Saratoga Recreation Therapy, LLC

Patient Name: _____ Date of Birth: _____

Guardian Name: _____ Date: _____

Intake and Consultation Packet:

Hello! Welcome to Saratoga Recreation Therapy, LLC. Please take note of several important documents to be thoroughly reviewed, signed and completed in entirety, in order to get you and/or your family on a path to a more purposeful, insightful, and connected life. I am grateful for the opportunity to walk with you and collaboratively create a healing environment that will help your family thrive!

- **Intentions for 'Initial Intake Consultation':** My intentions for the first meeting are to gather an overarching view of the multifaceted, dimensional, and strength-based presentation of you/your child/your family. In addition, obtaining an understanding of what factors could be preventing the ultimate wellness of you/your child/your family will be thoroughly explored. These dimensions and factors range in nature from physical, cognitive and behavioral, to developmental, emotional, spiritual and beyond. Using this longitudinal, historical, and holistic view allows for me to truly understand all aspects of you/your child and your family.

Flow Chart for Records Review and Intake:

- **Step 1:** Please *thoroughly* complete this packet and e-mail the completed material to SaratogaRecreationTherapy@gmail.com *prior to your appointment*. This allows for proper reviewing of materials prior to meeting.
- **Step 2: *Process:*** I will spend a considerable amount of time reviewing the information and the subsequent initial intake appointment will be about one hour in length. Following the intake, appointments are typically 50 minutes in length or more depending on community based interventions.
- **Step 3: *Procedure:*** On the day of your first appointment please bring:
- Credit Card number to be stored for potential future use, as well as a check or cash for the 'Initial Intake Appointment'.
- **Step 4: *Payment:*** The fee for each session is $100.00 for the first hour and $50.00 for every hour thereafter. If you choose, a credit card will be stored on file and charged directly following each visit. There are also options to pay in cash, check, or other means such as Venmo. I will help you arrange payments that are comfortable for you and your family, and I will also remain in close communication outside of therapy hours (though within normal business hours), to work collaboratively on you/your child's care. For example, emails are exchanged and regularly occur through SaratogaRecreationTherapy@gmail.com.

    - All checks must be made out to ***Saratoga Recreation Therapy, LLC.*** Payment is due on the day of service regardless of method of payment.

In addition, there is a $35 dollar fee for bounced checks.

    - Your credit card information must be provided regardless of your preferred method of payment, and in the event you are not prepared with alternate payment at the time of your visit it may be charged.
    - **Cancellation Policy:** There is a 24 hour Cancellation or Rescheduling Policy. Please provide a respectable 24 hour notice in the event you are unable to make your appointment. I reserve the right to charge you the full amount in the event you are unable to provide adequate notice.
- **Step 5:** ***Plan Forward:*** Following the intake, I will then evaluate, interpret, and explore the information you provided, in its entirety, and devise a treatment plan that is comfortable for you/your child/your family. It is collaborative in nature, and is meant to enhance and focus on wellness and healing.

By signing below, you acknowledge and accept the terms as outlined above, including but not limited to, the intake process, the cancellation policy, the length of sessions, the fees for sessions, and the approved methods of payment. By signing below, you also acknowledge that you do not hold Saratoga Recreation Therapy, LLC liable for the outcome of any services offered, and have freely participated in the services rendered.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Authorization to Obtain, Release, or Disclose Protected Health Information

- **Patient Information:**

Name: _____

Parent/Guardian Name (If applicable): _____

Date Of Birth: _____

Address: _____

Phone Number: _____

Email Address: _____

- **Recipient Information for Release or Disclosing Information:**

I, _____, do hereby authorize Saratoga Recreation Therapy, LLC to release or disclose my mental health information to the person or facility below:

Name of person/facility to receive mental health information:

_____

Phone Number: _____

Fax Number: _____

Address: _____

Information to be Released or Disclosed:

( ) My entire mental health record

( ) Only those portions pertaining to: _____

(Specific provider name and/or dates of treatment)

( ) Authorization to release Psychotherapy Notes ONLY

( )Other: _____

- **Information to be Obtained:**

I, _____, do hereby authorize Saratoga Recreation Therapy, LLC to obtain my personal information from the person or facility below:

Name of person/facility to provide information:
_____

Phone Number: _____

Fax Number: _____

Address:
_____

Please indicate whether you authorize Saratoga Recreation Therapy, LLC to obtain information from:

( ) Primary Care Doctor/Medical Records ( ) Legal Information

( ) Previous Mental Health Practitioners ( ) Vocational/Employment

( ) Academic Institutions and Affiliates (School psychologist, teachers, etc.)

