Clarksville Community Counseling, LLC
2515 Wilma Rudolph Blvd •Suite 110 • Clarksville, TN 37040 **Megan Kent, MMFT (931) 614-5202**

Client Intake Form

Name _____ Date _____

Address _____

City _____State _____ Zip _____

Tel: (Mobile) _____ (Home) _____

Email: _____

Gender _____ Date of Birth _____

Marital Status: ____ Never Married ____ Married ____ Divorced ____ Widowed

Education _____

Occupation_____

Emergency Contact_____

How were you referred? _____

Briefly describe what you hope to achieve in therapy.
_____

Dates of previous therapy _____

Reason_____

Therapist_____

Have you ever been hospitalized for a psychiatric disorder?_____

Dates _____ Reason_____

Please list any psychiatric medications you are currently taking.
_____

Have you ever, in the past, thought about committing suicide? _____

Have you ever attempted suicide in the past? _____

Are you currently having thoughts of killing or seriously hurting yourself? _____

Practice Policies
In order to answer questions that are frequently asked by clients regarding fees, confidentiality, services, etc., I have developed these policy statements for your information. I value you as a client and want you to be informed.

Confidentiality
Professional ethics and Tennessee State law indicate that the client controls confidential information. This means that, as a general rule, information shared in session with a counselor will be held in confidence. There are two exceptions to this general rule. In the case of an emergency where the counselor believes the client is at risk of hurting himself/herself or another person, the counselor may breach the requirement of confidentiality. Secondly, Tennessee law requires that child abuse in any form be reported to the Department of Human Services or another authority, such as a juvenile judge.

If a pastor, physician or other health care professional refers you, it is professional courtesy to maintain contact, as necessary, with that referral source. This may be done unless you request otherwise.

Professional Services
I am available for counseling appointments at selected times throughout the week. If for some reason you are unable to contact me during an emergency, you may obtain assistance by calling the Crisis Help Line at (615) 244-7444, the Community Assistance Program (CAPS) at (615) 342-1450, or by going to your local hospital emergency room.

Benefits and Risks of Counseling
Persons contemplating counseling services should realize they might make significant changes in their lives. People often modify their emotions, attitudes, and behaviors. They may change employment, begin to feel differently about themselves or others, and may change other aspects of their lives. They may also make changes in their marriages or other significant relationships, such as with parents, friends, children, relatives, etc. While I will assist the client in effecting change, I cannot guarantee specific outcome. Clients are ultimately responsible for their own growth.

Credentials
I hold a Master's Degree in Marriage and Family Therapy. I am pursuing my license of Marriage and Family Therapy and am under the supervision of Kris Hilton, LMFT.

Fee Policy
Fees for counseling services are $50 per 50-minute session. Fees are due via check, credit card/debit card or cash at the close of each session. Cancellations must be made 24 hours in advance; otherwise you will be charged for the full session fee. Other services, such as inpatient visits, significant telephone counseling, etc. are based on the $50 per session fee. Your health insurance may provide reimbursement for professional psychological services. I encourage you to consult your policy for specifics. Invoices remaining unpaid 90 days after services rendered will be turned over to a collection agency.

Termination of Therapy
Under normal circumstances, termination of therapy is a decision made in the therapist-client relationship in which both the therapist and client agree that treatment goals have been reached and further therapy is not presently needed. Additionally, I will close client files after six months without in-session contact and consider your case completely released from my treatment. Should you desire alternative counseling resources, please visit www.psychologytoday.com, www.counsel-search.com, or www.family-marriage-counsel.com

Limits to Services
If you are involved in a divorce and/or custody litigation you need to understand my role as a counselor is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in litigation. By signing this counseling agreement, you agree not to call me as a witness in any such litigation. Experience has shown that testimony by therapists in domestic cases causes damage to the clinical relationship between a therapist and a client. Only court-appointed experts, investigators, or evaluators can make such recommendations to the court on disputed issues concerning responsibilities and parenting plans.
It is not my role as a counselor to investigate or evaluate for any special services through social service and/or the school system.

