# Intake Form
# Family Therapy

***Katie Heiden-Rootes, PhD, LMFT***
***Certified Sex Therapist***
*Phone: 314-690-1894*
*Email: katie@katieheidenrootes.com*
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*Please fill items out as completely as possible and bring the intake form to your first session or email to Dr. Heiden-Rootes ahead of your session. You may leave blank any part that you feel uncomfortable filling out at this time.*

***Basic Information of Caregivers Attending Therapy***

***Caregiver 1***

First Name: _____ Last Name: _____
Date of Birth: _____ Age: _____
Occupation: _____ Employer: _____
Race/Ethnicity: _____ Religious Affiliation, if any:_____
Gender Identity: _____ Pronouns: _____ Sexual Orientation: _____
Cell Phone: _____ leave a message? ☐Yes ☐No
Email Address: _____ send a message here? ☐Yes ☐No
What is your preferred method of communication? _____
Home Address: _____
City, State: _____ Zip code: _____

***Caregiver 2***

First Name: _____ Last Name: _____
Date of Birth: _____ Age: _____
Occupation: _____ Employer: _____
Race/Ethnicity: _____ Religious Affiliation, if any:_____
Gender Identity: _____ Pronouns: _____ Sexual Orientation: _____
Cell Phone: _____ leave a message? ☐Yes ☐No
Email Address: _____ send a message here? ☐Yes ☐No
What is your preferred method of communication? _____
*(if different from above)*
Home Address: _____
City, State: _____ Zip code: _____

***Caregiver 3***

First Name: _____ Last Name: _____
Date of Birth: _____ Age: _____
Occupation: _____ Employer: _____
Race/Ethnicity: _____ Religious Affiliation, if any:_____
Gender Identity: _____ Pronouns: _____ Sexual Orientation: _____
Cell Phone: _____ leave a message? ☐Yes ☐No
Email Address: _____ send a message here? ☐Yes ☐No
What is your preferred method of communication? _____
*(if different from above)*
Home Address: _____
City, State: _____ Zip code: _____

***Caregiver 4***

First Name: _____ Last Name: _____
Date of Birth: _____ Age: _____
Occupation: _____ Employer: _____
Race/Ethnicity: _____ Religious Affiliation, if any:_____
Gender Identity: _____ Pronouns: _____ Sexual Orientation: _____
Cell Phone: _____ leave a message? ☐Yes ☐No
Email Address: _____ send a message here? ☐Yes ☐No
What is your preferred method of communication? _____
*(if different from above)*
Home Address: _____
City, State: _____ Zip code: _____

***Reason for Seeking Therapy***

1. Why are you coming to therapy now?

_____
_____

2. What would you like to see happen or change as a result of therapy?

_____
_____

***Basic Information of Children (minors and adults, if attending therapy)***

Name: _____
Date of Birth: _____ Age: _____
School: _____ Grade: _____
Employer (if any): _____
Race/Ethnicity: _____ Religious Affiliation, if any:_____
Gender Identity: _____ Pronouns: _____ Sexual Orientation: _____
Phone: _____

Name: _____
Date of Birth: _____ Age: _____
School: _____ Grade: _____
Employer (if any): _____
Race/Ethnicity: _____ Religious Affiliation, if any:_____
Gender Identity: _____ Pronouns: _____ Sexual Orientation: _____
Phone: _____

Name: _____
Date of Birth: _____ Age: _____
School: _____ Grade: _____
Employer (if any): _____
Race/Ethnicity: _____ Religious Affiliation, if any:_____

Gender Identity: _____ Pronouns: _____ Sexual Orientation: _____
Phone: _____

Name: _____
Date of Birth: _____ Age: _____
School: _____ Grade: _____
Employer (if any): _____
Race/Ethnicity: _____ Religious Affiliation, if any:_____
Gender Identity: _____ Pronouns: _____ Sexual Orientation: _____
Phone: _____

Name: _____
Date of Birth: _____ Age: _____
School: _____ Grade: _____
Employer (if any): _____
Race/Ethnicity: _____ Religious Affiliation, if any:_____
Gender Identity: _____ Pronouns: _____ Sexual Orientation: _____
Phone: _____

***Please complete the following page for each family member attending therapy***

***Name:*** _____

***Lifestyle & Health Questions***

1. Are any of the spaces in your home unusable because of the amount of clutter in them? ☐Yes ☐No
   Do any of the members of your family have a problem with this? ☐Yes ☐No
2. Are you a smoker? ☐Yes ☐No
   If yes, how much do you smoke in a 24-hour period? _____
   If yes, are you interested in resources to help you quit at this time? ☐Yes ☐No
3. Have you ever, or do you currently, engage in self-injurious behavior, like cutting?
   ☐Yes ☐ No
   If yes, when was the last time you did? _____
4. Do you ever have thoughts about ending your life? ☐Yes ☐No
   If yes, have you made a previous attempt? ☐Yes ☐No
   If yes, do you have a current plan you are considering acting on? ☐Yes ☐No
5. Do you or anyone else in your life have concerns about your use of medications (e.g., opioids, pain medications), alcohol, marijuana, or other substances? ☐Yes ☐No
   If yes, please explain with name of partner identified:

_____

_____

***Personal History***

1. Do you experience physical symptoms regularly, such as headaches, nausea, etc.?
   ☐Yes ☐No
2. Do you have any medical conditions, such as chronic pain, disabilities, etc.?
   ☐Yes ☐No
   If yes, please explain: _____
3. Have you ever been in treatment for substance abuse? ☐Yes ☐No
   If yes, for what substance(s)? _____
   If yes, what were the dates of treatment? _____
   If yes, where did this treatment occur (e.g., name of treatment center)?
   _____
4. Have you ever been hospitalized for a mental health concern? ☐Yes ☐No
   If yes, what were the circumstances? _____
   If yes, what were the approximate dates? _____
5. Have you ever been to counseling or therapy before? ☐Yes ☐No
   If yes, what were the circumstances (reason, etc.)? _____
   Name of provider? _____
   What were the approximate dates? _____
6. Do you have a previous mental health diagnosis that you know of? ☐Yes ☐No
   If yes, what is it? _____
7. Have you ever taken medication for a mental health concern? ☐Yes ☐No

*Please list all medications, dosage, reason for medication (e.g., diabetes, mood disorder):*

_____

_____

**Katie Heiden-Rootes, PhD, LMFT**
**AGREEMENT FOR PSYCHOTHERAPY SERVICES/INFORMED CONSENT**

Client name: _____ DOB: _____

Welcome. It can take a lot of courage to enter into psychotherapy, particularly if you are unfamiliar with the process. This document is intended to help answer your practical questions, and I am more than happy to discuss any remaining concerns in person at your initial appointment.

This document contains important information about my professional services and business policies. Although these documents are long and sometimes complex, it is very important that you read them carefully. When you sign this document, it will also represent an agreement between us and become a part of your medical record. You may revoke this Agreement in writing at any time. That revocation will be binding for me unless we have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

**CONSENT FOR SERVICES**
I have received and understand the Notice of Privacy Policy regarding my privacy rights per federal HIPAA laws.

Consent for Services: With enough knowledge, and without being forced, I enter into psychotherapy with this provider. I will keep my provider fully up to date about any changes in my feelings, thoughts, and behaviors. When difficulties arise I will let my provider know so that we can address them in an honest and direct manor. I understand the basic goals and methods of psychotherapy and that my provider may use different methods of helping me and my family and/or minor child based on the unique factors associated with the presented needs. I have no important questions or concerns that the provider has not discussed with me. I understand that reaching the agreed upon therapeutic goal(s) is not guaranteed and that psychotherapy has varying levels of effectiveness for different individuals. I also understand that my therapeutic goal(s) may evolve and change based on new insights and/or changes to my life situation.

I am agreeing to participate in the following types of services, while acknowledging that the course of psychotherapy may change, and the participants may change, by agreement of all required parties.

- ☐ Individual Psychotherapy
- ☐ Couples Psychotherapy
- ☐ Family Psychotherapy

I also agree that the following individuals will be part of the psychotherapy process: _____

**Risks and Benefits:** I further understand that the initial symptoms or problems presented may initially become more intense because confronting important questions about who I am and who I want to be may at times cause internal conflict. I understand the psychotherapy requires an active investment of various resources (emotional, time, financial, and others) that may lead to uncomfortable feelings like sadness, anger, or frustration. On the other hand, I understand psychotherapy has also been shown to have many benefits. Psychotherapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. I understand there are no guarantees of what I as an individual and/or my family or minor child will achieve as outcomes.

**Alternatives:** I understand there are many viable alternatives to psychotherapy, such as, but not limited to, self-help books, support groups, medication and other medical interventions, and psychotherapy interventions other than what is offered and that I am welcome to discuss any options with my provider at any time.

**Family Psychotherapy:** I understand that family psychotherapy can be beneficial in maintaining healthy family relationships that can positively impact the physical and mental health of individual family members. However, family psychotherapy can also pose unique challenges because more than one person is involved in the process. I agree to the following regarding couple and family psychotherapy:

- Information discussed is for therapeutic purposes and is not intended for legal purposes
- Signing this agreement means that I will not subpoena information from psychotherapy and try to use it later in legal proceedings
- Phone calls, texts, or emails between sessions should be used primarily for scheduling purposes only and not to communicate information to the therapist that I do not want other family members to know, unless that information is related to my safety.
- Sometimes in the course of couple of family psychotherapy, the provider will have sessions that do not include all family members. In such cases, the provider will not report back to other family members what was discussed without the permission of the family member who shared the information. However, anytime the provider believes that the couple or family cannot make progress toward their stated goals, he or she reserves the right to terminate psychotherapy. While the provider will not pass information between family members when specifically asked not to, if the unwillingness to engage in open communication will hinder goals, psychotherapy will not continue. Providers are not secret-keepers in family systems.
- If a couple or family breaks up and a family member contacts the family provider for individual services, the family provider reserves the right to proceed according to his or her clinical judgment. Referrals for some family members may be provided when the provider anticipates a potential conflict of interest. The decision of which family member(s) continue in psychotherapy with the family provider is at the provider's discretion.