Expiration:

Date of Authorization: _____/_____/_____Authorization to expire on one year from signature, or upon the happening of the following event:

Purpose of Obtaining or Disclosing Information:

( ) Further mental health care/ Psychological ( )Other: ( ) Educational/Institution Communication ( ) At the request of the individual ( )Vocational rehab, evaluation

Authorization and Signature:

I authorize the obtaining, disclosing, or releasing of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be obtained or disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient

unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. I understand that if I have any questions about my health information I can contact Saratoga Recreation Therapy, LLC directly.

Guardian Name (if applicable): _____

Guardian Signature (if applicable): _____

Patient Name: _____

Patient Signature (if applicable): _____

Consent to Treatment

1. I hereby request Saratoga Recreation Therapy, LLC, provide treatment as deemed appropriate by the provider. These sessions may include individual therapy, group therapy, family therapy, and other forms of integrative services such as community integration, art therapy, bibliotherapy, play therapy, music therapy, etc. These sessions may take place within the community, a different agreed upon location, or at times, may utilize telehealth measures such as phone or Zoom.
2. I understand that all information concerning participation of myself or my child is confidential and that no information will be given without written consent from me.
3. I agree that I have been fully oriented to the services offered, and the treatment that is being provided to me. I have reviewed my rights and responsibilities as a patient/guardian, and I am aware of the grievance process.
4. I agree for myself/my child to receive services, I understand I shall assist in following the individualized treatment plan that has been developed, and I shall ensure that all scheduled appointments are kept.
5. I also agree to promptly pay Saratoga Recreation Therapy, LLC all charges for providing services, as agreed upon in advance via confirmation. As an out-of-network provider, Saratoga Recreation Therapy, LLC is not affiliated or participating with any insurance company. I understand that, shortly after my/my child's session, I will be provided with a receipt.
6. I understand that Saratoga Recreation Therapy, LLC cannot be held liable or responsible for the outcome of my or my child's results from services sought either by Saratoga Recreation Therapy, LLC, or from recommendations such as social skills groups, psychopharmacology, etc. The efficacy of such measures is multifaceted, and I understand there is no guarantee in outcome.
7. I understand that Saratoga Recreation Therapy, LLC does not operate as a crisis center, nor does it maintain an emergency phone line. Practitioners are only available during normal business hours, and contact during those business hours is up to the discretion of the specific provider. In the event of an emergency, I agree to contact 911, or visit my nearest emergency room.

I, _____, understand and have read the above mentioned consent form.

Guardian Name (if applicable): _____

Guardian Signature (if applicable): _____

Patient Name: _____

Patient Signature (if applicable): _____

Confidentiality Form

All information given to or obtained by Saratoga Recreation Therapy, LLC will be used only for you/ your child's treatment and administration services such as scheduling. Information may be released for the purpose of you/your child's treatment if required by Federal Law or in response to legal investigations, CPS report and court order. Information requested about you/ your child for any other purpose can only be released by your written consent.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION: The following categories detail the various ways in which we may use or disclose your personal health information. For each category of uses or disclosures we will give you illustrative examples. It should be noted that while not every use or disclosure will be listed, each of the ways we are permitted to use or disclose information will fall into one of the following categories.

Your Authorization. Except as outlined above, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. This form will describe what information will be disclosed, to whom, for what purpose, and when. You have the right to revoke that authorization in writing, except to the extent we have already relied upon it.

Uses and Disclosures for Treatment. We will make uses and disclosures of your personal health information as necessary for your treatment. For instance, doctors, nurses, and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan or course of treatment for you/your child that may include evaluations, treatment planning, medications, tests, etc.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. At times it may be necessary for us to provide certain personal health information to one or more of these outside persons or organizations who assist us with our payment/billing activities and health care operations. In such cases, we require these business associates to appropriately safeguard the privacy of your information.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization. Subject to conditions specified by law:

- We may release your personal health information for any purpose required by law;
- We may release your personal health information to certain governmental agencies if we suspect child/elderly/or other incapacitated individual abuse or neglect. We may also release your personal health information to certain governmental agencies;
- If we believe you/your child to be a victim of abuse, neglect, financial exploitation, or domestic violence;
- We may release your personal health information if required by law to a government oversight agency conducting audits, investigations, inspections and related oversight functions;
- We may use or disclose your personal health information in emergency circumstances, such as to prevent a serious and imminent threat to a person or the public;
- We may release your personal health information if required to do so by a court or administrative order, subpoena or discovery request; in most cases you will have notice of such release.

