EVOLVING REFLECTIONS

Therapist: _____

Date of Appointment: _____

Intake Registration Form

Today's Date: _____

Client Information

Name: _____ Date of Birth: _____ Age: _____

Gender: ☐ Male ☐ Female

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May I have permission to mail to this address? ☐ Yes ☐ No

Email Address: _____

Marital Status:

☐ Never Married ☐ Domestic Partner ☐ Married – How many years? _____

☐ Separated ☐ Divorced ☐ Widowed – How many years? _____

Education and Employment

Education (List highest level of education attained): _____

Employer: _____ Occupation: _____

How long have you worked there? _____ How long in this occupation? _____

Insurance Information

Primary Insurance: _____ Phone Number: _____

Group Number: _____ Policy Number: _____

Subscriber's Name: _____ Social Security Number: _____

Date of Birth: _____ Employer: _____

Client's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance: _____ Phone Number: _____

Group Number: _____ Policy Number: _____

Subscriber's Name: _____ Social Security Number: _____

Date of Birth: _____ Employer: _____

Client's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

EVOLVING REFLECTIONS

Parent/Guardian Information

(Please complete if the client is under 18 years of age)

Parent/Guardian Name: _____

Date of Birth: _____ Phone Number: _____

Spouse/Partner Information

Name: _____ Date of Birth: _____ Age: _____

Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Education (List highest level of education attained): _____

Emergency Contact

Name of Local Friend or Relative (Not living at the same address): _____

Relationship to Client: _____ Phone Number: _____

Physician Information

Primary Physician: _____ Phone Number: _____

List any significant health problems:

_____

_____

Mental Health History

Referred By:

☐ Medical Provider: _____

☐ Insurance Provider: _____

☐ My Website: www.evolvingreflections.com

☐ Friend/Family Member: _____

☐ Other: _____

EVOLVING REFLECTIONS

I am interested in the following type(s) of counseling: (check all that apply)

- ☐ Individual
- ☐ Couples
- ☐ Family
- ☐ Group

What would you like to accomplish out of your time in therapy?

_____

_____

What issues or concerns bring you to counseling today?

_____

_____

When did your problem first start? Within the last:

- ☐ 30 Days
- ☐ 6 – 12 Months
- ☐ 2 Years
- ☐ During Adolescence
- ☐ During Childhood

Have you previously received any type of mental health services? ☐ Yes ☐ No

If yes, which of the following:

- ☐ Psychotherapy
- ☐ Medication
- ☐ Outpatient Hospitalization
- ☐ Inpatient Hospitalization

If yes, please provide:

Name of Provider or Facility: _____

Location: _____

Dates of Treatment: _____

Reason for Treatment: _____

Is there any other information that you feel is important for me to know before we begin our work together?

_____

_____

Family History

Names of Children	Age	Living with You

Please list your siblings (brothers and sisters) in order of their birth, including yourself.

Names of Siblings	Age	City and State of Residence	Describe Your Relationship (Close, Estranged, Best Friends, Etc.)

Where were you born? _____

Where did you grow up? _____

☐ City

☐ Suburbs

☐ Country

Who did you live with while growing up? _____

Mother's Name: _____ Father's Name: _____

Mother's Occupation: _____ Father's Occupation: _____

Lien/Lawsuit

Are you involved in a lawsuit?

_____

_____

Do you suspect that you will be involved in a lawsuit in the near future?

_____

_____

Understanding the Therapeutic Process

Therapy is most effective when both the client and the therapist make a commitment to the therapeutic process and relationship. Through mutual commitment, the therapist and the client create a relationship in which there is trust, respect, safety and an open exploration of the client's thoughts, feelings and experiences. Within the safety of the therapeutic relationship, change becomes possible.

As with any effort to create lasting change, psychotherapy requires time, energy and commitment. Our first few sessions will involve an evaluation of your needs, from which I will provide impressions of what our work will include and an initial treatment plan. Psychotherapy can feel frustrating because we often cannot control the pace of change. On the path toward healing, you may experience an increase in painful feelings; this is a normal part of the process. Psychotherapy has both risks and benefits. Usually people find psychotherapy helpful, although it can cause disappointing or unexpected outcomes.

If you have concerns about your progress or any aspects of treatment, I invite you to discuss this with me in person or in writing. You are free to terminate at any time; however, I hope you will discuss this prior to stopping. I can give you a referral to other providers if you choose to discontinue our work together.

