INTAKE FORMS PACKET (most clients need only print pages 2-6)

Included in this Packet

(1) Intake Form (p.2)
(2) Client Information Form (p. 3)
(3) Information and Consent Form (pp. 4-5)
(4) Confidentiality Statement (p. 6)
(5) Authorization to Treat Minor Children (p. 7)
(6) Telemedicine Informed Consent (pp. 8-10)

Instructions

Before your Appointment:

(1) Complete the **Intake Form**
(2) Complete the **Client Information Form**
(3) Read and sign the **Information & Consent Form**
(4) Read and sign the **Confidentiality Statement**
(5) If counseling is for a child under the age of 18, a parent or legal guardian must complete and sign the **Authorization to Treat Minor Children Form**
(6) If counseling will occur via phone or internet, read and sign the **Telemedicine Informed Consent**

Bring all completed forms to your first appointment:

Jasmine Tudy MFT

Licensed Marriage and Family Therapist
505 N. Riverside Drive Suite 201, IL 60031
(847) 946-5105

INTAKE INFORMATION

Date:_______________ Referral Source: _________________________

PATIENT INFORMATION

Primary Client(s):_____________________AGE:______DOB:____SEX: M / F
_______________________ AGE:______ DOB: ________SEX: M / F
_______________________AGE: ______DOB: ________SEX: M / F
Marital Status: Single Married Separated Divorced Widowed (# yrs._____)

Address:_____________________ City:_____________ State:_____ Zip Code:_______
Home Phone:____________Cell:_______________Work: ___________
May we leave messages at all these numbers? Yes or No
In Case of Emergency Notify:_________________ Phone: ___________
Relationship: _________________
Physician:_______________________ Phone: _________________

FINANCIAL RESPONSIBILITY INFORMATION (GUARANTOR)

Name:_________________________ Relationship to Client: ________
Address:________________________ City:____________ State:_____ Zip Code:_________
Home phone:____________Cell:____________Work:____________
Place of Employment:__________________________ # of Years_____ Annual Income: __________

Guarantor Agreement: I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Jasmine Tudy MFT.

Signature: _______________________ Date:___________

CLIENT INFORMATION

Name:____ Date:___________

MEDICAL HISTORY
Do you have any physical problems at this time? Yes or No
If yes, please explain:____
____
____

On average, how much alcohol do you drink in a week? __________ _____
Do you smoke? ________ How much? ___________ How often? _______
Do you use any illegal drugs? ____________________________________
____
____

Are you currently taking any medication? Yes or No
If yes, please list dosage and frequency (or attach list):
____
____
____

Please list any previous counseling, mental health treatment, psychiatric hospitalizations, and/or suicide attempts with approximate dates:
____
____
____

What are the areas of your life for which you need assistance? Counseling goals?
____
____
____

Thank you for choosing Jasmine Tudy MFT for your counseling needs. I am committed to giving you the best care possible. To acquaint you further with the procedures and policies of this practice, I am providing the following information:

COUNSELING INFORMATION AND CONSENT TO TREATMENT

1. APPOINTMENTS:

When a counselor sets an appointment with you, that time is yours and yours alone. **If you need to cancel your appointment, I require a minimum of 24-hours notice; otherwise, you are subject to a full charge for the missed appointment**. Messages may be left on the voice mail, which will accurately record the date and time you called. I will my best to be punctual for your appointment unless I have an emergency call or it is a field based appointment and I am subject to travel limitations. I ask that you try to be punctual as well. If you are late you will receive the remainder of your scheduled time. This is necessary so remaining clients can be seen at their scheduled times. Of course, in the case of an emergency or illness, late cancellations are acceptable.

2. COUNSELING FEES:

Counseling fees are set at the time of your first appointment. The counseling sessions last 50 minutes. The fee per session is based upon your annual income. **You are fully responsible for all services rendered. Full payment is expected at the time of service unless other contractual arrangements apply**. You may pay by cash, check or online. Online payments must be made before your session or can be billed by ACH withdrawl.

