_____

_____

Do your children live with you? Yes / No

If you use drugs or alcohol, how has your use affected your family relationships?

_____

_____

_____

_____

_____

_____

_____

Do any of your family members use alcohol or other substances? Yes / No

Who?

_____

_____

Sexual History

How did you learn about sex?

_____

_____

_____

_____

How old were you when you began dating?_____

Describe your first sexual experience.

_____

_____

_____

_____

Were you ever sexually abused? Yes / No

Describe any current sexual concerns.

_____

_____

_____

_____

Education/Military History

What was school like for you as a child? As a teenager?

_____

_____

_____

_____

_____

_____

_____

_____

Highest grade/degree completed: _____

Current employment status:

□ employed full-time

□ employed part-time

□ unemployed

□ student

□ disabled/unable to work

□ other: _____

Military history (*branch, length of service, rank, discharge type, any disciplinary proceedings*).

_____

_____

_____

_____

Legal History

Arrest history (dates/reasons).

_____

_____

_____

_____

Describe any current legal issues, including probation.

_____

_____

_____

_____

Social History

Where/with whom do you currently live?

_____

_____

_____

_____

What do you do for fun?

_____

_____

_____

_____

Who do you turn to for support?

_____

_____

_____

_____

What percentage of your friends use substances? _____

What do they use? _____

Emotional History

Have you ever been in counseling? Yes / No

Names of past therapists, counselors, mentors, sponsors, or coaches.

_____

_____

_____

_____

What was helpful?

_____

_____

_____

_____

What was not helpful?

_____

_____

_____

_____

Within the past 12 months…	never	rarely	sometimes	often	regularly
I have difficulty sleeping.					
I have difficulty eating well or with an appetite.					
I have difficulty concentrating.					
I feel down or depressed.					
I have thought about suicide or harming myself.					
I have felt restless or edgy.					
I have felt irritable.					
I worry or feel anxious.					
I hear voices or see things that others do not.					
I think of harming other people.					

Is there anything you would like to add?

_____

_____

_____

Has substance use affected your life? If yes, explain.

_____

_____

_____

Have you ever experienced abuse or trauma? If yes, describe.

_____

_____

_____

Substance Use History

Have you ever…

tried to cut down on your drinking/drug use? Yes / No

been annoyed by others commenting about your drinking/drug use? Yes / No

felt guilty about your drinking/drug use? Yes / No

drank/used to eliminate a hangover? Yes / No

	Age 1st used	**Date last used**	**Amount**	**Frequency**	**Circumstances of use**	**Currently using?**
Alcohol						
Marijuana						
Cocaine						
Stimulants						
Tranquilizers						
Heroin						
Pain medication						
Hallucinogens						
Steroids						
Nicotine						
Caffeine						
Other						

Anything else you would like to share?

_____

_____

_____

Treatment History for Substance Use

Dates of treatment	Name of treatment facility/providers	Outcome

Describe patterns of substance use over your lifetime and note any changes in patterns.

_____

_____

_____

_____

_____

_____

_____

Is there anything more you want to share?

_____

_____

_____

_____

_____

_____

_____

Signature: _____

Print name: _____

Date: _____

CHILD INTAKE FORM

Client name: _____ Age: _____

Date of Birth: ____/____/_____

Name of person completing form: _____

Relationship to Child: _____ Today's Date: ____/____/_____

School: _____ Grade: _____

Race: _____ Ethnicity: _____

Parent: _____ Mother / Father / Guardian

Parent: _____ Mother / Father / Guardian

Parent relationship: ___ partners ___ married ___ separated ___ divorced ___ widowed

If separated or divorced, provide date of separation: _____

If widowed, date of death: _____

Sibling(s) (name/age): _____

_____

Who suggested that you seek assessment and/or counseling for your child?
___ School teacher ___ School counselor ___ Myself as a caregiver ___ Other: _____

Describe the overall problem that led you to seek help for your child:

_____

_____

_____

My child has difficulty with a relationship in our family: Yes / No

If yes, who: _____

I have reason to suspect my child has been abused (emotionally, sexually, and/or physically): Yes / No

If yes, explain: _____

Describe your child's school experience:

_____

_____

_____

Describe your child's interactions with parents or guardians:

_____

_____

_____

Describe your child's interactions with siblings:

_____

_____

_____

Describe your child's ability to complete tasks and follow directions:

_____

_____

_____

I would describe my child as: Independent Dependent

Explain:

_____

_____

_____

My child appears to have high levels of stress: Yes / No

If yes, explain:

_____

_____

_____

Describe your child's sleep patterns:

_____

_____

_____

Describe your child's eating patterns:

_____

_____

_____

Describe your child's physical activity level:

_____

_____

_____

Medical History

Birth: Duration of labor: _____

Type of delivery: _____

Difficulties: _____

How soon did the mother see baby? _____

Birth weight: _____

Infancy: Age of weaning: _____

Feeding problems? _____

Approximate age of walking: _____

Approximate age of talking: _____

Sleep problems? Yes / No

If yes, please explain: _____

Any behavior such as head banging, rocking, etc.? Yes / No

If yes, please explain: _____

Does your child have difficulty separating from his/her parents? Yes / No

If yes, please explain: _____

Has your child had any severe, long-term illnesses or accidents? Yes / No

If yes, please explain: _____

Is your child on any medication? Yes / No

If yes, please explain: _____

Does your child have any digestive problems? Yes / No

If yes, please explain: _____

Does your child have any allergies? Yes / No

If yes, please explain: _____

Does your child have any physical pain? Yes / No

If yes, please explain: _____

Does your child ever appear disoriented or dizzy? Yes / No

If yes, please explain: _____

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate family member/relation affected.

Autism	Yes	No	_____
Attention Deficit	Yes	No	_____
Depression	Yes	No	_____
Anxiety Disorder	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____

Eating Disorder	Yes	No	_____
Learning Disability	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Obesity	Yes	No	_____
Obsessive-Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____
Other			_____

Any other information you would like to share?

_____

_____

_____

DEVELOPMENTAL HISTORY FORM

Date:_____

Child's Full Name:_____ Sex: _____

Child's Nickname/Preferred Name, if applicable: _____

Age: _____Date of Birth: _____Grade: _____School: _____

Child's Primary Language: _____Language spoken at home: _____

Home Address: _____

Home Phone: _____Okay to leave message? ☐ Yes ☐ No

Parent/Guardian #1 Name: _____

Email: _____

Cell Phone: _____ Okay to leave message? ☐ Yes ☐ No

Occupation: _____

Employer: _____

Parent/Guardian #2 Name: _____

Email: _____

Cell Phone: _____ Okay to leave message? ☐ Yes ☐ No

Occupation: _____

Employer: _____

Who referred you?_____

Initial here if you would like us to contact the referral source with feedback following your appointment: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____

Phone number: _____

Pediatrician: _____

Address: _____

Phone number: _____

Briefly describe the problems/concerns:

1. _____

2. _____

3. _____

Where was your child born (hospital name, city, state, country)?

_____

Developmental Milestones

Please note the age the following were achieved. If unsure of the age, check whether it was achieved early, late, or within normal limits.

Rolled over
Age: _____
☐ Early ☐ Normal ☐ Late

Sat without support
Age: _____
☐ Early ☐ Normal ☐ Late

Grasped pencil/crayon
Age: _____
☐ Early ☐ Normal ☐ Late

Crawled
Age: _____
☐ Early ☐ Normal ☐ Late

Stood up
Age: _____
☐ Early ☐ Normal ☐ Late

Walked holding on
Age: _____
☐ Early ☐ Normal ☐ Late

Tied shoes
Age: _____
☐ Early ☐ Normal ☐ Late

Pedaled tricycle
Age: _____
☐ Early ☐ Normal ☐ Late

Rode bike
Age: _____
☐ Early ☐ Normal ☐ Late

Grasped pencil/crayon
Age: _____
☐ Early ☐ Normal ☐ Late

Learned to swim
Age: _____
☐ Early ☐ Normal ☐ Late

Babbled
Age: _____
☐ Early ☐ Normal ☐ Late

Walked without holding on
Age: _____
☐ Early ☐ Normal ☐ Late

Spoke first words
Age: _____
☐ Early ☐ Normal ☐ Late

Fed self
Age: _____
☐ Early ☐ Normal ☐ Late

Put two words together
Age: _____
☐ Early ☐ Normal ☐ Late

Dressed self
Age: _____
☐ Early ☐ Normal ☐ Late

Spoke in short sentences
Age: _____
☐ Early ☐ Normal ☐ Late

Language Development:
At what age was your child easily understood by others when he or she spoke? _____

Please circle the following items that relate to your child's communication:
☐ Often asks others to repeat what they have said
☐ Unable to understand what you are saying
☐ Unable to follow one-step directions
☐ Unable to follow multi-step directions
☐ Unable to remember short messages
☐ Unable to respond correctly to yes/no questions
☐ Unable to respond correctly to who/what/where/when/why questions
☐ Has a hard time expressing his/her ideas
☐ Has a hard time asking for help/or making his/her wants and needs known to others
☐ Child does not enjoy listening to stories

Sleep:
What time does your child go to sleep? _____ PM
What time does your child wake up? _____ AM

Please briefly describe your child's nightly sleep routine:
_____

_____

_____

Does your child sleep in his/her own room? ☐ Yes ☐ No

If yes, at what age did your child begin to sleep alone? _____

Please check the following items that relate to your child's sleep:

□ Difficulty staying asleep
□ Difficulty falling asleep
□ Frequent wakening
□ Sleep walking
□ Nightmares
□ Enuresis (bed wetting)
□ Encopresis (fecal incontinence)

Describe any past or present concerns/difficulties regarding your child's sleep patterns:

_____

_____

_____

Behavior:

Please check any of the following items that seem to accurately describe your child's personality or behavior.

□ Shy
□ Immature
□ Well-behaved
□ Stubborn
□ Impulsive
□ Temper-tantrums
□ Cries easily
□ Cries excessively
□ Lies
□ Thumb-sucking
□ Head-banging
□ Tics and twitching
□ Always in motion
□ Excessively fidgety
□ Difficulty paying attention
□ Difficulty with transitions
□ Difficulty finishing a task
□ Disorganized
□ Forgetful
□ Angry
□ Easily frustrated
□ Poor self-esteem
□ Fears making mistakes
□ Harms animals
□ Willing to try new activities
□ Attentive
□ Destructive/aggressive
□ Fears looking "stupid"
□ Moods change quickly
□ Cooperative
□ Sees things that are not there
□ Hears voices that are not there
□ Impulsive
□ Engages in risky behavior
□ Lacks judgment
□ Uses drugs
□ Drinks alcohol
□ Skips school/classes
□ Refuses to go to school
□ Difficulty sharing
□ Difficulty listening
□ Difficulty understanding jokes
□ Self-abusive behavior
□ Withdrawn
□ Argumentative
□ Poor awareness of time
□ Gets lost easily
□ Becomes frightened easily
□ Accident-prone
□ Avoids being center of attention
□ Steals things
□ Fails to take responsibility for actions
□ Unable to empathize with others
□ Blames others
□ Rigid/Inflexible/unwilling to try new activities or new ways of doing things

□ Difficulty staying at one task for a long period of time
□ Distracted while watching television
□ Moods seem connected with the seasons
□ Difficulty making or keeping eye contact
□ Difficulty separating from caregiver
□ Plays alone for reasonable length of time

Compulsions (describe): _____

Obsessions (describe): _____

Fears (describe): _____

Suicidal ideation or attempt (describe): _____

_____

_____

Homicidal ideation or attempt (describe): _____

_____

_____

Current Medications:

Name: _____ Dose: _____

Reason Prescribed: _____

Name: _____ Dose: _____

Reason Prescribed: _____

Name: _____ Dose: _____

Reason Prescribed: _____

Other Medical/Behavioral/Mental Health Information:

Did you consult with any other medical specialists for your child? If yes, describe.

_____

_____

_____

Does your child have a diagnosis from a pediatrician, psychologist, psychiatrist, or other professional? □ Yes □ No

If yes, describe:

_____

_____

_____

Has child received any psychological or psychiatric treatment? □ Yes □ No
If yes, please describe:

_____

_____

_____

Has the child ever experienced any parental separations, divorce, or death? □ Yes □ No

If yes, when? _____

How old was the child at the time? _____

Describe the circumstances:

_____

_____

_____

Education:

Child attended nursery school □ Yes □ No Child attended Kindergarten □ Yes □ No

What (if any) problems were reported?

_____

_____

_____

Current School: _____

Teacher's name: _____

School Address: _____

School phone number: (_____) _____

Current Grade Level: _____ Current GPA/Grades: _____

Describe areas in which child excels at school:

_____

_____

_____

Describe any problems at school:

_____

_____

_____

Is your child in a regular education classroom? □ Yes □ No

Is your child currently in, or has he/she previously had, special ed/placements? □ Yes □ No
If your child has an Individualized Education Plan or 504 Plan, please provide copies.

If yes, at what age was your child was placed in special education? _____

Please describe any private support/services your child receives:

_____

_____

_____

Has school psychological testing been completed? □ Yes □ No

Please check any of the following problems reported by your child's school or teacher:

□ Reading	□ Writing	□ Math
□ Behavior	□ Social adjustment	□ Attention span
□ Spelling	□ Distractibility	□ Hyperactivity
□ Following directions	□ Getting along with other children	
□ Getting along with teachers	□ Completing homework	

Please describe your child's attitude toward school:

_____

_____

_____

Has your child ever missed an extended amount of school? □ Yes □ No

If yes, explain: _____

Family Relations:

Are there any significant marital conflicts? □ Yes □ No
If yes, briefly describe:

_____

_____

_____

Is there conflict between the child and parents? □ Yes □ No
If yes, briefly describe:

_____

_____

_____

Is there conflict between the child and siblings? □ Yes □ No
If yes, briefly describe:

_____

_____

_____

Who disciplines the child, and how?

_____

_____

_____

Do parents agree on discipline? □ Yes □ No
If no, describe disagreement related to discipline:

_____

_____

_____

Please explain how your child responds to discipline:

_____

_____

_____

Does your child have difficulty getting along with adults? □ Yes □ No
If yes, describe:

_____

_____

_____

Circle the activities in which the child participates with the family:

□ Movies	□ Meals	□ Conversations
□ Visits with relatives	□ Television	□ Church
□ Games	□ Sports	□ Trips
□ Other: _____		

Please describe your family's religious/spiritual affiliation (*if applicable*):

_____

_____

_____

Please describe your child's religious/spiritual affiliation, if different than above:

_____

_____

_____

Social and Emotional Development:
Describe your child's current social skills and peer relationships:

_____

_____

_____

Describe any history of your child being bullied/teased or being aggressive in play with others:

_____

_____

_____

How would you describe your child socially? How does your child interact with peers at school?

_____

_____

_____

Does your child have difficulty keeping friends? Explain.

Does your child have a best friend? Explain.

What special interests does your child have?

Please list your child's favorite hobbies, activities, and games, excluding sports. Please describe how well you feel your child does in these areas:

Which sports does your child most enjoy playing? Describe how well your child does in these sports compared to peers:

Please list any additional organizations, clubs, teams, or groups in which your child participates:

How does your child handle stress?

What are your child's strengths?

_____

_____

_____

What are your child's areas for growth?

_____

_____

_____

Is there any other important information you would like to share?

_____

_____

_____

Form completed by: _____Date: _____

Relationship to child: _____

COUPLES THERAPY INTAKE FORM

Please complete this form individually

First name: _____ Last name: _____

Age: _____ Birth date: _____ Sex/Gender: _____

Ethnicity: _____ Religion: _____

Marital status (dating, married, cohabiting, separated, divorced): _____

Number of children: _____ Ages of children: _____

Home address: _____

_____

Who lives with you at this address? _____

_____

Cell phone: _____ Home phone: _____

Work phone: _____ Email: _____

Name of emergency contact: _____ Phone: _____

EMPLOYMENT INFORMATION:

□ **Employed** □ full-time □ part-time

Position: _____ Employer: _____

□ **Unemployed** □ laid off □ terminated □ medical leave □ disabled

□ Other: _____

PSYCHIATRIC AND MEDICAL HISTORY

Please list any *psychiatric* diagnoses you have received.

_____

_____

_____

Have you ever been hospitalized for psychiatric reasons? □ Yes □ No
If yes, please describe when and where, and for what reasons.

