*InnerShanti*

*(801) 400-2931*



**CLIENT INTAKE INFORMATION**

Please provide the following information for our records. Leave any question you would rather not answer blank. Information you provide is held to the same standards of confidentiality as in therapy. Please print out this form and bring it to your first session.

Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Middle Initial)

Date of Birth: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_ Male \_\_\_Female

Local Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street Number) (City) (State) (Zip)

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please be aware that email might not be confidential/secure

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Phone) (Relationship to you)

What is the highest grade completed in school by the individual requesting treatment?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you here? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Person’s name) (Name of agency/position)

Race/Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:

\_\_ Never Married \_\_ Partnered \_\_ Married \_\_ Separated \_\_ Divorced \_\_ Widowed

Children at Home:

(Include first, middle, and last name) Age: Birth date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mark all possible times you are available for an appointment.**

| **TIME** | **MONDAY** | **TUESDAY** | **WEDNESDAY** | **THURSDAY** | **FRIDAY** | **SATURDAY** |
| --- | --- | --- | --- | --- | --- | --- |
| **09:00 AM** |  |  |  |  |  |  |
| **10:00 AM** |  |  |  |  |  |  |
| **11:00 AM** |  |  |  |  |  |  |
| **12:00 AM** |  |  |  |  |  |  |
| **01:00 PM** |  |  |  |  |  |  |
| **02:00 PM** |  |  |  |  |  |  |
| **03:00 PM** |  |  |  |  |  |  |
| **04:00 PM** |  |  |  |  |  |  |
| **05:00 PM** |  |  |  |  |  |  |
| **06:00 PM** |  |  |  |  |  |  |
| **07:00 PM** |  |  |  |  |  |  |

**CONFIDENTIAL INTAKE QUESTIONNAIRE**

What type of services are you seeking? Circle all that apply.

Individual therapy Couples therapy Family therapy

Massage Therapy Energy Work Yoga Therapy

Are you currently receiving psychiatric services, counselling or psychotherapy elsewhere?\_\_ Yes\_\_No

If yes, with whom and where ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous psychotherapy? \_\_\_Yes \_\_\_No

With whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking prescribed psychiatric medications (antidepressants or others)?

\_\_\_ Yes \_\_\_ No

For what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why are you currently seeking therapeutic services at this time?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please use the scale to indicate your level of concern with that problem. **(Only rate those that apply)**.

(small concern) **1 2 3 4** (high concern)

1. Depression \_\_\_\_\_\_\_\_\_\_\_\_
2. Stress/Anxiety \_\_\_\_\_\_\_\_\_\_\_\_
3. Death/grief/loss \_\_\_\_\_\_\_
4. Drugs/alcohol \_\_\_\_\_\_\_
5. Emotional Abuse \_\_\_\_\_\_\_
6. Physical Abuse \_\_\_\_\_\_\_
7. Sexual Abuse \_\_\_\_\_\_\_
8. Eating problems \_\_\_\_\_\_\_
9. Marital issues \_\_\_\_\_\_\_
10. Relationship issues \_\_\_\_
11. Family issues \_\_\_\_\_\_\_
12. Sexuality \_\_\_\_\_\_\_
13. Self Esteem \_\_\_\_\_\_\_
14. Spirituality \_\_\_\_\_\_\_
15. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health and Social Information:**

1. How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Excellent

1. Please list any persistent physical symptoms or health concerns (ex. Diabetes, migraines/headaches, chronic pain, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you having any problems with sleep habits? \_\_ Yes \_\_ No

Please check where applicable:

\_\_ Sleeping too little \_\_ Sleeping too much \_\_ Poor sleep quality \_\_ Disturbing dreams

\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How many times a week do you exercise?

How long each time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What physical activities do you engage in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you regularly use alcohol? \_\_\_ Yes \_\_\_ No

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any problems with appetite or eating habits? \_\_\_ Yes \_\_\_ No

Please check where applicable:

\_\_Binging \_\_\_Restricting \_\_\_Appetite increase \_\_Appetite decrease

Have you had any significant weight change in the last 3 months? \_\_\_ Yes \_\_\_ No

1. How often do you engage in recreational drug use?

\_\_ Daily \_\_Weekly \_\_Monthly \_\_Rarely \_\_Never

1. Are you currently in a romantic relationship? \_\_\_ Yes \_\_\_ No

On a scale of 1-10, 1 being extremely poor and 10 being excellent, how would you rate the quality of this relationship? \_\_\_\_\_\_\_\_\_\_\_

1. Have you had suicidal thoughts recently? \_\_Frequently \_\_Sometimes \_\_Rarely \_\_Never

Have you had them in the past? \_\_Frequently \_\_Sometimes \_\_Rarely \_\_Never

1. What, if any, significant life changes or stressors have you experienced in the last year?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupational Information:**

If you are employed, what is your current position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you happy at your current position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any work-related stressors, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Religious/Spiritual Information:**

Do you consider yourself to be religious? \_\_\_\_ Yes \_\_\_\_\_ No

If yes, what is your faith? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, do you consider yourself to be spiritual? \_\_\_\_ Yes \_\_\_\_ No

