Healing Paths Intuitive Therapy

Client Information

Name:_____ **Social Security #:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Date of Birth:_____**Identified gender:**_____**Preferred pronoun:**_____

E-mail address:_____**Okay to contact via e-mail?**_____

Phone:_____ **OK to leave voicemail?**_____ **OK to text?**_____

**I consent to receiving an appointment reminder via e-mail. (Circle one) Yes / No

I have a Psychiatric Advanced Directive: (circle one) Yes / No

Marital Status: _____ **Sexual Orientation:**_____

Highest level of education: _____ Are you currently a student? Yes / No

Employment status: *(circle one)* Full-time / Part-time / Unemployed / Disability / Retired / other

Religious preference:_____ Any spiritual issues or concerns? Yes / No

Which of the following best describes your living situation:_____

How did you hear about Healing Paths Intuitive Therapy?_____

Parent Information (if client is 17 years old and under or Adults covered under parent Insurance)

Mother's Name:_____	Father's Name:_____
Address:_____	Address:_____
_____	_____
Phone:_____	Phone:_____
E-mail:_____	E-mail:_____
Employer:_____	Employer:_____

Emergency Medical Consent

Emergency Contacts:

Name:_____

Phone: _____

Relationship to you:_____

Name:_____

Phone: _____

Relationship to you:_____

In the event of a medical or mental health emergency, I grant Healing Paths Intuitive Therapy staff permission to take whatever steps necessary to obtain emergency medical or mental health care. I will be taken to or referred to a community clinic or an emergency room of staff's choice to provide the appropriate care/treatment. By signing this form, I am consenting for Healing Paths Intuitive Therapy staff to notify the above individuals and seek emergency medical care for me in the event of an emergency.

_____ _____

Signature Date

Client Medical Information:

Your physical health is an important part of your emotional wellness. Thank you for completing your medical information to the best of your ability, as it will help your therapist provide you with quality care.

Client Name_____**Date**_____

In general, how is your general health? ___ *Good* ___ *Fair* ___ *Poor*

Do you have a Primary Care Physician? *(circle one)* *Yes / No*

Name of physician: _____Date of Last Exam_____

Are you currently seeing a psychiatrist? Yes / No. If yes, who?_____

Allergies ___ Yes ___ No (if yes, list allergies and reactions)_____

_____

Previous Counseling? Yes / No. If yes, names of providers and dates of service: _____

_____

_____

Please list current medications:

Medication	Dose/ Frequency	Do you take it regularly?	Reason	Last Dose	Prescribed by:

Medical History (please check any that you have experienced in the past or in the present.)

	Y	N		Y	N		Y	N
Arthritis	Y	N	Skin problems	Y	N	Have you had any head injuries or traumas?	Y	N
Asthma	Y	N	Cancer	Y	N			
Allergies	Y	N	Back Problems	Y	N	Have you had any major surgeries, illnesses, fractures, hospitalizations, blood exchanges? Please explain:	Y	N
High/Low Blood Sugar	Y	N	Reproductive /Sexual concerns	Y	N			
High/Low Blood Pressure	Y	N	Nutritional Concerns	Y	N			
Headaches	Y	N	History of IV drug use	Y	N			
Thyroid Disorder	Y	N	Updated Immunizations	Y	N	Do you exercise regularly	Y	N
Hearing Problems	Y	N	Recent lab tests	Y	N	Are you in any pain? Rate pain on scale 1-10	Y	N
Bowel problems	Y	N	Last HIV/STD test					
Urinary problems	Y	N	Caffeine Intake Daily			For Women: Could you be pregnant ? *Yes/No* Do you have regular menstrual periods? *Yes/No* Date of Last Pap Smear/Mammogram_____		
Ulcer	Y	N						
Fainting/Dizzy Spells	Y	N	Tobacco Intake Daily			Is there any other health information you would like to share with your therapist?		
Seizures/Stroke	Y	N						
Hepatitis	Y	N						

Please briefly indicate primary reason(s) for seeking therapy now:_____

_____

Additional Comments:_____

Completed by: _____**Date**_____

Reviewed with:_____**Date:**_____

Consent for mental health assessment and treatment

I,_____, herby give my permission for and authorize and consent for a representative of Healing Paths Intuitive Therapy to conduct a mental health and/or substance abuse assessment and provide appropriate treatment. No threat of other coercive measures have induced me to sign this consent form.

Signature of client/
Legal Representative:_____ Date:_____

Witness signature:_____ Date:_____

Notice of Privacy Practices and Confidentiality *(effective 1/1/2020)*

At Healing Paths Intuitive Therapy, I am committed to providing a safe, confidential, and private setting for you. This notice describes how I make use of information about you, how it may be disclosed to others, how you can have access to information, and your rights regarding this information. Please review it carefully.

