ADULT INTAKE FORM

Today's date: ____/____/____

CLIENT INFORMATION

Your Name: _____ Date of Birth: _____/____/_____

Address:_____
City Zip

Home Phone: _____ Work: _____ Cell: _____

Age: _____ Gender: _____ Preferred Pronouns: _____

Marital Status: ☐ Never Married ☐ Married ☐ Cohabitating ☐ Separated ☐ Divorced

Number of years married/cohabitating: _____

Spouse's/Partner's name and phone numbers:_____

Names and ages of your children including step-children: _____

Race (optional): ☐ African American ☐ Asian ☐ Hispanic ☐ White ☐ _____
(Specify)

Employment: ☐ Employed ☐ Full-Time Student
☐ Part-Time Student ☐ Other (specify) _____

Name of current employer: _____ Occupation: _____

Name of school (when applicable): _____

Highest level of education completed: _____

IN CASE OF AN EMERGENCY

If there is an emergency during our work together, or I become concerned about your personal safety, I am required by law and by the rules of my profession to contact someone close to you—perhaps a relative, spouse, or close friend. I am also required to contact this person, or the authorities, if I become concerned about your harming someone else. Please write down the name and contact information for your emergency contact person.

Name: _____ Relationship to you: _____

Phone Number: _____

Address: _____ City:_____ Zip:_____

MINDFUL COLLABORATION

CLIENT HISTORY

1. Have you ever received psychological, psychiatric, alcohol or drug treatment before?
   ☐ Yes ☐ No If yes, please indicate:

From Whom? For what? When? With what results?

_____
_____
_____

2. Have you ever been prescribed medications for psychiatric or emotional problems?
   ☐ Yes ☐ No If yes, please indicate:

From Whom? For what? When? Name of Medication With what results?

_____
_____
_____

3. Please list any psychiatric or substance abuse hospitalization/s (include dates of treatment):

_____
_____

4. Do you have a family history of mental illness or substance abuse? If so, please explain.

_____
_____

5. Please provide the name of your primary care physician: _____

_____
Phone Number Address City Zip

May Mindful Collaboration contact your primary care physician to coordinate your care?
☐ Yes ☐ No

6. Current medical/health-related conditions: _____

7. Current medications: _____
_____

8. Are you experiencing dissatisfaction or difficulties with your sex life? ☐ Yes ☐ No
9. Are you experiencing any dysphoria surrounding gender? ☐ Yes ☐ No

10. Do you have any current legal charges, court involvement or under court order to receive services?
If yes, please describe: _____

MINDFUL COLLABORATION

SYMPTOM CHECKLIST

PLEASE CHECK ALL THAT APPLY:

	Headaches		Memory problems		Depression
	Sleep problems		Heart palpitations		Feeling tense or nervous
	Academic concerns		Ideas of harming yourself		Drug use
	Worries about money		Feeling shy around others		Not confident
	Having a lack of friends		Stomach problems		Concerned about eating habits
	Feelings of panic, fear, phobias		Trouble concentrating		Alcohol use
	Feeling sad or depressed		Grief or loss		Nightmares
	Feeling restless		Feelings of hopelessness		Feelings of worthlessness
	Low self-esteem		Disturbing thoughts		Hallucinations
	Aggression		Mood swings		Recurring thoughts
	Chest pain		Suicidal thoughts		Trembling
	Sexual concerns		Sexual identity concerns		Anger
	Ideas of harming others		Gender Dysphoria		Chronic pain
	Blaming or criticizing self		Abusing others		Dizziness
	Feeling tired		Feeling a need to be on the go		Problems at work
	Anxiety		Antisocial or illegal behavior		Concerned about family members
	Irritability		Abused by others		Sick often
	Isolating self		Disorganized thoughts		Relationship problems
	Distractibility		Impulsive		Poor judgment

Please add any other information that would be helpful for the counselor to know.

_____

_____

_____

_____

REFERRAL INFORMATION

Referred by:_____

_____

City Phone Number

May I have permission to thank this person for the referral? ☐ Yes ☐ No

How did this person explain how I might be of help to you? _____

INSURANCE INFORMATION

Legal Name: _____ Date of Birth: _____

Gender on file with Insurance: _____

Address :_____

Home Phone: _____ Alternate Phone (specify if work or cell): _____

Name of Insurance Company: _____ Policy #:_____

Subscriber's Name: _____ Subscriber's DOB: _____

Client's Relationship to Subscriber: _____ Co-pay amount: _____

Name of Employer: _____Employer Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Insurance Company Phone: _____Effective Date: _____

Do you have a calendar year deductible? Yes ____ No ____ How much have you met? _____

Do you have secondary insurance that covers services that your primary does not? Yes ____No ____

Name of Insurance Company: _____ Policy #:_____

Subscriber's Name: _____ Subscriber's DOB: _____

Client's Relationship to Subscriber: _____Co-pay amount: _____

Insurance Company Phone: _____Effective Date: _____

All payments are due at the time of service, including insurance deductibles, insurance co-payments, late cancellation/missed appointment fees or any charges for returned checks.

