**Intake Information & Informed Consent**

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| Today’s Date: | Therapist: **Vonetta McClunie, MS,LMFT,OTR/L** |

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| **Client Information** |

(Please Print)

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| Client’s last name: First: MI: | Mr. | Miss | Marital Status: |
| Parents/Guardians: | Mrs. | Ms. | Single Mar Div Sep Wid |
| Is this your legal name? | If not what is your legal name? | (Former name): | Birth Date: | Age: | Sex: |
| YesNo |  |  |  |  | MF |
| Home Phone Number:( )Mobile Phone Number:( ) | Street Address: | Social Security Number: |
| Email: | City: | State: | ZIP Code: |
| Occupation: | Employer: | Employer’s Phone Number:( ) |
| Chose therapist because/referred to therapist by (please check one box) | Dr. | Insurance Plan | Hospital |
| Family | Friend | Close to home/work | Internet | Other (list) |
| Other family members seen here: |

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| Client’s last name: First: MI: | Mr. | Miss | Marital Status: |
| Parents/Guardians: | Mrs. | Ms. | Single Mar Div Sep Wid |
| Is this your legal name? | If not what is your legal name? | (Former name): | Birth Date: | Age: | Sex: |
| YesNo |  |  |  |  | MF |
| Home Phone Number:( )Mobile Phone Number:( ) | Street Address: | Social Security Number: |
| Email: | City: | State: | ZIP Code: |
| Occupation: | Employer: | Employer’s Phone Number:( ) |
| Chose therapist because/referred to therapist by (please check one box) | Dr. | Insurance Plan | Hospital |
| Family | Friend | Close to home/work | Internet | Other (list) |
| **Emergency Contact:** |
| Name of local friend or relative: | Relationship to client(s): | Home phone number:( ) | Work Phone Number:( ) |

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| **Informed Consent & Authorization for Treatment** |
| This is to inform you that Vonetta McClunie MS, LCMFT, #2776(KS), is a Licensed Clinical Marriage and Family Therapist (LCMFT) in Kansas and a Licensed Marriage Family(LMFT) and Occupational Therapist(OTR/L) in Missouri. Vonetta practices marriage and family therapy as an independent contractor in Kansas and Missouri. She receives and gives private and/or group clinical consultation for the purposes of client case management. By signing this form, I give my consent to Vonetta McClunie (therapist) to provide assessment and therapeutic services to me/us/my/our child, within the scope of her license. I/we understand that my therapist will work with me to develop a treatment plan and treatment will be formulated to resolve my problem(s) as quickly as possible. I agree to cooperate with my therapist in the treatment process to carry out therapeutic homework assignments and to follow through with any medical treatment, as prescribed by my physician. I further agree to keep my/our/ my/our child’s scheduled appointments and understand that failure to do so more than two times may result in my care being terminated. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature(s)/Responsibility Party(ies) Date  |
| **Authorization to treat minor child** |
| Name of Child(ren) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_I/we state that I/we are the custodial parent(s)/guardian(s) of the above named minor child (ren). I/we hereby give permission for him/her to receive counseling. I/we acknowledge that I/we are aware of the mandating reporting laws in the states of Kansas and Missouri. I/we are also aware that I/we can withdraw the permission to treat my/our child at any time. I/we will assume responsibility to notify my/our child’s other parent that counseling has been initiated and will take sole responsibility in arranging for the payment for all counseling services for my/our child.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature(s)/Responsibility Party(ies) Date  |

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| **Statement of Ethics and Legality** |
| In order to meet the professional standards under Kansas and Missouri laws, all therapists are bound by the professional ethics stated by the Kansas Behavioral Sciences Regulatory Board, Missouri Division of Professional Registration, American Occupational Therapy Association, and the American Association of Marriage and Family Therapists. You may request a copy of the AAMFT and AOTA ethical code at any time. All information regarding your file will remain strictly confidential with exceptions only as defined by Kansas and Missouri state laws. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature(s)/Responsibility Party Date  |

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| **Financial Policies** |
| **Session Fee:**Session fees are as follows: $\_\_\_\_\_\_ initial 75 minute intake session  $\_\_\_\_\_\_ per 50 minute session**Phone Calls and E-mails:** Appointment times are typically set at the end of the current appointment or over the phone. Phone calls and e-mails to or from you, or on your behalf that are over 10 minutes long may be charged to you at a prorated portion of your session fee, i.e. 15 minutes = ¼ charge of your regular session fee.**Reports and Court:** If you request a report, there will be a charge for the preparation of the report based on the time required to prepare the report. There are separate fees for testifying in court or for depositions, as outlined below. **FMLA/Letters to physicians, employers, schools $60.00\*** **Reports/Court testimony (includes all required time) $300.00/hour\*** **\*fees not covered by insurance****Insurance**: As an out-of-network clinician, I do not accept insurance; your session fee will be due at the time of service. If you have insurance, you will be provided with a receipt which you can turn into your insurance company for reimbursement according to your plan specifications upon request. **Payment Methods:**Payment is due at the time services are rendered. Cash, checks, cash app, HSA cards, and credit cards are accepted methods of payment. **Note:** A $35.00 fee will be added to your account for any check that is returned. You will have 10 days to clear up the outstanding check and your account will be placed on a cash/credit only basis; checks will no longer be accepted.**Cancellations:****A 24-hour notice is required for all cancellations in order to avoid incurring a $\_55\_\_\_ missed session fee**. This fee is your responsibility and will be due before another appointment can be rescheduled.**Late Arrival:** Ifyouarrive late to the session,the charge incurred will be the amount of the 50 minute therapy session. The session will end at the appointed time.**My/our signature below indicates that I understand and agree to the above financial policies.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature(s)/Responsibility Party(ies) Date  |

