Interconnections Therapy

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Parent 1 Guardian Information

Name_____ Date_____

Gender_____ Date of Birth_____ Age_____

Address_____

City_____ State_____ Zip_____ Phone_____

Email_____

Religion/Faith_____

Referred By/How Did You Hear About Me_____

Emergency Contact _____ Number_____

Relationship_____

Occupation_____

Employer_____

Education (List highest level attainted) _____

Marital Status_____ How Long _____

List any significant health problems _____

List any medications you are taking and dosage_____

Where can I contact you? WORK HOME CELL EMAIL (Please circle all that apply)

Parent 2 Guardian Information

Name_____ Date_____

Gender_____ Date of Birth_____ Age_____

Address_____

City_____ State_____ Zip_____ Phone_____

Email_____

Religion/Faith_____

Emergency Contact _____ Number_____

Relationship_____

Occupation_____

Employer_____

Education (List highest level attainted) _____

Marital Status_____ How Long _____

List any significant health problems _____

List any medications you are taking and dosage_____

Where can I contact you? WORK HOME CELL EMAIL (Please circle all that apply)

Minor - Child / Adolescent Information

Name_____

Date_____

Gender_____ Date of Birth_____ Age_____

Address_____

City_____ State_____ Zip_____ Phone_____

Email_____

Religion/Faith_____

Emergency Contact _____ Number _____

Relationship_____

Grade_____ School_____

List any significant health problems _____

Background Information

Immediate Family Members

Name	Relationship	Age	Living In Home

Have you had any treatment with a psychiatrist, psychologist or therapist in the past? _____Yes _____No

Was it Helpful? _____Yes _____No

Briefly explain why you are seeking counseling today:

_____
_____
_____
_____

Please describe any complaints associated with the problem:

_____
_____
_____

When did the problem start? _____
How long do you think it will take to resolve these problems? _____

Current Medications:

_____

Are you currently at risk of harming yourself or someone else? _____Yes _____No _____Unsure

Have you attempted to harm yourself in the past? (Please list dates)

_____

Following is a list of common obstacles that often lead people to seek counseling. Please check all that apply:

___Anxiety	___Communication	___Self-esteem	
	___Depression	___Addiction	___Grief
	___Eating Problems	___Insomnia	
___Alcohol	___Drugs	___Weight	
	___Stress		
___Smoking	___Gambling	___Work-Problems	
	___Shyness		
___Relationships	___Sexuality	___Panic Attacks	___Guilt
___Phobia (Please List)	___Abuse	___Trauma	
	___Anger		
___Suicide Attempts	___Suicidal Thoughts	___Self-Harm (Cutting)	___Pain
___Low Motivation	___Sexual Problems	___Social	
___Withdrawal	___School		

Is there a family history of?

___Alcoholism	___Drug Use	___Depression
	___Anxiety	
___Suicide	___Attempted Suicide	___Medical-Problems
	___Psychosis	

In the past 2 weeks have you (Minor) engaged in any of the following?

___Alcohol	Frequency_____
___Marijuana	Frequency_____
___Drugs	Frequency_____
___Prescriptions	Frequency_____
___Pornography	Frequency_____

Explain how you cope with stress:

_____

_____

What do you like to do with your free time?

_____

_____

Is there anything else that you feel is important for me to know?

_____

_____

FINANCIALLY RESPONSIBLE PERSON'S INFORMATION:

Name: _____ Relationship to Client: _____

Phone (if different from above): _____

Address (if different from above): _____

Social Security Number of Insured: _____

Employer: _____

INFORMED CONSENT

CONFIDENTIALITY STATEMENT:

1. I abide by and respect the AAMFT ethical code of confidentiality. This means that I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me, without your written permission. You may give written consent for me to share information with whomever you choose, and you can change your mind and revoke that permission at any time.
2. The following are the legal exceptions to your right to confidentiality. I will inform you if at any time I feel it is necessary to put these into effect.
   - If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also inform the police and ask them to protect that person.
   - If I have good reason to believe that you are someone else is abusing/neglecting a child or vulnerable adult, I must inform CPS or Social Services within 72 hours.
   - If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and contact the police or crisis team. However, whenever possible, I would explore all other options with you before taking this step. In any of these situations, I would reveal only the information necessary to protect you or the person in danger. I would not tell everything you have told me.

- If you become involved in a court case or proceeding, a judge or court may require that I provide information or testify.
- I may sometimes consult with another professional about your treatment. All counselors are required by professional ethics to keep your information confidential. These case consultations are helpful to both you and me in determining that I am providing you with the best treatment possible.
- When I treat children under the age of 12, I cannot guarantee confidentiality. Parents of young children have the right to remain informed about treatment. As children grow more able to understand and choose, their right to confidentiality increases. Therefore, for children between the ages of 12 and 18, most of the details of our work together will be kept confidential. However, parents and guardians do have the right to *general information*, such as how their child's therapy is going. The same legal exceptions to confidentiality also apply.
- If you and your partner decide to have individual sessions as part of your couples therapy, what we discuss in those individual sessions will most likely be discussed in your joint sessions. I will <u>not</u> be a part of keeping secrets between partners in couples therapy. If you do not wish to work on your concerns together, I suggest you see separate counselors for individual therapy.

<u>FINANCIAL AGREEMENT</u>:

The fee for a 45-50 minute session is $150.00 payable at the time of treatment. I accept credit cards (processing fee of **$5** per transaction will be added for cc), cash and checks. You will need to pay your session fee in full at the time of service.

(Initial)

_____ I agree to pay the regular fee of $150.00 per 45-50 minute session. (+$5 cc processing fee)

Fees are periodically reviewed and subject to change. However, you will receive a 30-day notice of any fee increase.

