Slater & Associates, LLC

Therapy Intake Form

Patient's Name: _____DOB: _____Age:_____
First Middle Last

Address: _____ City: _____ Zip:_____

E-Mail Address: _____

Occupation: _____ Employer:_____

Education Level (circle one): HS Bachelor Master Doctorate

Number of Marriages: _____ Gender (circle one): M F

Relationship Status (check one) ____Single _____ Married _____ Divorced ____Committed Relationship

Home Phone: _____ OK to leave message? Y N
Cell Phone: _____ OK to leave message? Y N
Work Phone: _____ OK to leave message? Y N

Family Information (If a minor or a family):

Mother: _____ Phone: _____
Address: _____ City_____Zip_____
Father: _____ Phone: _____
Address: _____ City_____Zip_____

Parent's relationship status (circle one)

Married Divorced Never Married

Current Custody (circle one): Joint Sole Split

Current Timesharing Arrangement:
Mother: **Father:**

Please list below all family members living in the household:

Name	Age	Gender	Relationship

Medical History (Patient):

Current Health Problem	Treating Physician	Medication

Date of last physical examination: _____ **Physician:**_____

List previous care by a mental health professional:

Treating Practitioner	Dates	Family Member & Reason

Who referred you?

_____	Doctor / Psychiatrist	_____	Mental Health Professional
_____	School	_____	Court (Specify) _____
_____	Friend	_____	Employer
_____	Internet	_____	Attorney
			Name: _____

Briefly describe the reason for seeking help:

_____

_____

_____

_____

_____

_____

_____

_____

_____

What do you hope will change by participating in therapy?

_____

_____

_____

_____

_____

Slater & Associates, LLC

Therapy Agreement

- Christy Leaver, LCSW is a Licensed Clinical Social Worker in the State of Kentucky.
- I agree to enter the therapy process knowing that there may be a potential for emotional strains, stresses and life changes as a result of therapy. I understand that the outcome of therapy is dependent on my personality and the personality of my therapist, as well as the variables related to the particular problems that I may be experiencing.
- In order for my therapy to most successful, I understand that I will have to work hard on issues that arise, both in session and at home. I understand that Slater & Associates, LLC does not guarantee any particular results or outcomes.
- I understand that therapy sessions are strictly confidential except when state law requires the reporting of threats of violence, harm or neglect (from evidence or suspicion) toward children or adults, and when information is ordered or subpoenaed by the courts. I have read and signed the Limits of Confidentiality for Therapy form. I agree that confidences revealed to my therapist alone, may be shared, at my therapist discretion, with other members of the family participating in treatment and/or my attorney, if applicable.
- I agree to respect the confidentiality of others and not discuss the presence of any other client I may meet or see at our office.
- My therapist will not accept friend requests from current or former clients (for a period of 5 years) on social networking sites such as Facebook, Twitter or Linkedin. We believe that mixing the therapy relationship with social networking relationships can compromise your confidentiality and our respective privacy. For that reason, we request that clients do not communicate with us via any interactive or social networking websites.
- If you choose to contact your therapist via email, telehealth, or telephone, you accept the risk that this may not be a secure or confidential form of communication and agree that Slater & Associates, LLC cannot be held liable should any outside individual or organization gain access to your personal information.
- **I agree to notify my therapist at least 48 hours in advance should I need to cancel an appointment. I understand that I will be charged the full session fee for any appointments that I miss or fail to cancel 48 hours in advance.**
- If I decide to terminate therapy on behalf of a minor, I agree to discuss this with the child's therapist during a regular therapy session, not by phone. I agree to make the appropriate arrangements for a suitable termination session between the therapist and the child or children.
- I understand that Slater & Associates, LLC does not operate an emergency, on-call or after-hours crisis service. Should a crisis arise, I agree to contact 911, visit the nearest Emergency Room or contact a local crisis line for immediate help.

I have read the information above and agree to the terms set forth and outlined above.

_____ _____

Signature of Client Date

_____ _____

Signature of Client Date

Slater & Associates, LLC

Limits of Confidentiality for Therapy

The law protects the confidentiality of all communication between you and your therapist. Information can only be released to others with your written permission. No disclosure can be made, with the following exceptions:

- If you have abused or are abusing a child or adult.
- If you are a danger to yourself.
- If you threaten harm to another person(s), including murder, assault or other physical harm.
- If you assert that your mental condition is an issue in a claim or defense as part of a civil or criminal law proceeding.
- If you report sexual exploitation by a therapist.
- If your treatment is court ordered.
- In proceeding to assist you with entering a hospital for emotional and/or chemical dependency treatment when you and/or your therapist, in the course of diagnosis or treatment, determine that you are in need of hospitalization.
- Confidentiality cannot be guaranteed in situations where you have given consent for clinical information to be provided to a third party, (e.g. insurance reimbursement, communication with schools). The use and confidentiality of the information, once it has been shared with other individuals, is beyond the control of this office.

I have read and understand the limits to confidentiality and have discussed this information with my therapist.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

_____ _____

Christy Leaver, LCSW Date

Slater & Associates, LLC

Authorization to Disclose Health and Educational Information

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

1. I authorize the use or disclosure of the above-named individual's educational and/or health information as described below for use by Slater & Associates, LLC to assist in the diagnosis and treatment of the named individual and/or the individual's family. I also authorize Slater & Associates, LLC to communicate relevant information obtained over the course of treatment/consultation to the individual, entity, institution and/or schools listed below.

