CONTENTS

Please take the time to read all the forms in it's entirety.

Please print out pages 10-16, complete them and bring them with you to your appointment or scan and email them back to me prior to your scheduled video chat appointment time.

Welcome!

The following papers involve information necessary for you to review and questions for you to answer. The information you provide will help me to be of service to you in helping you achieve your treatment goals. We will review the information and you may ask questions at any time during our sessions which may last between 60 - 90 minutes. The information provided by you is voluntary; however, if you limit the information you share, the quality of service provided to you may be impacted. Thank you for your patience with this process and I look forward to working with you.

Disclosure Statement

I am a Licensed Clinical Social Worker in the state of Florida and an energy practitioner. I utilize numerous evidence based and non-evidence based modalities in my work with the client.

These may include but are not limited to:

- EFT – Emotional Freedom Technique – an evidenced based therapy modality that merges Chinese acupressure and modern psychology to resolve the emotional energy that is stored in the 10 meridians of our body in order to enable the amygdala to return to its healthy state of equilibrium.
- NLP – Neuro Linguistic Therapy – the study of how our language programs our nervous system.
- Theta Healing – a God based healing modality.
- Matrix Energetics – maneuvering /playing in the energetic field of the possibilities of all that is.
- Hypnotherapy – accessing the subconscious by helping the patient relax through guided imagery
- Reiki – channeling the healing energy of the divine with the intention to bring healing.
- Sound Healing – utilizing sound frequencies (inaudible to our ears) to access memories stored in our subconscious and physical bodies.

I will happily explain these in further detail during our first session.

I am NOT a healer. I am a regular human being with tools that can facilitate healing. The Creator of all that is / GOD is the only one who can heal. I believe in God but do NOT require that you do. You must, however, be open to me using any of the tools not limited to the list above in order to assist you.

Our therapy session may be in person or via video chat using either Facetime, Whatsapp or Skype as agreed upon by us. I will call you at the agreed upon time to initiate our session. Please understand that with energy work, distance / location is irrelevant. I am able to utilize any / all of the tools above in either an in-person session or in a video-chat session.

During our therapy session, I will listen to you as you share your history, your current issues and your intended outcomes. I will then work to assist you in resolving your limiting beliefs, emotional pain from past trauma etc. utilizing any / all of the above modalities.

As your therapist, I will recommend certain practices which I believe, when practiced daily, will improve your state of mind, body and soul. It is up to you to follow the recommendations. In my experience of having worked with hundreds of clients, the ones who follow the recommendations benefit, while the ones that don't follow the recommendations do not. I would hope that if you are coming to therapy and investing the time, money and energy to improve yourself, you will do ALL the work recommended to the best of your ability.

I do not practice traditional talk therapy although I am trained as one, therefore, we will utilize the beginning of the session to understand the situation/problem but then we will get to work to address, resolve, release the issues at hand utilizing the various modalities mentioned above. If you are looking for a traditional talk therapist, I will be happy to refer you to one of my esteemed colleagues who utilize traditional psychotherapy modalities.

We are like an onion with layers of memories which are stored in our subconscious and our physical body in the form of memories and limiting beliefs. As we start to work through those layers of your subconscious, you may feel that you feel “worse” instead of “better”. Please understand that this is a normal part of healing. My intention is to empower you with tools that you can use so that you are able to cope with whatever is coming up for you.

There may be times when I may recommend that you see a psychiatrist for an evaluation of treatment through the use of psychotropic medications. You have the right to refuse. But please understand, that in some situations, we may be unable to proceed with individual therapy work unless you are being treated for the chemical imbalance in your brain. Refusing to follow through may result in us terminating our work.

Working with a minor child

Your child is a part of your family unit therefore it is important that you as the parent / caregiver be involved / engaged in the therapeutic process. Therefore, there may be times where I may invite you as the parent to be a part of the session. Also I may recommend that we have an individual session just with the parent / caregiver to address the issues from a family unit perspective.

If you are bringing your child in for therapy, I will discuss with you any/ all pertinent information. Please understand that I will NOT violate the confidence/rapport/trust of your child by revealing everything that they have shared with me in session. Your child is my client although you are the adult paying for the session. Please understand that I will definitely discuss any concerns/issues I have regarding your child’s physical / mental safety.

Patient Information

Your Rights as a Patient

A therapist/ client relationship requires both the therapist and a client to fully show up to sessions ready to engage in the session. Therapist-client relationship works in part because of clearly defined rights and responsibilities held by each person. This framework helps to create the safety to take risks and provide the support to become empowered to change. As my patient, you have certain rights that are important for you to know about because this is your treatment, whose goal is your well-being. There are also certain legal limitations to those rights that you should be aware of. As your therapist, I have corresponding responsibilities to you.