Your Protected Health Information (PHI) is defined by the Health Information Portability and Accountability Act HIPAA. examples of PHI are: your name, address, phone number(s), health information, health insurance information, payment/billing information, etc. PHI does not include the therapist's psychotherapy session notes unless insurance companies request an audit to make sure my practice is in line with their clinical standards.

How are use in a disclosure of PHI for treatment, payment, and healthcare options.

1. I may use and disclose PHI about you in order to provide healthcare treatment to you.
2. I may use and disclose PHI about you to obtain payment for services.
3. I may use and disclose PHI for healthcare operations.
4. I may use and disclose PHI under other circumstances defined by law, without your authorization (i.e., in the event of child abuse or suicide homicide concerns).
5. I may contact you at phone numbers and addresses that you give me.
6. I may contact you with information about treatment and services.

Your rights with regard to your PHI.

1. You have the right to review and receive a copy of your PHI.
2. You have the right to request limits on uses and disclosures of your PHI.
3. You have the right to request alternative ways to communicate with you.
4. You have the right to receive a list of the disclosures made by Healing Paths Intuitive Therapy.
5. You have the right to request an amendment to your PHI.
6. You have the right to a copy of this notice.
7. You have the right to file a complaint about my privacy practices to the Iowa Board of Social Work.

I have read and understand the privacy policy above. I understand that this form is not a release of information and no information can be released without my authorization acceptance have a defined above.

Signature:_____ Date:_____

Signature:_____Date:_____

*Please see the full version of the privacy policy if you have questions about any of the statements made above.

Client Rights and Informed Consent

- I have chosen to receive treatment services and understand I may terminate therapy at any time, unless ordered by the court.
- I understand there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between my therapist, and me I will work with my therapist in a cooperative manner to resolve my difficulties..
- I understand that during the course of my treatment, material may be discussed that will be upsetting and nature and this may be necessary to resolve my problems.
- I understand that records and information collected about me will be held or released in accordance with federal and state laws regarding confidentiality of such records and information.
- I understand that state and local laws require that my therapist report all cases of suspected abuse or neglect of minors or vulnerable adults.
- I understand that state and local laws require that my therapist report all cases in which there exists a danger to myself or others.
- I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.
- I understand that I may be contacted by my health plan to ensure continued continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.

I have read and explained to me the Basic rights of individuals including:

- The right to be informed of various steps and activities involved in receiving services.
- The right to confidentiality under federal and state laws relating to the receipt of services.
- The right to humane care and protection from harm, abuse, or neglect without regard to race, color, religion, gender, sexual orientation, age, disability, or cultural background.
- The right to make an informed decision whether to accept or refuse treatment.
- The right to contact and consult with counsel at my expense.
- The right to select practitioners of my choice at my expense.

I understand that my therapist, health plan representatives, and my primary care physician may exchange any and all information pertaining to my therapy to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance, and/or utilization review purposes. I understand that I can revoke my consent at anytime except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. I understand that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above.

Signature of client:_____Date:_____

Psychotherapy Information Disclosure Statement

Thank you for choosing Healing Paths Intuitive Therapy to help you with your concerns. I'm committed to bringing understanding, hope, and healing to people of all ages through counseling and education. I am guided by the following values: nurturing the health and growth of the whole person - mind, body, and spirit; developing relationships with clients built on trust, respect, and compassion; and maintaining the highest standards of care.

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

My Responsibilities to You as Your Therapist

I. Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you were in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, 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 so as to protect your privacy even if you release me in writing to share information about you. You may direct me to share information with whomever you choose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you.

You are also protected under the provisions of the Federal Health Information Portability and Accountability Act HIPAA. This law ensures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to ensure confidentiality.

E-mail

Risk of using email: If you elect to communicate with me by e-mail at some point in our work together, please be aware that e-mail is not completely confidential. All emails are retained in the logs of your or my Internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider.

Any email received from you, and any responses that I sent you, may be printed out and kept in your treatment record.

Please initial one:

_____I **DO** agree to e-mail exchanges regarding basic appointment times or clarification questions and understand the risk of e-mail exchanges.

_____I **DO NOT** agree to e-mail exchanges regarding the basic appointment times or clarification questions.

The following are legal exceptions to your rights to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have a 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.

2. If I have good reason to believe that you were abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform the Department of Human Services within 48 hours. If you are between the ages of 16 and 18 and you tell me that you are having sex with someone more than five years older than you, or sex with a teacher or a coach, I must also report this to DHS even though at age 16 you have the right to consent to sex with someone no more than five years older than you. I would inform you before I took this action.

3. 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 not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.