Informed Consent

Welcome to Evolving Reflections! We appreciate that you are entrusting us with your mental health needs and look forward to assisting you in achieving your mental health goals.

This document will provide you with important information about Evolving Reflections and our business policies. It is important that you read these documents carefully so that you can make an informed decision in regard to our services.

Services Provided:

Evolving Reflections offers a variety of mental health services that include, but are not limited to, the following:

* Individual Psychotherapy
* Assessments
* Consultation
* Referrals for Alternative Healthcare Providers

Typically, the first sessions will involve a comprehensive assessment of your needs and goals. You and your therapist will decide which service(s) best match your needs and create a treatment plan. It is important to provide accurate and complete information so that we can make the most appropriate recommendation for services for you. We encourage you to ask questions and talk openly with your therapist about any concerns,

requests, or needs you may have. Your therapist is always willing to discuss your treatment with you and to look at alternatives that might work better. Although during the course of the therapy relationship, you may be disclosing vulnerable or personal information, the therapy relationship is professional in nature. Planned contact outside of the therapeutic relationship or sexual interactions of any kind is prohibited.

Confidentiality Statement:

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone except where disclosure is required by law.

1. I abide by and respect the ethical code of confidentiality. This means that I *cannot* and *will not* tell anyone else what you have told me, or even that you are in therapy with me, without your written permission. You may give written consent or me to share information with whomever you choose, and you can change your mind at any time and revoke that permission.
2. The following are the legal exceptions to your right to confidentiality. **I will inform you if at any time I feel it is necessary to put these into effect.**
    - A. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also inform the police and ask them to protect that person.
    - B. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services or Social Services within 72 hours.
    - C. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and contact the police or crisis team. However, whenever possible, I would explore all other options with you before taking this step.
      **In any of these situations, I would reveal only the information necessary to protect you or the person in danger. I would not tell everything you have told me.
    - D. If you become involved in a court case or proceeding, a judge or court may require that I provide information or testify.
    - E. I may sometimes consult with another professional about your treatment. All counselors are required by professional ethics to keep your information confidential. These case consultations are helpful to both you and I in determining that I am providing you the best treatment possible. In addition, when I am out of town or unavailable, another therapist will be on hand to assist my clients. I must provide him or her with information about any clients that might be calling.
    - F. If I treat children under the age of 12, I cannot guarantee confidentiality. Parents of young children have the right to remain informed about treatment. As children grow more able to understand and choose their right to confidentiality increases. Therefore, for children between the ages of 12 and 18, most of the details of our work together will be kept confidential. However, parents and guardians do have the right to *general information,* such as how their child's therapy is going. The same legal exceptions to confidentiality also apply.
    - G. If you and your partner decide to have individual sessions as part of your couples therapy, what we discuss in those individual sessions will most likely be discussed in your joint sessions. I will ***not*** be a part of keeping secrets between partners in couple's therapy. If you do not wish to work on your concerns together, I suggest you see separate counselors for individual therapy.

Initial: _____

Therapist Communications:

Your therapist may need to communicate with you by telephone or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

- ☐ My therapist may call me on my home phone. My home phone number is: _____
- ☐ My therapist may call me on my cell phone. My cell phone number is: _____
- ☐ My therapist may send a text to my cell phone. My cell phone number is: _____
- ☐ My therapist may call me at work. My work phone number is: _____
- ☐ My therapist may communicate with me by e-mail. My e-mail address is: _____
- ☐ My therapist may send a fax to me. My fax number is: _____
- ☐ My therapist may send mail to me at my home address: _____
- ☐ My therapist may send mail to me at my work address: _____

Records and Your Right to Review Them:

I keep very brief session records, noting only that you have been here, what interventions happened in session, and the topics we discussed. Please note that clinically relevant information from emails, texts, and faxes are part of the clinical records. Both the law and the standards of my profession require that I keep treatment records for at least 7 years. I retain clinical records only as long as is mandated by Nevada law. You have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider with your written consent.

Social Networking:

I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites can compromise their privacy and confidentiality. In addition, accepting friend requests from clients is prohibited by ethical guidelines of the American Counseling Association, by which I am bound. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites.

