# Counseling Intake for Minor

**Amy Menke, MA, Licensed Mental Health Counselor, Certified Life Coach**
**163 5th Avenue Northeast, St. Petersburg, FL 33701**

**Client Information**

Name:______________________________________________________________

Parent/Guardian if client is under 18:________________________________________

Birthdate:____________________ Age:___________

Address:____________________________________________________________

City:______________________________ State:____________ Zip:_____________

Home Phone: _____________________ Cell:________________________________

Email: ______________________________________________________________

School/Employer:_____________________________________________________

Grade/Occupation:____________________________________________________

May I leave a message? If so which phone:___________________________________

Preferred method of follow up (phone, text, email): ____________________________

Do you have a diagnosed medical or mental health condition? If so, please list:

___________________________________________________________________________

___________________________________________________________________________

Please list any medication: ___________________________________________________

___________________________________________________________________________

Goals for Counseling: _______________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Referred By: _________________________________________________________________

**Counseling/Coaching Fees**

The standard fee is $100.00 for a 60 minute individual session; $130.00 for a 90 minute couples session. Fees are to be paid prior to the session beginning. If I fail to cancel with less than 24 hours notice, except in the case of emergency, I understand that I will be expected to pay for the counseling session.

Signed__________________________________________ Date:______________________

If under 18, Parent signature___________________________________________________

Date:__________________

**Texting and Emails**

Please keep in mind that communications via text or email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. Please do not include personal identifying information such as your birth date, or personal medical information in any text messages or emails you send to me. While we can communicate via text or email, this is to inform you that these are not secure forms of communication.

By signing below, I am stating that I understand the counselor's fees, cancellation policy, duty to confidentiality, and limits to electronic forms of communication.

Signed______________________________________ Date:____________________

**Informed Consent for Psychotherapy**
(Individual, Couple, Group, Family)

This document contains important information about professional services and policies. Please read it carefully and note any questions you might have so you can discuss them with me. Once you sign this consent form, it will constitute an agreement between you and me.

## Nature of Counseling Services

Psychotherapy is the process where mental health distresses and disorders are assessed, prevented, evaluated and treated. There are a variety of techniques that can be utilized to deal with the problem(s) that brought you to therapy. These services require your active participation and cooperation.

Psychotherapy has both benefits and risks. Possible risks include the experience of uncomfortable feelings (such as sadness, guilt, anxiety, anger, frustration, loneliness, or helplessness) or the recall of unpleasant events in your life. Potential benefits include significant reduction in feelings of distress, better relationships, better problem-solving and coping skills, and the resolution of specific problems. However, psychotherapy remains an inexact science and no guarantees can be made regarding outcomes.

## Confidentiality

State law and professional ethics protect the confidentiality of all communications between a client and a therapist, and I can release information to others about your therapy only with your written permission (Release of Information form). However, there are exceptions where:

- there is suspected child abuse, elder abuse, or dependent adult abuse.
- a serious threat to a reasonably well-identified victim is communicated to the therapist.
- a threat to injure or kill oneself is communicated to the therapist.
- client is required to sign a release of confidential information by you medical insurance.
- court ordered release of information.
- client initiates a malpractice lawsuit.
- Client is a below age 18, parents have rights to therapeutic information.

## Signature Verifying Agreement

Your signature below indicates that you have read the information in this document, that you have understood it, and that you agree to abide by its terms.

Client signature ______________________________ Date______________
Therapist signature______________________________ Date______________

## Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations, Per HIPAA Regulations

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care, such as referrals,
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

**I have been provided with a "*Notice of Patient Privacy Practices*" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:**

- The right to review the "*Notice*" prior to acknowledging this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

***PLEASE PRINT***

**Restrictions:**

****I request the following restrictions to the use or disclosure of my health information:**

______________________________________________

______________________________________________

****Please tell us with whom we may discuss your protected health information:**

(Example: spouse (name), children (name(s)), other relatives (name(s)), friends or caregivers (name(s)))

______________________________________________

______________________________________________

****Messages or Appointment Reminders:**

May we leave a message at your <u>home</u> using doctor's/practice name: Yes { } No { }

May we leave a message at your <u>work</u> using doctor's/practice name: Yes { } No { }

**Messages will be of a non-sensitive nature, such as, appointment reminders.**

**I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.**

**I fully understand and **accept / decline** (please circle one) the information of this consent.

______________________________ ______________________

Patient/Guardian Signature Date

______________________________

Print Name of Person Signing

*If other than the patient (Patient Name)______________________is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations?

Yes { } No { }

**FOR OFFICE USE ONLY**

{ } Consent form received and reviewed by ______________________ on ______________

{ } Consent form signature refused by patient

{ } Patient unable to sign consent form, Reason: ______________________________