

Client Intake Form

Name: _____

Phone Number: _____

Email: _____

Which is the best method to contact you? email____ cell____

Address: _____, _____, Nevada _____

Date of Birth: _____

How did you hear about us? _____

Would you prefer in-person/ telehealth (zoom) appointments? _____

We also offer walk-and-talk therapy appointments where we meet at a park or in the community – is this something you may be interested in? _____

What is your motivation to enter therapy at this time in your life now?

What is your #1 or chief complaint right now?

What obstacles are keeping you from living your best life?

- 1.
- 2.
- 3.

What are your top 3 strengths?

- 1.
- 2.
- 3.

What type of learner do you feel you are? (circle those that best suit you)?

- Visual – for those that like to doodle, those list makers or notetakers
- Auditory – those that love the verbal explanation or like to read out loud
- Kinesthetic learner – those that learn by experiencing or doing things – like those that excel at sports or dance, or learning a trade
- Reading/writing learners – those that love the act of writing in any way (journaling, writing in diaries and internet searching)

Are you experiencing any current legal issues, such as pending court cases or parole?

Please rate on a 1-10 scale, with 1 being the lowest and 10 as the highest:

- How would you rate your emotional health? _____
- How would you rate your physical health? _____
- How would you rate your spiritual health? _____
- How would you rate your health with others in key relationships with you (i.e. spouse/significant other/children/parents/siblings, etc.)? _____

From those listed above, which area would you like to see the most improvement?

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

Do you have a mental health diagnosis, and if so, what? _____

Do you take any medications? _____

If so, please list:

In your own words, what do you want to accomplish in therapy?

How would you measure progress in therapy to know if you've successfully met your goals?

What would a successful therapy outcome look like to you?

Welcome to No Limits Counseling – Therapy Consent

1. Psychological Services

There are various methods we may use to deal with the issues that you hope to address. Therapy is not like a medical doctor visit; instead, it calls for an active effort on your part both during and in-between sessions. Psychotherapy can have its benefits and risks since often it involves discussing difficult aspects of your life. As a result, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, resolutions to specific problems and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

2. Sessions

Your first, and possibly second session, will involve an evaluation of your needs, at which time your therapist will offer you some first impressions of what our work will include and a treatment plan to follow. During this time, you will have an opportunity to decide if your therapist is the best person to provide the services you need to meet your treatment goals. If therapy is initiated, your therapist will usually schedule a 90-minute session initially, and from there, one 45-minute session per week. You will be expected to pay for the appointments you schedule unless you provide 24 hours advance notice of cancellation.

3. Professional Fees

The usual fee for the first session is \$150, and \$90 for additional sessions. For other services you may need, the therapist's time is charged at \$100 per hour. This billable time for services includes letters to other professionals, attendance at meetings with other professionals you have authorized, telephone conversations lasting more than 10 minutes, preparation of treatment summaries, completion of forms, and the time spent performing any other service you may request outside of a normal therapy session. If you are requesting a sliding scale fee, it is your responsibility to communicate to the therapist you are seeking this option from.

4. Billing and Payments

It is our business policy to require full payment for therapy services at the time services are rendered unless we agree otherwise.

Currently, we accept cash or credit card payments, and are not accepting insurance.

5. Cancellation Policy

Once an appointment is scheduled, you will be expected to pay for it unless you provide at least 24 hours' advance notice of cancellation. If you must cancel and wish to reschedule, your therapist will attempt to find another time to reschedule your appointment. As such, there is a cancellation fee of \$50 for sessions not cancelled within 24 hours of their scheduled date and time.

6. Contacting your Therapist

Your provider is often not immediately available by phone, especially when in-session. However, your therapist has a confidential voicemail where he/she can be reached and that is monitored frequently during business hours. Your therapist will make every effort to return

your call within 24-48 hours, with the exception of weekends/holidays. If you are unable to reach your therapist, and it is an emergency, dial 911 or go to the nearest ER.

7. Professional Records

The laws and standards of our profession require that we keep treatment records. You are entitled to receive a copy of your records unless your therapist believes that seeing them would be emotionally damaging, in which case your therapist will review them with you or send them to another mental health professional of your choice. Clients will be charged an appropriate fee for any time spent in preparing information requests.

