KATE PIEPER, LMFT
A Brave Compassionate Journey

Couple's Intake

_____ _____
Date Referred By

_____ ___/___/___ _____
Husband Name Birthdate Age

_____ ___/___/___ _____
Wife Name Birthdate Age

_____ _____ _____
Street Address City Zip

_____ _____ _____
Mailing Address (if different) City Zip

(____)_____ _____ _____
Home Phone Husband Cell Wife Cell

_____ Would you like to receive my monthly newsletter on relationships? Yes - No
Wife's Email

_____ Would you like to receive my monthly newsletter on relationships? Yes - No
Husband's Email

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 Comments re: relationship

_____ ___/___/___ _____ _____
Name Birthdate Age Comments re: relationship

_____ ___/___/___ _____ _____
Name Birthdate Age Comments re: relationship

_____ ___/___/___ _____ _____
Name Birthdate Age Comments re: relationship

_____ ___/___/___ _____ _____
Name Birthdate Age 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 yourselves?

_____

_____

_____

Fees, Insurance, and Confidentiality & No Secrets For Couples Therapy

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. If you have an emergency or urgent need, please call my business number and press 0. My answering service will connect you to me or notify me of your need.

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 know the details of your coverage*. The co-payments will be made before the start of each session. For insurance plans that I am not a contracted provider, 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. Many insurances do not pay for couple's therapy. Please check with your provider regarding their policy.

YOUR APPOINTMENT TIME reserves a counseling time for you. Missed sessions will be billed at your full fee unless the appointment has been canceled 24 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 - 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 my respective privacy. Please do not contact me through a Social Networking site (Twitter, Facebook, LinkedIn, etc.) These sites are not secure and I may not read them in a timely manner for your needs. You are welcome to follow any of my business (Kate Pieper, LMFT – A Brave Compassionate Journey) Facebook Page, Instagram, and Twitter accounts. However, communication cannot be made through that forum. Please be aware I cannot insure your privacy if you comment on these posts. However, I have followers across the world, if you do not identify yourself as a client, chances are others will not know.

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. If you have any feedback or concerns 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.

NO SECRETS POLICY - While "one on one" sessions may take place as part of the couple's therapy, these sessions will be kept as private as possible in the sense that I will not triangle myself by sharing information needlessly between you as a couple. However, it is possible I may need to share information learned in an individual session with the other participant in couple's therapy. If I am not free to exercise my clinical judgment regarding the need to share this information with the identified patient – the couple – I might be prevented from effectively serving the needs of you as a couple. Therefore, I maintain a NO SECRETS policy. It is vital I am not information you do not want your partner to know. If there are things you would like to work through information your partner does not know, I will refer you to an individual therapist.

CONFIDENTIALITY is a basic policy. 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.

We UNDERSTAND AND AGREE TO THE ABOVE. MY FEE IS ___. IT IS MY RESPONSIBILITY TO NOTIFY Kate Pieper, LMFT AT LEAST 24 HOURS PRIOR TO MISSING A SCHEDULED APPOINTMENT. I AGREE TO PAY THE FULL FEE FOR EACH MISSED SESSION I CANCEL WITHOUT GIVING PROPER NOTICE.

_____ _____

Wife's Signature Date

_____ _____

Husband's Signature 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:_____