**In the past 12 months, have you experienced:**

Extreme Anxiety: \_\_\_Yes \_\_\_No

Panic Attacks: \_\_\_ Yes \_\_\_No

Extreme depressed mood: \_\_\_Yes \_\_\_No

Wild Mood Swings: \_\_\_Yes \_\_\_No

Phobias: \_\_\_ Yes \_\_\_No

Sleep Disturbances: \_\_\_Yes \_\_\_No

Hallucinations: \_\_\_Yes \_\_\_No

Unexplained losses of time: \_\_\_Yes \_\_\_No

Unexplained memory lapses: \_\_\_ Yes \_\_\_No

Frequent Body Complaints: \_\_\_ Yes \_\_\_No

Body Image Problems: \_\_\_ Yes \_\_\_ No

Repetitive Thoughts (Obsessions): \_\_\_Yes \_\_\_No

Repetitive Behaviours (Frequent checking, hand-washing, etc): \_\_\_Yes \_\_\_No

Homicidal Thoughts: \_\_\_Yes \_\_\_No

Suicide Attempt: \_\_\_Yes \_\_\_No

**Family Mental Health History:**

Has anyone in your family (immediate family members or relatives) experienced difficulties with the following? (Check any that apply and list family members, ex. Parent, Aunt, Sibling, etc.):

**Difficulty Family Member**

Depression \_\_\_Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bipolar Disorder \_\_\_Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety Disorders \_\_\_Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Panic Attacks \_\_\_Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Schizophrenia \_\_\_Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol/Substance Abuse \_\_\_Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eating Disorders \_\_\_Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Learning Disabilities \_\_\_Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicide Attempts \_\_\_Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Abuse \_\_\_Yes \_\_\_No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other information:**

What are your goals for therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you consider to be your strengths? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are some effective coping strategies you've learned so far in life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is included in your support network (ex. family, friends, colleagues, community groups, etc)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MESSAGE PERMISSION FORM**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give staff at InnerShanti permission to leave messages:

on my answering machine Yes \_\_\_ No \_\_\_

with my spouse/partner Yes \_\_\_ No \_\_\_

at my email address Yes \_\_\_ No \_\_\_

\_\_\_\_\_ **YES** I want a weekly reminder call/text \_\_\_\_\_ **NO** I do not want a weekly reminder call/text

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

*Inner Shanti*



**Jessica Salmon & Terri Thompson**

**REQUEST FOR TREATMENT, CONFIDENTIALITY,**

**AND HOLD HARMLESS FORM**

I request services at InnerShanti. I understand that all information obtained concerning me and/or my children or anything I tell the staff, orally or in writing, will be kept confidential within InnerShanti with these exceptions:

1. I sign a release of information specifying to whom the information is to go, what information I want released, and for what time period information may be released.
2. Upon a proper court order.
3. In emergencies when it appears I may be a danger to myself or to others.
4. In child abuse cases as the law requires.
5. As required by funding sources for employees of InnerShanti to receive payment.

I hold harmless Jessica Salmon & Terri Thompson for the fulfillment of their legal responsibilities stated above. All of the information of this sheet has been clearly explained to me by a staff member and I acknowledge that I understand it and am willing to abide by it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness

**CONSENT TO TREATMENT**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby give my consent to receive individual,

family, and/or group treatment for personal/family issues.

I understand that my relationship with InnerShanti is confidential and that **NO INFORMATION WILL BE RELEASED WITHOUT MY WRITTEN PERMISSION except as outlined in the Hold Harmless form.** I understand that I am free to terminate therapeutic services at any time.

I understand that treatment at InnerShanti will be free from discrimination by race, religion, sex, ethnicity, age, or disability.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Witness

**BILLING & PROCEDURE POLICY**

InnerShanti appreciates the opportunity to serve you in a therapeutic setting. We hope you feel the services provided are beneficial to you. In order to provide quality therapeutic services, please note the following necessary business policies.

Therapy and massage therapy services are billed per session. The cost of a session varies depending upon the funding source. Client's portion of payment is due at the time of service. The rates are as follows:

Self-Pay (Sliding scale available upon request): $100-165

If you have a funding source that is not mentioned above, it is your responsibility to determine session cost by contacting Jessica Salmon or Terri Thompson. Under limited circumstances, the client may be eligible for a sliding scale fee. This is determined by household size, income, and extenuating circumstances. Proof of income and other data may be requested. The client is responsible to notify the therapist of any financial or funding changes.

Requested written reports/letters will be billed at $15.00 per quarter hour; fee for service is due at time of receipt. Secondary parties will not be billed for this service.

If it is not possible to keep a scheduled therapy appointment, you are required to contact us to cancel the appointment. If circumstances and schedules allow, you may reschedule your appointment.

We believe you will find your time with InnerShanti to be healing and supportive. We look forward to working with you. Please feel free to ask any questions you have.

**Billing Policy Certification**

I have read and been provided a personal copy of the *Billing & Procedure* policy. I understand

the expectations outlined in the policy and agree to comply with the provisions therein. Any

questions or clarifications of the *Billing & Procedure* policy have addressed and discussed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client/guardian Date

**CONSENT TO TOUCH**

(For clients seeking reiki, yoga therapy, or massage)

Touch can be a powerful tool for healing and transformation. The use of touch is a key component to our approach with yoga therapy, energy work, and massage. When used skillfully, with clear boundaries, sensitivity, and good clinical judgement, touch has a legitimate and valuable role as a body-mind mode of clinical engagement.

Staff of InnerShanti are ethically bound to employ touch appropriately and abide by the scope of practice that apply to them. Informed consent is the practice of providing information to clients to enable them to make informed, reasoned decisions regarding the methods used during yoga therapy, energy work, or massage. Informed consent supports the ethical rights of a client to direct what is happening to their bodies, involved clients in their own care, and provide opportunity for self-empowered decision making. Informed consent may be written, verbal, or both. All touch by InnerShanti shall be non-sexual in intent.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , hereby declare that InnerShanti has informed me that the holistic healing art of yoga therapy, energy work, and massage, uses elements of mind/body psychology which uses consented touch and assisted yoga postures. I have a right to refuse touch at any given time during any session.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_