Jasmine Tudy MFT will bill insurance on your behalf and will generally accept in network and out of network rates for most major insurance carriers. In some instances, your carrier may request that you submit your bill directly and in those cases, I require full payment at the time of service and will assist you in billing your insurance. We are making no guarantees that your insurance will reimburse you.

3. RETURNED CHECKS:

A penalty fee of $20.00 will be assessed on all checks returned by the bank for any reason. Re-payment of the returned check must be made by cash, cashier's check, or money order only.

4. UNPAID BALANCES:

If your account has an unpaid balance any time, it may be necessary to suspend counseling sessions until the account is paid.

5. CHILDREN:

We do not provide care for your children and cannot responsible for any child that is left unsupervised. So, we ask that you do not bring children unless they are receiving counseling themselves.

6. Legal Limitation:

It is agreed that neither the client nor the client's attorney or anyone acting on behalf of the client will call on the therapist to testify in court or any proceeding including but not limited to divorce, custody disputes, injuries or lawsuits. It is extended to no request being made to disclose psychotherapy records or any communication that took place between the therapist and the client. This is due to the fact that disclosure often includes all records and the nature of the therapeutic process and other confidential matters.

I am dedicated to you and your counseling needs and appreciate your cooperation in these matters. Should you have any questions or concerns regarding fees, payments, or policies, feel free to ask prior to your first appointment.

___

*****Please sign below to indicate that "I have read the above policies, and I understand and agree to comply with them. I further agree that I am personally responsible for all financial obligations incurred. I also consent to receive treatment by Jasmine Tudy MFT.**

Signature: ______________________________Date:____________________

____

Please print your name

Signature:______________________________ Date:____________________

(Parent/Guardian if client is less than 18 years of age)

CONFIDENTIALITY STATEMENT

Your therapy records are the property of your counselor and shall be treated as confidential. To comply with state and federal laws your records will not be released without properly executed written consent. Everything about your care will be held in strictest confidence (with the exception of those situations which we are required by law to report). If you choose to have your counselor keep a third party informed of your progress, it is necessary to complete a ***"Release of Information Form"*** that will be kept on file.

The following circumstances are an exception to keeping confidentiality and are required by law to report:

A. When a client communicates threat of bodily injury to self another person or is suicidal.
B. When there is reasonable suspicion of abuse to a child or a dependent adult which has occurred or will occur.
C. When information is required by law or is ordered by the court.
D. Counselor Team. Counselors typically work as a team and reserve the right to consult and discuss pertinent information with other counselors and supervisors within the counseling field.

I have read and understood the above information regarding confidentiality. I agree to disclose personal information with these exceptions in mind.

_______________________________ _______________
Signature of Client Date

_______________________________ _______________
Signature of Parent/Guardian of Minor Date

_______________________________ _______________
Signature of Counselor Date

AUTHORIZATION TO TREAT MINOR CHILDREN

I, ______________________________________, give my permission to
(Name of parent or guardian)

_______________________________________ to see my son/daughter
(Counselor)

___________________________________ for treatment or counseling,
(Name of minor child)

with and / or without me being present in the same session. I / we understand that counselors must assert confidential privilege – the right to withhold disclosure of private counseling information about my child. However, in the interest of developing a trust relationship between the counselor and my/our child(ren), I / we give the counselor permission to reveal or withhold information that in her clinical judgment is necessary to best help and protect my / our child(ren).

The only exception to this discretion would be in the case of ___________

____

____

____

____

_____________________________Date____________
Parent / Guardian Signature

____________________________________Date___________Therapist/ Witness
Signature

TELEMEDICINE INFORMED CONSENT

Client Name (s): ___________________________________ Date of Birth:________________

Client Name (s): ___________________________________ Date of Birth: ________________

I hereby consent to engaging in telemedicine with Jasmine Tudy MFT as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

Client/Patient Rights with respect to Telemedicine

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

2. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential.
3. I understand that the Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers & documents & other items & prohibits the therapist from disclosing to the patient that the FBI sought/obtained the items under the Act.