_____

_____

_____

Please list the medications you currently take, and why they were prescribed:

_____

_____

_____

Please list any *medical* diagnoses you have received:

_____

_____

_____

Name of Physician: _____ Phone: _____

Name of Psychiatrist/Psychologist: _____

Phone: _____

Name of Therapist/Social Worker: _____

Phone: _____

MENTAL HEALTH COUNSELING HISTORY

Have you received *couples counseling* before? □ Yes □ No

If yes, when? _____

With whom? (current partner, previous partner, etc.) _____

_____

Length of treatment: _____

Problems addressed:_____

_____

_____

_____

Describe the effectiveness of the couples counseling:
☐ Very effective ☐ Somewhat effective ☐ No change ☐ Issues worsened

Have you ever received *individual counseling* before? ☐ Yes ☐ No

Length of treatment: _____

Problems addressed: _____

_____

_____

_____

Describe the effectiveness of your individual counseling:
☐ Very effective ☐ Somewhat effective ☐ No change ☐ Issues worsened

YOUR HABITS
Please describe how much/often you participate in the following:

Smoking: ☐ Never ☐ Seldom ☐ Regularly ☐ Constantly ☐ Very effective ☐ Would like to cut back ☐ Others want me to cut back

Gambling: ☐ Never ☐ Seldom ☐ Regularly ☐ Constantly ☐ Very effective ☐ Would like to cut back ☐ Others want me to cut back

Overspending/shopping: ☐ Never ☐ Seldom ☐ Regularly ☐ Constantly ☐ Very effective ☐ Would like to cut back ☐ Others want me to cut back

Drinking: ☐ Never ☐ Seldom ☐ Regularly ☐ Constantly ☐ Very effective ☐ Would like to cut back ☐ Others want me to cut back

Drug use: ☐ Never ☐ Seldom ☐ Regularly ☐ Constantly ☐ Very effective ☐ Would like to cut back ☐ Others want me to cut back

Overeating/Bingeing/Purging/Restricted eating: ☐ Never ☐ Seldom ☐ Regularly ☐ Constantly ☐ Very effective ☐ Would like to cut back ☐ Others want me to cut back

Social Media/Gaming/Electronic Devices: ☐ Never ☐ Seldom ☐ Regularly ☐ Constantly ☐ Very effective ☐ Would like to cut back ☐ Others want me to cut back

Sex (with partner): ☐ Never ☐ Seldom ☐ Regularly ☐ Constantly ☐ Very effective ☐ Would like to cut back ☐ Others want me to cut back

Sex (with others): ☐ Never ☐ Seldom ☐ Regularly ☐ Constantly ☐ Very effective ☐ Would like to cut back ☐ Others want me to cut back

Other _____: ☐ Never ☐ Seldom ☐ Regularly ☐ Constantly ☐ Very effective ☐ Would like to cut back ☐ Others want me to cut back

Other _____: ☐ Never ☐ Seldom ☐ Regularly ☐ Constantly ☐ Very effective ☐ Would like to cut back ☐ Others want me to cut back

YOUR STRESS

What is your current level of stress overall? (*circle one*)

1 2 3 4 5 6 7 8 9 10
No Stress *Extremely stressed*

Check off the areas in your life where you are encountering stressful situations. Use the notes section if you need more space.

____ Financial problems. Describe: _____
____ Health issues. Describe: _____

____ Legal issues/crime/community violence. Describe: _____

____ Race/ethnic/cultural issues. Describe: _____

____ Family conflict. Describe: _____

____ Social problems. Describe: _____

____ Educational or professional difficulties. Describe: _____

____ Housing issues. Describe: _____

____ Grief, bereavement, or loss. Describe: _____

____ Parenting issues. Describe: _____

____ Elder care issues. Describe: _____

____ Other: _____ Describe: _____

Notes: _____

_____

_____

YOUR RELATIONSHIP

How long have you been dating, married, cohabiting, separated, or divorced from the person with whom you are seeking therapy? _____

Why are you seeking help? Was there a particular event or problem that led to this decision?

_____

_____

_____

Whose idea was it to come to therapy? _____

What are your expectations for couples counseling?

_____

_____

_____

_____

What would you like to learn/achieve through therapy? (*circle all that apply*):

better communication

problem-solving

conflict resolution

more quality time together

more autonomy

more hobbies

more social connections

more separate friends and interests

increase respect/understanding

build trust

resolve individual issues

power and control issues

increased sharing of chores/household responsibilities

increased sharing of financial responsibilities/contributions

parenting skills

better sharing of parenting responsibilities

help with children's behavior

more intimacy (sexual)

more intimacy (emotional)

other (specify): _____

other (specify): _____

Have either you or your partner physically restrained, harmed, or injured the other person?
□ Yes □ No
If yes for either partner, who, how often, and what happened?

_____

_____

_____

If married, have either of you threatened to separate/divorce because of the current relationship problems? □ Yes □ No If yes, who? ____Me ____ Partner ____ Both of us

Have either of you consulted with a lawyer about divorce? □ Yes □ No
If yes, who? ____Me ____Partner ____Both of us

Have you or your partner ever emotionally or physically cheated on each other?
□ Yes □ No □ Unsure If yes, who? ____Me ____Partner ____Both of us

What are the top three concerns that you have about your relationship?

1. _____

2. _____

3. _____

What, if anything, have you tried to address these difficulties? How successful were you?

_____

_____

_____

What are your greatest strengths as a couple?

_____

_____

_____

What are the biggest areas for improvement?

_____

_____

_____

What is your current level of satisfaction and fulfillment in this relationship? (*circle one*)

1 2 3 4 5 6 7 8 9 10

extremely dissatisfied *extremely satisfied*

What is your current level of stress in the relationship?

1 2 3 4 5 6 7 8 9 10

extremely stressed *no stress at all*

How important is it to you to improve the quality of your relationship?

1 2 3 4 5 6 7 8 9 10

unimportant *very important*

How willing are you to make your relationship a priority in your life?

1 2 3 4 5 6 7 8 9 10

unwilling *extremely willing*

List three steps *you* can take to improve the relationship, regardless of what your partner does.

_____

_____

_____

Is there anything else that you would like to mention?

_____

_____

_____

_____

_____

FAMILY THERAPY INTAKE FORM

Complete Individually (*for clients ages 14+*)

First name: _____ Last name: _____

Age: _____ Date of Birth: _____ Ethnicity: _____

Religion: _____ Marital Status: _____

Sex/gender: _____ Number of children: ____ Ages of children: _____

Home address: _____

_____

Who do you live with? _____

Phone: _____

Email: _____

Name of emergency contact: _____

Phone: _____

EMPLOYMENT INFORMAITON:

- ☐ On sick leave, as of this date: _____ Return to work date: _____

  I was: ☐ Full-time or ☐ Part-time

  at: _____ Position: _____
- ☐ Full-time at: _____ Position: _____
- ☐ Part-time at: _____ Position: _____
- ☐ Not working because: _____
- ☐ Student at: _____

HOW YOU FOUND THIS CLINIC:

☐ Word of mouth ☐ I'm a former client ☐ Psychology Today

☐ Google search, using these words: _____

☐ Other: _____

PSYCHIATRIC AND MEDICAL HISTORY

Please list any psychiatric or problems you have been diagnosed with:

_____

_____

_____

Please list any medical or "physical" problems you have been diagnosed with:

_____

_____

_____

Please list any medications you currently take, dose, and what you take them for:

_____

_____

_____

_____

Name of family doctor: _____ Phone: _____

Date of last check-up/physical: _____

Results:

_____

_____

Name of Psychiatrist: _____ Phone: _____

Date of last visit: _____

Results:

_____

_____

MENTAL HEALTH TREATMENT HISTORY

Have you ever been hospitalized for psychological or psychiatric reasons? Yes / No

If yes, please describe when and where you were hospitalized, and for what reasons.

_____

_____

Have you ever received family counseling? Yes / No

If yes, for what problems? _____

When: _____ Where: _____

With whom: _____ Length of treatment: _____

Was the outcome successful? ☐ Very ☐ Somewhat ☐ No change ☐ Got worse

Have you ever been in individual counselling before? Yes / No

If yes, give summarize the concerns addressed: _____

_____

CURRENT HABITS

Please describe your ***current*** habits in each of the following areas. Write N/A if it doesn't apply to you.

Smoking: _____

Gambling: _____

Drinking alcohol: _____

Drug use: _____

Caffeine intake: _____

Exercise: _____

Eating problems: _____

Sleeping: _____

Fun and relaxation: _____

CURRENT STRESSFUL LIFE EVENTS

	No	**Yes**	**If yes, please describe**
Economic problems			
Difficulty accessing healthcare			
Legal issues or crime			
Cultural issues			
Family conflict or lack of support			
Social problems			

Educational or occupational difficulties			
Housing problems			
Grief or bereavement			
Other			

QUESTIONS ABOUT YOUR FAMILY

How close do you feel to your family members? (*circle one*)

1 2 3 4 5
distant very close

Explain.

_____

_____

_____

How well do you get along with your family members?

1 2 3 4 5
poorly very well

Explain.

_____

_____

_____

Describe your family's household rules?

_____

_____

_____

What are your expectations for family counseling?

_____

_____

_____

What are your goals for treatment objectives? (*check all that apply*):

☐ Improve communication	☐ Conflict resolution	☐ Parenting skills
☐ Problem-solving	☐ Increase emotional safety	☐ More physical safety
☐ More quality time together	☐ Resolve individual issues	☐ More autonomy
☐ More respect/understanding	☐ Power and control issues	☐ More hobbies
☐ Less harsh discipline	☐ More sharing of the chores	☐ Help for children's behavior
☐ Other (specify):		

What have you already tried to address these difficulties?

_____

_____

_____

Whose idea was it to come to therapy? _____

Was there a prompting event that led someone to make this call? Why seek help now?

_____

_____

_____

What are your greatest strengths as a family?

_____

_____

_____

Make at least three suggestions *you* could personally do to improve family relationships.

_____

_____

_____

Does anyone in your family drink alcohol or take drugs to intoxication (get drunk)? Yes / No

If yes, who, how often, and what drug/alcohol?

_____

_____

Has anyone in your family physically restrained, harmed, or injured another family member? (e.g., pushed, shoved, grabbed, slapped, etc.) Yes / No

If yes, who, how often, and what happened?

_____

_____

Is your family at risk for splitting up? ☐ Yes ☐ No ☐ Unsure

If yes or unsure, please explain.

_____

_____

Has anyone in your family withdrawn or given up trying to work things out? Yes / No

If yes, who? _____

Circle your current level of overall stress.

1 2 3 4 5

no stress very stressed

Circle your current level of stress within your family?

1 2 3 4 5

no stress very stressed

Name the top three concerns you have in your family ("1" being the most problematic).

1. _____

2. _____

3. _____

How important is it to you to improve the quality of your family relationships?

1 2 3 4 5

not important extremely important

How willing are you to make “working on these relationships” a priority in your life?

1	2	3	4	5
not willing				extremely willing

Is there anything else you would like to mention related to the above statements?

_____

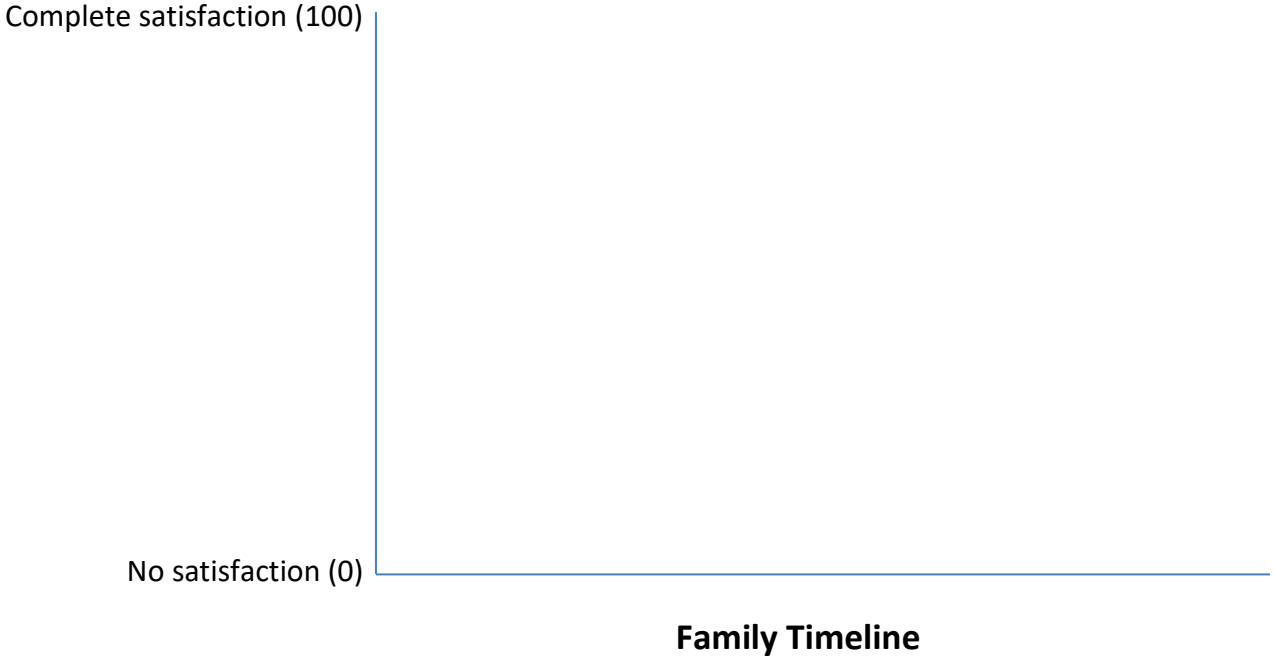
_____

_____

_____

_____

Finally, draw a graph indicating your level of family satisfaction from the start until now. Note any important events in your life (e.g., birth of a child, death of a family member, etc.).



Comments:

_____

_____

_____

OPIOID USE INTAKE FORM

Name: _____ DOB:_____

Address: _____Apt #: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____ VM message OK? Yes / No Preferred number? Yes / No

(_____)_____ VM message OK? Yes / No Preferred number? Yes / No

(_____)_____ VM message OK? Yes / No Preferred number? Yes / No

E-mail: _____

OK to contact you by e-mail? Yes / No
*Please note e-mail correspondence may not be encrypted and may not be confidential. _____ (*please initial*)

How do you identify your ethnicity? African-American Asian Caucasian Latino

Pacific Islander Bi-racial Multi-racial Other: _____

Insurance Carrier: _____ Policy #: _____

Person financially responsible for your treatment (*if other than you*)

Name: _____

Relationship to you: _____

Address: _____Apt #: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____

E-mail: _____

Emergency Contact: _____

Relationship to you _____

Phone: (_____)_____

Primary care physician: _____

Phone: (_____)_____ Referred? Yes / No

Approximate date of most recent lab work: _____

Where: _____

Psychiatrist: _____

Phone: (_____)_____ Referred? Yes / No

Therapist/Counselor: _____

Phone: (_____)_____ Referred? Yes / No

Name of referring person, if not above: _____

Phone: (_____)_____

Opioid Use History

When was the first time you used an opioid (heroin or painkiller)? _____

Name of drug: _____

☐ Oral (*by mouth*) ☐ Snorted ☐ Smoked ☐ Injected

Prescribed by a physician? Yes / No If yes, did you use as directed? Yes / No

If no, please explain: _____

Have you used other types of opioid drugs? Yes / No

If yes, please list them: _____

When did you begin using an opioid every day? _____

When did you first became dependent, or get sick if you did not use regularly? _____

_____

Have you ever injected opioids or other drugs? Yes / No

Have you had any periods when you did not use opioids? Yes / No

If yes, approximate dates when you were opioid free: _____

How did you stop? ☐ on your own ☐ with outpatient treatment, therapy, or a self-help group

☐ live-in program or detox ☐ methadone ☐ buprenorphine (Suboxone) ☐ incarcerated

☐ on parole, probation ☐ Other (*explain*): _____

Please complete this chart for all opiates you have used.