My Responsibilities to You as Your Therapist

I. Confidentiality

With the exception of certain specific situations described below, you have the absolute right to the confidentiality of your treatment. I cannot and will not tell anyone else what you have told me or even that you are in treatment with me without your prior written permission. I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act to protect your privacy even if you do release in writing authorization to share information about you. You may direct me to share information with whomever you chose, and you can change your mind by revoking permission at any time. You may request anyone you wish to attend a session with you.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect unless it is an emergency and I can't reach you:

If I have good reason to believe that you will 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 good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 72 hours.

If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am obligated by law to do this, but would explore all other options with you before I took this step.

If you are filing a complaint or are a plaintiff in a lawsuit where you bring up the question of your mental health, you will have already automatically waived your right to the confidentiality of these records in the context of the complaint or lawsuit. In spite of that, I will not release information without your signed consent or court order. We can also discuss obtaining a protective order to help maintain confidentiality of records. Please let me know if you are in this kind of situation so that I can take the utmost care possible to protect your privacy in my records.

II. Record-keeping
I will keep your records according to the provisions of the Health Care Information Act of 1992. I maintain your records in a secure location in my home office which cannot be entered by anyone else. I will discuss any concerns you may have regarding the record keeping completed on your treatment progress.

III. Collaboration with other clinicians/physicians
Under some circumstances you may be receiving treatment by other medical or mental health professionals. In those cases, it may be in your interest to sign a release to allow coordination of care and reduce duplication of services. If you will be receiving additional therapy by another mental health provider the respective responsibilities of each clinician will be discussed with you.

IV. Diagnosis
Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book titled the DSM-V; I have a copy in my office and will be glad to let you borrow it and learn more about what it says about your diagnosis.

V. Other Rights
You have the right to ask questions about anything that happens during your treatment. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave treatment at any time, however it is not recommended to do so without consultation.

VII. Availability
Each session usually lasts approximately between 60 – 90 minutes. We will schedule our sessions cooperatively for mutual convenience. Outside of session, if necessary, you can reach me on my cell phone (954-854-3942).
Also note that if you are calling from a cellular phone, I will request your location/address at the time of the crisis call in order to assist with the possibility of getting emergency personnel to you. If you are in an emergency/crisis situation call 911.

Your Responsibilities as a Patient
You are responsible for coming in to the appointments on time or being available when I call you via video chat at the time we have scheduled. If you are late, we will end on time and not run over into the next person's session. If you must cancel a session, please do so at the earliest so that I can make your session time available to another patient.
You are responsible for paying for your session at the time of services unless we have made other arrangements in advance. All payments must be made to Sat Nam Therapeutic Services.

If you find that you are having a hard time paying for treatment, please discuss it with me.
My intention is to be of service to you. Therefore I am happy to discuss your unique circumstance so that we may find a way to best serve your needs.

NOTICE OF PRIVACY PRACTICES

National Association of Social Workers,
@ Sat Nam Therapeutic Services, LLC, 2018, Page 1 of 2

Notice of Privacy Practices
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.
Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI").
This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU
For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Health Care Operations.
We may contact you to provide appointment reminders, no shows, or information about treatment alternatives or other health-related benefits. We will use all numbers you have provided us unless you request in writing to revoke any telephone number to be used to contact you.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department)
- Required by Court Order

- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

National Association of Social Workers,
@ Sat Nam Therapeutic Services LLC, 2018, Page 2 of 2

Verbal Permission
We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization.
Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI
You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Sat Nam Therapeutic Services, LLC. 10100 NW 7th St. Plantation, FL 33324

- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- Right to a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS
If you believe we have violated your privacy rights, you have the right to file a complaint in writing with your request in writing to our Privacy Officer at Sat Nam Therapeutic Services, LLC.
10100 NW 7th St. Plantation, FL 33324 or with the Secretary of Health and Human Services at
200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.
The effective date of this Notice is January 1, 2019.

Patient Informed Consent

I have read all pages of this statement. I have had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and I understand it. I hereby voluntarily agree to enter into treatment with Anita Lakhani, LCSW.

Patient Name: _____

Patient's Signature: **(if minor then parent/caregiver must sign):**_____

Name of parent/caregiver: _____

Witness: _____ Date: _____

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Acknowledgment of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I _____ have received a copy of this office's Notice of Privacy Practice.

Patient Name: _____

Patient's Signature: **(if minor then parent/caregiver must sign):**_____

Name of parent/caregiver: _____

Witness _____ Date: _____

PATIENT INFORMATION

Date: _____

Client Name: _____
Last Name First Name Middle

Social Security #: _____ Date of Birth: _____ Age:_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cellular: _____ Email: _____

As a function of office procedures I may text to confirm you appointments as a courtesy reminder to you. I may also return calls to the above numbers unless you explicitly instruct me to do otherwise. Messages left on voicemail will be brief and general. We may also use your email address for those purposes unless you indicate N/A (not applicable) in the email request line.

Employed by: _____

Occupation: _____

Whom may we thank for referring you? _____

In the case of an emergency, who should be notified? _____

Relationship: _____ Telephone: _____

Assignment and release:

I understand that Anita Lakhani, LCSW, does NOT accept insurance. I understand that I am responsible for payments agreed upon for the sessions. I understand that sessions may be in person or via video chat.