8. Minors

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Generally, we will provide them only with broad information about our work together, unless your therapist feels there is a high risk that you will harm yourself or someone else. In this case, your therapist will notify them of the concern. Before giving your parents any information, your therapist will discuss the matter with you, if possible, and will do their best to handle any objections you may have.

9. Confidentiality

In general, the law protects the privacy of all communications between a patient and therapist, and your therapist can only release information with your permission. However, there are a few exceptions in which your therapist is legally obligated to act to protect others from harm, even if it requires that your therapist reveal information about a client's treatment.

These exceptions include:

1. If you reveal information related to the abuse or neglect of a child, dependent adult, or elderly person, then the appropriate authorities may be contacted.
2. If you threaten bodily harm or death to yourself, your therapist may notify the appropriate authorities and appropriate others (e.g., family member, inpatient hospital staff).
3. If you threaten bodily harm or death to others, your therapist may notify appropriate authorities and/or the intended victim.
4. If there is clear or imminent danger to you or the public, or there is probable cause to believe that a potential victim is likely to be in danger, your therapist may notify the appropriate authorities and/or the intended victim(s).
5. If a court of law issues a legitimate subpoena for information stated in the subpoena.
6. If you are in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Your provider may occasionally find it helpful to consult with other professionals about a case. During a consult, information about you may be shared in this context without using your name. The consultant is legally bound to keep the information confidential.

Additionally, if we see one another outside of the office, your provider will not acknowledge you first. Your right and privacy and confidentiality are of the highest importance, and your provider will not jeopardize that. However, if you acknowledge your provider first, he/she will be more than happy to speak briefly with you, but it would not be appropriate to engage in any lengthy discussions in public or outside the office.

10. Litigation Limitation

Due to the nature of the therapeutic process, and the fact that it often involves making a full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither you (the client) nor your attorney, nor anyone else acting on your behalf will call on No Limits Counseling, LLC, to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. If, however, you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for all professional time, including preparation and transportation costs, even if your therapist is called to testify by another party. Because of the difficulty of legal involvement, No Limits Counseling, LLC, will assess an hourly charge of \$250 for preparation, travel, and attendance at any legal proceeding. If depositions, court hearings, or other legal meetings are canceled by the court, attorney or other-related party with less than 48-hour notice, there will be a cancellation fee of \$250 regardless of the reason for cancellation.

11. Freedom to Withdraw

If you decide to discontinue your work with your therapist, he/she can help you secure an appropriate referral to another qualified mental health professional within the community.

12. Consent

I understand and agree to the terms of the professional relationship. Further, I authorize and request that my therapist carry out psychological examinations, treatment procedures and recommendations which now or during my care are advisable. I understand that I can ask questions regarding the purpose of these procedures and that I have the right to be aware of all aspects of the working relationship. I understand that I have the right to participate actively in all aspects of treatment planning and that I can discontinue treatment at any time. I also understand that while the course of therapy is designed to be helpful, at times it may be difficult and uncomfortable.

I acknowledge that I participated in the development of therapeutic goals. I was given an opportunity to discuss my goals and ask questions about services that No Limits Counseling, LLC provides.

Client Signature

Date

Guardian Signature (if client under 18 years of age)

Authorization to Use, Disclose and Receive Mental Health Information and/or Medical Records:

I understand that by signing this form my care will be discussed with a therapist from No Limits Counseling, LLC, as part of my care. I understand that I have the right to revoke this authorization at any time and that cancellation or modification of this authorization must be provided to me in writing and received by No Limits Counseling, LLC, to be effective. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

I understand that I have the right to refuse consent and signing of this authorization and that No Limits Counseling, LLC, shall not condition my treatment upon this refusal. I understand that I am voluntarily signing this form to release my health information to the party or parties designated.