Name of drug	**Route(s) of use** **oral, snort, smoke, inject**	**How much used**	**Dates used**	**Prescribed?** **Yes / No**	**Used in past 30 days?** **Yes / No**

Opioid Dependence Treatment History

Dates	**Type of treatment** **methadone, buprenorphine, counseling, residential, other**	**Where did you receive treatment?**	**Why did you leave treatment?**	**How long did you remain drug-free after you left treatment?**

Current Use

Current opioid(s) used: _____

☐ Oral (*by mouth*) ☐ Snort ☐ Smoke ☐ Inject

How much do you use every day? _____

How many times a day do you use? _____

When did you last use? Date: _____ Amount: _____

Are you in withdrawal now? Yes / No

If yes, what withdrawal symptoms do you have? Check the symptoms.

( ) general discomfort	( ) diarrhea	( ) headache
( ) hot / cold	( ) runny nose	( ) weakness
( ) sweats	( ) watery eyes	( ) anxiety, irritability
( ) goosebumps	( ) sneezing	( ) restlessness, agitation
( ) stomachache	( ) yawning	( ) tremors, shakes
( ) nausea	( ) muscle aches, cramps	( ) sleep problems
( ) vomiting	( ) bone, joint aches	( ) cravings
( ) other:	( ) other:	( ) other:

If 1 means "I feel fine" and 10 means "I have the worst withdrawal ever," rate how you feel right now on a scale of 1 – 10 (*circle a number*):

1 2 3 4 5 6 7 8 9 10

I'm fine A little sick Moderately sick Very sick Worst ever

Other Substance Use History

Check the appropriate boxes on the following chart.

	No (Never used)	**If yes, age at first use**	**How did you take it?**	**How much?**	**How often?**	**Date of last use**	**Quantity last used**
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							

Inhalants							
LSD or Hallucinogens							
Marijuana							
PCP							
Stimulants (pills)							
Sedatives or Sleeping Pills							
Ecstasy							
Chewing tobacco							
Cigarettes							
Cigars							
Other:							
Other:							

Comments (*inpatient, detox, rehabilitation centers, outpatient IOPs, etc*.):

_____

_____

_____

Current or Past Medical Conditions (*check all that apply*)

( ) high blood pressure	( ) stroke, neurologic disorder	( ) thyroid problems
( ) diabetes	( ) stomach, intestinal problems	( ) arthritis
( ) heart disease	( ) pancreas problems	( ) chronic pain
( ) high cholesterol, lipid disorder	( ) kidney problems	( ) cancer Type:
( ) seizure disorder, epilepsy	( ) lung disease (asthma, COPD)	( ) nutritional problems

Hepatitis: Have you ever been tested for **Hepatitis C**? Yes / No When? _____
Result: _____

Have you ever had **Hepatitis A**? Yes / No When? _____

Have you ever had **Hepatitis B**? Yes / No When? _____

Have you been vaccinated against Hepatitis A or Hepatitis B? Yes / No

When? _____

HIV: Have you been tested for HIV? Yes / No When was your last test? _____
Result: _____

TB: When was your last TB skin test? _____

Have you ever tested positive for TB? Yes / No If yes, when? _____

STDs: □ Syphilis □ Gonorrhea □ Herpes □ Chlamydia □ Other: _____

Do you use condoms? Yes / No

Do you have tattoos? Yes / No

Do you have body piercings? Yes / No

Have you ever had surgery or been hospitalized overnight? Yes / No
If yes, please describe and list dates:

_____

_____

_____

Have you ever experienced physical trauma, such as bone fractures or accidents? Yes / No
If yes, please describe and list dates:

_____

_____

_____

To your knowledge, have you had all required and recommended vaccinations? Yes / No

Please list any allergies you have (*medications, bees, peanuts, environmental*):

_____

_____

_____

Current prescribed medications (*list medication, dose, and frequency*):

_____

_____

_____

_____

_____

_____

Describe any medical, psychiatric, or drug and alcohol use that runs in your family.

_____

_____

_____

_____

_____

_____

Women's Reproductive History

Have you ever been pregnant? Yes / No If yes, how many children have you had? _____

Their ages: _____

Have you had any miscarriages? Yes / No If yes, how many? _____

Have you had any abortions? Yes / No If yes, how many? _____

Date of last menstrual period: _____

Date of last gynecological exam: _____

Date of last mammogram: _____

Do you use birth control now? Yes / No If yes, what kind? _____

Comments: _____

_____

Male Reproductive History

Do you have children? Yes / No If yes, how many children have you had? _____

Their ages: _____

Do you use birth control? Yes / No If yes, what kind? _____

Comments:

_____

_____

Psychiatric History

Have you ever been diagnosed or treated for any psychiatric disorder? If yes, check off and explain.

☐ Depression _____

☐ Anxiety _____

☐ Bipolar Disorder

_____

☐ Schizophrenia _____

☐ ADHD _____

☐ Schizoaffective disorder _____

☐ Eating disorder_____

☐ Cutting/self-mutilation _____

☐ Learning disability _____

☐ Personality disorder_____

☐ Ever thought about hurting yourself? Yes / No

☐ Ever tried to hurt yourself? Yes / No When? _____

☐ Other: _____

If you have never been diagnosed or treated for any of the above, do you think you may have a diagnosis?

Yes / No Explain: _____

Current prescribed psychiatric medications (*include name, dose, how often you take it*):

_____

_____

_____

_____

_____

_____

List any previously prescribed psychiatric medications:

_____

_____

_____

List any prior hospitalizations for psychiatric conditions:

_____

_____

_____

Recent Stressful Events

- □ married
- □ engaged
- □ separated
- □ divorced
- □ breakup of important relationship
- □ legal problems
- □ personal injury or illness
- □ difficulties or changes at school or work
- □ moved or changed residence
- □ pregnancy
- □ birth of child
- □ child left home
- □ death of a loved one
- □ loved one's medical problems
- □ behavior problems in family member
- □ sexual problems
- □ retired or lost job
- □ foreclosure

□ financial problems □ other: _____

Notes: _____

_____

What are your goals and expectations for treatment/services?

_____

_____

_____

_____

_____

_____

_____

Any other information you would like to share?

_____

_____

_____

_____

_____

_____

Signature: _____

Print name: _____

Date: _____

NEW CLIENT BASIC INFORMATION

Legal Name: _____

Preferred Name: _____

Date of Birth: _____

Mailing Address: _____

_____

Do we have your permission to send you mail for administrative purposes only, which may include Protected Health Information (PHI), such as your name or your receipts for therapy sessions? Yes / No

Primary Phone Number: _____

(*circle one*): Home Cell Work Other: _____

Can we call you, and receive calls from you, at this number? Yes / No

Do we have your permission to leave you a message to schedule an appointment that may include PHI, such as your name, our name/practice, and reason for the call? Yes / No

Alternate Phone Number: _____

(*circle one*): Home Cell Work Other: _____

Can we call you, and receive calls from you, at this number? Yes / No

Do we have your permission to leave you a message to schedule an appointment that may include PHI, such as your name, our name/practice, and reason for the call? Yes / No

Email Address: _____

Do we have your permission to send you emails, or respond to emails from you, for the purpose of scheduling appointments, which may include PHI such as your name, our name, or therapy session dates? Yes / No

Emergency Contact Information:

Name: _____

Relationship: _____ Phone: _____

Name: _____

Relationship: _____ Phone: _____

EMERGENCY CONTACT FORM

Name: _____

Home Phone: _____

Cell Phone: _____

Home Address: _____

_____

Email Address: _____

Primary Emergency Contact Name: _____

Relationship: _____

Phone Numbers

Home: _____

Cell: _____

Work: _____

Secondary Emergency Contact Name: _____

Relationship: _____

Phone Numbers

Home: _____

Cell: _____

Work: _____

Preferred Local Hospital: _____

Comments or instructions (*including any special medical or personal information you would want an emergency care provider to know*):

_____

_____

_____

_____

_____

_____

INITIAL SESSION SOLUTION-FOCUSED QUESTIONS

Virtually all psychotherapists use the first session of therapy to begin creating a "therapeutic alliance," the beginning of a positive bond with a client. Therapists create this alliance by being attuned to the client's presenting needs, being open and curious, and setting a positive and realistic framework for what will happen during the therapeutic process. However, many therapists feel the first session can go far beyond this initial positive connection. With the current emphasis on short-term therapy, many therapists are also using the first session to "jump start" the therapeutic process. Solution-Focused Brief Therapy (SBFT), developed by de Shazer and Berg at the Milwaukee Brief Therapy Center (De Shazer, et al., 1986), has specific guiding questions to address a client's presenting problem in the first session.

Solution-Focused Therapy has a very specific format for asking questions that keep the client focused on the present and the future. Questions about the past are primarily a means of gathering information about the client and showing the therapist's empathy. Solution-focused questions are intended to:

- help clients define problems.
- help clients identify strategies that have worked in the past for the same or similar problems.
- rate different aspects of the client's experience on a 1 to 10 scale.
- look for exceptions to problems (for example, times when the client might have expected the problem to occur, but something else happened instead).
- encourage clients to do more of what is working.
- provide questions that remind clients about the positive ways they are dealing with problems.

The most well-known solution-focused technique is the Miracle Question. Although there are various nuances of the Miracle Question, the general idea is to ask the client, "How will your life be different if a miracle occurs, and the problem that brought you into therapy no longer exists?" The Miracle Question is a way of generating ideas for small, realistic steps the client can take immediately.

This form is designed to be used as a guide. Solution-Focused Therapy, like any form of psychotherapy, relies on a deep understanding and connection with the client, and the timing and wording of the questions is more important than the questions themselves. While this form is a guide for the first therapy session, the questions may be asked over several sessions or even over the entire course of therapy. For more information about Solution-Focused Brief Therapy, visit The Institute for Solution Focused Therapy: https://solutionfocused.net/

Note: It is important to get an idea of the problem in behavioral terms.

What do you want to get out of being here today?

_____

_____

_____

What changes have you made prior to coming to therapy?

_____

_____

_____

How would you define the problem for which you are seeking help?

_____

_____

_____

How often does this problem affect you?

_____

_____

_____

How long has it been going on?

_____

_____

_____

How have you dealt with it in the past?

_____

_____

_____

What is said or done when this problem occurs?

_____

_____

_____

What happens next?

_____

_____

_____

And then what?

_____

_____

_____

Note: If these questions don't give you a clear idea of the problem, you can ask something like: "If you made a video of ... happening, what would I see on the tape?"

_____

_____

_____

How have you tried to address this problem?

_____

_____

_____

What has worked, even a little bit?

_____

_____

_____

Have there been changes for better or worse since you decided to take action?

_____

_____

_____

Who else noticed this?

_____

_____

_____

What will it be like when the problem is solved?

_____

_____

_____

What will you be doing instead?

_____

_____

_____

When that happens, what difference will it make?

_____

_____

_____

How will other people know that things are better?

_____

_____

_____

Who will notice first?

_____

_____

And then who?

_____

_____

What else will be different?

_____

_____

_____

Tell me about times when the problem is not occurring or when it is not really affecting you very much.

_____

_____

_____

Is there something that makes the problem better at certain times?

_____

_____

_____

What are you doing differently at these times?

_____

_____

_____

What else is better at these times?

_____

_____

_____

Note: Focus on what the client is doing, rather than what they are *not* doing.

On a scale from 0 to 10, with 10 being the best, tell me how you felt when things were at their worst. _____

Where are you on that scale right now? _____

Tell me what was going on with you when you felt like a 10.

_____

_____

_____

Therapy can help you with your problem, but maybe a "10" is too big a goal. What number will be acceptable for you? _____

How will you recognize when you are one point further up the scale?

_____

_____

_____

What else will be different when you are one point further up?

_____

_____

_____

How long will it take to get one point up the scale? _____

How will you get through the rest of the day?

_____

_____

_____

How have you kept going so far?

_____

_____

_____

What else helps?

_____

_____

_____

Is there anyone else who helps you with this problem?

_____

_____

_____

Anyone else?

_____

_____

_____

How do these people help you with the problem?

_____

_____

_____

INITIAL SESSION CHECKLIST

Introductory information

_____ Obtain client's contact information

_____ Obtain client's emergency contact information

_____ Provide client with a summary of your treatment methods and your background

Office policies

_____ Explain your practice's privacy and confidentiality policies

_____ Ask client to read and sign a HIPAA compliance statement

_____ Explain your fees and methods of collecting payment

_____ If requested, give your client an application for reduced fees

_____ If appropriate, give your client a written copy of your sliding scale

_____ If you accept insurance, discuss the requirements of your client's plan

_____ Discuss your appointment and cancellation policies

_____ Other policy: _____

_____ Other policy: _____

Explanation of clinical process

_____ Give your client an overview of what to expect in therapy

_____ Discuss the estimated length of therapy

_____ Discuss therapy methods and techniques

_____ Discuss use of homework assignments

Intake

_____ Personal history

_____ Symptoms checklist

_____ Presenting problems

_____ Medical history and medications

_____ Previous therapy experience

_____ Goals and expectations for therapy (e.g., anticipated outcomes)

_____ Explanation of how you will develop treatment plan

_____ Client questions or concerns

Section 2. Permissions, Policies, and Agreements

AUTHORIZATION FOR APPOINTMENT REMINDERS

_____ {*name of clinic/practitioner*} offers the option to receive an appointment reminder ____ hours or ____ day before your scheduled appointment by email and/or by phone. If you choose the reminder by phone, you have the option of a text message or a computer-generated voice message.

Please select ONE of the following options:

☐ **Phone Reminder** (*choose one*):

☐ **Text Message.** I authorize _____ {*name of clinic/practitioner*} to send text message appointment reminders to me on my cell phone number. Text message charges from my cell phone provider may apply. Example of text message: "*Do not reply – reminder – You have an appointment MON 01/11 at 4:00 PM. If you have any questions, please call us at ( ) _____ {phone number} – Thank you,* _____ {*name of counselor}"*

Cell phone number to send text messages to: ( ) _____

☐ **Automated Voice Messages**. I authorize _____ {*name of clinic/practitioner*} to send computer-generated voice phone message appointment reminders to me on my provided phone number. Example of message: *"Hello. This is a reminder of your appointment on Monday, January 11, scheduled for 4 PM with _____ {name of counselor}. If you need to reschedule or have any questions, feel free to call us at ( ) _____ {phone number}. Once again, your appointment is scheduled for Monday, January 11, at 4 PM with* _____ {*name of counselor}. Thank you."*

Phone number for the automated system to call: ( ) _____

☐ **Email message**: I authorize _____ {*name of clinic/practitioner*} to send email message appointment reminders to me on my provided email address. Example of email message from _____@_____.com. "*This is a reminder of your appointment on Monday, 01/11/2022, scheduled for 4:00 PM with* _____ {*name of clinic/practitioner*}*. If you have any questions regarding your appointment, please feel free to contact us at ( ) _____ {phone number}. Thank you."*

Email address to send reminder messages: _____

☐ **None of the above:** I will remember my appointments on my own.

I understand that late cancellation and no-show appointment fees will apply if I cancel my appointment with less than ____ hours' notice.

Appointment information is "Protected Health Information" under HIPAA. By signing, I give my permission to receive appointment reminders as selected. My signature indicates that I am the person legally responsible for all use of the accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services if applicable. I understand that this authorization can only be revoked in writing.

Printed name: _____

Signature: _____

Date: _____

INFORMED CONSENT FORM FOR OUTPATIENT SERVICES

This contract is not a substitute for the HIPAA Notice of Privacy Practices or other required HIPAA documentation. Additionally, since regulations and laws governing institutions are somewhat different from private practitioners, this form may need modification.

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and write down any questions you have so we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

There are different methods I may use to deal with the problems you wish to address. For therapy to be most successful, you will be expected to work on things discussed during our sessions while you are at home, including homework assignments. Because therapy often involves discussing unpleasant aspects of your life, you may experience feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy often leads to improved relationships, problem-solving, and significant reduction in distress.

Our first few sessions will involve an evaluation of your needs. I will be able to offer you some suggestions of what our work will include and a treatment plan if you decide to continue with therapy. You should consider this information, along with your comfort level of working with me. If either of us feels that I am not the right therapist for you, I will provide referrals to other practitioners better suited to help you.

Therapy involves a commitment of time, money, and energy, so it is important to find the right fit. If you have questions about my therapeutic style, I encourage you to discuss them whenever they arise.

MEETINGS

I normally conduct an evaluation that will last from ___ to ___ sessions. During this time, we can decide together if I am the best person to provide the services you need to meet your treatment goals. If we agree to begin psychotherapy, I usually schedule one ____-minute session per week, at a time we will agree on together, although some sessions may be more frequent.

