New Patient Intake form

A. Identification.

Your name:________________________ Date of birth:____________ Age:____________

Nicknames or aliases:________________________ Social Security Number: ____________

Home street address:________________________ Apt:____________

City:________________________ State:______ Zip:____________

Home/evening phone:________________ E-mail:________________________

Calls or e-mail will be discreet, but please indicate any restrictions: ________________________

B. Religious/Faith and racial/ethnic identification.

Current religious denomination/affiliation (please specify): ________________________

Involvement: ❑None ❑Some/irregular ❑Active

How important are spiritual concerns in your life? ________________________

Ethnicity/national origin:________________________ Race(s):________________________

Other ways you identify yourself and consider important: ________________________

C. Education and training (High School, Higher Education, Trade Schools, Etc.):

Dates of attendance	School Name	Area of Focus/Major	Degree	GPA

D. Employment and Military Experience:

Dates of Employment/Service	Employer/Service Branch	Job Title/Rank	Reason for leaving

E. Your treatment (medical & mental health).

Current Primary Medical Care Provider/Doctor:________________________

Phone:________________ Address:________________________

Current Psychiatry Provider/Doctor:________________________

Phone:________________ Address:________________________

ANY CURRENT OR PREVIOUS MEDICAL PROBLEMS/DIAGNOSIS OR HEALTH CONCERNS?

❑ NO ❑ YES IF YES, PLEASE INDICATE (*PLEASE CLARIFY SERIOUS HEALTH CONCERNS*):

DATES OF ILLNESS	TYPE OF ILLNESS & TREATMENT RECEIVED	OUTCOME OF TREATMENT

HAVE YOU EVER RECEIVED PSYCHOLOGICAL, PSYCHIATRIC, DRUG OR ALCOHOL TREATMENT, OR COUNSELING SERVICES BEFORE?

❑ NO ❑ YES IF YES, PLEASE INDICATE:

DATES OF TREATMENT	TYPE OF ILLNESS & TREATMENT RECEIVED	OUTCOME OF TREATMENT

HAVE YOU BEEN PRESCRIBED AND ARE CURRENTLY TAKING MEDICATIONS FOR TREATMENT OF PSYCHIATRIC OR EMOTIONAL SYMPTOMS?

❑ NO ❑ YES IF YES, PLEASE INDICATE:

DATE STARTED	MEDICATION NAME – DOSAGE STRENGTH & FREQUENCY?	FOR WHAT?	OUTCOME OF TREATMENT?

** IF YOU ENTER TREATMENT WITH ME, DO I HAVE YOUR PERMISSION TO INFORM YOUR MEDICAL DOCTOR AND/OR PSYCHIATRIST* OF TREATMENT, *DISCUSS THE TREATMENT YOU ARE RECEIVING WHILE UNDER MY CARE, OBTAIN INFORMATION CONCERNING MEDICAL DIAGNOSIS, AND COORDINATE YOUR TREATMENT?* ❑ YES ❑ NO

F. SUBSTANCE/CHEMICAL USE.

INDICATE YOUR USE/CONSUMPTION OF THE BELOW:

I. CAFFEINE PRODUCTS (COFFEE, TEA, SODA, ENERGY DRINKS, CAFFEINE SUPPLEMENT, ETC.) ❑ YES ❑ NO

TYPE, QUANTITY, AND FREQUENCY OF CONSUMPTION: ______________________________

CURRENTLY CONSUMING? ❑ YES ❑ NO IF NO LONGER IN USE, WHEN WAS IT LAST CONSUMED?______________________________

II. TOBACCO PRODUCTS (CIGARETTES, CIGARS, VAPING, CHEWING, DIPPING, ETC.) ❑ YES ❑ NO

TYPE, QUANTITY, AND FREQUENCY OF CONSUMPTION: ______________________________

CURRENTLY USING? ❑ YES ❑ NO IF NO LONGER IN USE, WHEN WAS IT LAST USED?______________________________

III. ALCOHOL PRODUCTS (WINE, BEER, LIQUOR, ETC.) ❑ YES ❑ NO

TYPE, QUANTITY, AND FREQUENCY OF CONSUMPTION: ______________________________

CURRENTLY CONSUMING? ❑ YES ❑ NO IF NO LONGER IN USE, WHEN WAS IT LAST USED?______________________________

IV. Inhalants (glue, gas, paint thinner, etc.) ❑ Yes ❑ No

type, quantity, and frequency of use: ________________

Currently using? ❑ Yes ❑ No If no longer in use, when was it last used? ________________