I will:
____ Pay each visit in full and file my own insurance
____ Pay my insurance co-payments and any other fees each session and have my insurance billed
____ Self-pay

PSYCHOTHERAPY PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED CONSENT

Welcome to Mindful Collaboration. We appreciate you giving us the opportunity to help you. This document answers some questions regarding the practice of psychotherapy. We believe it is important you know how we will work together. Our work will be most helpful to you when you have a clear idea of what we are trying to do. After you have read this, we will discuss, in person, how these issues apply to your own situation. Your therapist will ask you to sign it at the end. This brochure is yours to keep and refer to later. This document is a part of the Standards of Practice of the North Carolina Board of Licensed Professional Counselors (LPC) and North Carolina Board of Licensed Clinical Social Workers (LCSW).

About Confidentiality: In all but a few rare situations, you have the absolute right to confidentiality in your therapy. Your therapist cannot and will not tell anyone else what you have told them, or even that you are in therapy without your prior written permission. You may direct your therapist to share information with whomever you choose, and you can change your mind and revoke that permission at any time. Under the provisions of the Health Care Information Act of 1992, we will always act so as to protect your privacy even if you do release us in writing to share information about you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. You will be given a copy of our *Notice of Privacy Practices* and you will be asked to sign a consent form for the use and disclosure of protected health information. In an emergency where your life or health is in danger, and we cannot get your consent, we may give another professional or a family member some information to protect your life.

The following are legal exceptions to your right to confidentiality. Your therapist would inform you of any time when he or she thinks they will have to put these into effect. In any of these situations, your therapist would reveal only the information that is needed to protect you or the other person.

a) If your therapist has good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give information about someone else who is doing this, we must inform Child Protective Services.
b) If your therapist believes that you are in imminent danger of harming yourself, he or she may legally break confidentiality and call the police. We are not obligated to do this, and would explore all other options with you before we took this step. However, if at that point you were unwilling to take steps to guarantee your safety, your therapist would call the police.
c) If your therapist has good reason to believe that you will harm another person, we must attempt to inform that person and warn them of your intentions. We must also contact the police and ask them to protect your intended victim.

The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in *couple's therapy*. If you and your partner decide to have some individual sessions with the same therapist as part of the couple's therapy, what you say in those individual sessions will be considered to be a part of the couple's therapy, and can and probably will be discussed in our joint sessions. *Do not share anything you wish kept secret from your partner.* We will remind you of this policy before beginning such individual sessions.

Children and families create some special confidentiality questions. When we treat children under the age of 12, we are legally able to fully disclose the contents of therapy to the legal guardian. As children grow more able to understand and choose, they assume legal rights. For those between the ages of 12 and 18, the details of things they tell their therapist will be treated as confidential. Parents or guardians have the right to *general* information, such as the progress of therapy.

We also request that you respect the right of confidentiality of others that you may see at this practice. We ask our clients to not disclose the identity of those they may see coming or going, as each individual has the right to decide with whom they share that information.

What You Should Know About Managed Mental Health Care: If your therapy is being paid for in full or in part by a managed care organization (MCO), there are usually further limitations to your rights as a client imposed by the contract of the managed care organization. These may include their decision to limit the number of sessions available to you, to decide the time period within which you must complete your therapy, or require you to use medication if their reviewing professional deems it appropriate. They may also decide that you must see another therapist in their network rather than Mindful Collaboration if we are not on their list. If you use your health insurance to help pay for psychotherapy, you must allow us to tell the MCO about your diagnosis. We are required to give a diagnosis in order to be paid for services provided. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term. If we do use a diagnosis, we will discuss it with you. Psychiatric diagnoses are listed in the Diagnostic and Statistical Manual V. We have a copies in our office and will provide you with information about your diagnosis. In addition, MCO's also usually require some sort of detailed reports of your progress in therapy, and in some cases, copies of your case file, on a regular basis. All of this information will become part of the MCO's records, and it will be included in your permanent medical record.

Therapist Background and Approach to Therapy: All Therapists who work for Mindful Collaboration are fully licensed in their field of study and able to provide effective treatment to a variety of clients. We come from a strengths based perspective and utilize each person's strengths in their treatment. The therapeutic partnership we form will allow us to determine together what therapeutic approaches will be most helpful to you as you work toward increasing your knowledge and tools, thus facilitating continued growth and development even after our therapy has ended.