4. If you tell me the behavior of another named health or mental health care provider that informs me that this person has either (a.) engaged in sexual contact with a patient including yourself or (b.) is impaired from practice in some manner by cognitive, emotional, behavior or health problems; then the law requires me to report this to their licensing board at the IA Department of Health. I would inform you before taking a step. *If you are my client and a healthcare provider, however, your confidential remains protected under the law from this kind of reporting.*

The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in couples therapy with me.

If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be part of the couples therapy, and can and probably will be discussed in our joint sessions. *Do not tell me anything you wish to keep from your partner.* I will remind you of this policy for getting such individual sessions.

II. Record keeping

I keep very brief records, noting only that you have been here, symptoms reported, what interventions happened in session, and the topics we discussed. Under the provisions of the Healthcare Information Act of 1992, you have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else.

III. Diagnosis

If a third-party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to the third-party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. All the diagnoses come from the book titled the DSM-5; I have a copy in my office and will be glad to let you browse it before after your session and learn more about what it says about your diagnosis.

IV. Professional consultation

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such a consultations, Therapist will not reveal any personally identifying information regarding Patient or Patient's family members or caregivers.

V. Patient litigation

I will not voluntarily participate in any litigation, or custody dispute in which Patient, or Representative, and another individual, or entity, or parties. I have a policy of not communicating with Representative's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's, or Representatives, legal matter. I will generally not provide records or testimony unless compelled to do so. If I am subpoenaed, or ordered by a court of law, to appear as a witness in an action involving a patient, the Representative agrees to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at the hourly rate of $250/ hr. In addition, I will not make any recommendations as to custody or visitation regarding clients. I will make efforts to be an uninvolved in any custody dispute between parents.

IV. Psychotherapist patient privilege

The information disclosed by clients as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between me and my clients in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If I receive a subpoena for records, disposition testimony, or testimony in a court of law, I will assert psychotherapist-patient privilege on your behalf unless instructed, in writing, to do otherwise buy a person with the authority to waive that privilege on Patient's behalf. When a patient is a minor child, the holder of the psychotherapist-patient privilege is either the minor, a court appointed guardian, or minor's counsel. Parents typically do not have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law. You are encouraged to discuss any concerns regarding the psychotherapist-patient privilege with your attorney. You should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she makes his/het mental or emotional state an issue in a legal proceeding.

Other rights: You have the right to ask questions about anything that happens in therapy. I am 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 you can request that I refer you to someone else if you decide I am not the right therapist for you. You are free to leave therapy at any time.

Managed mental healthcare: If your therapy is being paid in full or in part by a managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed-care firm. These may include their decision to limit the number of sessions available to you, to decide the time period within which you must complete your therapy with me, or to require you to use medication if their reviewing professional deems it appropriate. They may also decide that you must see another therapist in their network rather than me, if I am not on their list. Such firms also usually require some sort of detailed reports of your progress in therapy, and on occasion, copies of your case file, on a regular basis. I do not have control over any aspect of their rules. However, I will do all that I can to maximize benefits you receive by filing necessary forms and gain required authorizations for treatment, and assist you in advocating with the MC company as needed.

My Training and Approach to therapy: I have a Masters of Social Work granted by the University of Iowa in 2015. I am licensed in the State of Iowa to fight provide full services in the scope of professional therapy.

My approach to therapy is eclectic I use many different forms of therapy to help meet the needs of a person. I use a variety of techniques in therapy, trying to find what will work best for you. These techniques are likely to include dialogue, interpretation, cognitive reframing, awareness exercises, self monitoring experiments, visualization, guided imagery, breathing techniques, journal-keeping, mindfulness exercises, reading books, and Eye Movement Desensitization and Reprocessing (EMDR). If I propose a specific technique that may have special risks attached, I will inform you of that, and discuss with you the risks and benefits of what I am suggesting. I may suggest that you consult with a physical health care provider regarding somatic treatments that could help your problems. I may suggest that you get involved in a therapy or support group as part of your work with me. If another health care person is working with you, I will need a release of information from you so that I can communicate freely with that person about your care. You have the right to refuse anything that I suggest. I do not have social or sexual relationships with clients or former clients because that would not only be unethical and illegal, it would be an abuse of the power I have as a therapist.

Therapy also has potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time maybe painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings, some of them painful at times. It is important that you consider carefully whether the risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful.

You normally will be the one who decides therapy will end, with three exceptions. If we have contracted for a specific a short-term piece of work, we will finish therapy at the end of that contract. If I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. If you do threaten, verbally or physically, or harass the office, my family, or myself I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

I am away from the office a few times in the year for vacations or to attend professional meetings. If I am not taking and responding to phone messages during those times I will alert you of my absence prior to my leave. If you are experiencing significant mental health needs and are homicidal or suicidal, you will need to present to a local emergency room. I will tell you well in advance of any anticipated lengthy absences. I encourage all clients who are experiencing strong thoughts of self-harm to contact one 800-273-TALK.