V. Non-prescribed stimulants (Adderall, cocaine, bath salts, methamphetamines, etc.) ❑ Yes ❑ No

type, quantity, and frequency of consumption: ________________

Currently using? ❑ Yes ❑ No If no longer in use, when was it last used? ________________

VI. Non-prescribed depressants (marijuana, klonopin, xanax, etc.) ❑ Yes ❑ No

type, quantity, and frequency of consumption: ________________

Currently using? ❑ Yes ❑ No If no longer in use, when was it last used? ________________

VII. Non-prescribed opioids (hydrocodone, heroin, oxycodone, fentanyl, etc.) ❑ Yes ❑ No

type, quantity, and frequency of consumption: ________________

Currently using? ❑ Yes ❑ No If no longer in use, when was it last used? ________________

VIII. Other non-prescribed substances/chemicals not listed above ❑ Yes ❑ No

type, quantity, and frequency of consumption: ________________

Currently using? ❑ Yes ❑ No If no longer in use, when was it last used? ________________

G. Legal History.

Presently suing anyone or considering suing anyone? ❑ Yes ❑ No

If yes, please explain: ________________

____

____

Any misdemeanor or felony arrests? ❑ Yes ❑ No   Any arrests result in your incarceration? ❑ Yes ❑ No

If yes, please explain: ________________

____

____

Are there any other legal involvements I should know about that have not been disclosed? ❑ Yes ❑ No

If yes, please explain: ________________

____

____

H. Chief concern.

Please describe the main difficulty that has brought you to see me: ________________

____

____

____

What kind of stressors are you experiencing right now? ________________

____

____

____

WHAT IMPORTANT THINGS ABOUT YOU, YOUR RELATIONSHIPS OR FAMILY WOULD IT BE HELPFUL FOR YOUR THERAPIST TO KNOW? (I.E., HANDICAPS, DEATHS, DIVORCES, SCHOOL/JOB CHANGES, SUICIDE) ____________________

____

____

____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLIES:

❑ PLANS TO HARM SELF

EXPLAIN: ____________________

❑ INTENTIONS TO HARM SELF

EXPLAIN: ____________________

❑ ATTEMPTS TO HARM SELF

EXPLAIN: ____________________

❑ PSYCHIATRIC HOSPITALIZATIONS

EXPLAIN: ____________________

❑ ATTEMPTED SUICIDE

EXPLAIN: ____________________

❑ SUICIDAL NOW

EXPLAIN: ____________________

I. RELATIONSHIPS IN YOUR FAMILY OF ORIGIN.

PLEASE LIST FAMILY MEMBERS LIVING WITH YOU WHILE GROWING UP:

NAME	NATURE OF RELATIONSHIP	OLDER OR YOUNGER SIBLING?

PLEASE DESCRIBE THE FOLLOWING:

1. YOUR PARENTS' RELATIONSHIP WITH EACH OTHER: ____________________

____

____

____

2. YOUR RELATIONSHIP WITH EACH PARENT AND WITH ANY OTHER ADULTS PRESENT: ____________________

____

____

____

3. Your parents' medical problems, drug or alcohol use, and mental or emotional difficulties: ____________________

____

____

____

4. Your relationship with your sibling(s), in the past and present: ____________________

____

____

____

J. Present relationships (if applicable).

1. Are you single, Married, Divorced, or separated? ____________________
2. If married, date of current marriage: ____________________
3. Spouse's Name: ____________________ Date of Birth: ____________________

Please list additional family members currently living with you:

Name	relationship	Date of Birth	Employer/School

4. How do you get along with your present spouse/partner and/or children? ____________________

____

____

____

K. Abuse history.

❑ I was not abused in any way. ❑ I was abused.