What you can Expect from Psychotherapy: Psychotherapy is not like visiting a medical doctor. It requires your very active involvement. You must be open to change and the uncomfortable feelings that can be associated with stepping outside your typical way of viewing life, yourself and others, as well as the way you make decisions. In order for you to be successful in your therapy process, you must feel trust in our therapeutic partnership. It will be important for you to be honest about your feelings, emotions, and experiences. Together we will agree on a treatment plan that we will both work hard to follow. In our treatment plan, we will list the areas to work on, our goals and the methods we will use. We will periodically review your goals and progress.

Many different techniques will be utilized in order to work towards increasing your self-awareness and personal growth. Techniques may include dialogue, psycho-education, relaxation, reframing negative thoughts, art and writing exercises, role-playing positive communication techniques, etc. An

important part of your therapy will be practicing the new skills you will learn. Your therapist will ask you to practice outside our meetings, and we will work together to set up homework assignments for you. You can expect the unfamiliar feelings often associated with change to dissipate as you begin to incorporate the various techniques into your life and as you begin to reach the goals that we set together in our therapeutic partnership.

The process of ending therapy, called "termination," can be a very valuable part of our work. Stopping therapy should not be done casually, although either of us may decide to end it if we believe it is in your best interest. If you wish to stop therapy, we ask that you agree now to meet then for at least one session to review our work together. We will review our goals, the work we have done, any future work that needs to be done, as well as our choices. The following are two exceptions to our joint decision to end therapy; (1) If your therapist, in their judgment, is not able to help you, because of the kind of problem you have or because your therapist's training and skills are in their judgment not appropriate, we will inform you of this fact and refer you to another therapist who may meet your needs. (2) If you do violence to, threaten, verbally or physically, or harass your therapist, the office, or your therapist's family, we reserve the right to terminate you unilaterally and immediately from treatment.

About Our Appointments: We will usually meet for a 50-minute session once a week, then less often. The frequency of our sessions will be a joint decision, however we strongly encourage that for the first three to four months our sessions be weekly so goals may be established and we can fully develop a working relationship. An appointment is a commitment to our work. If you are late, we will be unable to meet for the full time. A cancelled appointment delays our work. Please try not to miss sessions. When you must cancel, please try to give your therapist at least a week's notice. **If you miss a session without canceling, or cancel with less than twenty-four hours notice, for non-emergency reasons, you will be charged $85.00**. We cannot bill these sessions to your insurance.

Fees and Payment: We agree to provide psychotherapy services in return for a fee of $150 for an initial intake session, and a $125 per 50 minute session or our insurance provider contracted rate. Payment or co-payment for each session will be collected at each session. We accept cash, check or credit card. There will be a fee of $35 for all returned or bounced checks. Please be aware that following the second returned or bounced check, you will be required to pay all fees in cash. If you eventually refuse to pay your debt, we reserve the right to give your name and the amount due to a collection agency and must end therapy at that time.

If your work requires phone coaching, calls will be charged $3 per minute after the first 5 minutes. If you need any written documentation or copying of your file, there is a charge of $15 per 15 minutes or any part thereof of work.

Consultation: During the course of treatment, consultation may be a required and/or necessary part of your care. If a court appearance is required a minimum rate of $250.00 will be charged. Each subsequent hour, including such actions as time spent in travel, preparation, document preparation, and consultation with attorneys or other professionals, you will be billed at a rate of $150.00. Payment for such will be required on the date of service. Time spent in consultation or attendance at school conferences, such as IEP meetings, will be billed at $150.00 an hour.

If You Need to Contact Your Therapist: We generally do not take phone calls when we are with a client. However, we always encourage you to leave a message and we will return your call as soon as possible. Generally, we will return messages within 24 hours except on weekends and holidays. **If you are experiencing an emergency when your therapist is out of town or outside of our regular office hours (after 5 pm weekdays or over the weekend), please call Holly Hill Respond at 919-250-7000, go to the nearest hospital emergency room or dial 911**. Your therapist may be away from the office several times in the year for various reasons. We will tell you well in advance of any lengthy absences, and give you the name and phone number of the therapist who will be covering calls during our absence. Of course, this therapist is bound by the same laws and rules of confidentiality.

Complaints: If you're unhappy with what's happening in therapy, we hope you'll talk about it with your therapist so that we can respond to your concerns. We take such criticism seriously, and with care and respect. If you believe that your therapist has been unwilling to listen and respond, or has behaved unethically, you can complain about your therapists behavior to the:

North Carolina Social Work and Licensure Board
PO Box 1043
Asheboro, NC 27204
1-800-550-7009

NC Board of Licensed Professional Counselors
PO Box 1369
Garner, NC 27529
919-661-0820

CLIENT RIGHTS AND RESPONSIBILITIES

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This framework helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about. There are also certain limitations to those rights.