_____ _____
Responsible Party Signature Print name

Client Intake Form

Form is being completed by: _____

Client Last name: _____ First: _____ Middle: _____

D.O.B.:_____ Age: _____ Sex:_____

PRESENTING PROBLEM

Please describe the problem that brought you to this office:

Describe current feelings about problem:

What steps have you taken to correct the problem?

Please give any other information that might be relevant:

Patient Name: _____

FAMILY HISTORY

Please list the significant people in your life (parents, siblings, and others), their relationship to you, and their age or date of birth.

Circle if applies. SA= substance abuse MI= mental illness VS= violence to self VO= violence to others.

NAME	RELATIONSHIP	AGE		Leave Blank
_____	_____	_____	O SA O MI O VS O VO	_____
_____	_____	_____	O SA O MI O VS O VO	_____
_____	_____	_____	O SA O MI O VS O VO	_____
_____	_____	_____	O SA O MI O VS O VO	_____
_____	_____	_____	O SA O MI O VS O VO	_____
_____	_____	_____	O SA O MI O VS O VO	_____

With whom do you currently reside? _____

What is your family's attitude regarding your problem?

Please give the names of family members, including yourself who are currently, or in the past, have been under the care of a mental health professional/ substance abuse treatment program:

Name	Relationship	Problem	Who Seen & When

O Yes O No Do you have a history of self-injurious behavior?
O Yes O No Do you have a history of suicide attempts?
O Yes O No Do you have a history of assaultive behavior?
O Yes O No Do you have a history of fire setting?
O Yes O No Do you have a history of animal cruelty?
O Yes O No Have you ever been involved in an abusive relationship?

Patient Name: _____

If you answered Yes, Please explain:

Describe benefits you obtained through previous treatment:

PERSONAL HISTORY

Place of birth: _____

Please list previous places where you have lived:

Marital Status: _____ Number of times married: _____

List children and ages:

Please describe your feelings regarding your current marital status:

Please describe your educational history: (highest grade completed, certificates, trainings)

Patient Name:_____

Military History: NO YES War Veteran: _____ Discharge type: _____
Occupation: _____ Employer: _____

Please list the types of jobs you have had:

Please list religious affiliations you have or have had in the past:

List any cultural beliefs that may interfere with your treatment:

Height: _____ Weight: _____ Last Physical Exam: _____
Primary Care Physician: _____ Phone Number: _____
Current Psychiatrist: _____ Phone Number: _____

Current Psychiatric Diagnosis and/or Medications:

Current Health Problems: Treating Physician:

Allergies: _____
Sometimes during an in-person session, I may use Doterra essential oils which have been shown to help reduce anxiety/depression etc. Are you allergic to any scents/perfumes?

Patient Name:_____

Are you compliant with your Prescribed Medications? YES NO _____
Previous Health Problems (Past illnesses and surgeries):

Hospitalizations: (Medical and Psychiatric)

SUBSTANCE USE INFORMATION

Do you drink Caffeine? _____ Cups per day: _____
Do you smoke? _____ How much? _____

How much alcohol do you consume a week?

Use of other drugs: YES NO: If yes, what drugs?

Date of Last Use (Alcohol or drugs):_____ How much clean time do you have? _____

PEER INTERACTION AND SELF PERCEPTION

In the past few years have you had difficulty getting along with others?

What feedback do you get about yourself from others?

How do you handle your anger?

Patient Name:_____

Has anger ever gotten you in trouble? If so, how?

What are your strengths?

Weaknesses?

Have you ever been bullied when younger or bullied others?

What do you do for fun?

PROBLEM AREAS *(Please circle or highlight)*

Study Habits	Making Decisions	Suicidal Thoughts	Chronic Pain	Repeating Thoughts
Nervousness	Depression	Marital Problems	Acute Pain	Racing Thoughts
Shyness	Sexual Problems	Alcohol Use	Nightmares	Self-Mutilation
Fears	Finances	Self Control	Habits	Legal Problems
Friends	Anger	Panic	Relationships	History of Abuse
Sleep	Stress	Tiredness	Concentration	Distressing Thoughts
Relaxation	Occupational	Weight	Appetite	Hearing Voices
Memory	Ambition	Loneliness	Energy	Paranoia
Inferiority	Career Choice	Appearance/Health	Drug Use	Resentment
Separation	Love/Affection	Family	Unhappiness	Revengeful Thoughts
Parenting	Stomach Trouble	Bowel Trouble	Eating Habits	Elevated Mood
Motivation	Gambling	Seeing things	Mood Swings	Impulsive
Submissive	Headaches	Muscle Tension	Shopping	Isolation

Other:

Patient Name:_____

COPING LEVEL

What are some coping tools that you have utilized?

On a scale from 1-10 with 10 being the best what is your **current level** of coping? _____
What is your **highest level** of coping in the last year? _____

List goals for self-improvement:

I hereby request that Anita Lakhani, L.C.S.W. provide services for me and/or my family.

Signature _____ Date ____/____/____