Once an appointment is scheduled, you will be expected to pay for it unless you provide ____ hours' advance notice of cancellation. An exception is if we both agree that you were unable to attend due to circumstances beyond your control, in which case I will find another time to reschedule the appointment.

PROFESSIONAL FEES

My hourly fee is $_____. If we meet more than the usual time, I will charge accordingly. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. (*Other professional services may include report writing, telephone conversations lasting longer than ____ minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me*).

If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. I charge $____ per hour for professional services that I am asked or required to perform related to your legal matter. I also charge a copying fee of $____ per page for records requests.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I will release regarding a client's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will complete forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

If you have questions about your insurance coverage for mental health services, call your plan administrator. Of course, I will be happy to help you understand the information you receive from your insurance company and, if necessary, I can contact the insurance company on your behalf to obtain clarification.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans often require authorization before they provide reimbursement for mental health services.

These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. Please note, some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will try to assist you in finding another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I must provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit if you request it. You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.

Once we have all the information about your insurance coverage, we can discuss what we can expect to accomplish with the benefits that are available, and what will happen if your benefits run out before you feel ready to end our sessions.

CONTACTING ME

I am often not immediately available by telephone. Though I am usually in my office between ____ AM and ____ PM, I will not answer the phone when I am with a client. I do have call-in hours at _____ on _____. When I am unavailable, my telephone is answered by my [*answering service/answering machine/voice mail/administrative assistant*] that I monitor frequently/who knows where to reach me. I will make every effort to return your call on the same day you make it, except for weekends and holidays.

If you are difficult to reach because of your schedule, please inform me of times you will be available. **If you are unable to reach me and feel that it is an emergency, call 9-1-1 or go to the nearest emergency room.** If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence, if necessary.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. A judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order. There are some situations in which I am legally obligated to take action to protect others from harm, even if I must reveal some

information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused or has been abused, I must make a report to the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice that I am unable to provide, formal legal advice may be needed. The laws governing confidentiality are quite complex, and I am not an attorney. If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client Signature: _____ Date: _____

Client Printed Name: _____

INFORMED CONSENT FOR GROUP THERAPY SERVICES

_____ (*therapist/practice name*) is committed to providing quality individualized services, and this consent addresses important information about service procedures and client rights in a group setting. A mental health provider will explain this information to you during your initial visit. It is important for you to understand the policy and treatment information described below prior to the start of your group therapy sessions.

PSYCHOLOGICAL SERVICES

Group therapy can help individuals develop skills to enhance interpersonal relationships, behavior, emotional and mental health, coping skills, and self-awareness. It is designed so group members can communicate and share experiences, allowing for the development of trust. The group therapy process might stimulate some uncomfortable feelings and emotions. Participation does not guarantee problem resolution. As with all medical and psychological treatments, there are benefits and risks. If you have any questions, please ask your therapist any time during the therapy process.

APPOINTMENTS

Group sessions run from _____ (*date*) to _____ (*date*) on _____ (*day of week*) at _____ (*time*) for _____ minutes.
Due to the importance of each member in the group dynamic, it is important for each participant to commit to the time periods identified above. If you will have difficulty attending all sessions or need a modified schedule, please talk to the therapist. Please be punctual. Each group has an allotted scheduled time. Tardiness may disrupt the start of the session, which will still conclude at the originally scheduled time.

PROFESSIONAL FEES

_____ (*name of therapist/practice*) charges $_____ fee for each group session. Exceptions to standard charges may be discussed and agreed upon by _____ (*name of client*) and _____ (*name of therapist/practice*).
_____ (*name of therapist/practice*) does not accept health insurance/accepts the following health insurance: _____.

It is important for you to be aware that your health insurance may not cover the cost of services. You are responsible for knowing your health insurance plan. The therapist/practice's billing department will assist you if necessary. If your health insurance policy covers the costs of mental health treatments and you choose to use your health insurance policy, the insurance group may require your therapist/the practice to share your medical records and diagnoses for their records. Some health insurance companies require authorization for treatment. If authorization is denied, the patient is responsible for fees accrued.
Under the circumstances that _____ (*name of therapist/practice*) does not accept your health insurance, your therapist/the practice will

supply you a receipt of payment for services. You can submit this receipt to your insurance company for reimbursement.

Payment must be made by **check**, **cash**, and/or **credit**. Your fee or co-pay is due at the time services are provided. The client is responsible for all fees. This includes any fees denied by insurance providers. Fees must be paid within 30 days after the date the claim is denied.

Returned checks will result in an additional service fee of $_____.

CONFIDENTIALITY

_____ (*name of therapist/practice*) is committed to following the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights regarding the use and disclosure of Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. All information, discussions, and documents are confidential and privileged information for all clients. Under federal law, disclosure of information regarding services provided and information about a client requires written consent to release to alternate or third parties.

The following are exceptions to the rules of confidentiality:

1. When there is imminent danger to the client or another person.
2. Under circumstances of suspected child, elder, or dependent adult abuse or neglect.
3. When disclosure must be made to medical professionals in the case of a medical emergency.
4. When the mental health professional is compelled by law to disclose client records.

_____ (*name of therapist/practice*) is a professional setting of mental health professionals. Your therapist might consult with colleagues/mental health professionals about your case. Your name will not be disclosed, and your identity will be kept disguised. Consults will only be used for the betterment of your treatment.

The therapist will adhere to the ethical and legal requirements of confidentiality. Each member of the group is required to sign a confidentiality agreement; however, the therapist cannot ensure that you or members of the group will maintain the same level of confidentiality about your group interactions.

PROFESSIONAL RECORDS

Service providers are required, by law, to keep medical records of psychological services provided. All records will be secured in a locked location following Health Insurance Portability and Accountability Act (HIPAA) standards. Records include, but are not limited to, documentation of attendance; purpose of treatment; any medical, social, and treatment history; evaluations and diagnosis; anecdotal notes of topics and discussions; copies of legal forms and consents; documents and copies of any forms or information shared with other professionals; and information provided by other professionals.

_____ (*name of therapist/practice*) utilizes health information technology (Health IT), which involves the storage and exchange of health information in an electronic environment. We are committed to upholding privacy and security standards for the protection of electronic health information standardized by HIPAA. The Security Rule requires covered entities to maintain reasonable and appropriate administrative, technical, and physical safeguards for protecting electronic protected health information (e-PHI). The therapist/practice is committed to ensuring the confidentiality and integrity of all e-PHI created, received, stored, or transmitted. This includes protecting client information from potential security threats, maintaining privacy disclosure statements, and using only authorized technical devices with security systems.

Patients have a right to copies of their files and to access copies of their files for other health care providers with a written request. These are professional records and there is a possibility they may be misinterpreted and/or upsetting to untrained readers. Your therapist/the practice recommends you review the documents with your therapist or have them forwarded to another mental health professional for initial viewing.

It is the right of the mental health professional to refuse access to your files if access to the documents may prove to be harmful to you. If your therapist/the practice refuses your request for access to your records, your rights will be discussed with you.

CLINIC HOURS

_____ (*name of therapist/practice*)'s regular office hours are from: _____ (*time*) to _____ (*time*), _____ (*day*) through _____ (*day*). If you would like to make additional appointments, please call the clinic during clinic hours. Appointments during off-clinic hours may be arranged with agreement from your therapist.

This clinic does not provide emergency services. Please call _____ if you would like to schedule an appointment as soon as possible. **If you have an immediate emergency, call 911 or go to the nearest emergency room.**

PATIENT RIGHTS

You have the right to considerate, safe, and respectful care, in the absence of discrimination regarding race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy, therapist training, and therapist experience. You have the right to communicate your therapeutic needs if you feel dissatisfied or feel like any of the above-mentioned rights have been violated in any manner. You have the right to request a change in service providers. In this case, your current service provider will assist in providing the necessary information to the new service provider with written consent by the patient.

TERMINATION OF TREATMENT

The therapist has the right to terminate treatment at any time due to lack of payment, prescriptions not filled, or a development occurring outside the scope of the therapist's area of

competence. In the case of termination, the therapist will support a transition to provider of continued care as needed.

Therapeutic counseling can result in changes in relationships, emotional state, and behavioral patterns. There are circumstances that result in a lack of improvement. Under circumstances of extreme discomfort and emotional pain, the client has the right to terminate or discontinue services.

CONSENT TO PSYCHOTHERAPY

I voluntarily agree to receive group therapy with _____ (*name of therapist/practice*). I understand I have the right to terminate such care and services that I receive from the undersigned therapist at any time.

My signature affirms that I have read and communicated the above information to my mental health service provider. The information presented is understood and enables me to make an educated, voluntary consent to treatment.

Group Name: _____

Meeting Times: _____

_____

Printed Name of Patient

_____ _____

Signature of Patient Date

_____

Printed Name of Therapist

_____ _____

Signature of Therapist Date

PERMISSION TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION

Name of Client: _____
Date of Birth: ____/____/____

I hereby give consent to _____ (*name of therapist or practice*) to exchange pertinent and relevant information with the individual/agency identified below.

Name: _____

Agency: _____

Street: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Email: _____

Information obtained may include (*check all that apply*):

____ Clinical impressions and records

____ Academic records (cumulative records, report cards, standardized test scores, etc.)

____ Health records

____ Special education records (504 plan/IEP/PPT/team minutes, evaluations)

____ Psychiatric evaluations

____ Psychological evaluations

____ Social work evaluations

____ Educational evaluations

____ Speech and language evaluations

____ Other evaluations (vocational, occupational, etc.): _____

____ Other: _____

Client or Parent/Guardian Signature: _____

Print Name: _____

Relationship to Client: _____

Date: _____

PARENTAL CONSENT FOR TREATMENT OF MINORS

Note to clinician: The sample language below relates to working with children and teens in individual treatment. It is recommended that clinicians meet first with the parents/guardians, and then with the children or teens, as appropriate to their developmental level. This will assist discussions with the child regarding confidentiality, information sharing, and records access. It also provides an opportunity for the clinician to decide whether to continue with the child's intake and treatment, based on the parents' responses to the contract.

Parent Authorization for Minor's Mental Health Treatment

To authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from your child's other parent, I will ask you to provide documentation that establishes custody rights or otherwise shows that you have the right to authorize treatment.

If you are separated or divorced from your child's other parent, it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents know their child is receiving mental health treatment.

During your child's therapy, there may be disagreement among the parents and/or disagreement between the parents and myself regarding treatment. In such instances, I will make every effort to understand your perspectives and explain mine. Ultimately, parents have the final decision about continuing their child's therapy. However, I may request a few closing sessions with your child to end our relationship appropriately.

Individual Parent/Guardian Communication with Me

During your child's treatment, I may meet with the parents/guardians separately or together. If I meet with you or other family members, I will include notes in your child's treatment records that will be available to any person or entity with legal access to that record.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether I have your or your child's permission. Confidentiality cannot be maintained in the following situations:

- Your child reveals a plan to cause serious harm or death to him/herself, and I believe the child has the intent and ability to carry out this threat in the very near future. I must inform a parent/guardian or others what the child has told me, how serious I believe this threat to be, and try to prevent the occurrence of such harm.
- Your child reveals a plan to cause serious harm or death to someone else, and I believe the child has the intent and ability to carry out this threat in the very near future. I must inform a parent/guardian or others. I also may be required to inform the person who is the target of the threatened harm, and the police.

- Your child is doing things that could cause serious harm to him/herself or to someone else, even if there is no intention to harm. I will need to use my professional judgment to decide whether a parent/guardian should be informed.
- Your child tells me, or I otherwise learn that he/she is being neglected or abused — physically, sexually, or emotionally — or has experienced neglect or abuse in the past. I am required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when there is trust between the practitioner and the patient, and honoring privacy can help earn and maintain trust. It is important for children to have a "privacy zone" to discuss their personal matters without their thoughts and feelings being reported to their parents. This is particularly true for teens, as they develop independence and autonomy.

I will provide you with general information about your child's treatment, but I will not share specifics that your child has disclosed without your child's permission. This may include activities and behaviors of which you disapprove but do not put your child at risk of serious or immediate harm. However, if your child engages in risk-taking behavior that I feel puts your child in danger, I will inform you.

For example, if your child tells me about drinking alcohol at a few parties, I will keep this information confidential. However, if you child tells me about instances involving drinking and driving, I would inform you. You can also ask me about the type of information I would disclose, using hypothetical situations. *("If a child told you that he was doing _____, would you inform the parents?")*

There may be times when it is important for you to know about a situation in your child's life. In these instances, I will encourage your child to share that information with you, and I will help your child find the best way to do this.

Disclosure of Minor's Treatment Records to Parents

The laws of [*this State*] may give parents the right to see any written records I keep about your child's treatment. However, by signing this agreement, you agree that your child should have a "privacy zone" in meetings with me, and you agree not to request access to your child's written treatment records unless circumstances require it.

[*IF APPLICABLE* **Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation]**

When a family is in conflict due to parental separation or divorce, it is especially difficult for children. Although my sessions with your child may include discussing conflicts between the parents, my role is strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me

to testify in court, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note this agreement may not prevent a judge from requiring my testimony, which I will do only if legally required to testify. I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, but I will not make any recommendation about the final decision(s).

Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, I will be reimbursed at the rate of $_____ per hour for time spent traveling, speaking with attorneys, reviewing, and preparing documents, testifying, being in attendance, and any other case-related costs.

Consent for Treatment

Child/Adolescent Client:

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature _____ Date_____

Parent/Guardian of Minor Client:

Initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will receive periodic updates about his/her general progress and may be asked to participate in therapy sessions. _____ _____

Since my child is a minor, I have the legal right to request written records and session notes. However, I agree not to request these records to respect the confidentiality of my child's/adolescent's treatment. _____ _____

I understand that I will be informed about situations that could endanger my child. I know the decision to breach confidentiality in such circumstances is up to the therapist's professional judgment, unless otherwise noted above. _____ _____

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

CHILD AND ADOLESCENT COUNSELING AGREEMENT

This agreement is between_____ (*child/teen name*) and _____ (*therapist/counselor name*).

I agree to meet with _____ (*therapist/counselor name*). We will usually meet once a week, and our meetings will last about ____ minutes. When we meet, we will talk, play games, or do other things to help my counselor get to know me better and understand my problems, strengths, and goals.

My counselor might talk with my parent/guardian to discuss how I am doing. They might also talk about concerns and worries they have. Or they might talk about things my counselor and I decide my parent/guardian needs to know. Sometimes my counselor will meet with my parent/guardian without me. At other times, we will all meet together.

The things I talk about in my meetings with my counselor are private. My counselor will not tell others about the specific things I say, and he/she will not repeat these things to my parent/guardian, my teachers, or the police. But there are two exceptions. First, because of the law, my counselor will tell others what I have said if I talk about seriously hurting myself or someone else. My counselor will have to tell someone who can help protect me or the person I have talked about hurting. Second, if I am being seriously hurt by anyone, my counselor must tell someone for my protection. I understand:

- Sometimes I might not feel good about some things we talk about.
- I may feel uncomfortable or embarrassed talking about myself.
- Some of the things we talk about might make me feel angry or sad.
- Coming to meetings might interfere with doing other things I enjoy more.
- I may find I can talk about things with my counselor that I can't talk about to anyone else.
- I may learn some new, important, and helpful things about myself and others.
- I may learn some new and better ways of handling my feelings and problems.
- Any time I have questions, or I'm worried about things that are happening, I know I can ask my counselor. He/she will try to explain things to me in a way that I can understand.
- If my parent/guardian has any questions, my counselor will try to answer them.
- My parent/guardian has a right to know about how I am doing in therapy.
- My parent/guardian can stop counseling if he/she thinks that is best. If I decide therapy is not helping me and I want to stop, my counselor will discuss this with me and with my parent/guardian. The final decision about stopping is up to my parent/guardian.

My signature below means that I read this agreement, or had it read to me. I understand what this agreement says and agree to act according to it.

Name of Child/Teen: _____Date: _____

Signature of Child/Teen: _____

PERMISSION TO SEND MAIL TO CLIENTS

Note to therapist: From time to time, you may find it necessary to send regular mail to a client's home address. If that mail identifies you as the client's therapist, you should keep your client's confidentially in mind.

You can raise the issue of whether the client wishes to receive mail from you during the initial session, or when the need comes up. However, there are situations when your office may need to contact your clients by mail without your involvement (for example, if you have a serious illness or are otherwise unable to perform your normal duties).

