Welcome to Leatherwood Counseling Services. Pleased that you have chosen my services to help you achieve emotional and relational health. Committed to partnering with you to work as effectively and helpful as possible. Time spent in counseling is a powerful investment in yourself and future. Sessions will typically last 50 minutes. Frequency will be determined by the client. On occasion, follow up emails will be sent with next steps and resources. To get started:

- Read, sign & return pages 1-4 prior to your first session.
- Pages 5-9 will be completed upon request during the first session.
- Pages 10-11, Notice of Privacy Practices for Protected Health Information.

Policies to be aware of, initial - indicating that you have read and understand stated policies:

______ Fees are collected when services are provided. Expect a text from Ivy Pay, a Hippa Compliant App. You will be responsible for submitting claims to your insurance company.

______ Additional fees for professional services provided beyond sessions may apply. Additional services include, but are not limited to, unscheduled phone sessions, written reports for third parties, consultation with other professionals, and any reports needed for legal reasons.

______ Client will be responsible for fees related to assessments as needed.

______ Notification for cancellations must be communicated 36 hours prior to scheduled service. Cancel through email, voicemail or text. If you cancel less than 36 hours prior to your appointment, expect to be billed. If you cancel twice in a row with less than 36-hour notice, or if you miss a total of 2 scheduled appointments without notification, services may be suspended.

______ If you or your children are actively pursuing counseling or psychotherapy, Leatherwood Counseling Services is prevented by Florida law from serving as expert witnesses in legal matters dealing with child custody, fitness of parenting, or divorce.

______ Your initials indicate you authorize password protected online zoom, facetime and/or google meets sessions.

______ Digital communication via email or cell phone may not be secure. Leatherwood Counseling is obligated ethically and legally to protect the confidentiality of all communication with you. Procedures and technology are in place to protect records.

______ Leatherwood Counseling is not available 24/7. In the event that you experience a behavioral or emotional crisis, contact the Crisis Center in your county by dialing 211, available 24 hours a day, 7 days a week. You can also dial 911 for emergencies.

______ Texts, emails and calls will be returned within 36 - 48 hours. Availability during holidays and scheduled vacations time away will be limited..

General Consent

I understand that by completing this form I am requesting counseling sessions from Leatherwood Counseling Services. I understand that Leatherwood Counseling Services will use the information in this form to determine what services Leatherwood Counseling Services may be able to offer. If Leatherwood Counseling Services determines they are not able to provide services, they provide appropriate referrals to other professionals.

If Leatherwood Counseling Services staff determine that they are able to provide services, I give my general consent to use the information in this form for treatment, payment, and health care operation purposes. This consent does not allow Leatherwood Counseling Services to release any protected health care information to any person or organization outside Leatherwood Counseling Services, except when mandated by law.

I understand that this consent is governed by the practices described in the document titled Notice of Privacy Practices for Protected Health Information,
which is found on pages 10-11 of this packet.

I have received and read this document. I also consent to digital communication with Leatherwood Counseling Services staff via email, cell phone and online sessions, that may not be secure.

I hereby give permission to Leatherwood Counseling Services to use my protected health information for purposes of treatment, payment, and health care operations.

Signature: ____

Date: ____

Leatherwood Counseling Services, LLC
Sherrie@leatherwoodcounseling.com
612-915-0677

Leatherwood Counseling Services, LLC - CREDIT CARD AUTHORIZATION

- Payment is due at time services are rendered.
- Following the session, you will receive a text from IVY PAY.
- IVY PAY is a secure, convenient, user-friendly, HIPPA Compliant App.

Name as it appears on card: ______________________________

Zip Code: ______________________________

Last 4 digits of credit card number: ______________________________

Expiration Date: ______________________________

Signature: ______________________________

Today's Date: ______________________________

Cell Phone: ______________________________

Current Email Address: ______________________________

Leatherwood Counseling Services, LLC
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612-915-0677

General Information

Date: ____

Name: ____

Date & Year of Birth: ________________ Sex: ____________

Address: ____

City, Zip: ____

Phone: ____

Email Address: ____

Consent to leave a voicemail? ____

(If a client is under age 18, request consent for minor client intake paperwork.)

