New Patient Intake

If you are uncertain what kind of information to provide, please kindly let me know and we can discuss it together.

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 anyrestrictions: _____

B. Religious and racial/ethnic identification.

Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑Jewish ❑Islamic ❑Buddhist ❑Hindu

Other (specify): _____

Involvement: ❑None ❑Some/irregular ❑Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting do you attend? _____

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

Other ways you identify yourself and consider important: _____

C. Your medical care.

From whom or where do you receive your medical care? _____

Phone: _____ Address: _____

Any chronic pain or serious health concerns? _____

List current and previous medical problems you have had:

Dates of illness	Type of Treatment Received	Outcome of Treatment?

If you enter treatment with me for Mental health concerns, may I tell your medical doctor so that she or he can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

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D. 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: _____

E. Treatment.

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:

When? From whom? For what? With what results?

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2. Have you ever been hospitalized for mental or nervous problems?

❑ No ❑ Yes If yes, please indicate:

When? From whom? For what? With what results?

3. Have you ever taken medications for psychiatric or emotional symptoms? ❑ No ❑ Yes If yes, please indicate: When?

From whom? Which medications? For what? With what results?

I. Relationships in your family of origin.

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 emotionaldifficulties: _____

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

J. Abuse history.

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

If you were abused, please indicate the following. For kind of abuse, use these letters: 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.

AGE? KIND OF ABUSE? BY WHOM? EFFECTS ON YOU? WHOM DID YOU TELL? CONSEQUENCES OF TELLING?

K. 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: _____
4. PLEASE LIST ADDITIONAL FAMILY MEMBERS LIVING WITH YOU:

NAME	RELATIONSHIP	DATE OF BIRTH	EMPLOYER/SCHOOL

5. HOW DO YOU GET ALONG WITH YOUR PRESENT SPOUSE/PARTNER AND/OR CHILDREN? _____

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: _____

M. INSURANCE INFORMATION.

PRIMARY INSURANCE COMPANY: _____ PHONE NUMBER: _____

CLAIMS ADDRESS: _____

POLICY HOLDER NAME AS IT APPEARS ON THE CARD: _____

POLICY HOLDER DATE OF BIRTH: _____ POLICY HOLDER SOCIAL SECURITY NUMBER: _____

POLICY HOLDER RELATIONSHIP TO PATIENT: _____

IF YOU ARE NOT SUBMITTING CLAIMS TO YOUR INSURANCE COMPANY, THEN TO WHOM SHOULD YOUR BILLS BE DIRECTED:

❑ SELF

❑ OTHER: _____

(NAME) (ADDRESS) (PHONE

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:_____

_____

_____

SIGNATURE:_____ DATE:_____

PRINTED NAME:_____

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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 BEHAVIOR'S, 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 I SUSPECT CHILD, ELDERLY, OR DISABLED PERSON ABUSE OR NEGLECT, THE THERAPIST IS REQUIRED TO REPORT THAT INFORMATION TO A STATE AGENCY.
- IF A PATIENT BRINGS CHARGES AGAINST THE THERAPIST.
- IF A COURT ORDERS THE THERAPIST'S TESTIMONY OF YOUR RECORDS.
- IF THE THERAPIST BELIEVES A PATIENT IS A DANGER TO THEMSELVES OR OTHERS (SUICIDAL OR HOMICIDAL).
- I AM UNDER THE SUPERVISION OF DR. PAUL HOARD WHO WILL HAVE FULL ACCESS TO YOUR FILE. DR. HOARD AND I WILL NEED TO CONSULT AND DISCUSS THE DETAILS OF THIS THERAPEUTIC RELATIONSHIP, OUR SESSION(S) CONTENT, AND VIDEOTAPED SESSIONS (ON OCCASION).
- TO GET AN OBJECTIVE POINT OF VIEW, THE THERAPIST MAY SOMETIMES CONSULT WITH ANOTHER PROFESSIONAL ABOUT YOUR CASE. IN THOSE INSTANCES, YOUR CONFIDENTIALITY WILL BE MAINTAINED AS NO IDENTIFYING INFORMATION WILL BE REVEALED, ONLY THE CIRCUMSTANCES OF YOUR SITUATION. ANY PROFESSIONAL CONSULTED WILL ALSO BE REQUIRED BY PROFESSIONAL ETHICS TO MAINTAIN YOUR CONFIDENTIALITY. THE EXCEPTION WILL BE THAT WHEN THE THERAPIST IS OUT OF TOWN; YOUR INFORMATION MAY BE RELEASED TO ANOTHER THERAPIST WHO WILL SERVE ON CALL SHOULD AN EMERGENCY ARISE. IN THIS CASE, A LITTLE CONFIDENTIAL INFORMATION WILL BE RELEASED AS IS 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 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 ADVANCE.
IF REQUIRED TO ATTEND COURT PROCEEDINGS MY FEE WILL BE $350 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 THE THERAPIST WITH A WRITTEN OBJECTION TO THE SUBPOENA OR INDICATE THAT AN OBJECTION WILL BE FILED WITH THE COURT (WITH A COPY TO THE THERAPIST). IT IS THE PATIENT'S RESPONSIBILITY TO FILE THIS WITH THE COURT WITHIN THE TIME FRAME LEGALLY ALLOWED.