This form can be modified to suit your individual needs without further permission.

PERMISSION TO SEND MAIL

It may occasionally be useful or necessary for your therapist to send you information by mail. If you believe this will compromise your privacy or safety, you have the right to deny permission and request an alternate form of communication, such as phone contact. If your circumstances change, you can withdraw your permission to receive mail at any time.

I give permission for _____ (*name of therapist or practice*) to send written communication to my home address via mail. I understand that I may withdraw this permission at any time.

_____ _____

Signature Date

Print name: _____

You may prefer to have mail sent to an alternate address instead, such as your business address, a friend's home, or a mailbox service. If so, please complete the following section:

I give permission for _____ (*name of therapist or practice*) to send written information to the alternate address below, instead of my home address. I understand I may withdraw this permission at any time.

_____ _____

Signature Date

Print name: _____

Name of business or name of person mail should be sent "in care of," if any:

_____

Street Address, including apartment or suite number:

_____

City, State, Zip Code:

_____

Should your name appear in the address? Yes / No

TREATMENT BY INTERN INFORMED CONSENT AND RELEASE

I understand that my child, my family, and/or myself will be receiving therapeutic services from a student intern who is under the supervision of _____ (*supervisor name*), _____ (*credentials*), at _____ (*clinic/agency name*). This student intern has completed the required education and competencies necessary to be deemed ready to apply their clinical skills to working with clients. The intern receives ongoing guidance, evaluation, and education in providing excellence in clinical skills to you and/or your family members. By working with a student intern, you receive the benefits of a clinically experienced supervision team assisting in assessment and treatment planning to address your concerns in therapy.

To provide you the best care, we require our student interns to record client sessions for use in supervision. To ensure your privacy, all photographs, video, and audio recordings must be stored on a password-protected device or in a locked file, with digital materials destroyed upon termination of therapy.

Your signature confirms your informed consent to receiving therapy services from a student intern under supervision and your informed consent to video and/or audio recordings of therapy sessions and photographs of artwork and play creations to be used for the purpose of providing supervision on your case. You further agree that video and/or audio recordings may not be used for any other purposes than those explicitly stated in this document.

You may terminate this agreement in writing at any time by mailing your written request to: _____. However, termination of this agreement will require transfer to another provider, as interns cannot be adequately supervised in cases that do not consent to recording. Clients ages 12 and up as well as a legal guardian who attests that they have the authority to consent for those under 18 must sign below to acknowledge their consent to treatment by an intern under supervision and the use of video and/or audio recordings of sessions and photographs of artwork and play creations in supervision of student intern. For divorced or separated parents who legally share custody, both parents must sign a copy of this document. For divorced parents or other legal guardians, the most recent copy of the custody agreement must be submitted with this document before therapy can begin.

Signature	Printed Name	Relationship to client	Date
Signature	Printed Name	Relationship to client	Date
Signature	Printed Name	Relationship to client	Date
Signature	Printed Name	Relationship to client	Date

Dialectical Behavior Therapy Client Agreement

I, _____ (*client name*), agree to the terms and conditions of Dialectical Behavior Therapy (DBT) as follows:

I. Basic Principles. Therapy is based on:

Mutual Trust. I trust that my therapist is committed to working with me and will be available per the terms and conditions of this agreement. Similarly, my therapist needs to trust that I will maintain my commitment to therapy. Each party is responsible for maintaining that trust.

Safety. I agree to commit to keeping myself and others safe. If there are concerns that I cannot maintain safety, my therapist and I will have a safety plan in place that outlines the steps I need to take to ensure safety. Harmful behaviors to myself or other people negatively impact my therapy goals. By agreeing to do my best to keep myself and others safe I will more likely apply the principles of DBT to my life. All participants in DBT are expected to act in a way that does not endanger their therapist, family members, or others (e.g., through threats or acts of violence against people or property). Such behavior may result in legal consequences or risk termination of therapy.

II. The Aim of This Agreement. Therapy is about learning skills that are likely to increase my ability to have a life that is worth living. Therapy is not about immediately "feeling better." In fact, DBT is about learning to be "better at feeling" some of my uncomfortable emotions to live a life that is worth living.

III. Target Behaviors.

1. **Eliminate behaviors that are harmful to self or others:** Reducing suicidal or self/other-harm behaviors are my primary therapy goal. I will work toward solving problems in ways that do not include intentional harm to self, others, attempts to die, or suicide.

2. **Eliminate therapy-interfering behaviors:** I agree to work on any problems that interfere with my therapeutic progress. I agree to give feedback to my therapist, especially if I am concerned about anything that occurs in therapy. Similarly, my therapist agrees to provide feedback on my progress.

3. **Reducing harmful behaviors:** This includes unhelpful behaviors that limit my progress. Problems linked to higher-priority targets or to my goals take precedence.

4. **Increase skills in the following areas:**

a. Mindfulness
b. Interpersonal effectiveness
c. Distress tolerance
d. Emotion regulation

IV. Timeframe. Therapy will begin on this date: _____ and will end on this date: _____. My therapist and I will occasionally review my progress, which may lead to refining or changing my targets and goals. At the end of this timeframe, the need for additional sessions will be discussed and may be implemented by mutual consent.

V. Frequency of Sessions. My therapist and I will meet weekly / bi-weekly / monthly (*circle one*) for _____ minutes. This might change depending on circumstances of either party and by mutual arrangement. When sessions are further apart than two weeks, it may be beneficial to schedule a longer session and, if possible or desirable, include phone, text, or email contact.

VI. Therapy Attendance. I agree to attend scheduled therapy sessions. It is not acceptable to miss sessions because I find them too uncomfortable, am not in the mood for therapy, wish to avoid certain topics, or feel hopeless.

VII. Cancelation Policy. I agree to do my best to give at least _____-hours-notice when unable to attend a scheduled session. Similarly, my therapist will give me at least _____-hours-notice if it has become necessary to reschedule a session. I agree to pay the missed session fee, if applicable: $_____ / missed session.

VIII. Homework Assignments. I agree to bring my completed homework assignments to each session because they will be an important part of in-session work.

IX. Termination of Therapy. If I miss _____ weeks of scheduled therapy in a row, therapy will be terminated.

X. Skills Training Agreement. Skills training is a central part of DBT. During therapy, I will be expected to participate in learning DBT skills through either group, family, or individual therapy sessions.

XI. Role of Therapist or Other Providers. This agreement neither replaces nor alters the roles of other providers. I understand DBT makes a distinction between the roles of my other providers and my therapist. I understand my therapist will seek consultation as needed.

I understand the goal of therapy is to no longer need therapy. Therefore, as I become more competent with my skills, and create a life worth living, this will result in a decrease in the need for therapy. Although my therapist and I will have developed a strong and positive therapeutic relationship, it is meant to be temporary.

Name: _____

Signature: _____ Date: _____

Dialectical Behavior Therapist's Agreement

I, _____ (*therapist name*), agree to make every reasonable effort to conduct the DBT program as competently as possible. This includes working within the limits of my scope of practice and abiding by the requirements of my profession's ethical code. My clients can expect me to make my best effort to be supportive, to help them gain insight and learn new skills, and to teach them the tools they need to deal more effectively with their problems.

I also make it clear that I cannot "save" clients, nor can I solve their problems or force them to cease self-harming behaviors.

Although I can help clients develop and practice new behaviors that may help them build a life worth living, I cannot build my clients' life for them. The analogy of therapist as guide is helpful: I can show someone the way, but I cannot walk the path for them.

Name: _____

Signature: _____ Date: _____

COUPLES THERAPY AGREEMENT

Date: _____

I requested to receive couples therapy for myself and my partner. In therapy, we may work on issues such as:

- Effective communication patterns
- Assertiveness skills
- Listening skills
- Acceptance of differences
- Anger management
- Problems that may be pertinent to our relationship
- (*other*): _____

I understand:

1. The focus of couples therapy is to learn new skills to work on relationship problems; however, it is not possible to guarantee any outcome.

2. Couples therapy may also involve talking about family history, important life events, past relationships, and any past or present emotional difficulties.

3. Couples therapy works best when communication is open and honest, and when individuals take responsibility for their own feelings and behaviors, rather than blaming a partner.

4. Everything discussed in-session is kept completely confidential by the therapist. It is recommended that issues discussed during sessions remain private between the couple, rather than discussed with family and friends.

5. If I am having any emotional problems, in addition to the issues we have come in for, the therapist may recommend other kinds of help for me.

I understand and accept the above purposes of Couples Therapy.

_____

Client's Signature

_____

Partner's Signature

_____

Therapist's Signature

DRUG TESTING CONSENT FORM

I authorize _____ (*therapist or practice name*) to take a urine sample for evidence of drug use.

I agree to be tested for:

_____ Marijuana ____ Opiates ____ Cocaine ____ Methamphetamines ____ Barbiturates

____ Other: _____

Please note: to provide the highest reliability of the test sample, a same-sex attendant will visually monitor the taking of the urine sample. Our office test results are highly dependable. However, due to the implications of a positive test, we recommend an independent re-evaluation when results of a test are positive. This step is a choice and is not mandatory.

I agree to the release of the drug test results to (*check as appropriate*):

_____ Client Only

_____ Parents - Name(s): _____

_____ Spouse - Name: _____

_____ Probation/Courts

_____ Social Services

_____Other (please specify): _____

_____

Signature of Client/Patient Date

_____

Print Name

_____

Signature of Parent/Guardian Date

_____

Print Name

This form will expire 90 days from the signed date, unless otherwise indicated.
Alternative Expiration Date: _____

CONSENT FOR TREATMENT USING EXPOSURE THERAPY

The purpose of this form is to request the client's consent for treatment through exposure therapy. By signing below, the client acknowledges that he/she has read the following information and grants consent to participate in exposure therapy with _____ (*name of therapist/practice*).

During exposure therapy, a client is exposed to the object or situation of his/her fears and anxiety to experience, and eventually manage, the emotional discomfort. All exposures are designed to be safe and non-threatening, and performed over time in a gradual, structured manner. The exposures are conducted in the presence of the therapist who helps the client work through the anxiety that arises while confronting those fears. The end goal is to help clients recognize that avoiding a feared situation only increases their anxiety, while confronting the situation actually reduces or eliminates the anxiety.

It is important to note that a client engaging in exposure therapy may experience uncomfortable feelings including sadness, anger, fear, helplessness, and stress. Additionally, _____ (*name of therapist/practice*) cannot guarantee specific outcomes of exposure therapy. If you have questions about exposure therapy, we encourage you to discuss them with your therapist.

The client understands that he/she is responsible for transportation to and from any site outside of the therapist's practice or client's home at which the exposure therapy will be conducted. _____ (*name of therapist/practice*) may not be held responsible for any loss, injury, damages, and/or death that occurs, to the fullest extent permitted by law, as a result of the client's travel to and from the site of the exposure therapy.

We will make every effort to ensure that your protected health information (PHI) is kept private. However, due to the nature of any exposure therapy taking place in public settings, a client's treatment may be performed in the presence of others, and his PHI may be incidentally disclosed to others.

Please initial to acknowledge that you understand and agree with these of these statements.

_____ I acknowledge that my therapist may ask me to engage in activities that I have been avoiding due to the sensations or fear they cause me.
_____I understand that I may experience anxiety, fear, or other overwhelming feelings, which is the purpose for this treatment. However, I will not be put in a situation against my will or exposed to objects or situations that endanger my health or safety.
_____Even though I can stop at any time, my therapist will encourage me to continue to experience my discomfort or fear, which is necessary for my symptoms to improve.
_____I understand that if I decide that I no longer want to engage in exposure therapy, I can revoke my consent at any time, and exposure therapy will be terminated immediately.

_____I understand that when sessions are held outside of the office, my therapist will provide the same level of care, with the same rights and protections.

_____If sessions are held outside the office, I consent to have my therapist be in public with me. I understand that confidentiality will be a priority, but that my PHI may be unintentionally disclosed.

_____ I acknowledge that I will use my insurance (personal, automobile, etc.) to place claims to cover any damages, or injury to self or others, that may occur before, during, or after the session.

_____I agree that _____ (*name of therapist/practice*) will not be held liable for all potential damages that may occur due to the actions of myself or others.

_____I understand and accept that I will be charged for my therapist's time, which includes any of his/her travel time.

I have read and agree to above and provide my agreement to participate in exposure therapy.

_____

Client Printed Name Date

_____

Client Signature

This form will expire 90 days from the signed date, unless otherwise indicated.
Alternative Expiration Date: _____

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION TO FAMILY MEMBERS

Name: _____

Date of birth: _____

I understand the release of treatment information and communication with important individuals in _____'s (*client's name*) life will be used for the sole purpose of improving treatment.

To further this goal, I authorize _____ (*clinic/therapist*) to release the information specified below regarding me/the client to the individual(s) listed below. I also authorize the professional to obtain information from my/the client's family. This authorization form will expire 90 days from the date it was signed unless the client lists a specific date below.

The information to be disclosed is indicated by an "X" in the applicable boxes:

☐ Names of professionals
☐ Treatment plan
☐ Admission and/or discharge information
☐ Psychological evaluations
☐ Medications
☐ Treatment notes/summary
☐ Other: _____

This information is to be disclosed to these persons, who have indicated their relationship to me/the client. Confidentiality and privacy have been reviewed with me, and I fully understand the risks.

_____	_____	_____
(Name)	(Relationship)	(Phone number)
_____	_____	_____
(Name)	(Relationship)	(Phone number)
_____	_____	_____
(Name)	(Relationship)	(Phone number)

Client's Signature: _____ Date: _____

This form will expire 90 days from the signed date, unless otherwise indicated.
Alternative Expiration Date: _____

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION TO PROFESSIONALS

Name: _____

Date of birth: _____

I understand my records contain information about my therapy sessions and my mental health. I understand all my records are protected by state and federal laws that require they are kept confidential and require my written consent to disclose.

I , _____ (*client's name*), hereby authorize

_____ (*practice/therapist name*) to disclose _____ (*name of document*) to _____ (*name of recipient*) for the sole purpose of:

_____.

I understand I have the right to revoke this release at any time. This release will expire on _____ (*date of agreed expiration*) or 90 days from the date this form was signed. I have been informed and understand this authorization to release records and information, the nature of listed content that I am willing to release, and the implications of their release. This request is voluntary.

_____	_____	_____
Signature of client	Printed name	Date
_____	_____	_____
Signature of parent/guardian/representative	Printed name and Relationship	Date

I witnessed the person understood the content of this authorization and freely gave his or her consent but was physically unable to provide a signature.

_____	_____	_____
Signature of witness	Printed name	Date

❑ Copy for patient or parent/guardian
❑ Copy for professional/clinic
❑ Copy for family member

AUTHORIZATION TO USE UNENCRYPTED EMAIL AND TEXT

This document is to ensure you are aware that email and/or text communications between you and your therapist are not encrypted (coded) and therefore are not secure communications. Email and texts are vulnerable to unauthorized access that can compromise your privacy and confidentiality.

While data on _____'s (*name of therapist*) computer is encrypted, emails and texts are not. There is also a risk that email, and texts can be sent mistakenly to the wrong address, or improperly acquired or intercepted by hackers. This risk is especially high if you access your email through your employer's network, or if access to your email is not password protected. If this happens, the information may be disclosed and is no longer protected by privacy law.

Please note _____ (*name of therapist*) attempts to use emails and texts only for appointment reminders and for scheduling or modifying appointments. Emails and texts used for other purposes will be kept as part of your clinical record. **Please do not use texts or email for emergencies.**

My signature below indicates that I have read and understand the following statements:

I understand that computer email and texts can be accessed or intercepted by unauthorized individuals or entities.

I understand _____ (*name of therapist*) will attempt to use emails and texts only for only appointment reminders and for scheduling/modifying appointments.

I understand all email and texts, other than those used for scheduling and reminders, will be kept as part of my clinical record.

I understand if I communicate confidential or private information via email or texts, _____ (*name of therapist*) will assume I have evaluated the risks of doing so and have made an informed decision.

I understand I may notify _____ (*name of therapist*) at any time if I decide to avoid or reduce my use of email or texts.

I understand email or texts should never be used in the case of an emergency or for urgent requests for information.

I understand, in the event of an emergency, I may call _____ (*name of therapist*) at _____ (*phone number*), but because my call may not be returned immediately, I should also call 911.