If you were abused, please indicate the following by using these letters to show the type of abuse:

P = Physical (such as beatings), S = Sexual (such as touching/molesting, fondling, or intercourse), N = Neglect (such as failure to feed, shelter, or protect), E = Emotional (such as humiliation, etc.)

Kind of abuse?	Your Approx. Age?	By whom?	Who did you tell? Outcome?

L. Emergency information.

If some kind of emergency arises and we cannot reach you, or we need to reach someone close to you, whom should we call?

Name: ____________________ Phone ____________________ Relationship: ____________________

Please mark all the items below that apply, and feel free to add any others at the bottom under "Other concerns or issues" option. You may add a note or details in the space next to the concerns checked.

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your childhood)
- ❑ Codependence
- ❑ Compulsions
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk-taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Pain, chronic
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism

- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems (see also “Career concerns ...”)
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness, distrust
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholism/overworking, can’t keep a job, dissatisfaction, ambition
- ❑ Other concerns or issues:____

NAME (printed):____

SIGNATURE:____DATE:____________________

INFORMED CONSENT FOR PSYCHOTHERAPY & COUNSELING

IT IS A PRIVILEGE TO SERVE YOU. I WILL DO ALL I CAN TO HELP PROVIDE THE HIGHEST QUALITY OF CARE TO MEET YOUR THERAPEUTIC NEEDS. PLEASE EXAMINE THE BELOW INFORMATION CAREFULLY AND MAKE NOTE THAT I WILL BE HAPPY TO ANSWER QUESTIONS OR CONCERNS OVER ITEMS WHICH MIGHT REQUIRE ADDITIONAL CLARIFICATION. KINDLY PROVIDE YOUR SIGNATURE ON THE LAST PAGE TO ACKNOWLEDGE TERMS OF TREATMENT.

I. THE THERAPY PROCESS: I PRACTICE THROUGH A CONTEMPORARY PSYCHOANALYTIC LENS, PROVIDING A HOLISTIC APPROACH TO TREATMENT WHILE GATHERING A DEEP UNDERSTANDING OF WHAT IS BEING COMMUNICATED THROUGH ONE'S BEHAVIORS, NOT JUST SYMPTOMS. CHANGE CAN OCCUR WHILE WORKING THROUGH ONE'S EXPERIENCES, THINKING, ACTIONS, EMOTIONS, FEELINGS, ENVIRONMENT, AND SPIRITUAL CONDITION. CHANGES CAN PRODUCE VARYING RESULTS, AND IT IS NECESSARY TO RECOGNIZE THAT AS ONE STRUGGLES WITH CHANGE, SOMETIMES THAT STRUGGLE MAY LEAD ONE TO GO THROUGH A MORE DIFFICULT VALLEY TEMPORARILY. IT IS VERY IMPORTANT THAT THERAPY CONTINUE UNTIL YOU HAVE PASSED THROUGH THAT VALLEY, SHOULD IT OCCUR.

II. CONFIDENTIALITY: I AM DEDICATED TO PRESERVING THE CONFIDENTIALITY AND PRIVACY OF ALL MY PATIENTS. HOWEVER, SOME STATE AND FEDERAL LAWS REQUIRE THAT I DISCLOSE INFORMATION IN CERTAIN SITUATIONS. PLEASE REVIEW THE FOLLOWING SITUATIONS IN WHICH I MUST BREACH CONFIDENTIALITY:

- IF CHILD, ELDERLY, OR DISABLED PERSON ABUSE OR NEGLECT IS SUSPECTED
- IF CHARGES WERE TO BE BROUGHT AGAINST ME BY A PATIENT
- IF A COURT ORDERS TESTIMONY OF YOUR RECORDS
- IF A PATIENT IS A DANGER TO THEMSELVES OR OTHERS (SUICIDAL OR HOMICIDAL)
- I AM UNDER THE SUPERVISION OF JENNIFER DEMBOWSKI (913-240-7774), WHO WILL HAVE FULL ACCESS TO YOUR FILE. JENNIFER DEMBOWSKI AND I WILL NEED TO CONSULT AND DISCUSS THE DETAILS OF THIS THERAPEUTIC RELATIONSHIP, OUR SESSION(S) CONTENT, AND VIDEOTAPED SESSIONS (WHERE APPLICABLE).
- TO GET AN OBJECTIVE POINT OF VIEW, I MAY AT TIMES CONSULT WITH ANOTHER PROFESSIONAL ABOUT YOUR CASE. IN THOSE INSTANCES, YOUR CONFIDENTIALITY WILL BE MAINTAINED AS NON-IDENTIFYING INFORMATION WILL BE REVEALED, ON THE CIRCUMSTANCE OF YOUR SITUATION. ANY PROFESSIONAL CONSULTING WILL ALSO BE REQUIRED BY PROFESSIONAL ETHICS TO MAINTAIN YOUR CONFIDENTIALITY. THE EXCEPTION WILL BE THAT WHEN I AM OUT OF TOWN; YOUR INFORMATION MAY BE RELEASED TO ANOTHER THERAPIST WHO WILL SERVE ON CALL SHOULD AN EMERGENCY ARISE. IN THIS CASE, AS LITTLE CONFIDENTIAL INFORMATION WILL BE RELEASED WHERE NECESSARY.

THE LAWS AND ETHICS OF CONFIDENTIALITY ARE COMPLICATED. IF YOU HAVE SPECIAL OR UNUSUAL CONCERNS, AN ATTORNEY IS RECOMMENDED FOR LEGAL ADVICE.

III. TREATMENT OF MINORS: PERSONS UNDER THE AGE OF 18 MUST HAVE PERMISSION OF THE PARENT OR LEGAL GUARDIAN TO RECEIVE THERAPEUTIC SERVICES. PARENTS/GUARDIANS WILL BE INVOLVED IN THE TREATMENT AS I DEEM NECESSARY WHILE MAINTAINING THE CONFIDENTIALITY OF THE PATIENT, EXCEPT IN CASES OF DANGEROUS DRUG USE, SUICIDAL IDEATION, HARM TO ANOTHER, OR RUNNING AWAY. IN CASES OF DIVORCE, I WILL WANT TO INVOLVE BOTH PARENTS UNLESS RIGHTS HAVE BEEN SEVERED FOR ONE OR IT IS OTHERWISE NOT FEASIBLE TO DO SO.

IV. SERVICES FOR LEGAL DISPUTES: I WILL NOT SERVE AS A WITNESS IN CUSTODY DISPUTES, DIVORCE CASES OR PROVIDE RECORDS FOR SUCH MATTERS. I ASK YOU TO AGREE TO ACCEPT THIS POLICY. IF YOU GO TO COURT, YOU WILL NEED TO RECEIVE AN EVALUATION FROM ANOTHER PROFESSIONAL FOR THOSE INVOLVED. I WILL PROVIDE A SUMMARY, IF NECESSARY, BUT NOT ACTUAL RECORDS TO THE COURT. MY FEE FOR THIS SERVICE WILL BE $300 PER HOUR OF PREPARATION, AND IT MUST BE PAID IN FULL IN ADVANCE. IF AT ANY TIME I AM REQUIRED TO ATTEND COURT PROCEEDINGS, MY FEE WILL BE $400 PER HOUR WITH THREE HOURS PAYABLE IN ADVANCE. THE CHARGE CAN BE AVOIDED IF CANCELLATION IS MADE TWO WEEKS IN ADVANCE.

