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 – All information shared in therapy sessions is considered confidential and protected under federal and state law. This means I cannot share information about you or your treatment without your written permission. This includes the content of our sessions, your records, and the fact that you are receiving services. Permission to release information can be revoked at any time.

The following are legal and ethical exceptions to confidentiality, including but not limited to:

- **Risk of Harm** - if you disclose an intention to harm yourself or someone else, I may take appropriate action to ensure safety, which may include contacting emergency services or other appropriate supports
- **Suspected Abuse or Neglect** - I am legally required to report suspected abuse or neglect of children, elders, or dependent adults to appropriate authorities.
- **Court Orders or Legal Proceedings** - if a court of law issues a subpoena or court order, I may be required to release information. I will take steps to limit disclosure and inform you when possible.
- **Supervision and Consultation**
  To support ethical practice, I may consult with professional peers or supervisors. In such cases, identifying details will be minimized or omitted to protect your privacy.

I. **Record Keeping** – As a licensed therapist, I am required to maintain records of our work together. These records help ensure the quality and continuity of care and may include: Intake forms and consent documents, session notes (progress notes), treatment plans and goals, communications relevant to your care, copies of any releases of information. Your records are stored securely and kept confidential in accordance with applicable federal and state laws. 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. To protect your confidentiality, I may provide a treatment summary instead of full records, depending on the nature of the request and what is clinically appropriate.

II. **Diagnosis** - If you are requesting a superbill for possible reimbursement, please note that a mental health diagnosis is typically required. This diagnosis will be based on information you provide and will align with criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). This diagnosis becomes part of your clinical record and may be shared with your insurance provider if you are submitting for reimbursement. While diagnoses are often necessary for coverage, they may carry implications for future insurance coverage, life insurance applications, or legal matters. If you have concerns about receiving a diagnosis, please let me know and we can discuss together.

III. **Other Rights** - You have the right to ask questions about anything that happens in therapy. I am always willing to discuss treatment plans, 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 therapeutic experience. If these measures are unsuccessful, you have the right to request a referral to another therapist.

YOUR RESPONSIBILITIES AS A CLIENT

I. **Scheduling** - You are responsible for coming to your session at the time we have scheduled. Appointments are typically 50 minutes, scheduled on a weekly or biweekly basis, depending on your needs and treatment plan.

Cancelations - If you are unable to attend a scheduled session, please notify me at least **48 hours in advance** by phone or secure messaging (if you have a Monday appointment, you must cancel on the Friday before the appointment.) **Cancellations made with less than 48 hours' notice** will be charged the **full session fee**.

No-shows (missed appointments without notice) – **will be charged the full session fee**. Please note that insurance companies will not reimburse you for missed/late/canceled appointments. If you arrive late, your session will still end at the scheduled time. If you are more than 15 minutes late and have not contacted me, the session may be considered a no-show.

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. If debt remains unpaid, I reserve the right to give your name to a collection agency. The signed Credit Card Authorization Form provides consent to charge through Ivy Pay, a HIPPA compliant platform.

- Initial Intake and Evaluation $350 - 90 minutes
- Individual/Family Sessions $225 - 50 minutes
- Sessions that extend beyond the allotted time will be billed at my standard hourly rate, prorated in 15-minute increments
- If a home evaluation/session is needed, travel time will be billed at my standard hourly rate

III. **Coordination of Care / Collaboration with Other Professionals**

At your request, I am available to communicate and collaborate with other professionals involved in your care. These communications are often helpful in supporting your treatment and ensuring continuity of care.

Please note that any such collaboration, including written reports, phone calls, emails, or meetings with third parties, will be billed at my standard hourly rate, prorated by the time spent. This includes, but is not limited to:

- Consultation with medical providers
- Written reports or treatment summaries
- Participation in meetings or legal proceedings
- Communication with schools or other institutions

Written authorization will be required before any information is released.

IV. **Insurance** - I am considered an out-of-network provider and do not bill insurance companies directly. Payment is due in full at the time of service. If you have out-of-network benefits, I can provide you with a superbill (an itemized receipt) that you may submit to your insurance company for potential reimbursement. Please note that reimbursement is not guaranteed and depends on your specific insurance plan. I encourage you to contact your insurance provider in advance to understand your out-of-network mental health benefits.

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

Consent and Authorization for Release of Information
Waiver of Social Worker and Client Privileged Communications

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

Client Name: _____ Date of Birth: _____

A Release of Information (ROI) form is a legal document used to obtain a client's written permission to share their protected health information (PHI) with a third party, in compliance with laws such as HIPAA (Health Insurance Portability and Accountability Act).

The following is an authorization for the stated parties to consult with one another regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information with your signature/date below. Signing this bi-directional ROI gives permission to both parties to consult.

I, _____ (client/legal guardian), hereby authorize Sandee Isaacs, LCSW and the following party or parties to discuss my treatment, information and records obtained during the course of psychotherapy treatment including but not limited to diagnosis. Please list any person/entity you would like me to communicate with and list contact information):

Name: _____ Phone/Email: _____

Name: _____ Phone/Email: _____

Name: _____ Phone/Email: _____

Please indicate your preference regarding the information to be shared:

____ The parties stated above may discuss my medical and or mental health information without limitations.

____ I would prefer to limit the information shared between the party stated above. The limitations are:

_____

_____

The above-named parties, therapist and person(s) or entity (entities) agree to exchange information only between themselves (and/or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Client Rights:

- **I understand that I have the right to revoke this authorization at any time by providing written notice to my provider.**
- **I understand that a revocation will not apply to information already released to other parties.**
- **I understand that I am not required to sign this form to receive treatment.**
- **I understand that once information is disclosed, it may no longer be protected by HIPAA and could be re-disclosed by the recipient.**

Signature of Client/Guardian: _____ Date: _____