Initial: _____

Financial Agreement:

The fee for a 45-minute session is $125.00 payable at the time of treatment. I accept cash, checks and credit cards. Many insurance plans are accepted with prior authorization. If your insurance is not one that I accept, you may be able to utilize your out-of-network benefits. You will need to pay your session fee in full at the time of service, and I can provide you with a HCFA billing form, which you can submit to your insurance company for reimbursement.

- ☐ I am an EAP Client – all approved services are billed to the EAP company.
- ☐ I agree to pay the regular fee of $125.00 per 45-minute session.

☐ My insurance carrier is:

Company Name: _____

Co-pay amount: _____

Fees are periodically reviewed and subject to change. However, you will receive a 30-day notice of any fee increase.

Financial Policy:

1. You are responsible for full payment of all services. **If your insurance refuses a claim, you will be required to pay the entire amount.**
2. Payment is due at the time of treatment. If you choose to pay by check and your check is returned for insufficient funds, your account will be assessed a $25.00 returned check fee, in addition to the amount of the returned check.
3. Any fees left unpaid for 30 days will accrue interest of 20% per month.
4. If you require a receipt for services, please indicate below.

   ☐ I will need a receipt for services.

5. Your appointment time has been set aside for you. You are responsible for coming to your session on time and at the time we have scheduled. If you are late for your session, we will still end on time and your regular session fee will apply.

Initial: _____

Cancellation Policy:

Once an appointment has been scheduled, you will be expected to keep the appointment. Our office policy requires that sessions be cancelled at least 24 hours prior to the scheduled appointment time to avoid being responsible for the charges. If less than 24-hour notice is given, you will be charged for the appointment. Appointment times are scheduled exclusively for each client and generally cannot be rescheduled on short notice. This office cannot bill your insurance company for "no shows" or late cancellations. You alone will be responsible for the full $125.00 fee for any appointments missed for any reason.

Initial: _____

Telephone calls, Reports and Legal Representation:

1. I prefer to see and talk with you in person at our scheduled session time. However, I am aware that telephone calls are necessary at times. When you call, you will be connected to my voicemail. Please leave me a message, including your phone number, and I will return your call as soon as possible. Since I remain quite busy most of the time, I must limit phone calls to five minutes.
2. If you request that I write reports to be sent to schools, employers, lawyers, doctors, courts, Child Protective Services, etc., you will be charged for the time it takes me to write these reports. Court appearances will have a minimum charge of $250.00 and will be billed at $250.00 per hour.
3. I am not a legal consultant or representative. I do not do custody evaluations or make recommendations regarding child custody.

Initial: _____

Ending Therapy:

You normally will be the one who decides therapy will end. However, if I am in my judgement unable to help you, because of the kind of problem you have or because my training and skills are in my judgement not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. Your

participation is voluntary, and you have the right to terminate therapy and communication at any time. If you choose to do so, it is best to share your decision so that we may have the opportunity to take one or more sessions to review and close our work together. Closure is an essential element in the process of good therapy, which I highly value. If I do not have contact or communication from you for a period of 120 days, I will assume that you no longer intend to remain active in this therapeutic relationship and your file will be closed. Returning to therapy for "tune-ups" or to restart with new goals is always a possibility after termination.

Emergency Procedures:

Should an emergency situation arise, and we are unavailable, or it is after our normal business hours, please contact the following resources:

* Call 9-1-1 or go to the nearest emergency room for an emergency, OR
* Call Southern Nevada Adult Mental Health Services, Hotline: (702) 486-8020, Voice: (702) 486-6400 8-5p Monday- Friday (must not have insurance coverage)
    - 6161 West Charleston Blvd., Las Vegas, Nevada
    - 1785 East Sahara Ave., Las Vegas, Nevada
    - Emergency After Hours Phone: (702) 486-6408
* Spring Mountain Hospital, 24/7 Services
    - (702) 873-2400
    - 7000 Spring Mountain Rd., Las Vegas, Nevada
* National Suicide Prevention Lifeline (800) 273-8255
* Nevada Suicide Prevention Hotline (877) 885-4673

Statement of Understanding:

I have read the enclosed policies and procedures, asked any questions that I needed to, and understand the terms of this consent. I understand my rights and responsibilities as a client and my therapist's responsibilities to me. I agree to these conditions and consent to treatment.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature (if client is a minor) Date

_____ _____
Provider/Therapist Signature Date