Do you agree with the conditions and provisions of the Practice Policies? _____ Yes _____ No

Signature _____ Date _____

HIPAA Notification

I am required by law to follow the practices described in this form. This notice applies to personal medical/mental health information that I have about you, and which are kept in or by this office. With some exceptions, I must obtain your authorization to disclose (or release) your health care information. There are some situations in which I do not have to obtain your authorization. I can use your protected health information and share it with members of our organized health care arrangement (like a community provider). Neither this form nor the full Notice of Privacy Practices covers every possible use or disclosure. If you have any questions, please let me know.

Who Has Access To Your Personal Information?

Medical/Mental health information about you can be used to:

- Plan your treatment and services. This includes releasing information to qualified professionals who work at our facility and are involved in your care or treatment. It may also include provider agencies whom you select and pay to provide services for you. I will only release as little as possible for them to do their jobs.

- Obtain approval in advance from your insurance company should you seek Insurance Coverage. Note, I do not accept insurance payments but will provide a receipt of services should you decide to go through that route.

- Exchange information with Social Security, Employment Security, or Social Services.

Without your permission, I may use your personal information to exchange information with other State agencies as required by law, to treat you in an emergency, to treat you when there is something that prevents me from communicating with you, to inform you about possible treatment options, to send you appointment reminders, for agencies involved in a disaster situation, for certain types of research, when there is a serious public health or safety threat to you or others, as required by State, Federal or local law (this includes investigations, audits, inspections, and licensure, when ordered to do so by a court, to communicate with law enforcement if you are a victim of a crime, involved in a crime at our facility, or you have threatened to commit a crime, to communicate with coroner, medical examiners and funeral homes when necessary for them to do their jobs, to communicate with federal officials involved in security activities authorized by law.

What Are Your Rights?

You have the right to limit how I use or disclose information about you. For example - not to release information to your spouse or a particular provider agency. This must be made in writing, and I am not required to agree to the request. You have the right to ask that I communicate with you about medical matters in a certain way or at a certain location. This must be made in writing. You have the right to tell me (authorize) other release of your personal information not described above. You may change your mind and remove the authorization at any time (in writing). You have the right to see and get a copy of your record (with some exceptions), to appeal if I decide not to let you see all or some parts of your record, to ask for the record to be changed. If you believe you see a mistake or something that is not complete, you must make this request in writing. I may deny your request if I did not create the entry, the information is not part of the file I keep, or the information is not part of the file that I would let you see, or I believe the record is accurate and complete. You have the right to know to whom I have sent information about you for up to the last six years. The first request in a 12 month period is free. I may charge you for additional requests.

Signature _____ Date _____

Non-secure Communication Policy

Email Confidentiality Agreement

It is my normal practice to email my clients appointment reminders 24 hours in advance. At times, I email clients regarding other matters as well. Occasionally I text message my clients regarding scheduling an appointment or for other reasons. When communicating via email or text message, it is important to remember that confidentiality is limited. By signing below you are saying that you have considered and understand these limitations of confidentiality and agree that you are responsible for keeping your email and text messages private to the extent that you desire for them to be private.

I allow Megan Kent, MMFT intern to email me and to text message me at the email address and mobile phone number provided on page 1 of the Client Intake Form, or to return email and text messages from any additional email address or telephone number I use to contact her.

Signature _____ Date _____

Crisis Care Contract

I _____ commit that I will not harm myself in any way.

In the event that I should develop suicidal or other self-harm ideation, I further commit to contact 911, Crisis Help Line (615-244-7444), the Community Assistance Program (615-342-1450), the Suicide Prevention Hotline (800-SUICIDE) or will go to the emergency room at a local hospital.

Signature_____ Date_____

(Client Copy)

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It is not my role as a counselor to investigate or evaluate for any special services through social service and/or the school system.