4. I understand that all information disclosed during psychotherapy is confidential including the written notes that the therapist makes of my sessions. However, by law there may be times when my therapist is required and/or permitted to break confidentiality. I also understand that I am expected to keep my communications confidential. I agree that all records of communication between client and therapist remain the property of my counselor.

5. I understand that my therapist may not be available at times of emergency. I agree to seek medical help and go to the nearest hospital or emergency care in the city I live in or call 911.

6. I do understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

7. I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. It is my responsibility to determine who has access to my computer and electronic information. I understand that this may include but is not limited to family members, friends, and co-workers. I agree to communicate through a computer that I know is safe and I will fully exit the medium of communication after my session with the therapist. In addition, in the event of an interruption due to technological breakdown, I will try to reconnect within 10 minutes. If reconnection is not possible, another session time will scheduled.

8. I understand that telemedicine based services and care may not be as complete as face-to-face services.

9. I understand that my therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy. This means that if I were to participate in family, and/or marital/couples therapy, my therapist is permitted to use information obtained in an individual session that I may have had with her, when working with other members of your family. This also extends to communication between sessions as well.

10. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

11. I understand that the length of my treatment and the timing of the eventual termination of my treatment depend on the specifics of my treatment plan and the progress I achieve. I do understand that therapy involves both benefits and risks. Risks could include the possibility of experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, loneliness and helplessness. Therapy often requires recalling experiences, some of which may be unpleasant. Therapy may involve making changes that can feel threatening to me or to those close to me. Should I experience any negative effects I will inform my therapist immediately. If I or my therapist determine that I am not benefiting from treatment, either of us may elect to initiate a discussion of my treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing treatment plan, or terminating my therapy. I have the right to discontinue therapy at any time.

Mediation and Arbitration

All disputes that occur as a result of psychotherapy shall first be referred to mediation, before and as a pre-condition, to the initiation of arbitration. The client(s) and Hope Point counselors shall choose a neutral third party that they both agree upon. Any expenses that occur shall be split equally, unless otherwise agreed by the parties involved. If the mediation is unsuccessful and the matter is taken for arbitration; the arbitrator will determine the expenses to be paid by either party.

Litigation Limitation

It is agreed that neither the client nor the client's attorney or anyone acting on behalf of the client will call on the therapist to testify in court or any proceeding including but not limited to divorce, custody disputes, injuries, lawsuits. It is extended to no request being made to disclose psychotherapy records or any communication that took place between the therapist and the client. This is due to the fact that disclosure often includes disclosing the nature of the therapeutic process and other matters that may be confidential in nature.

Financial Arrangements

- Payment is expected prior to each session unless other arrangements have been made in advance. Therapy sessions are 50 minutes in length, unless otherwise agreed upon. You are responsible for payment for all services rendered.
- Cancellation of appointments must be made at least 24 HOURS in advance. Voice mail is reachable 24 hours a day, 7 days a week. Late cancellations will be charged at the regular hourly fee.
- There is a twenty dollar ($20.00 USD) service charge for all checks returned by the bank, should you choose this medium.. If 1 or more session fees are not paid, therapist reserves the right to terminate therapy.
- If you have an urgent need to speak with me between your scheduled sessions, a brief call (5 minutes or less) or email not requiring more than 5 minutes to read and respond is appropriate. Should you wish to

discuss issues at a greater length, please schedule a session or arrange a time for a telephone consultation, which will be charged at the regular rate (in 15 minute segments).

Therapist's Requests and/or Recommendations

I recommend that each client obtain a thorough physical exam prior to commencing therapy. This is especially important if you are suffering symptoms of anxiety or depression, headaches, and/or weight gain/loss. Symptoms may be biologically caused or may be there for a protective reason.

Counseling services are available only during office hours. In the event of a crisis, you may visit the nearest hospital to you. Alternatively, you could call 911. In case of suicide tendencies, another option is 1-800-SUICIDE.

Signatures

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Signature of patient (s): ____ Date: ________________

Signature of patient (s): ____ Date: _________________

Psychotherapist Signature: ____ Date: _________________