**Annette D. Reiter (ADR), MA, LMFT**

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

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

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

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

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

**Status**

Married \_\_\_\_\_\_ Living with someone \_\_\_\_\_ Partnership \_\_\_\_\_\_\_\_\_\_\_ Single \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**

**We would like your permission to contact you periodically during the course of treatment for appointment setting and other communication regarding treatment, as well as to contact you following the completion of treatment to fill out a short questionnaire about our services. You will not be asked to identify yourself on the questionnaire. We are requesting your comments in an effort to help us improve our services to our clients.**

**Please check the following communication methods that are acceptable to you:**

**\_\_\_**Home telephone (area code & number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Home Voice Mail

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

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

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

\_\_\_Work telephone (area code & number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Work Voice Mail

\_\_\_May we leave message with people at work? \_\_\_ Yes \_\_\_ No

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

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

\_\_\_Cell (area code & number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_Work Email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We appreciate your willingness to help us improve our services and the delivery of care.

**I hereby grant permission for the office of Annette D. Reiter, M.A., LMFT (aka ADR and StPetersburgTherapy) to contact me by the methods noted above, during and after treatment**.

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

**Annette D. Reiter, (ADR) M.A., LMFT**

**33 – 6th Street South, #202**

**St. Petersburg, FL 33701**

**(727) 826-6807**

**Annette D. Reiter, (ADR) MA, LMFT (#1896)**

**727-826-6807 (landline)**

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

**CLIENT’S RIGHTS AND INFORMED CONSENT**

**Acknowledgement of Receipt of HIPPA 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.**

**ADR** 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 **ADR**.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_have received and read the “Client’s Rights” and “HIPPA Privacy Notice” form, and I give my consent to participate in counseling with Annette D. Reiter. 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 $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(payment due date of service)

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

This acknowledgement will be retained in your clinical record.