**Mary Craven, M.Ed., RMHCI**

**Confidential Information for use by this counselor only**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_ Birthplace \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education Level \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Status**

Married \_\_\_\_ Living with someone/Partnership \_\_\_\_ Single \_\_\_\_ Pronoun Preferences: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Divorced \_\_\_\_\_ Separated \_\_\_\_\_\_\_ Widowed \_\_\_\_\_\_\_\_\_\_\_\_ How Long? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Relationships/Marriages**

Date How Long?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Health Information**

Very good \_\_\_\_ Good \_\_\_\_ Average \_\_\_\_ Poor \_\_\_\_ Allergies \_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Illnesses, recent surgeries, special needs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Counseling**

Dates Reason Counselor

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**Children/Stepchildren**

Name Date of Birth School/Grade Stepchild? (Y/N)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family of Origin**

Mother’s age, if living \_\_\_\_\_ Father’s age, if living \_\_\_\_\_ Guardian (if applicable) \_\_\_\_\_\_\_\_\_\_

How many brothers? \_\_\_\_\_ Stepbrothers \_\_\_\_\_ How many sisters? \_\_\_\_\_ Stepsisters? \_\_\_\_\_

**What brings you to counseling?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Who should I contact in case of an emergency:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Contact**

**Please check the following communication methods that are acceptable to you. Inform therapist if there are any safety concerns in regards to contact from the therapist.**

**\_\_\_** Telephone (area code & number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_May we leave messages with people at this number? \_\_\_ Yes \_\_\_ No

If yes, Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Home Address (street, city, state, zip) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective January 1, 2022, a ruling went into effect called the **“No Surprises Act”,** which requires mental health practitioners to provide a **“Good Faith Estimate” (GFE)** about out-of-network care to any patient who is uninsured or who is insured but does not plan to use their insurance benefits to pay for health care items and/or services.

|  |  |
| --- | --- |
| **Number of Weeks** | **Total Estimated Charges for 1 Session Per Week** |
| 1 Week of Service (55 min) | $ 120.00 |
| 1 Week of Service (30 min) | $ 70.00 |
| 50 Weeks of Service (approx. 12 months) | $ 6,000.00 |

\* ¼ hour telephone consultation $ 45.00 as needed +/for extra session time

Cancellations after the 24 hour mark before the scheduled session will still have a charge of $120.00 for that session. Sessions of 55 minutes and 30 minutes are offered following the initial 55 minute intake session.

Please review the full **Good Faith Estimate (GFE)**, **Authorization to Release Information, HIPAA full document, Informed Consent for In-Person Therapy,** and **Informed Consent for Teletherapy** on my website at cravenbetterdaystherapy.com.

**I hereby grant permission for the office of Mary Craven, M.Ed., RMHCI to contact me by the methods noted above, during and after treatment**.

**Patient Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mary Craven, M.Ed., RMHCI**

**33 – 6th Street South, #202**

**St. Petersburg, FL 33701**

**Craven Better Days Therapy**

**mcraventherapy@gmail.com**

**CLIENT’S RIGHTS AND INFORMED CONSENT**

**Acknowledgement of Receipt of HIPAA Privacy Notice**

Each client will be treated with respect and dignity.

Each client will participate in establishing the goals for counseling.

Each client’s records will remain confidential. No information regarding you or your participation in counseling will be disclosed with the following exceptions:

1. A request is made by you and you have read and signed a “Release of Information” form.
2. You express the intent to harm yourself or another person.
3. You inform me of child and/or elder abuse.
4. Information is required for the purpose of insurance claims reimbursement.

A fee will be established with you on or before the intake session. The fee is payable after the session. If you

**\_\_\_\_\_** set an appointment for a future date and find that you must cancel, you will not be charged for the session if **Initial** you **provide 24 hours notice by email or voice mail.**

**Mary Craven** has explained A) the ways that my identifying information is protected, B) the times when information about me may be released without my specific permission, and C) my rights related to my medical information.

I hereby agree to protect the confidentiality and privacy of other patients at all times. I will not discuss any information concerning other patients with individuals, organizations, agencies or any person not directly employed by or supervising **Mary Craven**.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that my **“Client’s Rights”, “HIPAA Privacy Notice”, and “Informed Consent for Teletherapy”** forms have been emailed to me. I may also request them again by contacting Mary Craven. I give my consent to participate in counseling with Mary Craven. If applicable, I authorize her and her contracted services to file insurance claims and to receive payment for assessment and counseling services provided to me.

Fee $120\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (payment due date of service)

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This acknowledgement will be retained in your clinical record.

**Mary Craven, M.Ed., RMHCI (#25708)**

**Craven Better Days Therapy**

[**mcraventherapy@gmail.com**](mailto:StPetersburgTherapy@gmail.com)