Guardian Name (if applicable): _____

Guardian Signature (if applicable): _____

Patient Name: _____

Patient Signature (if applicable): _____

PATIENT RIGHTS STATEMENT

1. The right to receive appropriate humane treatment.
2. The right to be protected form harm and to be free from mental, physical and sexual abuse.
3. The right to participate, in a manner appropriate to the individual's condition, in the development of a collaborative plan of treatment.
4. The right to receive treatment as agreed upon by both parties.
5. The right to be told in appropriate terms and language of:
    a. The content, course, and objectives of treatment.
    b. The nature of significant possible negative effects of treatment.
    c. The name, title and role of staff members who are directly responsible for carrying out the individual's treatment when appropriate.
6. The right of the individual to have limited access to his/her treatment records, as determined by Saratoga Recreation Therapy, LLC
7. The right to refuse treatment.
8. The right, prior to admission, to explain in terms and language that the individual can understand, the charges and fees that will be required to pay.
9. The right to be informed of payment methods.
10. The right to file a grievance if the individual is not satisfied with the treatment.

I, _____ have been informed of the Patients Rights by Saratoga Recreation Therapy, LLC. By entering my signature below, I am acknowledging that I understand in all terms, verbiage language and concepts herein and throughout the document in its entirety.

Guardian Name (if applicable): _____

Guardian Signature (if applicable): _____

Patient Name: _____

Patient Signature (if applicable): _____

INFORMED CONSENT FOR TELEHEALTH

This Informed Consent for Telehealth contains important information focusing on providing healthcare services using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

- **Benefits and Risks of Telehealth**

Telehealth refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telehealth is that the patient and clinician can engage in services without being in the same physical location. This can be helpful particularly during the Coronavirus (COVID-19) pandemic in ensuring continuity of care as the patient and clinician likely are in different locations or are otherwise unable to continue to meet in person. It is also more convenient. Telehealth, however, requires technical competence on both our parts to be helpful. Although there are benefits of telehealth, there are some differences between in-person treatment and telehealth, as well as some risks. For example:

- **Risks to confidentiality:** As telehealth sessions take place outside of the office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end, I will take reasonable steps to ensure your privacy. It is important; however, for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.
- **Issues related to technology:** There are many ways that technology issues might impact telehealth. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.
- **Crisis management and intervention:** Usually, I will not engage in telehealth with clients who are currently in a crisis situation requiring high levels of support and intervention, and in a crisis situation, you may require a higher level of services. If what I provide (an office-based, non-crisis level of service) does not suit your needs, please contact appropriate services, call 911, or proceed to the nearest emergency room.
- **Confidentiality** I have a legal and ethical responsibility to make best efforts to protect all communications that are a part of telehealth services. The nature of electronic communications technologies, however, is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telehealth sessions and having passwords to protect the device you use for telehealth). For communication between sessions, I will often use email and text messaging with your permission. However, despite my best efforts, you should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. If you prefer to discuss confidential matters solely in person or by phone, please let me know.
- **Fees** The same fee rates will apply for telehealth as apply for in-person therapy and you will be solely responsible for the entire fee of the session. If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

- **Records and Recording** The telehealth sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.
- **Informed Consent** This agreement is intended as a supplement to the general informed consent and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

Guardian Name (if applicable): _____

Guardian Signature (if applicable): _____

Patient Name: _____

Patient Signature (if applicable): _____

HISTORY AND PSYCHOSOCIAL FORMS

1. Identifying Information:

A. Patient's Name: _____

1. Patient's Address: _____
2. Patient's Living Situation: _____
3. Patient's Age/ Date of Birth: _____
4. Religion: _____
5. History Provided By:_____

B. Patient's Mother/Father/Caregiver (circle) Name: _____

1. Age: _____
2. Date of Birth: _____
3. Occupation: _____
4. Work Address: _____
5. Home Phone Number: _____
6. Cell Phone Number: _____
7. Email Address: _____

C. Patient's Mother/Father/Caregiver (circle) Name: _____

1. Age: _____
2. Date of Birth: _____
3. Occupation: _____
4. Work Address: _____
5. Home Phone Number: _____
6. Cell Phone Number: _____
7. Email Address: _____

D. Sibling Information (Name, age, residence, etc.):

_____

E. Name, ages, and relationship of others who reside in the home:

_____

F. Credit Card Information to be kept on file:

1. Name on Card: _____
2. Credit Card #: _____
3. Expiration Date: Security Code: _____
4. Address on File: _____
5. Phone Number: _____

