Heidi Wilson LLC, LPC

The Atrium, 4 Terry Drive, Suite 3, Newtown, PA 18940
heidi_lpc@outlook.com 267-399-0002

CLIENT INTAKE FORM

confidential

Date _____ Client Name _____

Home Phone _____ Cell Phone _____ Ok to leave message? Yes No

OK to leave message?
Yes No

Ok to receive texts?
Yes No

DOB _____ Email address _____ Gender _____

Home Address _____

City _____ State _____ ZIP Code _____

Emergency Contact/Relationship _____ Phone number _____

How did you hear about my practice?

Have you been in therapy before? Yes No

Have you ever been diagnosed with a mental health condition? Yes No

If yes, please list with dates of diagnosis:

Are you currently taking any medications for mental health? Yes No

If yes, please list name, dosage, and reason for taking:

Have you ever been hospitalized for psychiatric reasons? Yes No

If yes, please list dates, length of stay and reasons for admission:

Have you ever attempted suicide? Yes No

If yes, please list dates:

Do you currently wish to harm yourself? Yes No

Do you have a current plan to harm yourself? Yes No

Do you use recreational drugs? Yes No

If yes, please list with frequency of use:

Do you drink alcohol? Yes No

How many times per week do you consume alcohol?

Is there anything else you would like me to know about you?

Please complete this section if you are a student:

Current School/Grade:

Academic Strengths:

Academic Weaknesses:

IEP plan? Yes No 504 plan? Yes No

If yes, what accommodations are in place?

PROFESSIONAL DISCLOSURE

I am a Licensed Professional Counselor (LPC), licensed by the State of Pennsylvania State Board of Social Workers, Marriage and Family Therapists and Professional Counselors. I am also certified by the state of Pennsylvania as a Secondary School Counselor. My degree is a Masters of Arts in Counseling Services. I have been working as a full-time counselor since 2005. I am an Independent practitioner at Pinnacle Counseling Center, sharing space with other practitioners. I am not a legal expert; therefore, my role does not include providing testimony at court hearings nor does it include evaluation for disability or custody cases. My focus is to assist my clients with treatment goals, as well as guide individuals and families on their journey to a healthier version of themselves.

THERAPY

Therapy is not easily described. How the process unfolds depends on the personalities of the therapist and client, the particular problem and desired outcome. Identifying and working through emotions can be challenging and difficult, but successful treatment often leads to improved relationships, solutions to a specific problem, and reduced feelings of distress. I wholeheartedly believe that it is essential to your well-being to know your deeper self, values, and personal needs, but there is no guarantee of what your outcome will be. If you feel our work is not proceeding in a way that is productive for you, I welcome you to speak with me to address your specific needs. Together we will work towards a resolution and/or goals that lead you to a more fulfilled life.

LIMITATIONS TO CONFIDENTIALITY

I understand that information about my treatment and communications with my therapist may not be released without written consent authorizing me to do so. I understand that there may be specific situations in which my therapist may need to disclose information without my authorization, but every effort will be made to ensue I am aware of any disclosures. The following circumstances are example of when such disclosures may be made:

1.) **If necessary to protect your safety or the safety of others;**
2.) **If there is suspected abuse;**
3.) **In some legal situations, when there is a court order;** records may be subpoenaed which my therapist is legally responsible to follow court orders. I understand in these circumstances, only the minimal information requested to comply with any orders will be released.

SUPERVISION AND CONSULTATION

In keeping with generally accepted standards of practice, I may consult with other mental health professionals regarding therapeutic issues and management of cases. The purpose of this consultation is to assure quality care. Identifying information such as names or addresses is not disclosed.

COMMUNICATION

I may be reached at my business line at 267-399-0002 and messages may be left on a confidential voicemail box. I generally do not correspond via email or text messages, unless it is specific to scheduling. Phone contact is more secure and preferred, and texts will be used to book and confirm appointments. Please be aware that confidential information

sent via email or text **may not be protected and use your discretion** when forwarding personal information via email or text.

I **do not** provide 24-hour crisis intervention service. In the event of an emergency, please call 911 or go to the nearest emergency room. Adult & Children's Mobile Crisis can be reached at 1-877-HELP-709. If you feel you need a therapist who is available on a crisis basis, please let me know this **today,** so we can discuss if I am the best therapist for your treatment needs or if you would prefer referrals to another therapist.

