

*Marie D. Wilson, PhD, CSAT-S, LPC*  
*Licensed Professional Counselor PC001865*  
*Certified Sex Addiction Therapist*  
*4949 Liberty Lane, Ste 230*  
*Allentown, PA 18106*  
*610-248-4943*

**INTAKE FORM**

Date \_\_\_\_\_

Name \_\_\_\_\_ D.O.B \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (H): \_\_\_\_\_ (W): \_\_\_\_\_

Email: \_\_\_\_\_ Cell: \_\_\_\_\_

Preferred communication: ☐ Cell ☐ Home Phone ☐ Email ☐ Text Message to Cell

Occupation \_\_\_\_\_ Highest level of education \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Phone: \_\_\_\_\_

With whom are you now living? List people and relationship.

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Please list all medications:

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Prescribing Physician: \_\_\_\_\_

**INFORMED CONSENT  
GENERAL COUNSELING SERVICES CONTRACT**

Welcome to my counseling practice. This document contains important information about my professional services and business policies. Please read it carefully and make note of any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

***COUNSELING SERVICES***

Counseling varies depending on the personality and needs of the client, the particular problems you would like to address and the style and methods of the counselor. There are many different methods I may use to deal with the problems that you hope to address. In order for counseling to be most effective, active involvement on your part is important. For instance, you will have to work on things we talk about both during our sessions and at home. I will likely recommend reading materials, workbooks or videotapes to assist our work together. Frequently I also recommend attendance at Self-Help meetings in the area and will discuss this fully with you. These Self-Help meetings are free of charge and of benefit to your recovery program.

Counseling can have benefits and risks. Since counseling often involves discussing problematic behaviors or challenging aspects of your life, you may experience uncomfortable feelings like shame, sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to have benefits for people who go through it. Counseling often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But I cannot guarantee that you will experience any of these benefits, as the process is different for each person.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with counseling. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Counseling involves a large commitment of time, money, and energy, so you should be sure of your decision to move forward. If you have questions about my procedures, we should discuss them whenever they arise.

### ***SESSIONS & PROFESSIONAL FEES***

The Sex Addiction Assessment/Evaluation is \$350.00 and involves several paper and pencil tests and one computer-based test that you will complete on your own. In addition to these tests, the fee also covers two sessions: the first is a personal interview and the second a review of the testing and treatment recommendations. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals.

If counseling is initiated I will usually schedule one 50-minute session per week at a time we agree on. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. If it is possible, I will try to find another time to reschedule your appointment. The rate and billing are the same for phone or Skype sessions.

My session fee is \$120.00. In addition to weekly appointments, I charge this amount for other professional services that you may need such as report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

### ***PAYMENT & INSURANCE***

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. I do not accept insurance at this time, however, if you have out of network coverage, I am happy to provide you with a monthly statement to submit to your insurance company. However, you will be expected to pay for each session at the time it is held by cash or check.

If you choose to submit a statement to your insurance provider you should be aware that this will require me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases,

they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

### ***MISSED APPOINTMENTS AND LATE CANCELLATIONS***

Please note that as a counselor, I commit a specific hour to you alone. Unlike other professionals, such as physicians and dentists, I do not double schedule, nor can I operate on an inexact schedule. Thus, a cancellation without sufficient notice usually means a lost therapy hour for the counselor, since it is difficult on short notice to reassign the hour to another person.

Therefore, I require 24 hours cancellation notice prior to your appointment. If 24 hours notice is not given or you forget to come to your appointment, you will be charged the regular fee for the counseling hour. Insurance companies will not cover charges for missed appointments and, thus, the client must pay these fees. I appreciate your cooperation in regard to this matter.

### ***CONTACTING ME***

I am often not immediately available by telephone. When I am unavailable, you can leave me a confidential voice message of any length at 610 248 4943. I will make every effort to return your call on the same day, with the exception of weekends and holidays. You can also reach me by confidential email at [mwilsonlpc@aol.com](mailto:mwilsonlpc@aol.com).

### ***PROFESSIONAL RECORDS***

The laws and standards of my profession require that I keep treatment records. Largely these records consist of notes that I make during our sessions, some initial impressions and plans or follow-up questions for our next meeting. I keep these records in a locked file in my office. You are entitled to receive a copy of the records or summaries. Because these are professional records, they can be misinterpreted and/or upsetting to untrained reader, therefore, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any time spent in preparing information requests.

### ***CONFIDENTIALITY***

In general, the law protects the privacy of all communications between a client and a counselor, and I can only release information about our work to others with your written permission. But there are a few exceptions.

### *Duty to Warn and Protect*

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

### *Abuse of Children and Vulnerable Adults*

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

- If I have reason to suspect, on the basis of my professional judgment, that a child is or has been abused, I am required to report my suspicions to the authority or government agency vested to conduct child abuse investigations. I am required to make such reports even if I do not see the child in my professional capacity.
- I am mandated to report suspected child abuse if anyone aged 14 or older tells me that he or she committed child abuse, even if the victim is no longer in danger.
- I am also mandated to report suspected child abuse if anyone tells me that he or she knows of any child who is currently being abused.

### *Prenatal Exposure to Controlled Substances*

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

### *Insurance Providers (when applicable)*

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of counseling, case notes, and summaries.

### *Consultation*

I may occasionally find it helpful to consult other professionals about a case. During such a consultation, I will not reveal the name or identity of any client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these

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consultations unless I feel that it is important to our work together.

*Lastly....*

It is not uncommon for us to frequent the same shops or businesses in the Lehigh Valley area, so there is always the chance we may see each other in venues beyond the counseling office. I will not initiate contact with you in order to protect your confidentiality, but will acknowledge you if you initiate contact.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

*I have read and agree to the above conditions and limits of confidentiality and understand their meanings and ramifications.*

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Client Signature

Today's Date

## CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and

Accountability Act of 1996, as amended from time to time ("**HIPAA**").

1. Tell your counselor if you don't understand this authorization, and the counselor will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. *Special Instructions for completing this authorization for the use and disclosure of Psychotherapy*

**Notes.** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes."

All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical record.

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**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

1. Client's name: \_\_\_\_\_

2. Date of Birth: \_\_\_\_\_

3. Date authorization initiated: \_\_\_\_\_

4. Authorization initiated by: \_\_\_\_\_

5. Information to be Released:

☐ Authorization for Counseling Notes ONLY

\_\_\_\_\_

☐ Other (describe information in detail; phone consultation/assessments/discharge summary, etc):

\_\_\_\_\_

\_\_\_\_\_

6. Purpose of Disclosure: The reason I am authorizing release is:

\_\_\_\_\_

\_\_\_\_\_

7. Person(s) Authorized to Make the Disclosure:

\_\_\_\_\_

\_\_\_\_\_

8. Person(s) Authorized to Receive the Disclosure:

\_\_\_\_\_

\_\_\_\_\_

9. This Authorization will expire on \_\_\_\_\_ or upon the happening of the following event:

\_\_\_\_\_

**Authorization and Signature:** I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

**Signature of the Client:**

**Date:**

\_\_\_\_\_