Welcome to Leatherwood Counseling Services. We are pleased that you have chosen us to help you achieve emotional and relational health. We are committed to doing all we can to make your work with us as effective and helpful as possible. To get started:

- **Read, sign & return pages 1-3 prior to your first session.**
- **Pages 4-11, G<u>eneral Information,</u> can be completed during our first session together, however it is beneficial if you complete it prior to session.**
- **Pages 12-13, <u>Notice of Privacy Practices for Protected Health Information.</u>**

What follows is our intake materials. The information we request will give your counselor background information on you. Completing it is part of your preparation for counseling.

Our sessions will typically last 50 minutes each. How many times you meet with your counselor depends on the issues you bring and your commitment to the process. We believe that time spent in counseling is a powerful investment in yourself and future.

We have several policies about fees that you should be aware of: (Please initial each blank, indicating that you have read and understood each policy.)

_____ We collect fees when services are provided. Expect a text from Ivy Pay, a Hippa Compliant resource. If you have insurance coverage, you have the responsibility of submitting claims to collect from your insurance company.

_____ We bill for any additional professional services we provide beyond the office visit. 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.

_____ If you and your counselor decide that a psychological assessment may be needed, you will be responsible for the fees for the assessment.

_____ Please notify us of cancellations at least 36 hours in advance. You may cancel by leaving a voicemail message. If you cancel less than 36 hours before your appointment, we will bill you for the appointment. If you cancel twice in a row with less than 36-hour notice, or if you miss a total of two scheduled appointments without notifying us, we reserve the right to suspend services.

_____ If you have provided us with a debit or credit card for billing purposes, that card may be used for payment in the event of a missed appointment with less than 36-hour notice.

_____ If we are seeing you or your children for counseling or psychotherapy, we are 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 sessions.

_____ Digital communication with us via email or cell phone may not be secure. We are obligated ethically and legally to protect the confidentiality of all communication with you. We have procedures and technology in place to protect all records we keep, but we cannot protect digital communication that leaves our office.

_____ We also want you to know that we cannot guarantee around-the-clock availability. If you should experience a behavioral or emotional crisis and you cannot reach us by phone, you should 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. Most calls to Leatherwood Counseling, however, will be returned within 36 hours. Availability during holidays and scheduled time away will limit access to your therapist.

General Consent

I understand that by completing this form I am requesting services from Leatherwood Counseling Services. I understand that Leatherwood Counseling Services staff will use the information in this form to determine what services Leatherwood Counseling Services staff may be able to offer. If Leatherwood Counseling Services staff determine that they are not able to provide services, they will give me 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 12-13 of this packet. I have received a copy of 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 the staff of 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

Thank you for understanding that payment is due at time services are rendered.

Following each session, you will receive a text from IVY PAY, an online HIPPA Compliant app.

Cell Phone: _____

Name as it appears on card: _____

Billing Address:
_____

City _____ State _____ Zip Code _____

Type of Card (circle one): VISA MASTER CARD DISCOVER

Last 4 digits of credit card number: _____

Expiration Date: _____

Signature: _____ Date: _____

Leatherwood Counseling Services, LLC

Sherrie@leatherwoodcounseling.com **612-915-0677**

General Information

Take time to respond to the following items as completely and honestly as you can. If you are completing this form anywhere other than our office, you are responsible for keeping the form confidential.

Date _____

Name _____

Sex _____ Date & Year of Birth _____

Address _____

City, State _____ Zip _____

Primary phone_____ May we leave a voicemail? Yes or No

Email Address_____

Driver's License: _____ Social Security: _____

Under 18? Please request additional forms.

How did you learn 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 problems ___ 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?

_____

_____

_____

_____

_____

_____

_____

_____

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 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. You may exercise this right by delivering the request in writing to our office.

- 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 by delivering a written request to our office.

- 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 to you.

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office.

- Revoke any authorizations that you made previously to use or disclose information by delivering a written revocation to our office. This revocation does not apply to any disclosures your 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.