V. SUBPOENAS: IF YOUR RECORDS ARE REQUESTED THROUGH SUBPOENA, YOU WILL BE NOTIFIED IN WRITING AND PROVIDED WITH A COPY OF THE SUBPOENA. YOU MUST THEN PROVIDE ME WITH A WRITTEN OBJECTION TO THE SUBPOENA OR INDICATE THAT AN OBJECTION WILL BE FILED WITH THE COURT (WITH A COPY PROVIDED TO ME). IT IS THE PATIENT'S RESPONSIBILITY TO FILE THIS WITH THE COURT WITHIN THE TIME FRAME LEGALLY ALLOWED.

VI. APPOINTMENTS: ALL SESSIONS ARE 45 MINUTES IN LENGTH AND INCLUDE THE TIME NEEDED TO SCHEDULE FOLLOW-UP CARE OR MAKE PAYMENT(S). STANDING APPOINTMENT TIMES WILL BE OFFERED (AS AVAILABLE) TO AVOID HAVING TO SPEND UNNECESSARY TIME ON SCHEDULING DURING APPOINTMENTS. AN OPTION TO HOLD PAYMENT INFORMATION ON FILE IS OFFERED TO MAKE PAYMENT LESS TIME CONSUMING DURING YOUR APPOINTMENT. DUE TO THE DIFFICULTY OF SCHEDULING, CANCELLATIONS AND REQUESTS FOR RESCHEDULED APPOINTMENTS MUST BE PROVIDED AT LEAST TWO BUSINESS DAYS (48 HOURS) PRIOR TO YOUR SCHEDULE APPOINTMENT START TIME TO AVOID BEING CHARGED FOR THE APPOINTMENT. BUSINESS DAYS ARE CONSIDERED MONDAY THROUGH FRIDAY, 9:00 AM TO 5:00 PM. APPOINTMENT CHARGES FOR LATE CANCELLATIONS OR MISSED APPOINTMENTS WILL BE THE COST PAID FOR YOUR USUAL APPOINTMENT VISIT(S); THIS COST IS PAYABLE AT THE APPOINTMENT TIME. IN THE EVENT AN EMERGENCY OCCURS AND PROHIBITS YOUR ATTENDANCE, PLEASE NOTIFY ME AT YOUR EARLIEST CONVENIENCE. CONCERNS FOR CONSIDERATION TO THIS APPOINTMENT ATTENDANCE POLICY CAN BE DISCUSSED DURING YOUR APPOINTMENT AND EXEMPTIONS WILL BE CONSIDERED AT MY DISCRETION. SEVERAL TIMES IN THE YEAR I WILL PLAN TO BE OUT OF MY OFFICE FOR ONE WEEK OR MORE; EFFORT WILL BE MADE TO PROVIDE YOU WITH ADVANCED NOTICE FOR MY ABSENCES. DURING SUCH TIMES, A NAME AND PHONE NUMBER WILL BE PROVIDED FOR A THERAPIST WHO WILL BE PROVIDING SUPPORT DURING MY ABSENCE (WHEN NECESSARY). ON OCCASION UNFORESEEN EVENTS OCCUR THAT WILL PREVENT ME FROM KEEPING OUR APPOINTMENT TIME. WHEN SITUATIONS LIKE THIS OCCUR, I WILL NOTIFY YOU AND TRY TO PROVIDE ALTERNATIVE APPOINTMENT OPTIONS; IF OPTIONS PROVIDED TO YOU (IN THESE INSTANCES) DO NOT WORK FOR YOU TO RESCHEDULE, YOU WILL NOT BE CHARGED

VII. FEES & PAYMENTS: MY STANDARD RATE IS $125 PER 45 MINUTE SESSION FOR INDIVIDUALS AND $150 PER 50 MINUTE SESSION FOR COUPLES. PLEASE NOTE THE FOLLOWING CONDITIONS WILL RESULT IN ADDITIONAL CHARGES OR INCREASED RATE FOR SESSIONS AS STIPULATED:

- IF AFTER HOURS OR WEEKEND APPOINTMENTS CAN BE PROVIDED, THE FOLLOWING RATES WILL APPLY:
  - $250 FOR INDIVIDUALS
  - $300 FOR COUPLES
- IF ADDITIONAL TIME IS REQUESTED OR REQUIRED FOR A SCHEDULED SESSION, A PRORATED CHARGE OF MY STANDARD FEE WILL BE ASSESSED.
- BRIEF PHONE CALLS OF LESS THAN TEN MINUTES ARE COMPLIMENTARY. IF MORE THAN 10 MINUTES IS REQUIRED DURING A GIVEN WEEK, A PRORATED CHARGE OF MY STANDARD FEEL WILL BE ASSESSED.
- EMAIL AND MESSAGING REGARDING SCHEDULING AND PAYMENT OF LESS THAN 10 MINUTES (WEEKLY) ARE COMPLIMENTARY, IF ADDITIONAL TIME IS REQUESTED OR REQUIRED FOR EMAIL AND MESSAGING COMMUNICATION DURING A GIVEN WEEK, A PRORATED CHARGE OF MY STANDARD FEEL WILL BE ASSESSED.

REQUESTS FOR A REDUCED RATE ARE CONSIDERED ON A CASE-BY-CASE BASIS. IF A REDUCED RATE HAS BEEN DISCUSSED WITH ME AND HAS MY APPROVAL, PLEASE STIPULATE THE AGREED UPON RATE AND THE DATE I PROVIDED YOU WITH THE APPROVAL.

THE AGREED UPON REDUCED RATE FOR YOUR TREATMENT IS ____________ PER SESSION, AS OF ____________.

KINDLY NOTE: FEE AMOUNTS ARE EVALUATED FOR ALL PATIENTS PERIODICALLY AND ARE SUBJECT TO CHANGE, HOWEVER, ANYTIME A DETERMINATION IS MADE FOR YOUR RATE TO BE INCREASED; YOU WILL BE NOTIFIED IN ADVANCE.

VIII. INSURANCE: I AM NOT CURRENTLY PANELED WITH INSURANCE COMPANIES, HOWEVER, IF YOU BELONG TO A PLAN THAT PAYS FOR OUT OF NETWORK SERVICES, A SUPERBILL CAN BE PROVIDED TO YOU (UPON YOUR REQUEST). IF YOU'D LIKE TO TAKE ADVANTAGE OF THIS OPTION, PLEASE INDICATE THE NEED FOR DOCUMENTATION TO BE PROVIDED TO YOU IN THE FORM OF A SUPERBILL.

PLEASE PROVIDE A SUPERBILL EACH MONTH TO THE EMAIL ADDRESS PROVIDED FOR ME ______________

IX. Consultation: If you could benefit from a treatment I cannot provide, I will help to find a resource providing treatment. You have a right to ask about such other treatments, their risks, and benefits. I will fully discuss the reasons for any additional recommendations I have so you can decide what is best for you.

X. Communication: Sending confidential information through text and email are not a safe and secure means of communication because there is not proper means for assuring the confidentiality of the information communicated. For the protection of your confidentiality, I will not utilize the methods of texting or email with patients for anything other than scheduling or payment related topics. Please communicate with me by telephone or in person regarding topics of a personal nature to help protect your privacy and ensure it is responded to in a therapeutic manner. It is important that we be able to communicate and also keep confidential space as this is vital to the therapeutic process. Kindly make note of the following:

- I will not be available at all times as I do not take phone calls when I am with a patient or when I am away from my office. You are most welcome to leave a message, and I will return your call within 24-48 hours of the next business day, barring an urgent situation.
- It is my policy not to have current or former patients in my social media network. I will not accept friend requests from patients (current or former) as a way to preserve the therapeutic relationship. I will also not send current or former patients friend requests.

