

Name: _____
Cell #: _____

Name: _____
Cell #: _____

Stephanie O'Hanlon-Kayalar RN, BSN, MFT Intern
Under the supervision of Diana Palmer, LMFT
New York State Marriage & Family Therapist - License no.: 001210-1
499 Glen St., Glens Falls, NY 12801
Phone: 518.798-9187 Fax: 519.223.067

Intake: Confidential Client Information

INSTRUCTIONS: To assist me in helping you, please fill out this form as fully and openly as possible. Your answers will help me to plan a course of couples' therapy that is most suitable for you and your partner.

Date: _____

How Did You Hear About me?: _____ May I thank this person for the referral?

_____ If this person is a licensed Mental Health Professional, may I discuss aspects of your case as needed?

Partner A (to be filled out by Partner A)

Name: _____ DOB: _____

Address: _____

Street & Number

City

State

Zip

Email: _____

Profession: _____

If you are under the care of another Health Care Provider (GP, psychiatrist, therapist), may I discuss aspects of your case only as needed? Y N

Name/Contact info of Health Care Provider(s)

Current Medication(s)/dose/frequency:

Mental Health Diagnosis (if applicable) made by, date, diagnosis:

Briefly, what is your immediate concern in coming to couple's counseling?

—

—

Have you seen a therapist before, and if so, for what purpose?

Date Married or Plan to be Married (if applicable): _____

Have you been married before, and if so, how many times? _____

How long have you and your partner been in this relationship? _____

Are you and your partner presently living together? Yes _____ No _____

Are you and your partner engaged, separated, or in any litigation or arbitration (explain)?

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

—

—

Partner B (to be filled out by Partner B)

Name: _____ DOB: _____

Address:

Street & Number

City

State

Zip

Email: _____

Profession: _____

If you are under the care of another Health Care Provider (GP, psychiatrist, therapist), may I discuss aspects of your case only as needed? Y N

Name/Contact info of Health Care Provider(s)

Current Medication(s)/dose/frequency:

Mental Health Diagnosis (if applicable) made by, date, diagnosis:

Briefly, what is your immediate concern in coming to couple's counseling?

—

—

Have you seen a therapist before, and if so, for what purpose?

Date Married or Plan to be Married (if applicable): _____

Have you been married before, and if so, how many times? _____

How long have you and your partner been in this relationship? _____

Are you and your partner presently living together? Yes _____ No _____

Are you and your partner engaged, separated, or in any litigation or arbitration (explain)?

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

Children

Fill out the following information for each child of whom the natural parent is both you/your partner, children from other relationships, adopted children, and if there are any significant health concerns.

_____ Neither of us has children

_____ One or each of us has children (continue)

<u>Child's Name</u>	<u>Age</u>	<u>Sex</u>	<u>Parent</u>	<u>Lives with Whom?</u>
----------------------------	-------------------	-------------------	----------------------	--------------------------------

OFFICE POLICIES AND PROCEDURES

- Therapy sessions are approximately 45 minutes with a charge of \$50 or sliding scale per session. Payment is due in full at the time of the appointment for non-insured patients.
- Proof of insurance is required at time of initial appointment. It is the patient's responsibility to inform office staff of any changes in insurance coverage and billing information in order that we may file as a courtesy to you.
- All deductibles, co-pays and non-covered services are due at the time of service unless payment

arrangements have been made in advance. I accept cash and personal checks.

- In the case that your insurance company denies payment of any claim we file on your behalf we will bill you the denied amount. Payment will be due at your next appointment.
- Scheduled appointments are commitments. Please make every effort to be on time. If you are late, time will be lost from your session. If you miss an appointment and fail to notify the office at least 24 hours in advance, you will be charged a missed appointment fee of \$50.00 which will be billed to you with payment expected within 15 days of the billing date.
- You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, and you also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. If, for any reason, I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of \$300.00 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other court-related costs.
- All records and communications about the patient will be treated confidentially with applicable state and federal laws. These laws may oblige me to report suspected abuse or neglect, domestic violence, and those who pose a danger to themselves or others. Managed care requires that you waive your rights to keep your psychotherapy confidential. They require treatment reports which request information about why you are using your outpatient mental health benefit. They will not authorize and therefore will not pay for sessions without this information

- **PSYCHOLOGICAL SERVICES**

- Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient and the particular problems you are experiencing. There are many different methods that may be used to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part.
- Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant parts of your life, you may temporarily experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.
- Therapy sessions sometimes involve a large commitment of time, money, and energy so you should be very thoughtful about the therapist you select. Our first few sessions will involve an evaluation of your needs and requests so that I can offer impressions and formulate a treatment plan if you decide to continue therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. You should participate in your treatment plan and have the right to discuss and revise it at any time.