2. Name of the individuals, entities, institutions and/or schools authorized to make the disclosure:
   1._____
   2._____
   3._____
   4._____
   5._____
   6._____

3. The type and amount of information to be used or disclosed is as follows:

□ All special education records
□ All school records (including attendance, faculty observations, anecdotal and/or counseling notes, and discipline records)
□ All medical records
□ All diagnostic and assessment information including psychological or psychiatric reports and evaluations
□ Results of Drug & Alcohol Testing
□ Laboratory results
□ All records as needed for assessment, treatment planning and coordination of services or other: _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Slater & Associates, LLC. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.

6. I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Client or Legal Representative Date

_____ _____
Signature of Client or Legal Representative Date

Slater & Associates, LLC

Permission to Render Services to a Minor

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

- I give permission for my child, listed above, to receive individual or family counseling. I affirm that I am the custodial parent or legal guardian of the above-mentioned minor.
- I give permission for Slater & Associates, LLC to perform classroom observations and gather behavioral data from teachers, parents, or other caregivers.
- I understand that I can withdraw my permission for testing or counseling at any time, and that any information received by Slater & Associates, LLC during the course of counseling will remain confidential, under the limits of the law, without my or my child's expressed permission.
- Although the law may provide for my inspection of treatment records, I understand that Slater & Associates, LLC will only provide me with general information about my child's therapy unless it is believed that my child will seriously harm themselves or another person or has been the victim of abuse. I understand that insisting on reviewing disclosures my child has made in the course of therapy may seriously undermine the trust established between the therapist and my child, and may negatively impact my parenting relationship.
- I agree to refrain from asking my child probing questions regarding the information they have revealed to my therapist in private sessions and to allow for their natural disclosure of information they may wish to share outside of sessions.
- I agree to facilitate regular therapy appointments for my child, as they are recommended by my child's therapist. Although I have the right to terminate counseling for my child at any time, I agree that it is in the best interest of my child to attend a termination appointment with the therapist to provide my child with a sense of closure regarding his/her treatment.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____
Signature of Mother or Legal Guardian Date

_____ _____
Signature of Father or Legal Guardian Date

Slater & Associates, LLC

Release for Audio/Video Recording

I hereby authorize Slater & Associates, LLC to audio and/or video record the assessment and/or therapy services rendered to me and/or my child/ren. I understand that the use of audio or video taping may be used for clinical review and/or training purposes. I therefore consent to the use of AV equipment during treatment sessions. The recording will not be released to any external entity without my explicit written permission unless subpoenaed by a court of law. I understand that Recordings may be destroyed following clinical review. I understand that any other audio/video recording other than that by Slater & Associates, LLC is prohibited.

Name of Client: _____ Date of Birth: _____

Signature of Client/Guardian:_____ Date: _____

Name of Client: _____ Date of Birth: _____

Signature of Client/Guardian:_____ Date: _____

Name of Client: _____ Date of Birth: _____

Signature of Client/Guardian:_____ Date: _____

Name of Client: _____ Date of Birth: _____

Signature of Client/Guardian:_____ Date: _____

Name of Client: _____ Date of Birth: _____

Signature of Client/Guardian:_____ Date: _____

Name of Client: _____ Date of Birth: _____

Signature of Client/Guardian:_____ Date: _____

Slater & Associates, LLC

Fee Agreement

- I understand that I will be responsible for full payment of the session fee, as well as for any outstanding balance, prior to my scheduled session. Face-to-face appointments, as well as telehealth calls, lasting longer than 5 minutes, will be billed at the same hourly rate. The initial hourly rate shall be $_____.

- If two or more parties will be responsible for services, Slater & Associates, LLC may charge either party the full fee, or at our discretion, the fee may be charged disproportionately.

- All time involved in the preparation of written reports, telephone calls, communication with other professionals and travel will be billed at the same hourly rate.

- I understand that I will be responsible for any postage (first class postage rate) or copying fees ($1.00/page) incurred on my behalf by Slater & Associates, LLC.

- Any time set aside in preparation for a subpoenaed court appearance, including actual appearances, preparation of testimony or reports to your attorney or the court, travel, depositions, or any schedule adjustments necessary to accommodate such a court appearance will be billed at an hourly rate of $300/ hour. Slater & Associates, LLC will charge a retainer in advance of any agreed or subpoenaed court proceeding in a minimum amount of $2,500 (or such time estimated to be expended). This retainer shall be a deposit towards fees for professional time expended. If time expended is less than the retainer, the balance will be refunded within 30 days of termination of services. If time extended exceeds the retainer, the balance will be charged to the account/s on file.

- **I agree to notify Slater & Associates, LLC at least 48 hours in advance should I need to cancel an appointment. I understand that I will be charged <u>the full regular session fee</u> for any appointments that I miss or fail to cancel 48 hours in advance.**

- I agree to pay any Slater & Associates, LLC costs of collection including reasonable attorney fees.

- I understand that I will need to provide a valid credit card that will remain on file with Slater & Associates, LLC, and I authorize Slater & Associates, LLC to keep my signature on file for charges incurred on my account.

Name on card: _____
Credit Card (1) Number: _____
Expiration: _____
3-digit security code: _____
Billing zip code: _____

Cardholder signature: _____

Name on card: _____
Credit Card (2) Number: _____
Expiration: _____
3-digit security code: _____
Billing zip code: _____

Cardholder signature: _____

I have read the information above and agree to the terms set forth and outlined above.

_____ _____
Signature of Client Date

_____ _____
Signature of Client Date