I, _____, hereby authorize No Limits Counseling, LLC, to disclose, receive and exchange all records pertaining to:

Name of Provider –

Address –

Phone Number –

Client Signature

Date

Guardian's Signature (if client is under 18 years of age)

CONSENT TO USE UNENCRYPTED E-MAIL OR TEXT

It is important that you are aware that computer email, text and fax communication can be relatively easily accessed by unauthorized people, and hence can compromise the privacy and confidentiality of such communication. E-mails, texts and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited or direct access to all e-mails, texts and e-faxes that go through them. As such, e-mail messages on your computer, laptop, ipad, phone or other devices have inherent privacy risks – especially when your e-mail access is provided through an employer or when access to your email is not password protected. We, at No Limits Counseling, do have virus protection and are password-protected, and all confidential information from the computer is backed up on a hard drive. Please do not use texts, emails, voicemail or faxes for emergencies. In addition, the purpose of this consent is that:

I, acknowledge that there are inherent risks of using unencrypted e-mail or text, and understand the limits of such. I will abide by these rules in the professional relationship with No Limits Counseling, LLC.

Client's Name:

Cell Phone Number:

Email Address:

Client's Signature:

Date:

HIPAA PRIVACY STATEMENT

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

The privacy of your health information is important to us at No Limits Counseling, LLC. We will maintain the privacy of your health information and will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

HIPAA, also known as the Health Insurance Portability and Accountability Act, is a federal law that restricts access to individuals' private information. We want to share with you our commitment to providing you with this policy in writing which assures how we may use and disclose your "Protected Health Information" (or PHI). This notice also shows your rights regarding health information that No Limits Counseling, LLC, maintains regarding you and your care, and is a brief synopsis of how you may exercise these rights.

I. Uses and Disclosures for Treatment, Payment and Health Care Operations

We may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when your therapist consults with another provider, such as your family physician or another therapist.
- Payment is when we obtain reimbursement for your care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management or care coordination.
- "Use" applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our office such as releasing, transferring, or providing access to information about you to other parties.

II. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating and managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant, only with your authorization.

For Payment: We may use and disclose PHI so that we may receive payment for the treatment services provided to you. This will only be done with your authorization. Examples including processing credit card transaction, maintaining billing records, etc., and/or communication with insurance or claims processing.

For Healthcare Operations: We may disclose, as needed, your PHI in order to support our business activities, including, but not limited to, quality assessment activities, licensing or conducting other business activities. For example: billing or typing activities. For training or teaching purposes: PHI will only be disclosed with your authorization.

Required by Law: Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

III. No Limits Counseling, LLC, may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse/Neglect – Elder Abuse/Neglect – Emergencies
- National Securities – Law Enforcement – Public Safety (Duty to Warn)

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are as follows:

- 1. Required by law, such as mandatory reporting of child abuse or neglect to mandatory government agency audits or investigations.
- 2. Required by Court Order.
- 3. Necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or to the public. This includes notification to the target of the threat.

Verbal Permission: We may disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time.

IV. YOUR RIGHTS REGARDING YOUR PHI:

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, No Limits Counseling, LLC, is not required to agree to a restriction you request.

Right to Request Confidential Communications: You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment or health care operations. We are not required to agree to your request.

Right to Access to Inspect and Copy: You have the right, which may be restricted only in exceptional circumstance, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. No Limits Counseling, LLC, may deny your request. On your request, No Limits Counseling, LLC, will discuss with you the details of the amendment process.

Right to an Accounting of Disclosures: You generally have the right to receive an accounting of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Copy of this Notice: You have the right to a copy of this notice.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision No Limits Counseling, LLC, makes about access to your records, or have other concerns about your privacy rights, you should inform us of your concerns. If you believe your privacy rights have been violated and wish to file a complaint with No Limits Counseling, LLC, you may send your written complaint to the Secretary of Health and Human Services, at 200 Independence Ave., S.W., Washington, D.C., 20201, or by calling (202) 619-0257. You have specific rights under the Privacy Rule, and No Limits Counseling, LLC, will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy – the effective date of this Notice is on May 28, 2023.

No Limits Counseling, LLC, reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that No Limits Counseling, LLC, maintains.

If No Limits Counseling, LLC, changes this Notice, we will post the revised Notice on our website.

This form is educational only, does not constitute legal advice, and covers only federal, not state law.

Client Signature

Parent or Legal Guardian's Name (if client is under the age of 18)

Date