Client's signature: _____ Date: _____

Therapist signature: _____

This form will expire 90 days from the signed date, unless otherwise indicated.
Alternative Expiration Date: _____

AUTHORIZATION FOR RECURRING CREDIT CARD CHARGES

Note: This form may be used to allow clients to authorize recurring charges on their credit cards without having to sign a separate authorization for each charge. This enhances convenience for clients and may help them to budget for therapy services more effectively. It can also increase your collection rate and minimize the time and effort involved in obtaining payment for each session.

To use this form effectively, it is important to have a comprehensive conversation with clients about their financial obligations and expected charges for professional services and associated fees. Clients should know what to expect on their credit card bill.

This form may be customized to meet the needs of your practice and the individual circumstances of your clients. All information in brackets should be replaced with your practice-specific information and you may choose to make other modifications to be consistent with your office policies and procedures.

As a practical matter, it is important to check that clients have written their information legibly when they fill out the form. It is essential that you maintain this sensitive financial information in a highly secure manner and that you inform clients of how you safeguard their credit card details.

Authorization for Recurring Credit Card Charges

For your convenience, you may authorize recurring charges to your credit card to pay for your therapy sessions. You will be charged the day of your therapy appointment unless other arrangements have been made. The charge will be made under the name *[the name of your practice or company as listed with your credit card processing service]*. You agree that no prior notification is necessary unless the amount billed each time exceeds *[insert amount of per session charge],* in which case you will receive notification in advance.

Name of Client: _____

Account Type: Visa MasterCard American Express (AmEx) Discover

Cardholder name: _____

Account number: _____

Expiration Date: _____

CVV: _____

I authorize *[practice or practitioner name]* to charge this credit card for professional services and associated charges as agreed below. These charges may include:

Co-pay and/or co-insurance for session: $_____

Self-pay for session or payment for session not covered due to deductible: $_____

Charge for cancellation without 24 hours' notice: $_____

Other charges *[specify]*: _____ $_____

_____ $_____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify this practice in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date.

Signature of Authorized Credit Card User: _____

Date: _____

REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

You have the right to request that _____ (*name of therapist/practice*) restrict the use and disclosure of your protected health information (PHI). You may ask _____ (*name of therapist/practice*) not to use or disclose any part of your PHI for purposes of treatment or payment.

You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care, or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restrictions requested, and to whom you want the restriction to apply, as shown below. _____ (*name of therapist/practice*) is not required to agree to a restriction you request. Exceptions include situations where [*I/we*] need to use or disclose the information to provide emergency treatment to you, or if the law requires its disclosure.

_____ *(name of therapist/practice*) must agree not to disclose your PHI to your insurance carrier if the disclosure is for payment of treatment and relates to a service which you paid in full, out of pocket.

If _____ *(name of therapist/practice*) agree(s) to the requested restriction, [*I/we*] may not use or disclose your PHI unless it is needed to provide emergency treatment.

_____ *(name of therapist/practice*) reserve(s) the right to terminate your requested restriction if you agree to it in writing or verbally, or if you request the termination yourself.

Client name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number (daytime): _____

Description of PHI to be restricted:

_____

_____

_____

State the restriction you want to apply to the PHI.

_____

_____

_____

Provide the names of persons/organization to be restricted from uses/disclosure.

_____

_____

_____

Client printed name: _____

Signature: _____

Date: _____

This form will expire 90 days from the signed date, unless otherwise indicated.
Alternative Expiration Date: _____

SLIDING SCALE FEE AGREEMENT

I, _____ (*client name*), certify that I do not have health insurance (or certify that I will not/cannot utilize any health insurance for services rendered by *clinician/company name and information)* and/or due to my current financial situation, I cannot afford the full fee rate of (*enter amount*). I, therefore, request that my fee be adjusted.

My current monthly income is currently insufficient to cover my monthly expenses and therapy at the rate of (*enter amount*). This is also true of my total household income, if living with a partner.

Therefore, I understand that the fee for services with *(clinician/company name and information)* will be $_____/session and is payable at the time of each session (unless other arrangements are made in advance).

I further understand that I will not be charged for any appointments that are cancelled at least _____ hours in advance. I understand that appointments not cancelled at least _____ hours in advance are subject to a late cancellation charge of $_____. I am solely responsible for all these charges as they apply, as well as the costs associated with collecting these charges.

I agree to notify the *(clinician/company name and information)* of any substantive changes in my financial situation (e.g., 10% increase or decrease in income) within _____ days of the change and understand the fee may change according to my updated financial situation. I further acknowledge that my therapist will periodically verbally review my financial status with me, to reassess eligibility. A continuance of Sliding Scale benefits is not guaranteed and is subject to modification and/or elimination at the sole discretion of *(clinician/company name and information).*

_____

Client printed name Date

_____

Client signature

_____

Therapist printed name Date

_____

Therapist signature

Please note the following conditions apply to reduce fees:

- Sliding scale fees are based on the average family size of 2-4 people and can be adjusted based on the number of people living in the home.
- Fees agreed upon under previous sliding scale charts will remain in effect and be honored for the duration of client's time.
- Other extenuating circumstances regarding the client's ability to pay (e.g., high medical bills) can be considered when agreeing on a fee.

Sliding Scale for Therapeutic Services

Standard Fees

Fees are as of _____ (*date*) and are adjusted periodically.

Services	Intern	Mental Health Practitioner	Licensed Mental Health Professional
Intake session			
Individual, couple, or family session			
Extended session (75-80 minutes)			
Brief session (25-30 minutes)			
Group therapy session			
Other services:			

**Sliding fee scale available for all cash clients seeing intern, mental health practitioner, or licensed mental health professional*

Sliding Fee Scale

Annual Income	Intern	Mental Health Practitioner	Licensed Mental Health Professional
<$20,000			
$20,000 - $35,000			
$35,000 - $50,000			
$50,000 - $60,000			
$60,000 – $70,000			
$70,000 – $80,000			
>$80,000			

General Office Policies

The general policies of the office are explained below. Please take a few minutes to review them and bring up any questions with your therapist.

Contacting Your Therapist

- The phone contact number for your therapist is: _____
- There are times when your therapist is with a client, or not able to answer the phone, and you are encouraged to leave a voicemail message with your name, number, time of the call, as well a brief message and the best time to reach you. All messages are treated confidentially. Your call will be returned as soon as possible.
- **If you need immediate assistance, please call 911 or go to the nearest emergency room.**
- We do not encourage emailing your therapist. Email can be overlooked or can go into a spam filter.
- Clients are discouraged from contacting their therapist in any form of social media.

Intake and Consent Forms

- For ethical and legal reasons, clients are required to read, complete, and sign intake, HIPAA, and consent forms and bring these to the initial appointment.
- You may also be asked to fill out forms describing your personal history, the history of the problem that brought you to therapy, and your goals for therapy.
- Please read these forms thoroughly and sign where indicated.
- Please note the release of client clinical information is strictly governed by Health Insurance Portability and Accountability Act (HIPAA). Under this law, the release of any information cannot be made until a specific authorization to release is signed by the client.

In Session Behavior

- The therapeutic process can sometimes be very difficult. You are encouraged to talk about all your feelings and thoughts during the therapy session.
- It is okay to express your anger in a therapy session, but loud shouting and throwing things is never appropriate.
- While your privacy is of utmost concern, you should be aware that any incidents of abuse or threats to others must be reported.
- If you feel that you may harm yourself in any way, you should discuss this immediately with your therapist. Suicidal threats may result in notifying your emergency contact and other people who can keep you safe. Your safety is our primary concern.
- It is never appropriate to bring any form of weapon into therapy, and clients who bring in a weapon will be asked to leave.

Waiting Room and Building Rules

- Please do not bring children under 12 to wait while you are in therapy.
- Please do not bring pets into the building except for service dogs.
- Please do not bring food or beverages to your therapy sessions.
- This is a smoke-free building and any kind of smoking, including e-cigarettes, is not allowed.

Payment Policies

- All payments, including insurance co-payments, are due at the time of the appointment unless prior arrangements have been made with the therapist.
- A reduced fee schedule is possible for clients with inadequate health insurance with proper documentation.
- All personal checks returned for insufficient funds are charged a $_____ fee, applied to the client's account.
- Bartering for services is not permitted.
- To avoid being charged the full fee for the session, the client is asked to cancel at least _____ hours in advance. If a session is missed without notice the session fee will be applied to your account within 15 days or at the next therapy session, whichever event comes first.
- In the event of severe weather, please contact the office to see if it is open.
- If you arrive late to a session, the session will still end at the regular time. Exceptions to this policy may be made at the therapist's discretion if there is no one waiting.

Miscellaneous

- For ethical reasons, your therapist does not accept gifts of any kind.
- If you would like to bring a friend or family member to a session, please notify your therapist at least one week in advance. You will be asked to sign a release giving your therapist permission to talk about issues that may be confidential.
- Occasionally, at the agreement of both the therapist and the client, therapeutic services may be provided outside the office by phone or video call. In these circumstances, the same fees for treatment will apply as for in-office sessions, unless discussed in advance with the therapist.

I have read and understand the office policies.

Client name: _____ Date: _____

Signature of the client, guardian, or personal representative:

_____

Office Policies are in effect as of: _____
(*date*)

APPOINTMENT POLICY

When completing counseling services, continuity is vital to success. Frequent cancellations or failing to schedule appointments can lead to delays between therapy sessions that may impede progress. As a mental health service provider, I try to assist in finding suitable times for us to meet for sessions. Our work together is a joint effort. Your cooperation in keeping appointments is critical to your success. I would like to outline for you the attendance policy for _____ (*clinician/practice name*).

1. To schedule appointments, please call _____ (*phone number*).
2. We require a minimum of _____ hours' notice for changes or cancellations of appointments. If you do not cancel with a minimum of _____ hours, the client is responsible for accrued fees.
3. Please contact the practice/therapist as soon as you are aware you need to cancel. (*This is also within the minimum of _____ hours*).
4. If you are late for an appointment, the appointment will still end at the scheduled time.
5. If you cancel or do not show up for two consecutive appointments, you will receive notice that your session time may be made available to other clients. In this case, call the clinic to schedule a time suitable for you.

I look forward to working with you.

_____

Therapist's name Date

I have read and understand the above terms. All my questions and concerns have been discussed.

_____

Printed Name

_____

Signature Date

FINANCIAL POLICY

Below are the terms of agreement regarding payment for sessions with _____ (*therapist/practice name*).

1. Session fees are based on a clinical hour, which is defined by insurance providers as 45-50 minutes with the therapist or mental health professional.

2. If I, the client, fail to appear for an appointment without a 24-hour notice of cancellation, appointment fees will be charged, and I will be responsible for payment.

3. I understand if I am late to a session, that session will end at the time originally scheduled. It is my responsibility to arrive on time.

4. Services including phone calls, emails, record reviews, and professional consultations at times other than the scheduled therapy session are the client's responsibility. These services will be billed per quarter of an hour.

5. I authorize my health insurance to provide payment of benefits to _____ (*therapist's/practice's name*).

6. I understand records of my treatment may be shared with _____ (*client's insurance company*) when necessary to process claims.

7. I understand I am responsible for payment if my insurance company declines payment.

I have reviewed this document and understand the above statements.

_____

Signature Date

_____

Printed name

GOOD FAITH ESTIMATE FOR MENTAL HEALTH SERVICES

No Surprises Act - for use by mental health providers no later than January 1, 2022

Instructions

Under Section 2799B-6 of the Public Health Service Act, mental health providers are required to provide a good faith estimate of expected charges for services to clients who are not enrolled in a plan, coverage, or federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing, upon request or at the time of scheduling mental health services.

This form may be used by the mental health providers to inform uninsured or self-pay clients of the expected charges they may be billed for receiving certain services. A Good Faith Estimate must be provided **within 3 business days**. Information regarding services must be furnished **within 1 business day** of scheduling a service to be provided in 3 business days, and **within 3 business days** of scheduling a service to be provided in at least 10 business days.

Fill in the form with the appropriate information. The use of this form allows you to be in compliance with the Good Faith Estimate requirements.

Disclaimer: This Good Faith Estimate shows the costs of services that are reasonably expected for your mental health care. The estimate is based on information known at the time the estimate was created. This estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill. If you are billed for more than this estimate, you have the right to dispute the bill. You may contact the provider or facility listed on this form to let them know the billed charges are higher than the estimate. You can ask them to update the bill to match the estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises. Keep a copy of this Good Faith Estimate in a safe place or take a picture of it. You may need it if you are billed a higher amount.

Good Faith Estimate for Mental Health Services

Client Name: _____

Date of Birth: _____

Client Identification Number: _____

Mailing Address: _____

Phone Number: ( ) _____

Email Address: _____

Client's Contact Preference: [ ] By USPS mail [ ] By email [ ] By text

Service Scheduled: _____

Primary Diagnosis: _____

Primary Diagnosis Code: _____

Secondary Diagnosis: _____

Secondary Diagnosis Code: _____

If scheduled, list the date(s) the service will be provided:

[ ] *Check here if this service is not yet scheduled.*

Date of Good Faith Estimate: _____/_____/_____

Summary of Expected Charges

Clinician Name: _____ Estimated Total Cost: _____

Clinician Name: _____ Estimated Total Cost: _____

Clinician Name: _____ Estimated Total Cost: _____

Total Estimated Cost: $_____

The following is a detailed list of expected charges for _____ [*primary service*], scheduled for _____ [*date of service, if scheduled*]. ***Note if services are reoccurring***.

The estimated costs are valid for _____ months from the date of this Good Faith Estimate.

[*Provider/Facility #1*] Estimate

Name:	Type:
Address:	City/State/Zip:
Contact Person:	Phone:
Email:	NPI:

Details of Services

Service	Address where service will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost

Total Expected Charges from [*Provider/Facility #1*] Estimate: $_____

Notes:

[*Provider/Facility #2*] Estimate [*delete this section if unnecessary*]

Name:	Type:
Address:	City/State/Zip:
Contact Person:	Phone:
Email:	NPI:

Details of Services

Service	Address where service will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost

Total Expected Charges from [*Provider/Facility #2*] Estimate: $_____

Notes:

[*Provider/Facility #3*] Estimate [*delete this section if unnecessary*]

Name:	Type:
Address:	City/State/Zip:
Contact Person:	Phone:
Email:	NPI:

Details of Services

Service	Address where service will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost

Total Expected Charges from [*Provider/Facility #3*] Estimate: $_____

Notes:

Clinician Name: _____ Date: _____

Signature: _____

CLIENT RIGHTS

As a client, when you enter a therapist-client professional relationship, you have certain rights.

I, _____ (*therapist name*), will do my best to honor your rights and give you the best treatment possible. You, as a client, have the following rights. To:

• be an active participant in decisions regarding your treatment and the scope of treatment

• be informed of where to access emergency attention if the practice does not offer these services

• be informed of the practice's policy for financial responsibility

• express grievances and concerns regarding treatment

• receive truthful communication from your therapist

• be assured that your therapist is practicing within their scope of experience, license, and education

• receive services, including evaluations and treatments, within a reasonable time frame

• be treated and receive services in the absence of bias regarding age, race, religion, gender, national origin, or sexual preference

• be treated courteously by all professionals within the practice

• know that all professionals involved in your case maintain confidentiality

• have all professionals adhere to the ethical standards of the professional organizations to which they are licensed and affiliated

• terminate treatment or request a change of service provider

I, _____ (*client name*), understand my rights described above.

Client printed name: _____ Date: _____

Client signature: _____

CLIENT RIGHTS AND EXPECTATIONS

(client with substance abuse issues)

Client Rights

I understand I have the right to treatment, and that I am voluntarily seeking services.

I have the right to individual privacy and respect. My problems do not diminish my intrinsic worth as a human being.

There will not be any prejudicial treatment because of age, sex, race, religion, or cultural background.

I have the right to know my diagnosis, evaluation details, treatment goals, and the methods recommended to attain those goals. I will be involved in establishing my treatment goals.

If I am not satisfied in any way with answers or treatment provided, I have the right and responsibility to discuss these with the Director.

I understand my right to confidentiality includes the following:

- my presence in therapy is not to be disclosed to anyone without my permission
- no portion of my clinical records may be disclosed to anyone without my permission
- my condition, progress, or any other information concerning me may not be disclosed to anyone without my permission
- by law, all suspected cases of child, disabled, or elder abuse/neglect must be reported to the Department of Children & Families
- my therapist is required to warn individuals whose lives are known to be in danger

I have the right to report client abuse by calling _____ (*organization*) at ( ) _____ (*phone number*).