TREATMENT CONCERNS

I would appreciate your making me aware of any concerns that may impact your appointments with me. You may call me anytime to discuss concerns or let me know if there is something you wish to discuss during a session.

SESSION LENGTH

Sessions are typically 50 minutes in length starting from your scheduled time. The 50 minutes includes scheduling the next appointment and paying fees. If you are going to be late I ask that you contact me to let me know what time you might be arriving. I will generally wait up to 20 minutes after the scheduled appointment time. If you have not arrived within 20 minutes of your scheduled time, then I will not continue to wait, but you will be charged the full session fee. When you do arrive late for an appointment, our session will still end at the regularly scheduled time due to other clients that may be scheduled after you.

PAYMENT

All payments/copays are due at the end of your session. You may pay by cash, check (payable to Heidi Wilson LLC), or by credit card. There is a $25 fee for all returned checks.

CANCELLATION/NO SHOW POLICY

Payments for missed or cancelled sessions without 24 hours notice will result in the full session fee. In the therapy contract, the therapist reserves a space for the client and assumes liability for sessions canceled prior to 24 hours. The client assumes responsibility for sessions cancelled less than 24 hours before the appointment, even if there is a valid reason. More notice is appreciated as it frees slots for other clients. As a *one-time courtesy*, failure to provide adequate notice will result in you paying 50% of the first missed session of $125. After that, you will be responsible to pay my regular full session fee. I cannot bill your insurance for missed appointments/no shows. For this reason, missed session fees will be charged in full to you.

FEES AND CHARGES

Fees for sessions will be discussed during either the initial contact or the initial session. All fees are to be paid at the time of service. Payment is accepted through cash, check, or credit card. **Credit card payments will be assessed a $3.00 surcharge.** There is a $25.00 fee for all returned checks without exception. Monthly invoices can be provided upon request if using out of network insurance benefits.

REFERRALS

I welcome and appreciate referrals to my practice.

Please **sign below** to **indicate your consent to treatment and agreement with the outlined policies.**

Client Name:

_____

Parent/Guardian Name:

_____

Signature:

_____

Date:

_____

CONSENT AND GENERAL RELEASE

I, _____, do hereby declare and acknowledge the following:

1. That I require treatment and care of a type offered by Pinnacle Counseling Center and do hereby voluntarily consent to Heidi Wilson LLC as a client.

2. I have been made aware of and understand the nature, methods and purpose of treatment, as well as the rights involved, and do hereby voluntarily submit myself to such treatment and care that Heidi Wilson LLC in her judgment believe necessary or desirable.

3. I have been made aware of and understand that part of my treatment may consist of individual/group counseling and hold harmless, Heidi Wilson LLC, and its counselors from liability for any personal injuries which result from such activities, of which aggravate any past or present injury or physical condition. I am aware that previous medical conditions must be made known at the time of admission and do hereby voluntarily release and hold harmless Heidi Wilson LLC for exacerbation of any conditions under the stress of therapy, not so reported.

4. I have been made aware of and understand that part of my treatment may consist of group therapy sessions and psychological and emotional interaction with Heidi Wilson LLC, and do hereby voluntarily release Heidi Wilson LLC and hold harmless all those connected with, with regard to invasion of privacy and intentionally or unintentionally caused emotional stress.

5. I further release and hold harmless Heidi Wilson LLC from any claim I now have or shall come to have and do hereby agree that this Consent and Release will be binding on my heirs, executors, administrators or assigns.

6. I have been informed of the Criteria for Admission to Heidi Wilson LLC. Additionally, I have been made aware of and acknowledge the treatment methodologies employed by Heidi Wilson LLC, including group, individual and family therapy, psychiatric and/or psychological services. I also understand the requirements for Completion of Treatment and the Criteria for Involuntary Discharge.

7. I agree to hold sole responsibility for payment of sessions as agreed upon at the time of admission. I agree to pay in full, at the time of each session, the amount owed per the hourly rate to Heidi Wilson LLC. If using health insurance, I agree to pay all copays in full at the time of each session. I agree that cancellations/no shows are subject to 100% of the agreed upon rate within the 24 hour period of the scheduled session. Acceptable forms of payment are cash/credit.

8. I have been offered a copy of this consent form, which I accept in its entirety.

Client name: _____ Date: _____

Client (or parent/guardian) Signature: _____

Witness: _____ Date: _____