2. Chief Complaint/ Present Symptoms: (Time of onset, precipitating events):

_____

_____

3. Presenting Problem(s): (Please Circle All That Apply and Indicate Past or Present):

Verbal Aggression	Involvement with the Law	Phobic Behavior
Physical Aggression	Starts Fires	Panic Attacks
Anxiety	Abuse of Animals	Mania
Compulsions	Wetting/Soiling the Bed	Gambling
Depression	Regression	Disruptive Behavior at Home
Sleep Difficulty	Dissociation	Difficulty Sustaining Romantic
Impulsivity	Hallucinations	Relationships
Substance Abuse	Delusions	Gender Issues
Poor School Performance	Nightmares	Irritability
Constant Worrying	Poor Interpersonal Skills	Low Energy
Perfectionism	Abusive Relationships	Memory Impairment
Bulimia	Avoidant Behavior	Suicidal Behavior
Anorexia	Identity Conflict	Suicidal Thinking
Lack of Assertiveness	Difficulty Planning Future	Poor Self Esteem
Fear of Rejection	Behavior with Parents	Traumatic Experience
Excessive Shyness	Disinterest and Lack of	Underachievement
Daydreaming	Motivation	Careless Performance on
Body Image Disturbance	Poor Attention to Health	Assignments
	Poor Personal Hygiene	

Other/More Information:

_____

_____

4. Presenting Stressors (Please Circle All That Apply and Indicate Past or Present) Other/More Information:

Abuse	Conflict with peers	Marriage
Arrest	Conflict with teachers	Parental discord
Financial stressors	Death of child	Parental divorce
Birth of child	Death of loved one	Peer interaction

Birth of sibling Breakup of relationship Change in residence Change of employment Change of school Chronic illness Conflict with boss Conflict with child Conflict with co-worker	Disability Divorce Divorce of parents Family conflict Family illness Illness of child Illness of parent Lawsuit/ court trial	Personal injury Pregnancy Retirement School suspension Unemployment Victim of violent crime Witnessing of a crime

Other/More Information: _____

_____

5. Past Psychiatric History (Past Treatments):

Psychiatric Hospitalization (Inpatient Treatment):

_____

Dates: _____ Reason: _____

Outcome:

_____

Psychiatric Outpatient Treatment: _____ Name of Previous Provider: _____

Dates: _____ Reason: _____

Outcome: _____

Previous Psychiatric Medications:

_____

Name: _____ Dose: _____

Dates Used: _____ Reason: _____

6. Realms of Functioning: Please describe the patient/yourself within these various realms. Please include areas of strength and areas of concern where applicable.

a. Family Relations:

_____

_____

b. Social Relations:

_____

_____

c. Employment Experiences:

_____

_____

d. Academic Performance:

_____

_____

e. Self-Care Behaviors (Hygiene, nutrition, exercise, sleep, etc. Please include any significant weight gain or loss, as well as changes in sleeping.):

_____

_____

f. Spirituality/ Religion:

_____

_____

7. Risk Factors:

Assessment of Suicide Risk (Check):

	Current	Past
Suicidal Thoughts		
Suicidal Attempts		
Suicide Plan		
Suicide Means		
Details/More Information:		

Assessment of Dangerousness to others/Homicide Risk (check):

	Current	Past
Homicidal Thoughts		
Homicidal Attempts		
Homicidal Plan		
Homicidal Means		
Details/More Information:		

8. Substance Abuse History: (if yes please explain) Yes No

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9. Developmental History:

A. Developmental History:

1. Were there any issues/complications during pregnancy for the patient or mother?
   _____
2. Drug/alcohol/smoking during pregnancy?
   _____
3. Were the patient's developmental milestones met on time?
   _____
4. Was the patient able to emotionally attach to caregivers?:
   _____
5. Were there any speech/language Problems?
   _____
6. Were there any gross motor delays (walking etc.)?
   _____

7. Does the patient have a history of bed wetting or fecal soiling?

_____

B. Early Childhood:

1. Name of Preschool if Applicable:

_____

2. Were there any major issues/adjustments? (Childhood illness, infections, trauma, injuries, divorce, bullying, behavioral problems, etc. – Include Dates/Ages):

_____

3. What was the patient's personality and play pattern as a young child?

_____

4. What type of emotional expression was common for the patient? (e.g. joyous, frightened/angered/worried easily, reclusive, easy going, cheerful, etc.)