You Have the Right To:

- Receive respectful treatment that will be helpful to you.
- A safe treatment setting, free from sexual, physical, and emotional abuse.
- Ask for and get information about the therapist's qualifications, including licensure, education, training, experience, membership in professional groups, special areas of practice, and limits on practice.
- Have written information before entering therapy about fees, confidentially, method of payment, insurance coverage, and cancellation policies.
- Share aspects of our sessions that you believe are helpful for you and which aspects are not.
- Refuse to answer any question or give any information you choose not to answer or give.
- Ask to be informed of your progress.
    - File a complaint with the government or professional association if you believe that you have been treated unethically.
    - Refuse any treatment offered or suggested.
- End therapy at any time. The only thing you will have to do is to pay for any sessions you have already received.
- Ask any questions, at any time, about what we do during therapy, and have any therapy procedure or method explained before it is used.
- You have the right to keep what you tell private. Generally, no one will learn of our work without your written permission. There are some situations in which the therapist is required by law to reveal some of the things you tell, even without your permission. These exceptions are:

    d) If you seriously threaten to harm another person, that person must be warned and the authorities.
    e) If a court orders the therapist to testify about you, they must do so.
    f) If the therapist has good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give information about someone else who is doing this, the therapist must inform Child Protective Services or Adult Protective Services.
    g) If the therapist believes that you are in imminent danger of harming yourself, they may legally break confidentiality and call the police. The therapist would explore all other options with you before they took this step. However, if at that point you were unwilling to take steps to guarantee your safety, the therapist would call the police.

Your Responsibilities as a Therapy Client

- You are responsible for actively participating in our therapeutic partnership, by making a commitment to your success, which includes addressing feelings which may be difficult or uncomfortable, following through with homework, honestly sharing your thoughts and feelings, actively participating in the development of your goals, making sure your goals are understood, and being on time for your sessions.

- **You are responsible for canceling your session with at least twenty-four hours notice, unless it is deemed an emergency, otherwise you will be charged $85.00.**
- You, not your insurance company or any other person or company, are responsible for paying the fees we agree upon.
- You are responsible for checking your insurance coverage, deductibles, payment rates, co-payments, and so forth.
- You are responsible for knowing how to contact me or other resources in case of an emergency.

Informed Consent

I have read The Professional Disclosure Statement and I understand and accept the policies contained therein. Having read that information, I hereby agree to assessment and treatment. I acknowledge that this consent is truly voluntary and is valid until revoked. I understand that I may revoke this consent at any time and that my involvement in therapy is completely voluntary.

I, or as the legal guardian of _____, do hereby seek and consent to take part in psychotherapy services provided by Mindful Collaboration. I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective. My signature below shows that I understand and agree with all of the statements contained in the document.

Client's Signature_____ Date_____

Client Rights and Responsibility

My signature below acknowledges that I, the client or his/her parent or guardian, have received, have read (or have had read to me), and understand the "Client Rights and Responsibilities" form. I have discussed those points I did not understand, and have had my questions, if any, fully answered.

Client's Signature_____ Date_____

Financial Release

I further understand that Mindful Collaboration may use confidential information to bill and be paid for services. I hereby consent for Mindful Collaboration to release information to the billing agent/funding source and for the billing agent/funding source to release information to Mindful Collaboration for this purpose.

I understand that I am responsible for any fee not covered by insurance and agree to pay for sessions or co pays at time of service. I also understand the cancellation policy and that I will be responsible for the $85 payment if I do not cancel with 24 hours notice.

Client's Signature_____ Date_____

Therapist's Signature_____ Date _____

Credit Card Authorization

Client Name: _____ Today's date: ____/____/____

Credit Card type: ☐ Visa ☐ MasterCard ☐ Other:

Card Holder's Name (as it appears on card): _____

Credit Card #: _____ - _____ - _____ - _____ Expiration Date: _____/_____

Three Digit Security Code: _____

Billing Address of Credit Card Holder:_____
Street

_____
City Zip

Phone Number of Credit Card Holder: (____)_____

Authorization:
I hereby authorize Mindful Collaboration to charge the above credit card in order to collect payment for services rendered. I understand this credit card will be used to collect payment for such items as unpaid co-payments, un-met deductible or outstanding balances, for which I have not made arrangements to pay and/or have failed to pay. Additionally, I authorize Mindful Collaboration to charge my credit card $85.00 for appointments that are missed or not cancelled with a minimum of 24 hours notice. This agreement shall remain in effect for one year from the date indicated above and shall be cancelled in writing. I attest that the above information is true and correct and that I am the legal cardholder for this credit card. My signature below acknowledges that I have read and agree to all the above terms and conditions.

_____ _____
Signature of card holder Date