As the need arises to contact me, I can be reached via the following:

- Phone & Text: (816) 895-2515
- Email: jon@reality-reverie.com

Providing protected health information through unsecured means leaves little to no control over who might be able to access your information. I do not provide protected health information via text or email. Automated reminders for in-person scheduled appointments are provided in advance to each appointment and can be provided via text or email. Automated reminders with a link to our virtual appointments are provided in advance via email; if virtual appointments are requested, email notifications will automatically be selected for you. If in-person appointments are preferred, please indicate below which notification method you would prefer:

- ____________I authorize appointment reminders, receipts, and invoices to be sent via email.
- ____________I authorize appointment reminders to be sent via text.

Please note, I will do my very best to be available for brief between-session phone calls as time permits. If you are experiencing an emergency when I am unavailable, please call 911, or go to your nearest hospital emergency room for assistance.

XI. Hipaa: I acknowledge that a copy of the HIPAA notice of privacy practices has been made readily available to me via https://reality-reverie.com. It may be beneficial for me to confer with your medical doctor concerning your psychological treatment or to discuss any medical problems for which you are receiving treatment. An option to allow me authorization to contact your physician(s) with regard to your treatment has been made available under section 'E' of the intake portion of this form. Please indicate there if you would like treatment to be coordinated with your PCP and/or Psychiatrist.

XII. Telehealth Services: telehealth involves the use of electronic communication to enable me to connect with patients using live interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral resources, education, and the transfer of medical and clinical data.

I understand I have the following rights with respect to telehealth:

- The laws that protect the confidentiality of my personal information as provided by HIPAA and referred to within this document.
- I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of Jon Soileau, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Jon Soileau utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth via Simply Practice.
- By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer based psychotherapy or counseling services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or crisis oriented health care facility in my immediate area.

XIII. Marriage or couples counseling: for the protection of both parties involved in the marriage or couples counseling, please read the below terms for marriage and couples counseling and sign at the bottom of this document to signify you read, understand, and agree to the below terms:

- I reserve the right to call time out or become more directive in a session. While I do want to understand and experience patterns within the relationship and the way the couple experiences the patterns, I do not want to witness abuse and will not allow abuse to go unaddressed.
- If I discover either of the involved parties uses content from sessions to hurt the other party between sessions, we will move to implementing individual sessions as part of our marriage or couples counseling process (in concert with the couples sessions). If I am seeing one spouse individually, I like to keep things symmetrical and work also with the other; and at the same time if this is not possible for financial or other reasons, I can be flexible. Individual sessions may be occasionally suggested by either one of the spouses or by me, and/or may be part of an ongoing weekly pattern of treatment.
- If abusive behavior is exhibited in session, I will not use couples therapy to work on addressing individual abusive behaviors. Instead, I will recommend individual therapy be used to address the individual behaviors.
- Disclosed secrets will not be kept by me from any of the parties involved in this process; however, I will help both parties share in an honest way.
- If either of the involved parties chooses to consult with a lawyer to proceed toward filing for divorce, I request this be disclosed to me at that time. Once this is disclosed, we will discuss how each party wishes to proceed with the counseling process.
- If either of the parties would benefit from seeing an individual therapist, I will be happy to provide referrals. If at any time I assess there to be necessity or benefit for either party to have their own counseling space, I will recommend an individual therapist be used.

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I need to, and understand it. I agree to pay the fees outlined in this document. I further understand my rights and responsibilities as a patient and my therapist's responsibilities to me. I agree to undertake therapy with Jon Soileau, I know I can end therapy at any time I wish, and I can refuse any requests or suggestions made by Jon Soileau. I do attest to be over the age of eighteen and hereby give my informed consent to participate in therapy both in person and in the use of telehealth services, for treatment under the terms described herein. by my signature below, I hereby state that I have read, understand, and agree to the terms stated within this document.

PRINT PATIENT NAME:______________________________ DATE:______________

PATIENT SIGNATURE:______________________________ DATE:______________

PARENT/GUARDIAN SIGNATURE:______________________________ DATE:______________