VI. **APPOINTMENTS**: PSYCHOTHERAPY AND COUNSELING SESSIONS ARE 45 MINUTES IN LENGTH AND INCLUDE THE TIME NEEDED TO SCHEDULE FOLLOW-UP CARE AND MAKE PAYMENT. 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 VISITS.

DUE TO THE DIFFICULTY OF SCHEDULING, CANCELLATIONS, AND REQUESTS FOR RESCHEDULED APPOINTMENTS MUST BE PROVIDED 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT START TIME TO AVOID BEING CHARGED FOR THE APPOINTMENT. APPOINTMENT CHARGES FOR LATE CANCELLATIONS OR MISSED APPOINTMENTS WILL BE THE COST OF YOUR USUAL APPOINTMENT FEE/RATE (PAYABLE AT THE APPOINTMENT TIME). IN THE EVENT AN EMERGENCY PROHIBITS YOUR ATTENDANCE, PLEASE NOTIFY ME AT YOUR EARLIEST CONVENIENCE. CONCERNS FOR CONSIDERATION TO THIS APPOINTMENT ATTENDANCE POLICY CAN BE DISCUSSED DURING YOUR APPOINTMENT. EXEMPTIONS WILL BE CONSIDERED AT MY DISCRETION.

SEVERAL TIMES IN THE YEAR I WILL PLAN TO BE OUT OF MY OFFICE. ADVANCED NOTICE WILL BE PROVIDED TO YOU FOR ANY LENGTHY ABSENCES. DURING SUCH TIMES, A NAME AND PHONE NUMBER WILL BE PROVIDED OF THE THERAPIST WHO WILL BE PROVIDING SUPPORT TO MY PATIENTS DURING MY ABSENCE.

VII. **FEES & PAYMENTS**: MY STANDARD RATE IS $125 PER 45 MINUTE SESSION. REQUESTS FOR A REDUCED RATE ARE CONSIDERED ON A CASE BY CASE BASIS; A LIMITED NUMBER OF REDUCED RATES ARE AVAILABLE. IF A REDUCED RATE HAS BEEN APPROVED, PLEASE STIPULATE THE AGREED-UPON RATE AND THE DATE OF THE APPROVAL.

THE AGREED UPON REDUCED RATE FOR YOUR SESSION(S) IS _____ AS OF _____.

PLEASE NOTE THE FOLLOWING ADDITIONAL CHARGES WILL APPLY AS STIPULATED BELOW:

- *IF A LONGER SESSION IS REQUESTED OR REQUIRED, A PRORATED CHARGE OF MY STANDARD FEE WILL BE ASSESSED.*
- *EMERGENCY PHONE CALLS OF LESS THAN TEN MINUTES ARE COMPLIMENTARY. IF MORE THAN 10 MINUTES OF PHONE CALLS IS REQUIRED DURING A GIVEN WEEK, A PRORATED CHARGE OF MY STANDARD FEE WILL BE ASSESSED.*
- *EMAIL AND MESSAGING REGARDING SCHEDULING AND PAYMENT OF LESS THAN TEN MINUTES (WEEKLY) ARE COMPLIMENTARY. IF ADDITIONAL TIME IS REQUESTED FOR EMAIL AND MESSAGING COMMUNICATION DURING A GIVEN WEEK, A PRORATED CHARGE OF MY STANDARD FEE WILL BE ASSESSED.*
- *A PRORATED CHARGE OF MY STANDARD FEE WILL BE ASSESSED FOR SUPERBILL DOCUMENTATION TO BE GATHERED AND PROVIDED, IF INDICATION IS NOT MADE DURING THE COMPLETION AND SUBMISSION OF THIS INFORMED CONSENT TO HAVE SUPERBILL DOCUMENTATION PROVIDED REGULARLY.*

TWO SESSIONS WITHOUT PAYMENT WILL CANCEL FUTURE SESSIONS UNTIL PAYMENT CAN BE MADE TO BRING THE ACCOUNT CURRENT, OR A PAYMENT ARRANGEMENT CAN BE AGREED UPON.

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 DO NOT CURRENTLY ACCEPT INSURANCE, 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 TOYOU BELOW.

PLEASE PROVIDE A SUPERBILL FOLLOWING EACH OF OUR SESSIONS_____

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 ISBEST.

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 CLIENTS 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 TELEPHONE 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 HOURS 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 CLIENTS FRIEND REQUESTS.