There may be times when the provider appears to take someone's side or be against someone else. The provider is on the side of the family or couple *relationship* and will do what he/she deems necessary to improve it.

**Differentiation from Other Services:** Psychotherapy is a process by which concerns, symptoms, and behaviors are treated in the hopes of symptom reduction and increased overall functioning and satisfaction with life. Psychotherapy is not coaching (coaching is not reimbursable by insurance). Psychotherapy is also not a custody evaluation. When a custody evaluation is performed, it is an extensive process meant to provide recommendations related to parenting time outcomes for minor children. Because Katie Heiden-Rootes, PhD, LMFT (here after KHR) does not conduct custody evaluations, KHR does not make the recommendations that would typically ensue from one.

**PROFESSIONAL BOUNDARIES**

I understand that psychotherapy is a professional relationship. Though my provider cares deeply about my life, the relationship is different from a friendship. This means I will not be friends with my provider on social media or see my provider outside of sessions simply because the professional boundaries for mental health providers do not allow for it. In additional, I understand ethical boundaries prevent my provider from having both concurrent personal and professional relationships with me and/or my family members or from having a personal relationship with me following the termination of our work together in psychotherapy.

**TERMINATION OF SERVICES**

I understand that I can terminate therapeutic services at any time. When doing so I agree to notify my provider and schedule a final session. I understand that if I miss three appointments in a row without informing my provider, he/she will begin the process of terminating my psychotherapy. If my provider believes there to be a conflict of interest, he or she may terminate services with me but will not do so without providing me with viable alternatives to seek treatment from another qualified professional.

**PSYCHOTHERAPY FEES**

The length of a session can vary depending on many factors including time available for you or myself and if particular lengths of time seem to work best for making progress. Generally, 60-90 minute sessions for family therapy is useful and 45-60 minutes for individual therapy.

| SESSIONS | TIME | FEE |
|---|---|---|
| Individual Psychotherapy | 90 MIN | $295 |
| Individual Psychotherapy | 60 MIN | $195 |
| Couple or Family Psychotherapy | 90 MIN | $340 |

| | | |
|---|---|---|
| Couple or Family Psychotherapy | 60 MIN | $225 |

I understand that if I am a parent seeking psychotherapy for a minor child, I am the financial guarantor of my client's account. If I am an adult seeking services for myself, I am the financial guarantor of my own account. By signing below I agree to the above fee schedule and understand payment (cash, check, Visa, MasterCard, or Discover) is due in full (including copays) at the beginning of each counseling session. I also agree to pay a fee of $30 plus the amount of the check for any returned checks.

Comments or notes about fees or fee arrangements:
_____

Note: Should you become involved in any legal action in which you or someone else require the provider's participation, KHR charges $250 per hour for all time spent to meet our obligations, including but not limited to personal preparation, professional consultation, travel to and/or attendance at any legal proceeding. The extra fee is due to the complex nature of preparation and the extra costs that can be incurred for a provider while preparing. Clients will need to pay in advance of any legal preparation.

**FORMS OF PAYMENT**
I understand I am welcome to pay for my services in cash or check, or use my Visa, MasterCard or Discover debit or credit card. I understand KHR follows the Payment Card Industry Data Security Standard (PCI DSS) set of requirements designed to ensure that all companies that process, store, or transmit credit card information maintain a secure environment for financial data.

**CANCELLATION POLICY/NO-SHOW POLICY**
I understand I am welcome to come to any part of my scheduled session, even if I have to be late. If I am running late, I will call KHR to let her know. **If I need to cancel or reschedule an appointment, I will give KHR twenty-four (24) hours' notice. For late cancellations (those less than 24 hours prior to the appointment time) a $150 fee will be charged.**

**CONFIDENTIALITY (AND EXCEPTIONS TO CONFIDENTIALITY)**
Federal and state law, as well as ethical codes protect the privacy and confidentiality of both your identity as my client and the information you share with us. You should be aware that we practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

Under the rules governing mental health professionals in Missouri, a provider or counselor, and employees and professional associates of the provider, must not disclose any private information that the provider, employee, or associate may have acquired in rendering services except as stated in Missouri statue 337.736. For example, when state law mandates the report of suspected abuse or neglect of a child or vulnerable adult or prenatal exposure to drugs and alcohol.

