Counseling Intake

Amy Menke, MA, Licensed Mental Health Counselor, Certified Life Coach
163 5th Ave NE, St. Petersburg, FL 33701

Client Information

Name:_____

Parent/Guardian if client is under 18:_____

Birthdate:_____ Age:_____ Marital Status:_____

Please list any children/ age:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone: _____ Cell:_____

Email: _____

Employer:_____ 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.

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 **home** using doctor's/practice name: Yes { } No { }
May we leave a message at your **work** 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: _____

Patient Name: _____ Medical Record No: _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.
8. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____	_____	_____
Patient's/parent/guardian signature	Date	Time
_____	_____	_____
Witness signature	Date	Time