How did you hear about Leatherwood Counseling Services?

____

____

Presenting Circumstance

Describe the challenges you are having and when they began.

____

____

____

What seems to make the challenge worse?

____

____

____

What seems to make the challenge better?

____

____

____

Provide some ways in which you have worked to resolve your challenges?

____

____

Have you been court ordered to discuss this challenge? ____YES ____NO

Rate the severity of your challenges-1 being not at all - 10 being very severe. ________

When did this challenge begin?

____

Please check any symptoms you are experiencing:

___Aggression/Anger Outbursts
___ Distractibility
___ Dizziness
___ Drug abuse
___ Eating disorders
___ Elevated mood
___ Fatigue
___ Impulsivity
___ Sexual difficulties
___ Alcohol abuse
___ Indecisiveness
___ Sleeping problems
___ Stressed out
___ Suicidal thoughts
___ Trembling
___ Weight gain/loss
___ Withdrawal
___ Worrying
___ Worthlessness
___ Anxiety
___ Loneliness
___ Avoidance of people
___ Memory problems
___ Chest pains
___ Fears
___ Gambling
___ Hallucinations
___ Headaches
___ Mood swings
___ Computer addiction
___ Muscle tension
___ Depression
___ Panic attacks
___ Difficulty concentrating
___ Racing thoughts
___ Difficulty thinking
___ Helplessness
___ Hopelessness
___ Restlessness/on edge
___ Irritability
___ Sexual addiction
___ Other symptoms____

List all previous mental health treatment and the provider:

____

____

Please list any mental health problems in your extended biological family:

____

____

Please check current stressors:

___ Conflict with children
___ Financial problems
___ Poor peer relations
___ Separation or divorce
___ Conflict with parents
___ Health problems
___ Problems at school
___ Substance abuse
___ Victim of abuse
___ Conflict with siblings
___ Housing problems
___ Challenges at work
___ Conflict with other family
___ Job loss or change
___ Recent death of family/friend
___ Emotional problems
___ Marital conflict
___ Legal problems
___ Recent move
___ Sexual challenges
___ Physical problems
___ Other ____

Please check any substance use:

___ Tobacco ___ Caffeine ___ Alcohol ___ Marijuana
___ Cocaine/Crack ___ Heroin ___ Amphetamines ___ LSD
___ Ecstasy ___ Inhalants ___ Prescription Drugs
___ Other Drugs ____

Medical History

Who is your primary care physician? _______________________________________
Date of last visit ____________________ Date of last physical _____________________

Describe your overall physical health:

____

____

List current medications, prescribed, over the counter, herbal supplements:

____

____

____

Social History

How many siblings do you have? __________ Which family members are you close to?
Place of birth

____

Where did you grow up?

____

If your family moved around, please describe.

____

____

Describe your childhood.

____

____

____

List any trauma you may have suffered (physical, sexual, emotional).

____

____

In 10-12 words, describe your relationship with your father when you were a child.

____

____

In 10-12 words, describe your current relationship with your father.

____

____

In 10-12 words, describe your relationship with your father when you were a child.

____

In 10-12 words, describe your current relationship with your mother.

Please describe any significant conflicts you have had with family members.

Whom do you rely on for emotional support?

What belief system (moral, spiritual, cultural, religious) influences your life?

If you attend a church, what is its name? ____

Relationship History

Do you make friends easily? ____Yes ____No If no, please describe why not.

What is your marital status?

____ Single ____ Married ____ Divorced ____ Widowed ____ Separated ____ Other

Describe your current relationship, including stressors.

Describe any prior marriages or long-term relationships.

If you have children, list their names and ages.

List who currently lives with you.

What challenges do you have with your children?