Your Responsibilities of therapy client: You are responsible for coming to your session on time at the time we have scheduled. Sessions last for 40 to 55 minutes depending on your insurance coverage. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than 24 hours notice, you must pay for that session prior to or at your next regularly scheduled meeting. The voicemail has a time and date stamp which will keep track of the time that you called me to cancel. I cannot bill these sessions to your insurance. The only exception to this rule about cancellation is if you would endanger yourself by attempting to come (for instance driving on icy roads without proper tires.) If you no-show for two sessions in a row and do not respond to my attempts to reschedule, I will assume that you have dropped out of therapy and will make the space available to another individual.

You are responsible for paying for your session weekly unless we have made other firm arrangements in advance. My fee for session is $105-$155, depending on session length. If we decide to meet for a longer

session, I will bill you for prorated on an hourly fee. Emergency phone calls of less than 10 minutes are normally free. However, if we spend more than 10 minutes in a week on the phone, if you leave more than 10 minutes worth of phone messages in a week, or if I spend more than 10 minutes reading and responding to emails from you during a given week I will bill you on a prorated basis for that time. My fees go up to $10 every two years on the even year. If a fee raise is approaching I will remind you of this well in advance.

If you have insurance, you're responsible for providing me with the information I need to send in your bill. You must pay me your deductible at the beginning of each calendar year if it applies and any co-payment at each session. You must arrange for any pre-authorizations necessary. I will bill directly to your insurance company via electronic means following the session. You must provide me with your complete insurance identification information, and the complete address of the insurance company.

I am not willing to have clients run a bill with me. I cannot except barter for therapy. Any overdue bills will be charged a 1.5% per month interest. If you eventually refuse to pay your debt, I reserve the right to give your name and the amount due to a collection agency.

Dual relationships: If there is a circumstance where a relationship occurs that intersects in personal life, I will talk about this with you. I may decide to to refer you to another provider if the relationship that is discovered conflicts with an area of my personal life. Protecting your confidentiality and reduce complicated intersections in relationships is important for the therapeutic relationship.

Social media: I do not except or friend any of my clients on personal social media sites. I believe the therapeutic relationship is one that must be kept confidential and limiting this intersection/duality is important in preserving this.

Complaints: If you're unhappy with what is happening in therapy, I hope you'll talk about it with me so I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved ethically, you can complain about my behavior to the Iowa Board of social work.

Client consent to psychotherapy: I have read the statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and a release of that information and other information necessary to complete the billing process. I agree to pay the fees. I understand my rights and responsibilities a client, and my therapist's responsibilities to me. I agreed to undertake therapy with Sarah Cavan, LISW. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Sarah Cavan.

Signature_____Date_____

Printed name:_____

Healing Paths Intuitive Therapy

Authorization for Collaboration with Primary Physician

Outpatient Mental Health

As part of providing you comprehensive care, your therapist is able to contact your primary physician to notify him/her of your participation in mental health services and coordinate your care.

Client Name_____

Primary Care Physician's Name_____

Practice Location_____

___**Yes,** I would like my primary physician to be notified regarding my participation in services at Healing Paths Intuitive Therapy (*please sign a release of information form with your therapist).*

___**No,** I would NOT like my primary physician to be notified regarding my participation in services a Healing Paths Intuitive Therapy.

___I do not currently have a primary physician, and I **am** interested in establishing a primary physician.

___I do not currently have a primary physician , and I **am NOT** interested in establishing a primary physician.

Client Signature_____ Date_____

Healing Paths Intuitive Therapy

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I,_____,
(Name of Patient)

authorize communication between _____

Healing Paths Intuitive Therapy
(Name of program making disclosure)

to authorize the following information pertinent to my treatment episode:

- assessment and evaluation
- proposed treatment plan
- diagnosis
- progress notes related to pre-authorization or concurrent review
- continuing care plan
- other psychosocial information relating to pre-authorization or concurrent review
- follow-up contact
- other (specify) _____

The purpose of the disclosure authorized herein is to support care management and reimbursement, satisfaction surveying and quality improvement

I understand that my records are protected under the federal regulation governing confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2 and can not be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires when there has been a resolution of all outstanding claims or one year from discharge, whichever is later.

_____ _____
Signature of Client Date

_____
(Signature or parent, guardian or authorized representative, when required)

Prohibition on Redisclosure of Information Concerning Patient in Alcohol or Drug Abuse Treatment: This notice accompanies a disclosure of information concerning a patient in alcohol/drug abuse treatment, made to you with the consent of such patient. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.