AS THE NEED ARISES TO CONTACT ME, I CAN BE REACHED VIA THE FOLLOWING:

- PHONE & TEXT: (816) 895-2515 - YOU MAY LEAVE YOUR NAME, CONTACT INFORMATION AND INFORMATION RELATED TO APPOINTMENT SCHEDULING OR INSURANCE BILLING/PAYMENT. KINDLY REFRAIN FROM MESSAGING OR LEAVING PERSONAL INFORMATION.
- EMAIL: SOILEAU.THERAPY@GMAIL.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 SCHEDULED APPOINTMENTS ARE PROVIDED APPROXIMATELY 24 HOURS IN ADVANCE TO YOUR APPOINTMENTS AND CAN BE PROVIDED VIA TEXT OR EMAIL. PLEASE INDICATE BELOW WHICH YOU WOULD PREFER:

- _____YOU ARE AUTHORIZED TO SEND APPOINTMENT REMINDERS, RECEIPTS, AND INVOICES VIA EMAIL.
- _____YOU ARE AUTHORIZED TO SEND APPOINTMENT REMINDERS VIA TEXT.

KINDLY NOTE, I DO MY BEST TO BE AVAILABLE FOR BRIEF BETWEEN-SESSION PHONE CALLS AS TIME PERMITS. IF YOU ARE EXPERIENCING AN EMERGENCY WHEN I AM OUT OF TOWN, OR OUTSIDE OF MY REGULAR OFFICE HOURS, PLEASE CALL 911, OR GO TO THE 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 THE THERAPISTS WEBSITE. IT MAY BE BENEFICIAL FOR YOUR THERAPIST TO CONFER WITH YOUR MEDICAL DOCTOR CONCERNING YOUR PSYCHOLOGICAL TREATMENT OR TO DISCUSS ANY MEDICAL PROBLEMS FOR WHICH YOU ARE RECEIVINGTREATMENT.

PLEASE CHECK ONE OF THE FOLLOWING:

- _____I AM DECLINING PERMISSION. YOU ARE NOT AUTHORIZED TO CONTACT MY PHYSICIAN WITH REGARD TO MY TREATMENT.
- _____YOU ARE AUTHORIZED TO CONTACT THE FOLLOWING PHYSICIAN (WHOSE NAME AND PHONE NUMBER ARE SHOWN BELOW) TO DISCUSS THE TREATMENT THAT I AM RECEIVING WHILE UNDER YOUR CARE AND TO OBTAIN INFORMATION CONCERNING MY MEDICAL DIAGNOSIS.

PHYSICIAN_____

PHONE_____

XII. 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 EACH PARTY WILL INITIAL ON ALL LINES PROVIDED TO SIGNIFY YOU 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 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 OCCASIONAL, 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.

XIII. TELEHEALTH SERVICES: TELEHEALTH INVOLVES THE USE OF ELECTRONIC COMMUNICATION TO ENABLE JON SOILEAU, MA, LPC, PLPC, NCC TO CONNECT WITH INDIVIDUALS USING LIVE INTERACTIVE VIDEO AND AUDIO COMMUNICATIONS. TELEHEALTH INCLUDES THE PRACTICE OF PSYCHOLOGICAL HEALTH CARE DELIVERY, DIAGNOSIS, CONSULTATION, TREATMENT, REFERRAL TO RESOURCES, EDUCATION, AND THE TRANSFER OF MEDICAL AND CLINICAL DATA.

I UNDERSTAND THAT I HAVE THE 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 ABOVE.

- 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 THE THERAPIST, 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, MA, LPC, PLPC, NCC UTILIZES SECURE, ENCRYPTED HIPAA COMPLIANT AUDIO/VIDEO TRANSMISSION SOFTWARE TO DELIVER TELEHEALTH VIA DOXY.ME.
- 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 9-1-1 OR SEEK HELP FROM A HOSPITAL OR CRISIS-ORIENTED HEALTH CARE FACILITY IN MY IMMEDIATE AREA.

I HAVE READ THIS STATEMENT, HAD SUFFICIENT TIME TO BE SURE THAT I CONSIDERED IT CAREFULLY, ASKED ANY QUESTIONS THAT I NEEDED 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, MA, LPC, PLPC, NCC. I KNOW I CAN END THERAPY AT ANY TIME I WISH AND THAT I CAN REFUSE ANY REQUESTS OR SUGGESTIONS MADE BY JON SOILEAU. I AM OVER THE AGE OF EIGHTEEN.

I 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, UNDERSTOOD, AND AGREE TO THE TERMS STATED WITHIN THIS DOCUMENT.

PRINT PATIENT NAME:_____ DATE: _____

PATIENT SIGNATURE:_____ DATE: _____

PARENT/GUARDIAN SIGNATURE:_____ DATE: _____

THERAPIST SIGNATURE:_____ DATE:_____

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