## Individual Intake

______________________ ______________________
Date Referred By

________________________________ ____/____/____ Age ______
Name Birthdate

________________________________ ____________________ __________
Street Address City Zip

________________________________ ____________________ __________
Mailing Address (if different) City Zip

(_____)________________________ ___(______)__________________
Home Phone Cell Phone

______________________ Would you like to be added to my newsletter? Yes – No
Email address

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

________________________ ___________________________
Employer Employer Address

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

Marital Status: Married Single Divorced Widowed Separated

________________________________ ____/____/____ ______
Spouse's Name (if applicable) Birthdate Age

________________________ ___________________________
Spouse's Employer Spouse's Employer Address

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

Marital History:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Additional Comments on Children or Marital History:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

| Church affiliation (if any) | City | Pastor |
|---|---|---|

Are 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 |
| Counselor/Location | Dates/Length of counseling | Issues addressed |
| Counselor/Location | Dates/Length of counseling | Issues addressed |

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

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Goals for counseling:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please circle any appropriate answers:

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

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Give a brief history of relationships with:

Father

Mother

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. If you have an emergency or urgent need, please call my business line 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. 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 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 a 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, Twitter, etc. However, communication cannot be made through that forum. Please be aware I cannot insure your privacy if you comment on these posts. I have followers across the world. If you do not identify yourself as a client, 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. 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. 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 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.

**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 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.

________________________________ 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:_________________________________