If you are involved in a court proceeding and a request is made for information concerning the professional services we provided for you, such information is protected by the privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order KHR to disclose information.

**I understand the provider is required to participate in legal proceedings when court-ordered, and I understand the provider's fee for involvement in legal proceedings.**

- When a client is a minor, parents have access to records. Minor clients can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the provider. As a general rule, all minor clients under the age of eighteen (except when the minor is married or has born a child) must have the consent of their parents or guardians to receive on-going therapeutic services. Parents who share joint legal custody BOTH need to consent for ongoing mental health services for their child(ren). **I understand that when a client is a minor, parents have access to records and that the provider can withhold records anytime that harm could come from records being released.**

- When the provider presents the case in consultation with other professionals, supervisors, or consultants, who are bound by the legal framework of privacy and confidentiality, for professional development and guidance purposes. Similarly, we may use examples from your case, without revealing personal details that could identify you, when training other students and providers. **I give permission to this provider to present my case in consultation with other professionals, supervisors, or consultants, who are bound by the legal framework of privacy and confidentiality, for professional development and guidance purposes and to use examples from my case that would not identify me when training other students and professionals in the field of mental health.** It is assumed that your provider may consult with other providers to get feedback about how to best provide your care.

- All other private information must be disclosed only with the informed consent of the client. When a patient agrees to a waiver of the privilege accorded by this section, and in circumstances where more than one person in a family is receiving psychotherapy, each such family member agrees to the waiver. Absent a waiver from each family member, a marital and family provider cannot disclose information received by a family member.

**HEALTH RECORDS DISCLOSURE**
KHR maintains records for 10 years past the final date of service for adults and 10 years past the 18th birthday for minors. These records are stored in according to HIPAA regulations. I may use or disclose your health information to provide you with therapeutic services, and as needed for payment or health care operations. However, uses or disclosures of your health information for non-healthcare purposes (for example, certain legal, administrative, or research uses) will not include sensitive information about your reproductive health unless you give specific written authorization.

**YOUR RIGHTS REGARDING PRIVACY OF RECORDS**
You have the right to request restrictions on how your health information is used or disclosed, request access to your records, request amendments, and request an accounting of disclosures. If you believe information about your reproductive or other sensitive health care has been used or disclosed inappropriately, you may notify your therapist or the appropriate regulatory body.

**COMMUNICATIONS POLICY**
When telehealth, text, email, or online portals are used, reasonable safeguards will be in place to protect your health information, including sensitive reproductive health information. Electronic communication carries additional risks of unauthorized access, and we will discuss the safest available options for you.

I understand that, in most circumstances, KHR upholds the following communication expectations and commitments:

- For confidential questions, you can reach my confidential voicemail at 314-690-1894. I try to get back to those who leave messages within 48 hours (on business days – Mondays – Fridays) but may take longer if this 48 hours includes weekends.
- Email at katie@katieheidenrootes.com is also available for communication though not required.
- I do not utilize text messaging for communicating with clients.
- In a crisis or emergency, appropriate communication methods will be utilized to promote safety in a way that poses the least amount of risk to client confidentiality.

**CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS**
I understand that if I deem it useful during the course of treatment to communicate by email or other electronic methods of communication, I need to be informed that these methods, in their typical form, are not confidential means of

communication. If I use these methods to communicate with KHR, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in my home or other environments who can access my phone, computer, or other devices that I use to read and write messages
- My employer, if I use my work email to communicate with KHR
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

**I consent to allow KHR to use unsecured email to transmit to me the following protected health information:**

☐ Information related to the scheduling of meetings or other appointments
☐ Information related to billing and payment
☐ Completed forms, including forms that may contain sensitive, confidential information
☐ Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
☐ My health record, in part or in whole, or summaries of material from my health record
☐ Other information. Describe: _____

**BY THE FOLLOWING NON-SECURE MEDIA:**

☐ Unsecured email.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time. I also understand that I incur the risk involved in transmitting clinical information through non-secure electronic means and that this authorization will terminate 60 days after I have been discharged from care by KHR.

**ACCESS TO MEDICAL RECORDS**

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. Unless your provider believes viewing your record could be harmful to you or another person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

**EMERGENCY PROCEDURE**

In the event of a life-threatening emergency, call 911. If I have another crisis that cannot wait I am aware I can call the Provident Crisis Hotline at **1-800-273-TALK (8255)**, the National line at 988, or **The Trevor Project** for LGBTQ youth and young adults at **1-866-488-7386**.

My signature on this AGREEMENT FOR PSYCHOTHERAPY SERVICIES/INFORMED CONSENT means I have reviewed, understand, and consent to everything above and indicates my consent to participate in psychotherapy at KHR.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____