Client Expectations

- maintain regular and consistent attendance to individual and/or group counseling sessions
- show evidence of motivation to change and to participate in treatment
- remain alcohol and drug free or work at a specifically developed Responsible Drinking Treatment Plan.

Treatment will be extended if unable to maintain abstinence or comply with other treatment expectations.

For D.U.I.-related substance abuse counseling you are expected to:

- attend counseling regularly
- go to self-help meetings
- stay sober
- be responsible for payment at time of services.

Generally accepted hygiene practices are encouraged and a copy of infection control policies is available.

There shall be no violence or threats of physical violence in group settings.

Other individuals' confidentiality must be respected. No discussion of other individuals outside the group setting is acceptable.

These rules were designed to foster the safety and trust necessary for a positive therapeutic environment.

Prescription drug use must be reported and verified by your prescribing doctor.

Client printed name: _____ Date: _____

Client signature: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the client's medical decisions relative to the treatment situation.

I, _____ (*client*), hereby acknowledge that

_____ (*therapist/practice*) has either offered me or provided me with a copy of the **Notice of Privacy Practices** that describes how information about me may be used and disclosed, and how I can access this information. I understand if I have questions or complaints, I may contact:

_____ (*therapist/practice*).

I also understand that I am entitled to receive updates upon request if _____ (*therapist/practice*) amends or changes the **Notice of Privacy Practices** in a material way.

_____ _____

Client Signature Date

_____

Relationship to Client (*if signed by someone other than client*)

_____

Printed Name

IF SIGNATURE OBTAINED FROM PERSON OTHER THAN A LEGALLY RESPONSIBLE INDIVIDUAL, ACTION TAKEN TO OBTAIN LEGAL SIGNATURE:

- Given to above signee
- Sent via U.S. Mail
- Advised person that policy is available on our website at:
  _____

In either situation the parent/legal guardian must sign and return this form either in person or by mail to:

_____

_____

THIS SECTION IS TO BE COMPLETED BY MENTAL HEALTH PROVIDER

I made a good faith effort to obtain a written acknowledgement of receipt of the **Notice of Privacy Practices** from the above-named client, but was unable to because:

- Client declined to sign this Written Acknowledgement.
- Other (specify): _____

_____ _____

Therapist Signature Date

_____

Printed Name and Title

ELECTRONIC COMMUNICATION POLICY

To maintain clarity regarding our use of electronic communication during your treatment, I have prepared the following policy. Some electronic communication may put your privacy at risk and can be inconsistent with the standards of my profession.

Therefore, this policy has been prepared to ensure the security and confidentiality of your treatment and to make sure it is consistent with my profession's ethics and laws. If you have any questions about this policy, please discuss them with me.

Email Communications and Text Messaging

I use email communication and text messaging only with your permission and only for administrative purposes, unless we have made another agreement. Email exchanges and text messages with my office should be limited to topics like scheduling and changing appointments and billing matters. Please do not email or text me about clinical matters because these are not secure ways to contact me.

If you need to discuss a clinical matter with me, please call me so we can discuss it on the phone or wait until your next therapy session so we can discuss it in person.

[ALTERNATIVE TEXT FOR TEXT MESSAGING] Because text messaging is a very unsecure and impersonal mode of communication, I do not send text messages to clients, nor do I respond to text messages from anyone receiving treatment. Please do not text me unless we have made other arrangements.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter or Facebook. If I discover that I have accidentally established an online relationship with you, I will remove that connection. These types of casual social contacts can create significant security risks for you.

I participate on various social networks, socially and/or professionally. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have the potential to compromise our professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online connection.

[IF APPLICABLE Websites] I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions, we can discuss them during your therapy sessions**.**

Internet Searches

I will not use Internet searches to gather information about you without your permission because I believe this violates your privacy rights. However, I understand that you might choose to gather information about me in this way. If you encounter any information about me through internet searches, please discuss it with me during our sessions so we can address any potential impact on your treatment.

Some clients write reviews about their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and any related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work while we are in treatment together on any of these websites because it has a significant potential to damage our ability to work together.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client signature: _____ Date: _____

Client printed name: _____

HIPAA COMPLIANCE CHECKLIST

This document is not a substitute for legal advice or consultation, or a substitute for clinical or ethical consultation or advice. These checklists are for reference only. Consult with your attorney, licensing organization, and professional code of ethics prior to use. Additionally, we suggest you have your legal counsel review and approve all your practice's HIPAA-related policies, consent forms, office procedures, and risk assessments.

☐ **Share your Notice of Privacy Practices policy**

- Post an updated "Notice of Privacy Practices" (NOPP) policy in your office that is compliant with current HIPAA rules.
- Offer all new clients a copy of your updated NOPP. For existing clients, post on your website, or distribute directly.

☐ **Review your state-specific HIPAA requirements**

Most states have specific additions or revisions that provide more protection to clients than federal HIPAA guidelines. This can include expanded definitions, required training expectations for new therapists, and client access to records. Visit your state's department of public health, department of human services, or health office of compliance and technology for details.

☐ **Make sure you have all the HIPAA-compliant forms you need for your practice**

These may include:

- NOPP form
- Risk Assessment
- Informed Consent
- Email Consent
- Consent to Release Form
- Business Associate Policy
- Business Associate Form
- Breach Policy
- Breach Notification Log
- Complaints Log
- Disclosure Log
- Ongoing Compliance Review Log
- Policies & Procedures document

☐ **Perform a HIPAA-compliant Risk Assessment**

- **Conduct a risk assessment for privacy and security breaches, including an inventory of electronic devices containing client Protected Health Information (PHI)**. Identify all the places your clients' PHI is located where privacy and security might be at risk.

- Common places include your computer, cell phone, email; paper files and file cabinets; your digital copier/printer's hard drive; deleted computer files; and even your website's contact form.
- **Make a risk management response plan that meets both the HIPAA Security standards and your own security needs**. Ask yourself: What could go wrong? What is the likelihood of that happening? What problems would it cause for my clients and my practice?

  Your risk assessment should include:
  - Potential risks
  - Current security/privacy protocols
  - Likelihood of a breach
  - Potential impact of a breach
  - Prioritization of high risk or high impact issues
  - Plans and timeline to address those risks
  - Progress made/ date fixed
- **Maintain documentation of all assessments, plans, actions, and resources in a safe place.** Update these documents annually if possible.
- **Understand what constitutes a breach, and what your responsibilities are, if there ever is one.** The action steps vary, depending on the size of the breach. Also understand your obligations for client disclosures and HIPAA complaints.

☐ **Protect Your Practice and Your Clients**

- Appoint a "Privacy Officer" and/or "Security Officer" for your practice (which can be yourself). This person would also be responsible for updating his/her HIPAA training regularly.
- Have a disaster recovery plan. Designate a person to put a contingency plan in place in case you are sick, incapacitated, or die. Document this plan and share with that person.
- Use strong passwords, virus protection, and a firewall for all your electronic devices. Consider consulting with an IT professional to identify areas of vulnerability.
- Request signed Business Associate Agreements (BAAs) from your vendors and service providers, employees, cloud storage providers, and other businesses that have access to your clients' PHI.

☐ **Research HIPAA Compliant Business Tools**

- Tools may include a cloud-based practice management system allows you to keep stored PHI off your own devices, lowering your tech risks.
- Make sure that whatever service you use for your practice provides a BAA.
- Remember that a product cannot make you "HIPAA compliant."

☐ **Check out these suggested resources**

HIPAA Resources, U.S. Department of Health & Human Services
https://www.hhs.gov/hipaa/index.html

- ***HIPAA Training***
  https://www.hhs.gov/hipaa/for-professionals/training/index.html

HIPAA and Preemption of State Law
https://www.hhs.gov/hipaa/for-professionals/faq/preemption-of-state-law/index.html
Information on Breaches
https://www.hhs.gov/hipaa/for-professionals/breach-notification/index.html
HIPAA for Therapists free resources
https://hipaafortherapists.com/category/free-resources/
Person-Centered Tech free articles
https://personcenteredtech.com/articles/collections/
Review of practice management software from American Psychological Association: "How Does This Practice Management Software Stack Up?"
https://www.apaservices.org/practice/business/technology/tech-column/practice-management-software
Recommended technology, tools, and resources for therapists and counselors (from TameYourPractice.com)
https://www.tameyourpractice.com/blog/recommended-technology-tools-resources-for-therapists/

HIPAA COMPLIANCE PRIVACY NOTICE

YOUR INFORMATION, YOUR RIGHTS, OUR RESPONSIBILITIES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. *Please review it carefully.*

Name of Therapist/Practice: _____

Address: _____

Phone: _____ Email: _____

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record.
- Correct your paper or electronic medical record.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a list of those with whom we have shared your information.
- Get a copy of this Privacy Notice.
- Choose someone to act on your behalf.
- File a complaint if you believe your privacy rights have been violated.

Your Choices

You have some choices in the way we use and share information, as we:

- Tell family and friends about your condition.
- Share information in a disaster relief situation.
- Share information for marketing, sales, or fundraising purposes.

Our Uses and Disclosures

We may use and share your information as we:

- Treat you.
- Run our organization.
- Bill for your services.
- Help with public health and safety issues.
- Perform research.
- Comply with the law.
- Respond to organ and tissue donation requests.
- Work with a medical examiner or funeral director.
- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions.

This information is discussed in further detail on the following pages.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.

- You can ask to see or receive an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Correct your medical record.

- You can ask us to correct your health information that you think is incorrect or incomplete. Ask us how to do this.
- We may deny your request, but we will tell you why in writing within 60 days.

Request confidential communications.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will agree to all reasonable requests.

Limit what we use or share.

- You can ask us not to use or share certain parts of your health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may deny it if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to your request unless a law requires us to share that information.

Receive a list of those with whom we have shared information.

- You can ask for a list ("accounting") of the times we have shared your health information for six years prior to the date you ask, with whom we shared this information, and why.
- We will include all the disclosures except those about treatment, payment, and health care operations, and certain other disclosures (such as any you requested us to make). We will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you request another within 12 months.

Get a copy of this privacy notice.

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act on your behalf.
• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
• We will make sure the person has this authority and can act on your behalf before we take any action.

File a complaint if you feel your rights are violated.
• You can complain if you feel we have violated your rights by contacting us.
• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ .
• We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
• Share information with your family, close friends, or others involved in your care.
• Share information in a disaster relief situation.

If you are not able to tell us your preference – for example, if you are unconscious – we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the following cases, we never share your information unless you give us written permission:
• Marketing purposes.
• Sale of your information.
• Most sharing of psychotherapy notes.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

To treat you.
• We can use and share your health information with other professionals who are treating you.
To run our organization.
• We can use and share your health information to run our practice or improve your care and contact you when necessary.

To bill for services.
• We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually to contribute to the public good, such as public health and research. We must meet many legal conditions before we can share your information for these purposes. For more information, visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html .

To help with public health and safety issues.
• Preventing disease.
• Helping with product recalls.
• Reporting adverse reactions to medications.
• Reporting suspected abuse, neglect, or domestic violence.
• Preventing or reducing a serious threat to anyone's health or safety.

To perform research.
• We can use or share your information for health research.

To comply with the law.
• We will share information about you if state or federal laws require it, including the Department of Health and Human Services, if it needs to confirm that we are complying with federal privacy law.

To respond to organ and tissue donation requests.
• We can share health information about you with organ procurement organizations.

To work with a medical examiner or funeral director.
• We can share health information with a coroner, medical examiner, or funeral director when a person dies.

To address workers' compensation, law enforcement, and other government requests.
• For workers' compensation claims.
• For law enforcement purposes or with a law enforcement official.
• With health oversight agencies for activities authorized by law.
• For special government functions, such as military, national security, and presidential protective services.

To respond to lawsuits and legal actions.
• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Name of Person Responsible for HIPAA Notification: _____

OUR RESPONSIBILITIES

• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices detailed in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you give us written permission. If you give us permission, you may change your mind at any time. Let us know in writing if you change your mind. For more information, visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html **.**

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective date: _____

This Privacy Notice applies to the following (*your information*):

_____

_____

_____

Privacy Officer information:

_____

_____

_____

CONSENT TO USE TOUCH IN THERAPY

With your consent, and according to my clinical judgment, I may use touch in our therapeutic work together to benefit your healing. I will draw from techniques in which I have received training, including [*Yoga Therapy (YT), somatic psychology, Hakomi, Processwork, Somatic Experiencing (SE), Body Memory Reset Therapy (BMR), and/or Other* _____].

I believe the use of touch is a powerful tool for clients to get grounded and help them move through body-based trauma reactions. As infants, we experience feelings of being loved and nurtured through touch. Throughout our lives, our non-verbal touch experiences determine how we feel about ourselves and how we connect to others.

The interventions used in our sessions may include:

- Touching your hand or arm to reduce anxiety
- Positioning your feet, hands, and shoulders to create awareness of your body in relation to the earth
- Holding your physical tension so that you can relax
- Correcting your breath and posture to improve oxygen flow
- Interacting together with an object during role play to process past experiences

At each session, I will make sure you understand the nature and purpose of using touch in therapy and evaluate the appropriateness of touch in your situation. I will also check your comfort level regarding the location of touch, the amount of pressure, and the length of contact before and during each session.

The touch I provide in therapy is never sexual. Sexual touch of clients by therapists is unethical and illegal. I will never use touch in a manner that is shaming or derogatory, or to deliberately stimulate clients sexually.

While touch interventions are expected to enhance our therapeutic work together, they may have unintended side effects. They may trigger emotions, memories, or physical reactions that may be upsetting. I encourage you to share and process uncomfortable feelings and sensations with me as they arise, and you can revoke your consent of touch at any time.

Your needs and wishes take priority over any therapeutic touch intervention. You may request not to be touched at any time during our therapy sessions, even if you previously provided consent. You might also change your mind about the frequency and type of touch that feels comfortable from session to session.

I have read the above informed consent, understand, and agree to it. I will also make my concerns and considerations known to my therapist as they arise.

Client signature: _____Date: _____

Printed name: _____

CONSENT TO RECORD THERAPY SESSION

I hereby give permission to _____,
(*therapist/therapist-in-training*) to record our therapy session(s) on [*audio/video*].

I understand that the purpose of this recording is to enable you to review and evaluate our therapeutic work together, so that you can continue to improve your counseling techniques. **OR** I understand that these recordings will be used only for the purpose of providing clinical supervision and peer review to the counselor-in-training.

I understand that listeners and viewers of the recording may include your supervisors or peers in your group supervision. All of them, including you, are bound by the ethical standards of the [*professional organization*] and to the same ethical principal of confidentiality as professionals providing counseling.

My signature below indicates that I give _____ (*name of therapist*) permission to be audiotaped/videotaped (*circle one or both*) and that I understand the following:

1. I can request that the audio recorder or video recorder be turned off at any time. I may also request that the tape, or any portion of it, be erased.
2. I can revoke my permission for you to record me at any time.
3. The contents of the taped sessions are confidential, and the information will not be shared outside of your individual, peer, and group supervision.
4. The recordings will be stored in a secure location and will not be used for any other purpose without my written permission.
5. The recordings will be erased after they have served their professional purpose.

_____ _____
Client signature Date

_____
Client printed name

_____ _____
Counselor/therapist signature Date

GUEST THERAPY CONSENT

The purpose of this form is to allow a “collateral” or “guest” to participate in a therapy session as a third-party participant. The role of a collateral/guest can vary according to his/her relationship with the client. The therapist will discuss the role in the client's treatment during the first session the collateral/guest participates.

The collateral/guest, _____, will attend sessions upon the request

and permission of the client, _____.

The purpose of collateral/guest's participation is to provide information to the therapist about the client, both factual and from his/her personal perspective, in order to help the client achieve treatment goals. During sessions, the collateral/guest may also be asked to participate in exercises to help further the client’s treatment, or to support the client in other ways.

The collateral/guest will not be considered a client of _____ (*therapist/practice*) and will not use this attendance for his/her own therapy needs. The therapist's legal and ethical responsibility resides strictly with the client.

I, _____ (*client*), do hereby authorize

_____ (*collateral/guest*) to participate in my counseling

sessions with my therapist, _____.