Consent to Treatment

We, with full knowledge of the benefits and consequences of psychotherapy, consent to be

treated by Stephanie O'Hanlon-Kayalar under the supervision of Diana Palmer, LMFT ("the therapist") on a voluntary basis. We the undersigned understand and give permission to Stephanie O'Hanlon-Kayalar under the supervision of Diana Palmer, LMFT, to make assessment and evaluation, including treatment recommendations and decisions, with my involvement, to carry out a professional mental health therapeutic service.

We agree to take financial responsibility for our sessions at the rate of **\$50 per 50-minute hour**. We will pay for services at the time they are rendered. We realize that failure to pay for any of the given services will require me to send payment by mail before the next session or it will not be conducted. Payment may be made by cash or check, however, if a check is returned by the bank, you will be charged a \$20.00 fee and denied the right to write checks as payment for your sessions. **Please be aware that you must give 24-hour notice for cancellations or be charged a \$50 fee.**

On occasion, there may be reason to video an aspect of our session. If so, this will be discussed in advance, and of course you will have the option to decline. If a video is produced, no copies will ever be made, it will never be shared on a social network of any kind, and it will be destroyed immediately and forever once its purpose has been reached.

We agree to be as honest as possible in our discussions as part of our attempt to improve our relationship. In the event of divorce or any other litigation, we agree not to use the therapy (progress) notes of Stephanie O'Hanlon-Kayalar under the supervision of Diana Palmer, LMFT against each other for any reason (e.g. child custody, divorce legal proceedings, etc.). In addition, we agree to a NO SECRETS policy; any and all information shared with the therapist is consented to be disclosed to or between the partners.

While I have taken training in the Gottman Method of couples therapy, I want you to know that I (or my agency, if applicable) am completely independent in providing you with clinical services and I alone am fully responsible for those services. The Gottman Institute or its agents have no responsibility for the services you receive.

LIMITS OF CONFIDENTIALITY

The contents of a counseling, intake, or assessment session are considered to be confidential. 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. It is the policy of this private practice not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, 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.

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 health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

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

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access their spouse or child's records.

Professional Misconduct

Other health care professionals must report professional misconduct by a health care provider. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be shared in order to substantiate disciplinary concerns.

Court Orders

Health care professionals are required to release records of clients when a court order has been placed. In the event that Stephanie O'Hanlon-Kayalar under the supervision of Diana Palmer, LMFT is summoned to court or any other legal arena on behalf of the client, there will be a \$300.00 per hour charge.

PATIENT 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").

- I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION.
- Tell your counselor if you don't understand this authorization, and the counselor will explain it to you.
- 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, and you are in the 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.

- 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, your provider has the right to decide not to treat you or accept you as a client in their practice.
- 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.
- If this office initiated this authorization, you must receive a copy of the signed authorization.

7. 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 (such as a therapist, psychologist or psychiatrist) 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, status, treatment plan, symptoms, prognosis, and progress to date.

8. 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 records.

We the undersigned understand and agree to adhere to all rights and responsibilities contained in this agreement.

Name: _____

Name: _____

Signed: _____

Signed: _____

Date: _____

Welcome! Thank you for taking the time to complete this basic intake information and consenting to all sections contained herein. I believe couples therapy is the single most far-reaching and important opportunity there is for healing and growth, and I thank you sincerely for entrusting me as your guide in this endeavor. As your therapist, and with your full, mutual participation, you have my unwavering commitment to the betterment of your relationship to the very best of my abilities. It is an honor to serve you in this most important way.

Sincerely,

Stephanie O'Hanlon-Kayalar RN, BSN, MFT Intern under the supervision of Diana Palmer, LMFT