_____

5. Please describe the patient's academic performance:

_____

C. Middle School:

1. Name of Middle School if Applicable:

_____

2. Were there any major issues/adjustments? (Illness, infections, trauma, injuries, divorce, bullying, behavioral problems, etc.- Include Dates/Ages):

_____

3. What were the patient's personality traits and social patterns?

_____

4. What type of emotional expression was common for the patient? (e.g. joyous, frightened/angered/worried easily, reclusive, easy going, cheerful, etc.)

_____

5. Please describe the patient's academic performance:

_____

D. High School:

1. Name of High School if Applicable:

_____

2. Were there any major issues/adjustments? (Illness, infections, trauma, injuries, divorce, bullying, behavioral problems, etc.- Include Dates/Ages):

_____

3. What were the patient's personality traits and social patterns?

_____

4. What type of emotional expression was common for the patient? (e.g. joyous, frightened/angered/worried easily, reclusive, easy going, cheerful, etc.)

   _____

5. Please describe the patient's academic performance:

   _____

10. Medical History: Please include any current and past medical illness, diagnosis, and treatment (allergies, surgery, injuries, prescribed medications/ dosages, over the counter medications/dosages including supplements, etc.)

_____

_____

11. History of Abuse/Trauma:

1. Has the patient experienced trauma in any form? If yes, please explain, including dates:

   _____

   _____

2. Has the patient experienced abuse (physical, sexual, emotional, verbal, abandonment or neglect)? If yes, please explain including alleged perpetrator, dates, and resolution (reported to authorities etc.):

   _____

   _____

12. Family History:

1. Is there a family history of Mental Illness? If so please specify the illness and the family member.

   _____

   _____

2. Is there a family history of Substance Abuse? If so please specify the substance and family member.

   _____

   _____

3. Is there a family history of Medical Illness? If so please specify the illness and the family member.

   _____

   _____

4. Is there a family history of Suicide? If so please specify the family member.

   _____

   _____

13. Legal History:

1. Does the patient have current or past experiences with the law? If yes, please explain the circumstances and resolution:

   _____

   _____

14. Patient's Strengths and Interests:

1. Strengths: (Circle all that apply)

Capacity for Analytic Thinking	Good Social Support System
Capacity for Critical Self Evaluation or Introspection	Maintains Stable Employment
Capacity for Openness	High Level of Emotional Support from Family
Capacity to Tolerate Painful Emotions	Intellectual Resources and Insight
Flexibility in Thinking and Behavior	Interested in Relationships
Good Ability to Establish Rapport	Mature
Good Capacity for Empathy/Compassionate	Responds well to peers and teachers,
Good Expressive Language and Communication Skills	Motivated for Treatment
	Special Skills
Good Personal Hygiene	Empowered
Good Physical Health	Good Level of Self Esteem
Creative	Thinking is Well Organized
Passionate About Life Activities	Other:_____

2. Leisure Interest Form:

Domain	Activity	Description	Interest/ Engagement			Enjoyment		
			Lots	Some	None	Past	Now	Future
Social	Group Outings							
	Local Clubs							
	Visiting Others							
	Volunteering							
	Live Music							
	State Parks							
	Museums							
	Theater							

	Other:							
			Lots	Some	None	Past	Now	Future
Physical	Yoga							
	Hiking							
	Run/Jog							
	Nature Walks							
	Pickleball							
	Team Sports							
	Dance							
	High Ropes Adventure Course							
	Rock Climbing							
	Weight Lifting							
	Ski/Snowboard							
	Other:							
			Lots	Some	None	Past	Now	Future
Emotional	Therapeutic Animals							
	Journaling							
	Scrapbooking							
	Gardening							
	Fishing							
	Other:							
			Lots	Some	None	Past	Now	Future
Cognitive	Trivia							
	Board Games							
	Bingo							
	Reading							
	Movies							
	Arts and Crafts							

	Creative Writing							
	Other:							
			Lots	Some	None	Past	Now	Future
Spiritual	Meditation							
	Community Service							
	Musical Expression							
	Painting							
	Pottery							
	Reflection in Nature							
	Visiting Places Of Worship							
	Prayer							
	Other:							

15. Patient/ Caregiver Expectations for Treatment: Please explain your expectations/hopes/goals of treatment, as well as any significant questions you have:

_____

_____

_____

It is an honor to embark on this journey with you and/or your family! I look forward to discovering and embracing renewed strengths and watching you thrive, as you bravely explore, insightfully heal, and consciously evolve!