Couple's Intake

______________________ Date   ______________________ Referred By

______________________ Husband Name   ___/___/___ Birthdate   _____ Age   _____-___-______ SS#

______________________ Wife Name   ___/___/___ Birthdate   _____ Age   _____-___-______ SS#

______________________ Street Address   ______________ City   _________ Zip

______________________ Mailing Address (if different)   ______________ City   _________ Zip

(_____)____________ Home Phone   ______________ Husband Cell   ______________ Wife Cell

If I contact you at home, may I say who I am? Yes No

______________________ Husband Employer   ______________________ Employer Address

If needed, may I contact you at work? Yes No   (______)______________ Work Phone

______________________ Wife Employer   ______________________ Employer Address

If needed, may I contact you at work? Yes No   (______)______________ Work Phone

How long have you been Together _______ Married ________ Engaged_________ Separated _________

Children's Names (include step) & Relationships

Name	Birthdate	Age	SS#	Comments re: relationship
____________	___/___/___	_____	_____-___-_____	______________
____________	___/___/___	_____	_____-___-_____	______________
____________	___/___/___	_____	_____-___-_____	______________
____________	___/___/___	_____	_____-___-_____	______________
____________	___/___/___	_____	_____-___-_____	______________

Marital History Husband

____

____

Marital History Wife

____

____

Additional Comments on Children or Marital History:

____
____
____
____

_________________________ _______________ _____________
Church affiliation (if any) City Pastor

Are either of you currently under medical treatment? Yes No If yes, name of doctor:

____

Any medication currently taking? Yes No If yes, please list:

____
____

Please describe any current or chronic diagnosed medical conditions:

____
____

Are you currently involved in any legal matters, including custody disputes or insurance settlements? If so, describe:

____
____
____

Previous counseling experiences:

____________________ _______________ __________________
Counselor/Location Dates/Length of counseling Issues addressed

____________________ _______________ __________________
Counselor/Location Dates/Length of counseling Issues addressed

Husband's Reason for currently seeking counseling: (describe presenting problem, including length & precipitation event, if applicable)

____
____
____

Wife's Reason for currently seeking counseling: (describe presenting problem, including length & precipitation event, if applicable)

____
____
____

Goals for counseling:

____
____
____

Please circle any appropriate answers: “H” for Husband, “W” for wife, or no indication for both.

Current or previous alcohol or drug abuse Eating Disorder Family/spouse current or previous alcohol/drug abuse

Anger difficulty History of sexual abuse History of physical abuse Changes in sleep Changes in level of energy

Financial stress Marital distress Parenting difficulties Recent loss of a loved one

Job difficulties Anxiety difficulties

Have either of you ever had suicidal thoughts? If yes, please explain:

Give a brief history of relationships with:
Husband w Father

Husband w/ Mother -

Husband w/ Siblings -

Wife w Father

Wife w Mother

Wife w/ Siblings-

Children

Friends

Are there any additional comments you would like to tell me about yourself?

Fees, Insurance and Confidentiality

THE STANDARD FEE for a psychotherapy session is $110.00 per fifty-minute session and 160.00 per 90-minute session. Group therapy sessions have rates that vary with the type of group. Phone Sessions will be billed at your normal psychotherapy rate. Mediation and court appearances will be billed at the rate of $200.00 per hour, regardless of your established fee for psychotherapy. Letters will be billed at your psychotherapy fee for hour(s) spent in preparation. Court reports, psychological evaluation reports, and legal reports will be billed at the rate of $110.00 per hour spent in preparation, regardless of your established fee for psychotherapy, with a minimum charge of at least $250.00. Also, there are additional charges for psychological testing and for copying of records.

EMERGENCY OR URGENT NEEDS – I do provide phone counseling for emergency or urgent needs that may occur during your time of being a client here. Please note Emergency or Urgent Calls will be billed at your regular hourly rate. Depending on your insurance plan, these fees may not be paid by your insurance provider and will therefore be billed in total to the responsible party.

FEE PAYMENTS and co-pays are presented ahead of the session, unless prior arrangements are made.

REGARDING INSURANCE: Be aware of your deductible and co-pay per your insurance benefits. *I recommend you make a call to your insurance to verify the coverage for mental health*. I am a Preferred Provider for many insurances. *However you are responsible to insure the details of your coverage*. For those individuals with HMO's, the co-payment will be made before the start of each session. For all other insurance plans, payment will be made in full before each appointment and a Superbill (submittal form) will be given to you so you may bill your insurance company for reimbursement, unless other arrangements are made.

YOUR APPOINTMENT TIME reserves a counseling time for you. Missed sessions will be billed at your full fee unless the appointment has been canceled 48 hours in advance of the scheduled time. A missed session will not be rescheduled automatically. You must call to reinstate appointments, or mention during canceling that you wish another appointment.

SOCIAL MEDIA POLICY for our therapists and clients – As professional therapist, I do not accept friend or contact requests from current or former clients on any social networking site. I believe adding clients could compromise your confidentiality and our respective privacy. Please do not contact me through a Social Networking site (Twitter, Facebook, LinkedIn, etc.) These sites are not secure and we may not read them in a timely manner for your needs. The best way to reach me is by phone unless otherwise we have a mutual agreement of another way.

You are welcome to follow ***my Facebook Page***. However, communication cannot be made through that forum and I cannot insure your privacy if you comment.

EMAIL POLICY for myself and clients – I prefer using email only to arrange or modify appointments. Please do not email regarding content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate content, please be aware all emails are retained in the logs of your and my internet service providers. These logs are, in theory, available to be read by the system administrator of the internet service provider. Also, these emails received and responded to will become part of your legal record.

MY PURPOSE is to provide excellence of service to each of my clients. Still, the success of therapy does not just depend on the skill of the therapist. Many other factors, such as the client's openness to working with difficult material, help to determine the outcome of therapy. If you have any questions regarding your progress in therapy at any point during therapy, please communicate this with me. I am open to growing and learning as we journey together.

CONFIDENTIALITY is a basic policy. Information and records regarding clients are kept confidential unless a signed, written consent form is obtained to release records. The court and legislature have determined that confidentiality cannot override the obligation of a therapist to report child abuse, elder abuse, or threats to harm oneself or others.

I UNDERSTAND AND AGREE TO THE ABOVE. MY FEE IS ___. IT IS MY RESPONSIBILITY TO NOTIFY Kate Pieper, LMFT AT LEAST 48 HOURS PRIOR TO MISSING A SCHEDULED APPOINTMENT. I AGREE TO PAY THE FULL FEE FOR EACH MISSED SESSION I CANCEL WITHOUT GIVING PROPER NOTICE.

_______________________________ SIGNED

_______________ DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that we have provided.
Kate Pieper's Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change the notice, you may obtain a copy of the revised notice from my office by contacting me at (530)268-3558.

If you have any questions about our Notice of Privacy Practices, please contact me at
10091 Streeter Road, Suite 5, Auburn, CA 95602 (530) 268-3558.

I acknowledge receipt of the Notice of Privacy Practices of Kate Pieper, LMFT.

Signature: ______________________________ Date:______________________________________
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain the patient(s) acknowledgement of his or her receipt of the Notice of Privacy Practices, including _________________________. However, because of __________________________________, we were unable to obtain the patient's acknowledgement.

Signature of Provider: _______________________ Date:_________________________________