kTherapy / Brainspotting with Katherine
45 Lyme Road, Suite 310A • Hanover, NH 03755 • 833-4-BSPKAT (833-427-7528)

CLIENT INTAKE FORM

Today's Date:_____Referred by: _____

GENERAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____
Street Address: _____
City, State, Zip: _____
Home Phone: _____ May I contact you at home?: ❍Yes ❍No Messages OK?: ❍Yes ❍No
Work Phone: _____ May I contact you at work?: ❍Yes ❍No Messages OK?: ❍Yes ❍No
Cell Phone: _____ May I contact your cell?: ❍Yes ❍No Messages OK?: ❍Yes ❍No

Marital Status: ❍Single ❍Cohabitating ❍Married ❍Separated ❍Divorced ❍Widowed

Children?: ❍Yes ❍ No If yes, custody status: _____
Household members: _____ Age: _____
_____ Age: _____
_____ Age: _____
_____ Age: _____

Name of Emergency Contact: _____ Relationship: _____
Emergency Contact's Phone #: _____

Name of Employer: _____ Title/Position: _____

Treatment of Minor Child

Parent or Legal Guardian Name _____ I give consent for treatment _____(initial)
Child Name_____ Age/Grade_____

SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

- **None** = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning
- **Moderate** = Significant impact on quality of life / functioning • **Severe** = Profound impact on quality of life / functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Depressed Mood	❍	❍	❍	❍	Hyperactivity	❍	❍	❍	❍
Appetite Disturbance	❍	❍	❍	❍	Delusions	❍	❍	❍	❍
Sleep Disturbance	❍	❍	❍	❍	Hallucinations	❍	❍	❍	❍
Fatigue/Low Energy	❍	❍	❍	❍	Aggressive Behaviors	❍	❍	❍	❍
Poor Concentration	❍	❍	❍	❍	Bingeing/Purging	❍	❍	❍	❍
Mood Swings	❍	❍	❍	❍	Anorexia	❍	❍	❍	❍
Agitation	❍	❍	❍	❍	Family Conflict	❍	❍	❍	❍
Elevated Mood	❍	❍	❍	❍	Weight Loss/Gain	❍	❍	❍	❍
Emotionality	❍	❍	❍	❍	Hopelessness	❍	❍	❍	❍
Irritability	❍	❍	❍	❍	Grief	❍	❍	❍	❍
Social Isolation	❍	❍	❍	❍	Sexual Problems	❍	❍	❍	❍
Worthlessness	❍	❍	❍	❍	Phobias	❍	❍	❍	❍
Panic Attacks	❍	❍	❍	❍	Obsessions/Compulsions	❍	❍	❍	❍
Self-Inflicted Wounding	❍	❍	❍	❍	Difficulty Making Friends	❍	❍	❍	❍
Financial Problems	❍	❍	❍	❍	Difficulty Keeping Friends	❍	❍	❍	❍

PURPOSE FOR VISIT

What brings you into therapy today? _____

_____

_____

_____

_____

_____

How did the issue arise? _____

_____

_____

_____

_____

Who is supportive of you? Where do you go for help? _____

_____

_____

PSYCHIATRIC HISTORY

Prior suicide attempts? ❍Yes ❍No

If yes, when?_____

Circumstances that led to the attempt: _____

_____

_____

Current suicidal thoughts? ❍Yes ❍No

If yes, please describe: _____

_____

_____

Have you had any prior therapy? ❍Yes ❍No

If yes, when and for how long? _____

What was the focus of previous treatment? _____

_____

Was it helpful? _____

Prior hospitalization for mental/emotional problems? ❍Yes ❍No

If yes, please describe (year/duration/reason for hospitalization): _____

_____

_____

_____

MEDICAL HISTORY

Are you currently taking ***any*** prescription medication? ❍Yes ❍No

If yes, please provide the following details (*to the best of your ability*):

Medication	Dose	Method	Physician

Are any of these medications for mental/emotional problems? ❍Yes ❍No

Do you have any medical conditions that may affect your treatment? ❍Yes ❍No

Please describe your overall health today: _____

_____

_____

Date of last visit to Physician: _____

Do you drink alcohol? ❍Yes ❍No If yes, how much do you consume in a week?: _____

Do you currently use drugs (street, non-prescription or herbal supplements)? ❍Yes ❍No

If yes, please describe your drug use: _____

_____

_____

ADDITIONAL INFORMATION

What do you consider to be your strengths?: _____

_____

_____

What do you like most about yourself?: _____

_____

_____

What do you consider to be your weaknesses?: _____

_____

_____

GENOGRAM

CLINICAL SUMMARY:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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INFORMED CONSENT

Client Name: _____

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at the office of kTherapy / Brainspotting with Katherine, hereby referred as kTherapy. The rights, risks and benefits associated with the treatment have been explained to me. I understand that therapy may be discontinued at any time by either party. kTherapy encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge. I agree to pay an hourly fee of $_____, payable at the beginning of each session.

Recipient's Rights: I certify that I have received the HIPAA agreement and certify that I have read and understand its content.

Therapy may be Discontinued Non-Voluntarily: Therapy services may be discontinued non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at kTherapy, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of discontinued services by letter or e-mail.

