Sandee Isaacs, LCSW
678-948-8390
sandeelcsw@gmail.com

Client Intake Form

Date: _____ Date of Birth: _____ Age: _____

Client Name: _____ Phone Number: _____

Address: _____

_____

Email Address: _____ Referred By: _____

Names and Ages of Siblings: _____

Single Married Divorced Male Female Student
(please circle) (please circle) (please circle)

If client is a Student: Grade in School: _____ School: _____

If client is a minor under the age of 18:

Mother's Name:_____ Email: _____

Cell: _____ Home: _____ Office: _____

Father's Name: _____ Email: _____

Cell: _____ Home: _____ Office: _____

Any History of Mental Health challenges in the family/extended family? Please describe.

_____

_____

Please list any medications? _____

Presenting Problem: _____

_____

_____

Personal Goals for Treatment: _____

_____

_____

_____

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Psychotherapy Information and Informed Consent

Confidentiality - Your records and the information discussed between us are strictly confidential. Any information I have about you, including the fact that you are in therapy, can be released only with your written consent (or consent of legal guardian in the case of a minor). You may direct me to share information with whomever you choose, and you can revoke that permission at any time.

The following are legal exceptions to your right to confidentiality:

- If I have reason to believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police. I would certainly explore other options with you prior to taking this step.
- If I have reason to believe that you intend to harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
- If I have reason to believe you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone who is doing this, I must inform the Department of Family and Children's Services.

I. **Record Keeping** - I normally keep brief records of our sessions. You have the right to request that I make a copy of your file and make your file available to other health care providers by providing a written request. I maintain your records in a secure location in my office.

II. **Diagnosis** - If an insurance company is paying for part of your bill, I am usually required to give a diagnosis to that third party in order to be paid. I will be glad to discuss your diagnosis with you.

III. **Other Rights** - You have the right to ask questions about anything that happens in therapy. I am always willing to discuss why I have decided to do what I am doing, and to look at alternatives that might work better.

IV. **Termination** - You have a right to end your therapy at any time. Please discuss any conflicts or disagreements you have with me before deciding to leave treatment, and give me an opportunity to resolve them with you directly, as this can be a very important part of your experience here. If these measures are unsuccessful, you have the right to request a referral to another therapist.

V. **Managed Mental Health Care** - If your therapy is being paid for by a managed care company, there are usually other limitations to your rights as a client, imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, and to decide their time period within which you must complete your therapy with me. This decision may differ significantly from your and/or my assessment of what is needed. They may also decide you must see another therapist in their network rather than me, if I am not on their list. Such firms also require some sort of detailed report of your progress in therapy. I have no control over their rules, but will do my best to assist you in communication with the managed care company as needed.

YOUR RESPONSIBILITIES AS A CLIENT

I. **Scheduling** - You are responsible for coming to your session at the time we have scheduled and/or being at home or school if I am coming to you. If you are late, we must still end on time and not run over into the next person's session**. If you miss a session, or cancel without a 48 hour business day notice, you will be charged the full fee for that session**. If you have a Monday appointment, you must cancel on the Friday before the appointment. Please note that insurance companies will not reimburse you for missed appointments. If you want to reschedule an appointment, and I am able to offer you another time during that same week, you will not be charged for the original appointment time.

I am away from the office a few times per year for vacation and professional conferences. I will always give you notice and a colleague will be available for emergencies.

II. **Payment** - Payment is required at the time of service unless other arrangements have been made. If you eventually refuse to pay your debt, I reserve the right to give your name to a collection agency.

- Initial Intake and Evaluation $295 - 90 minutes
- Individual/Family Sessions $195 - 50 minutes
- Should the session go beyond the allotted time, there will be a $35 charge for each 15 minutes or any part thereof
- If a home evaluation or session is needed there is an additional $50 travel charge.

III. **Insurance** - If you are filing insurance for your therapy, it is important for you to understand the contract is between you and your insurance company. You are responsible for paying your fee at the time of service and filing for reimbursement from your insurance company. You must pay any deductibles and co-payments, arrange for any pre-authorization necessary.

Emergency Contacts:

Name: _____ **Phone Number:** _____

Name: _____ **Phone Number:** _____

Client Consent to Treatment

I have read this agreement and asked any questions necessary to understanding the agreement. I consent to the release of any medical information necessary to complete the billing process. I understand my rights and responsibilities as a client and my therapist's responsibilities to me.

_____

(Print Client Name) or (Parent Name if under 18)

_____ _____

(Client Signature) or (Parent Signature if under 18) **Date**

Release of Information
Waiver of Social Worker and Client Privileged Communications

To: _____
(Name of Individual releasing information to)

_____
(Street Address of Individual releasing information to)

_____
(City, State, Zip of Individual releasing information to)

RE: _____
(Name of Client)

_____
(Street Address of Client)

_____
(City, State, Zip of Client)

I have been advised that there is a special privilege between a social worker and client protecting all admissions and communications from the client to the social worker, unless the privilege is waived by the client. I specifically waive my protection of all privileged admission and communications between myself and Sandee Isaacs, LCSW, my social worker, to _____ and further authorize Sandee Isaacs, LCSW, to
(Name of individual to whom waiver of privilege is granted)
furnish _____ all information and records and opinions
(Name of individual to whom waiver of privilege is granted)
_____ request (s) concerning findings, treatment rendered and opinions regarding my
(they/he/she/it)
condition, treatment and care. This waiver of my privilege admissions and communications to my social worker is a limited waiver to _____
(Name of individual to whom waiver of privilege is granted)
and is not a general waiver of my privilege to anyone else. The foregoing waiver and authority shall continue in force until revoked to me in writing.

_____ _____
(Print Client Name) or (Parent Name if under 18) **(Client Signature) or (Parent Signature if under 18)**

_____
(Date)