

INTAKE FORM

Dr. Pruedence Brooks, Licensed Psychologist

Please provide the following information and answer the questions below.

NOTE: The information you provide here is protected as confidential information.

1. Name: _____
(Last) (First)

Birth Date: ____ / ____ / ____ Age: ____ Gender: Male Female

Marital Status: Never Married Domestic Partnership Married Separated Divorced

On a scale of 1-10, how would you rate the issue you're coming in for today? _____

Please list any children/age:

Address: _____
(Street and Number)

(City)

(State)

(Zip)

Home Phone: (_____) _____ May we leave a message? Yes No

Cell/Other Phone: (_____) _____ May we leave a message? Yes No

E-mail: _____ May we email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

What significant stressful events have you experienced recently?

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

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

Referral Source:

- American Psychological Association
- PsychologyToday.com
- GoodTherapy.org
- NetworkTherapy.org
- Relationship911.com
- Other Online Sources: _____
- Friend
- Yellow Pages
- Unknown
- Other: _____

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions 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. Noted exceptions are as follows:

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.

Abuse of Self

If a client states or threatens that he or she will hurt themselves, the therapist will make every effort to enlist their cooperation in ensuring their safety. If they do not cooperate, further measures may be taken without their permission in order to ensure their safety.

Abuse of Another Person

If a client states or threatens that he or she will hurt another person, the therapist will contact the authorities.

Abuse of Previous Therapist

If a client states that he or she has been abused by a previous therapist, this information must be reported to the appropriate legal authorities and/or ethics board.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

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 therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Signature Today's Date: _____

Witness Today's Date: _____

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full fee of \$ 125.00 is charged for missed appointments or no show cancellations with less than a 24 hour notice unless due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment. Please note that your insurance company cannot be billed for missed appointments.

Thank you for your consideration regarding this important matter. Your signature below indicates your agreement to adhere to Dr. Brooks' Cancellation Policy if you fail to show up for or cancel an appointment without a 24 hour notice.

_____ Today's Date: _____
Client Signature

INFORMED CONSENT FOR INDIVIDUAL THERAPY

I understand that therapy begins with an evaluation of my situation, past and present. While Dr. Brooks is deciding whether she is the appropriate therapist for me, I will decide whether I wish to begin therapy with her. I understand that because of the commitment of time and money, plus the potential impact on myself and others, it is important to make an informed choice for a therapist.

I have read (or have had read to me) and understand the potential limits of confidentiality, including those imposed by Dr. Brooks' policies and by state law, and I have received a copy to keep. I have been given the opportunity to ask questions and discuss confidentiality and disclosure policies with Dr. Brooks. I understand all policies as described on the *Client Information Form* and accept them as conditions for entering into therapy with Dr. Brooks.

I agree to share responsibility with Dr. Brooks for the therapy process, including goal setting and termination. By entering into therapy, I accept and understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapy goals. I understand that the changes made will have an impact on myself and on others around me. I accept that such changes can have both positive and negative effects and agree to clarify and evaluate potential effects of changes before undertaking them.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Dr. Brooks. I am aware that I may stop my treatment with Dr. Brooks at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment. I understand that I may lose other services or have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive.

By signing below, I agree to accept mental health services from Dr. Brooks at \$125 per hour and accept full responsibility for payment of such services.

Printed Name _____

Signature _____ **Date** _____

I, Dr. Brooks, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Therapist _____ **Date** _____