<u>FINANCIAL POLICY:</u>

1. You are responsible for full payment of all services.
2. Payment is due at the time of treatment. If you choose to pay by check and your check is returned for insufficient funds, your account will be assessed a **$40.00** returned check fee, in addition to the amount of the bounced check.
3. Any fees left unpaid for 30 days will accrue interest of 25% per month.
4. If you require a receipt for services, please indicate below.

_____ I will need a receipt for services

5. Your appointment time has been set aside for you. You are responsible for coming to your session **on time** and at the time we have scheduled. If you are late for your session, we will still end on time and your regular session fee will apply.

CANCELLATION POLICY:

If you cannot attend your appointment, you **MUST cancel at least 48-hours in advance**. If you do not cancel within 48 hours, or miss a session without canceling, **you will be obligated to pay a FULL fee for no show or late cancellation fee before I will schedule another visit for you . ****Please note that I will discuss how emergency cancellations are handled on a case by case basis.

P/G1 Initial Here _____
P/G2 Initial Here_____
Minor Initial Here_____

TELEPHONE CALLS, REPORTS AND LEGAL REPRESENTATION:

1. I prefer to see and talk with you in person at our scheduled session time. However, I am aware that telephone calls or text messaging are necessary at times. If I am unable to answer, please leave a message, including your phone number, and I will return your call as soon as possible. **Please be aware that text messaging, email and telephone are NOT confidential means of communication.**
2. If you request that I write reports to be sent to schools, employers, lawyers, doctors, courts, Child Protective Services, etc., you will be charged for the time it takes me to write these reports. Court appearances will be billed at $500.00/hour port to port.
3. I am not a legal consultant or representative. *I do not do custody evaluations or make recommendations regarding child custody*. If you do require these services I will be happy to provide you with referrals.

ENDING THERAPY:

Usually, ending therapy happens naturally and takes place over several weeks in the process of treatment. Should you wish to stop therapy at any time, I ask that you allow yourself and/or your child to have a final session, regardless of the reason for ending. Closure is an essential element in the process of good therapy, which I highly value. If you request, I will refer you to another provider.

EMERGENCIES:

In the event of a psychological emergency, please call 911. You may also call the Suicide Prevention Hotline of Nevada at 1-877-885-HOPE, Montevista Hospital at 364-1111, Spring Mountain Treatment Center at 873-2400, or Nevada Adult Mental Health at 486-8020.

STATEMENT OF UNDERSTANDING:

I have read the enclosed policies and procedures, asked any questions that I needed to, and understand the terms of this consent. I understand my rights and responsibilities as a client and my therapist's responsibilities to me. I agree to these conditions and consent to treatment.

_____	_____	_____
Client Name (print)	Client Signature	Date
_____	_____	_____
Parent/Guardian if minor (print)	Parent/Guardian Signature	Date
_____	_____	_____
Parent/Guardian if minor (print)	Parent/Guardian Signature	Date
Mandy Squires, LMFT	_____	_____
Provider/Therapist	Provider/Therapist Signature	Date

*****Next Page Required for File**

***Required**

Interconnections Therapy, LLC

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The security of your personal information is extremely important. Interconnections Therapy is committed to protecting the security and privacy of any personal information you provide, including any financial information. Please inquire of any questions concerning this authorization, the "information regarding services" and/or "Notice of Privacy Policy Practices" forms provided for your review and agreement.

CREDIT CARD AUTHORIZATION

I hereby grant Interconnections Therapy permission to process credit/debit charges

This form is requested for all clients and required to be on file.

Client Name/s: _____

Please read all below:

Acceptable forms of payment are: cash, check, debit card or credit card.
My initials below:
_____ Without my debit/credit card, I authorize Interconnections Therapy to use my credit/debit card number provided below to process charges/fees assigned to any named individual listed above.
_____ I authorize Interconnections Therapy to be compensated for missed appointments of which the client/s named above did now show up for session or cancel session less than 48 hours before the time of the appointment. Missed and late canceled appointment fees are billed at **FULL FEE** per session (plus $5 processing fee). All Tele-Therapy appointments/late cancellation fee will be billed at $155.00 per session.

Please complete all of the information below:
Type of card (circle) VISA, MC, Discover, American Express

Exact name on card _____

Relationship to client _____

Card number _____

Expiration Date _____

CUV _____

Billing address_____

_____

Signature _____

Date _____

Informed Consent for Tele-Therapy Services

I hereby consent to engage in distance counseling with my therapist, Mandy Squires, as part of my psychotherapy. I understand that distance counseling includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that I have the following rights with respect to distance counseling:

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

The laws that protect the confidentiality of my medical information also apply to distance counseling. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

I understand that there are risks and consequences from distance counseling, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. These risks are offset by my therapist's use of a HIPAA-compliant service that is encrypted for video tele-mental health communications.

I understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services, group therapy), I will be referred to a psychotherapist who can provide such services in my area.

I understand that I may benefit from distance counseling, but that results cannot be guaranteed or assured.

Considerations:

It is important to note that there are limitations of distance counseling that can affect the quality of the session(s). These limitations include but are not limited to the following:

I cannot see you, your body language, or your non-verbal reactions to what we are discussing.

Due to technology limitations, I may not hear all of what you are saying and may need to ask you to repeat things.

Technology might fail before or during the counseling session.

Although every effort is made to reduce confidentiality breaches, breaches may occur for various reasons.

To reduce the effect of these limitations, I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.

I have read and understood the information provided above. I have discussed it with my psychotherapist, and all my questions have been answered to my satisfaction.

Tele-Therapy flat fee of $155 per 45-50 minute session, including late cancellation fee.

_____

Client Signature Date

_____

Therapist's Signature Date