Educational History
What is the highest grade you completed? ____________________________
What kind of student were you? ____________________________
If you received special educational services, describe them.
____
Describe any discipline challenges you had in school?
____
____

Occupational History
Are you currently employed? ____ Yes ____ No
Where do you work?____
How long have you been there? _______
What is your position? ____
What do you like about your job?
____

____
What do you not like about your job?
____
____
What job stressors are you experiencing?
____
How do you get along with your work colleagues?
____
____
Anything else about your work environment?
____

Military History (complete the following if this applies)
What branch did you serve in and when?
____
Combat or other high- risk zones? please describe.
____
If you were discharged, what type of discharge did you have?
____

Legal History
Have you been court ordered, now or past, to receive counseling? ____Yes ____No
List any current involvement with either the criminal or civil legal system.
____

What additional information would be helpful for your therapist to know?

____
____
____
____
____
____
____
____

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Protected health information (PHI) is the information we record when we provide counseling services to you. Such information may include your reason for seeking counseling, assessment results, diagnosis, treatment plan, notes from your counseling sessions, and both billing and payment records.

With your consent, Leatherwood Counseling Services, LLC, is permitted by federal privacy laws to use and disclose your health information for purposes of treatment, payment, and health care operations.

Here are examples of how we might use your PHI for each of these purposes:

- We use your PHI for treatment purposes when a counselor reviews notes about your last counseling session prior to your next session.
- If requested, we use and disclose your PHI for payment purposes when we submit a request for payment to your health insurance company or to any other organization, such as a church, that may be paying for a portion of your treatment costs.
- We use your PHI for health care operations when the Director reviews your records in order to evaluate how well clinical staff members are documenting their counseling services.

Your health information rights:

The health and billing records we maintain are the physical property of this office. The information, however, belongs to you.

You have a right to:

- Request that we restrict our use/disclosure of your protected health information by delivering the request in writing to our office. We are not required to grant the request, but we will work to comply with the request granted or negotiate with you an acceptable alternative.
- Request that you be allowed to inspect and receive a copy of your health and billing records.
- Appeal a denial of access to your PHI except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information.
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your PHI.
- Obtain an accounting of all disclosures of your health information to third parties outside this office not associated with treatment, payment, or health care operations, or disclosures made.
- Request that communication of your health information be made by alternative means or at an alternative location.

- Revoke any authorizations that you made previously to use or disclose information. This revocation does not apply to any disclosures you authorized and that have already taken place.

Review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

If you want to exercise any of the above rights, please contact Sherrie Leatherwood in person or in writing, during normal business hours, she will help you take steps to exercise your rights.

Our responsibilities:

- Maintain the privacy of your health information as required by law.
- Provide you with this notice that explains how we protect information that we collect and maintain about you.
- Abide by the terms of this Notice.
- Notify you if we cannot accommodate a requested restriction or request.
- Accommodate your reasonable requests regarding methods to communicate health information to you.
- Within our rights and responsibilities by law, we reserve the right to amend, change, or eliminate provisions in our privacy and access practices and to enact new provisions regarding the PHI we maintain. Any time our practices change, we will amend our Notice to reflect these changes.

To request information or file a complaint:
If you want to file a complaint or report a violation of the privacy of your PHI, please contact Sherrie Leatherwood, in person, or in writing, during normal business hours. You may also file a complaint by mailing or emailing your complaint to the Secretary of Health and Human Services.

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from our office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

When will we disclose your PHI:
Leatherwood Counseling will only release, or disclose, your PHI to any person or organization not a part of Leatherwood Counseling if you give us written authorization to do so. By law, however, we must report to legal authorities if we suspect abuse of children, elderly persons, or disabled persons. Such a report would only disclose that you are receiving services at Leatherwood Counseling. By law, also, we may disclose appropriate portions of your PHI if you are receiving services under workers compensation, if you are a danger to yourself or others, or if we are legally compelled by a court order or similar judicial action. In these cases, our practice will be to secure written authorization from you unless doing so is dangerous or will lead to harm to you. You may revoke any written authorization you have given to us at any time.