I, _____ (*collateral/guest*), understand that my participation is voluntary, and that at any time I can decline to answer any question, to participate in any exercise, or to participate in _____’s (*client*) therapy sessions.

By signing below, both client and collateral/guest understand and acknowledge the following:
1. All information discussed during a counseling session is to be kept confidential and private.
2. The therapist will not be liable for any violations of confidentiality or privacy by the collateral/guest.
3. Participation in counseling sessions does not grant the collateral/guest access to the client's medical records.
4. The client can terminate the collateral/guest's participation at any time.
5. If the client wants the therapist and collateral/guest to communicate when the client is not present (email, phone), the client must complete an "Authorization to Release Information" form.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

Printed Name of Collateral/Guest: _____

Signature of Collateral/Guest: _____ Date: _____

Signature of Therapist: _____ Date: _____

POLICY FOR TREATING A CHILD OF DIVORCED, SEPARATED, OR UNMARRIED PARENTS

For children experiencing the divorce, separation, or distancing of parents, a safe and neutral setting to discuss their feelings can help ease the transition. For your child's therapy to be effective, it is important for you to understand how treatment works and to agree to the following terms and conditions.

Please read this information carefully and ask me any questions before your child starts treatment.

1. My priority is your child's emotional and behavioral health. Treatment will focus on your child, any adjustments to changing family conditions, and his/her achievement of therapy goals.

2. I will not be involved in any legal issues involving divorce, separation, or custody agreements, nor will I take sides in any disputes between you and the other parent. If you are involved in legal proceedings, please notify me as soon as possible so I can determine how this involvement might affect our work together.

3. The practice's staff will not be exposed to domestic issues or disagreements over the phone or in the office. Additionally, please make decisions regarding appointments and/or any office procedures prior to visiting the practice.

4. I will not provide the child's parents mediation, marital counseling, adult treatment, or custody/parenting evaluations. However, I can provide referrals for those services.

5. I will involve both parents in your child's treatment as necessary and in accordance with my professional judgment, except in cases of abuse or serious impairment on the part of one or both parents, or when your involvement would be detrimental to the child's mental health or treatment.

6. Only in situations where there is a confirmed, documented Court Order will a parent be denied visits to the office.

7. Please protect your child from conflict related to separation, divorce, or custody issues. Try not to argue in front of your child or involve your child in adult conflicts. Whenever possible, support your child's relationship with the other parent.

8. I will provide each parent with updates on your child's progress in treatment as requested. In addition, I will discuss what you can do to improve your child's outcomes in treatment. However, I will not discuss with one parent what the other parent can do to improve outcomes.

9. It is both parents' responsibility to communicate with each other about their child's care, office visit dates, and any other relevant information. I will not communicate your child's session information to each parent separately or contact a non-attending parent following visits.

10. Additionally, my practice will not call the other parent for consent regarding appointments scheduled or restrict either parent's involvement in their child's care unless authorized by law.

11. Any information you disclose to me may be included in your child's treatment record, which is accessible by the other parent. Only in situations where there is a confirmed, documented Court Order will a parent be denied access to the child's records.

12. Telephone, face-to-face, video, e-mail, or written communication from either parent may be shared as is clinically appropriate at the discretion of the therapist, with the other parent, or with the child. These communications become part of the child's permanent record.

13. If there is not a Court Order on file with our office, either parent can sign a "Consent to Treat" form that authorizes any named individuals (grandparents, nanny, etc.) to bring your child to our practice, be present during the visit, and consent to any treatment during that visit.

14. I will report safety concerns. Although your child's treatment is a confidential and privileged relationship, if I become concerned that your child's safety is in jeopardy, I will make a report to the authorities.

15. If I feel that the actions of either parent are compromising client care, I have the right to discharge the family from the practice.

I have read this information and have had an opportunity to ask questions. My signature below indicates that I agree to all the above terms and conditions.

Child's name: _____

Parent printed name: _____

Parent signature: _____ Date: _____

Parent printed name: _____

Parent signature: _____ Date: _____

Therapist printed name: _____ Date: _____

Therapist signature: _____

Section 3. Telehealth Forms

TELEHEALTH SESSION CHECKLIST

Before the Session

- Restart your computer. Close background programs or tabs.
- Test your Internet connection speed. You can check your speed by searching for "Speedtest Google" and click "Run Speed Test." You will need a minimum of 600 Kbps (0.6 Mbps) download speeds to make one-on-one video calls. Doing group video calls in 1080p resolution requires at least 2.5 Mbps upload and download speeds.
- Confirm your webcam, microphone, and speakers are all working. Check that your audio is not muted.
- Tidy the area behind you, as your client will see this space during the video session.
- To prevent interruptions during the session, set your cell phone to silent and consider hanging a "Do Not Disturb" sign on your door.
- If necessary, contact client's insurance to obtain payment coverage authorization.

At Start of Session

- Verify client's identity, if needed. Document full name and confirm client's phone number in case the connection fails.
- Review the safety plan with client.
- Review your session back-up plan in case the connection fails.
- Inform client of the potential risks and limitations of receiving telehealth treatment.
- Remind client there are alternative, non-video therapy options.
- Obtain verbal or written consent from the client for telehealth treatment.
- Confirm client is in a safe, private, quiet place to talk.
- Explain what the client can expect during the telehealth session.
- Mention that even though you may briefly look away from the camera while taking notes, you are still listening and engaged.
- Emphasize the importance of consistent session attendance and homework completion.
- Give client the opportunity to ask questions about the session.

INFORMED CONSENT FOR TELEHEALTH SERVICES

Name: _____ Date of Birth: _____

Telephone number where telehealth occurs: _____

Address where telehealth occurs: _____

Counselor/Therapist: _____

Date Consent Discussed: _____

Online psychotherapy, also known as telemental health services ("telehealth"), involves a therapist or counselor providing psychological counseling and support over the Internet through email, video conferencing, online chat, or phone calls. The information may be used for diagnosis, therapy, follow up and/or education.

Electronic platforms used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to mental health services by enabling the client to remain in his/her home or other remote site.
- Mental health services are more accessible and convenient—increasing mental health treatment outcomes.
- More efficient evaluation and continuity of mental health services.

Possible Risks:
There are potential risks associated with the use of telehealth services. These risks include, but may not be limited to, the following:

- In rare cases, information transmitted may not be sufficient to allow for appropriate decision making by the counselor/therapist.
- Delays in evaluation and treatment could occur due to deficiencies or failures of the Internet connection or equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal information.

Please initial indicating that you understand the benefits and risks of telehealth services: _____

By signing this form, I understand the following:

1. I understand the laws that protect privacy and the confidentiality of information also apply to telehealth services, and no information obtained in the use of this service which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment.

3. I understand I have the right to inspect all information obtained and recorded during a telehealth session, and I may receive copies of this information.

4. I understand that a variety of alternative methods of therapeutic care may be available to me, and that I may choose one or more of these at any time. My counselor/therapist has explained the alternatives to my satisfaction.

5. I understand telehealth services may involve electronic communication of my personal information.

6. I understand I may expect benefits from the use of telehealth services, but no results can be guaranteed or assured.

Client Consent to the Use of Telehealth Services

I have read and understand the information provided above regarding telehealth.

I have discussed it with my counselor/therapist, and all my questions have been answered.

I hereby give my informed consent for the use of telehealth in my psychotherapeutic care.

I hereby authorize _____ *(name of counselor/therapist)* to use telehealth in the course of my diagnosis, evaluation, and treatment.

Signature (*or person authorized to sign for client*): _____

Printed name: _____ Date: _____

If authorized signer, relationship to client: _____

I have been offered a copy of this consent form (*client initials*): _____

TELEHEALTH SAFETY RISKS AND PLANNING

Safety planning is an essential component of competent and ethical telehealth practice. Safety planning involves identifying steps and procedures for addressing situations that present a risk to the safety of clients and others during telehealth services. There is no evidence that telehealth is less safe than traditional in-office services when sessions are conducted using evidence-based protocols.

Safety Risks

The primary safety issues encountered during telehealth sessions are generally the same as those in office settings. These risks may include client harm to self or others; worsening of symptoms that may contribute to suicidal ideation or other heightened risk; and medical emergencies that could occur during a session. A client might also disclose that she/he recently experienced an injury but chose not to pursue medical attention.

Access to firearms should be considered when assessing the appropriateness of telehealth services, including firearm ownership. Access to firearms is a particular risk if a client is known to have a history of violent behavior toward self or others.

Telehealth professionals should take additional safety precautions when working with victims of domestic violence by asking the client if the abuser is on site and if the client is able to speak privately.

Safety Planning

Safety plans are the written steps for carrying out safety procedures and emergency protocols during emergency situations. Safety planning is an ongoing process, with risk assessment completed during each session. Key considerations and actions to consider when developing a safety plan:

- Review procedures for screening/assessing clients before initiating telehealth.
- Consult with the referring provider or on-site staff, if applicable.
- Review client history, including a history of violence or self-harm.
- Assess firearms safety.
- Establish back-up communication (e.g., mobile phone call) in case of disrupted Internet connection.
- Review safety plan and expectations with client.
- Identify and document local resources, including collateral support and contacts for local emergency response.
- Request client's physical location in the event emergency services or referrals are needed.

TELEHEALTH EMERGENCY PLAN

While receiving behavioral health services remotely (telehealth) is convenient, it also has limitations and risks. The therapist's ability to respond to a medical or psychiatric emergency may be impacted. Please complete this form to help inform your therapist's creation of an emergency plan to help reduce some of those risks.

Name: _____

Address where your telehealth occurs:

_____

_____

_____

Telephone number where your telehealth occurs: _____

Alternate phone number: _____

Therapist's location: _____

Telephone number: _____

A support person is someone who knows you are receiving therapy and is accessible to you (nearby and willing to help) during your telehealth session. This support person could help in case of emergency. Sign this form to allow your therapist to contact this person.

Support person name: _____

Support person telephone number: _____

I give my consent for my therapist to contact my support person. I understand this means my therapist may disclose private and confidential information. _____(*initial*)

In case of a behavioral/medical emergency, the therapist will attempt to contact emergency services in your local area. Emergencies might include expressing intent to harm yourself or another person, a medical emergency, or any other condition requiring medical or psychiatric attention.

The therapist will try to maintain communication with you while he/she calls for help. This might mean paramedics, mental health professionals, or local police will come to your home to make sure you are safe and well. If appropriate, the therapist will also contact your support person.

In case of a technological videoconferencing failure, the therapist will contact you using the telephone. In case of telephone failure (and without safety concern), the therapist will use secure text messaging, email, or another agreed-upon communication platform.

Client signature: _____ Date: _____

Printed name: _____

Telehealth Group Counseling Agreement

As a participant in telehealth group counseling services offered by _____ (*name of therapist or practice*), it is important that you read this document to understand the nature of online groups, confidentiality, safety, and the risks and benefits of these services to you and fellow participants.

Although online group therapy has been shown to be beneficial for participants, not everyone will find it helpful. If another form of intervention is determined to be more appropriate for you, we will work with you to obtain a referral to a more appropriate service.

Confidentiality and Privacy

_____ (*name of therapist or practice*) adheres to the professional, legal, and ethical guidelines of confidentiality. Information about your participation in group sessions will be released only with your signed consent, unless otherwise authorized by applicable law, such as including situations involving allegations of abuse, or risk of immediate danger or harm to self or others. To have information released regarding couple's counseling, both partners will need to give signed consent (unless otherwise authorized by applicable law, as stated above).

The group leader will use email to schedule and organize the online group sessions and to receive cancellation notifications from group members. Please note that email is not a secure method for sharing detailed clinical information. If you need to discuss any clinical concerns, please call _____ (*phone number*) and leave a secure voicemail message. **Please note: messages may not be checked for more than 48 hours. If you find yourself in crisis, call 911 or go to your nearest hospital emergency department.**

To help protect everyone's privacy online, all group members must agree to the following:

• Headphones/earbuds are recommended so that conversations are more private and protected.

• If someone enters your room or personal space, alert your group members, cover your screen, and reduce the volume to 0. You may need to exit the group until you are alone again. If you are unable to return to group before the session ends, email your group leader to explain your exit.

• Use a secure Wi-Fi/Internet connection instead of public or free Wi-Fi.

• Do not record or take screenshots of the sessions.

• Do not identify another member to anyone outside of the group, including names, physical descriptions, biological information, and discussions.

To optimize your experience in an online group therapy session, here are some suggestions:

• Connect using both video and audio, unless prior arrangements are made with your group leader.

• Eliminate distractions: put a “do not disturb” sign on your door, turn off your cell phone, turn off music/TV, and try to be in a separate room from children and pets.

• Look at the screen/camera when others are speaking to show you are paying attention.

• Use as large a screen as possible (laptop or tablet, instead of phone screen).

• Dress and prepare for the group as if you were attending an in-person group.

• Communicate directly with your group, instead of using the video’s chat feature.

• Sit with a window or light source behind you, so that your face is visible.

• If technological issues disconnect you from the group session, please try to rejoin. If you are unsuccessful, email the group leader to explain your exit.

Because online technology is not as dependable as in-person sessions, your audio and video may be interrupted or frozen. Non-verbal cues, like body language and facial expressions, can be harder to read or may be misinterpreted by the group. Please clarify if you feel misunderstood after sharing information or expressing yourself.

Contact Information/Emergency Contact Information

To participate in a telehealth group counseling session, you will need to provide the address where you will be during the group session. You will also be asked to provide the name and contact information of an Emergency Contact. If there is a concern for your wellbeing during the group, the group leader may contact your Emergency Contact. If you experience an emergency during the group, the group leader may also request a welfare check by your local safety department.

Between group sessions if you find yourself in crisis, please call 911 or go to your nearest hospital emergency department.

I have received, read, and understand the guidelines of this agreement.

Signature: _____ Date: _____

Printed name: _____

SECURITY CHECKLIST FOR ELECTRONIC DEVICES

Here are some "HIPAA-friendly" security measures for your computer and smartphone. For more detailed information on HIPAA security compliance, risk assessment, and breach notifications, visit your professional organization's licensing board or membership websites.

Security Settings

✓ **Full-device or full-disk encryption:** By scrambling (encrypting) your data before it gets written onto your device's hard drive, the information becomes invulnerable to confidentiality breaches if your device is ever lost or stolen. For instructions and more details, visit https://spreadprivacy.com/how-to-encrypt-devices/ and https://www.wired.com/story/encrypt-all-of-the-things/

✓ **A strong password:** A strong device password is necessary for the encryption process. Strong passwords should consist of upper- and lowercase letters, as well as at least one numeral and/or symbol. For tips, see this CNet article: https://www.cnet.com/howto/strong-passwords-9-rules-to-help-you-make-and-remember-your-login-credentials/

✓ **Antivirus/anti-malware software:** Make sure you have antivirus software updated and running each day. Popular products include Norton, McAfee, and Malwarebytes. PC Magazine published its top picks at https://www.pcmag.com/picks/the-best-antivirusprotection

✓ **Active firewall:** Firewall software serves as your computer's gatekeeper, filtering traffic and blocking unauthorized access to the private data on your computer. It can also help block malicious software from infecting your computer. Make sure your device has its firewall turned on (for instance Windows 10 includes Microsoft Defender Firewall), or that your antivirus protection software includes firewall protection.

✓ **Automatic logout or lockout:** Set your device's security options so that it locks you out after a short period of inactivity. This ensures unauthorized users will not have access to your programs and files when you leave your phone or computer unattended.

Maintenance Tasks

✓ **Backup your files:** If your client information is only stored on a single device and is not accessed elsewhere, that information needs to be backed up. If you perform backups using an external hard drive or USB/thumb drive, remember to encrypt it. It is also important to have your computer and backup stored in two different locations (for instance, storing your computer at home and your backup at your office).

✓ **Update your OS (operating system) software:** By keeping your device's software updated with the latest patches and fixes, you will be protected from new security issues that develop.

✓ **Beware of data syncing:** To make your life easier, your devices synchronize your app data for you: Apple syncs to your iCloud, and Android and Chrome sync to Google. However, this convenience becomes a security risk when stored client information is sent to Apple servers, Google servers, or Microsoft servers without the HIPAA-required Business Associate

Agreements (BAAs). You can either change the settings on your devices so they no longer sync to apps that handle your client information, or you can download the server's BAA.

✓ **Create a separate user account for your practice:** By creating a separate user account on your computer for your therapy practice, you can prevent potential security errors or breaches to your client's identity and personal information.