Client Notice of Confidentiality: The confidentiality of patient records maintained by kTherapy is protected by Federal and/or State law and regulations. kTherapy may not say to a person outside the company that a patient attends treatment or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a client either at kTherapy, against any person who works for kTherapy, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. It is kTherapy's duty to warn any potential victim, when a significant threat of harm has been made. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

_____

I consent to treatment and agree to abide by the above stated policies and agreements with kTherapy / Brainspotting with Katherine.

_____ _____
Signature of Client/Legal Guardian Date
(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____
Witness Date

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FINANCIAL PRACTICES

ALL FEES ARE PAYABLE AT THE TIME OF SERVICE

Fees for Services: Therapy sessions are fifty-five- (55) minutes in duration at a charge of $150.00. Brainspotting sessions are $250 for ninety (90) minutes and $100 for each additional thirty (30) minutes. If insurance benefits are utilized, you are responsible for all co-pays or deductibles at the time services are rendered.

Adjusted Fees and Payment Schedules: Adjusted fees and payment schedules must be worked out with your clinician prior to scheduled treatment; they will be based on need, and held confidential.

Payments for Services: Fees/co-payments are to be paid at the time of the session, unless otherwise arranged with your clinician. Please make checks out to "kTherapy" or to the name of your clinician. There will be a $10.00 charge for all returned checks. Any outstanding balances of over 30 days are subject to a 10% interest charge.

Regardless of medical coverage, you are responsible for your fees for professional services. Clients who default on their financial obligations will be referred to a contracted collection agency and revoke the right to confidentiality in this process. Defaulting clients will be liable for all collection costs including agency fees and legal fees.

Cancelled or Missed Appointments: If you are unable to attend your scheduled appointment, a minimum of twelve (12) hours notice must be given in order to avoid a missed appointment fee.

If less than 12 hours are given before cancellation or an appointment is missed without cancellation (no-show), you will be charged a $75.00 missed appointment fee plus a $4.00 processing fee. Insurance will not cover any of this cost and you are responsible for the full fee. Appointment rescheduling will be at the discretion of the clinician.

Insurance Coverage: Insurance claims will be submitted for coverage, which may include outpatient treatment reports and diagnostic treatment summaries.

You are responsible for informing your clinician of any changes in your insurance information, including coverage changes. If you fail to inform your clinician of any changes, you may become responsible for payment in full for professional services.

You are responsible for the costs of professional services, regardless of coverage. By signing this form, you are authorizing insurance carriers to make payment directly to your provider. If your insurance carrier will only submit payment directly to the client, you are responsible for paying for services in full at the time rendered and seeking reimbursement from said insurance carrier.

Credit Card: Your credit card will be held confidential and only be charged the amount of the cancellation or missed appointment fee plus a $4.00 processing fee in the event that you cancel or miss an appointment: Type: MC V AE DIS
Name on card: _____ Expiration: _____

Account number: _____ Security Code:_____ Zipcode:_____

Acknowledgement and Agreement of Financial Practices and Fees:
I have read and understood the above stated policies and agreements with kTherapy / Brainspotting with Katherine.

_____ _____
Signature of Client/Legal Guardian Date
(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____
Witness Date

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HIPAA RELEASE

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Our Legal Duties
State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information
Information about you may be used by your Clinician for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with kTherapy such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of kTherapy not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person or persons, the health care 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.

Public Safety
Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse
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 health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Professional Misconduct
Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings
Health care professionals are required to release records of clients when a court order has been placed.

Other Provisions
When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains

unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of kTherapy or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

In the event in which kTherapy or your mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say kTherapy or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of kTherapy. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify kTherapy (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Your Rights
You have the right to request to review or receive your medical files. The procedure for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $1.00 per page, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from your Clinician.

Complaints
If you have any complaints or questions regarding these procedures, please contact kTherapy. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the American Association of Marriage and Family Therapy.

Direct all correspondence to kTherapy, 45 Lyme Road, Suite 310A, Hanover, NH 03755.

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name (please print): _____

Signature: _____ Date: ___/___/___ Signed by: ___client ___guardian

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RELEASE OF INFORMATION

Client's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____

I, _____, authorize _kTherapy_ to:

__X__ (send) __X__ (receive) the following __X__ (to) __X__ (from)

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Type of information requested:

- __X__ Treatment plans
- __X__ Progress reports
- __X__ Diagnostic Information
- ____ Discharge Summary
- ____ *Psychotherapy Notes
- ____ Other, specify: _____

*A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR PSYCHOTHERAPY NOTES.

The above information will be used for the purpose of:_____
and will only be exchanged with the individual/agency specified in this document for the period of time that I have authorized.

I understand that the confidentiality of these records is required under the New Hampshire General Statutes N.H. Rev. Stat. Ann. § 135-C:19-a. This information shall not be transmitted by us without written consent or other authorization as provided in the aforementioned statute(s).

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

A facsimile of this Release shall be considered as valid as the original.

Your relationship to client: ____Self ____Parent/legal guardian ____Personal representative
____Other (describe)_____

Client's Signature: _____ Date: _____/_____/_____

Parent/guardian/personal representative (if applicable)

Signature: _____ Date: _____/_____/_____

Witness (if client is unable to sign)

Signature: _____ Date: _____/_____/_____