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| **Client Rights** |
| **YOU HAVE THE RIGHT:** |
| 1. To be treated with consideration and respect.
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| 1. To expect quality services provided by a concerned, competent clinician.
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| 1. To receive a clear statement of purposes, goals, techniques, rules of procedure and limitations, as well as potential dangers of the services to be performed, plus all other information related to or likely to effect the on-going counseling relationship.
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| 1. To obtain information about the case record and to have the information explained clearly and directly.
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| 1. To be fully knowledgeable and responsible in participation of the on-going treatment plan.
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| 1. To expect complete confidentiality and that no information will be released without written consent. See confidentiality information below for legal and ethical obligations.
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| 1. To see and discuss charges and payment records.
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| 1. To refuse any recommended services and be advised of the consequences of this action.
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| 1. To end therapy at any time without moral, legal or financial obligation other than those already accrued.
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| **CONFIDENTIALITY OF INFORMATION:** |
| Laws ensuring your right to privacy protects matters discussed with your therapist. In most cases, your therapist is prohibited from disclosing information about your care without your written consent and then only to the extent you authorize. Due to legal or ethical obligations specific circumstances may require your therapist to break confidentiality and report information obtained as a result of the therapy process. Those circumstances exist when:  |
| 1. It is known or suspected that a child, elderly or disabled person may be subject to abuse or neglect (reporting is required by law).
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| 1. The therapist believes that the client may be a danger to him/herself or to others (reporting is required by law).
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| 1. A court order exists that information regarding the therapy process be provided (reporting is required by law).
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| 1. If you commit a crime against a staff member or another person on the premises.
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| **SECURITY OF RECORDS:** |
| Your treatment of record and related financial records are kept in a locked file cabinet. Records will not be made available to others without signed authorization to release information and payment for the records prior to releasing them. Special rules relating to the release of treatment records containing information regarding drug and alcohol abuse: CFR 42, PART 2(KS) prohibits disclosure of such information without written consent of the client and only to the extent specifically authorized. This information cannot be disclosed to another source without written consent. A general release for medical or other information is not sufficient. Use of information in records for criminal investigation and prosecution is strictly prohibited. |
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| **RETENTION OF RECORDS:** |
| Treatment records are retained for a period of at least six to seven years following the termination of treatment for adults. For a client who is a minor on the date of termination of treatment, at least until the later of the following two dates: |
|  (A) Two years past the date on which the client reaches 18; or |
|  (B) six years after the date of termination of treatment of the minor. |
|  At the end of that period the records are destroyed in a manner that assures the confidentiality of the information unless the client requests otherwise, in writing, prior to the destruction of records. |
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| **INFORMATION REGARDING PSYCHOTHERAPY:** |
| * Psychotherapy may involve remembering unpleasant events and can arouse intense emotions of fear and anger; feelings of anxiety, depression, frustration, loneliness and helplessness may be experienced. Also feelings of relief, energy, power, self-acceptance, and well-being may also occur.
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| * There are numerous forms of psychotherapy, which vary, not only underlying theory and methods employed, but also in terms of time commitment and cost. I will attempt to provide treatment that is realistic in both areas.
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| * Depending upon a client’s condition, there may be available alternatives to psychotherapy, such as medication or behavior modification; I will make these recommendations if they are appropriate, based upon the assessment.
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| **ADDITIONAL INFORMATION REGARDING THERAPY:** |
| 1. I/we understand that the therapist provides therapy to individuals, couples, and families from a systems perspective utilizing therapeutic approaches/models associated with the marriage and family therapy profession.
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| 1. I/we understand that the therapist is bound by the Code of Ethics set forth by the American Association for Marriage and Family Therapy (AAMFT) and American Occupational Therapy Association (AOTA) that I/we can request a copy of those ethics at any time.
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| 1. I/we understand that, as a client, I have certain rights and those rights have been reviewed with me/us by my therapist.
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| 1. I/we understand that, under Kansas Law, the therapist is required to consult with my/our primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to symptoms of a mental disorder. In order to complete such a consultation, the therapist will request that I/we complete a Release of Information form. I/we also understand that I/we may waive this consultation, in writing, and that the therapist will discuss this process with me/us at any time if I/we so request.
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| 1. I/we understand that I/we may leave therapy at any time and agree to discuss the termination of therapy at a regular therapy session.
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| 1. I/we understand if there is no session activity or phone contact recorded in my/our file for a period of 3 weeks, my/our file will automatically be closed. I/we understand that, in most circumstances, my/our file can be re-opened upon completion of a new intake and payment of any balance due.
2. I/we understand that on occasion the therapist may discuss general case information with another therapist on issues of professional referral, and/or professional/ethical judgment without confidentiality being violated.
3. I/we waive any confidentiality rights in an emergency, and understand that the therapist may contact the above stated emergency contact on my behalf and I/we agree to hold them harmless.
4. I/we understand that this therapist maintains a “no secrets” policy in individual, couple’s and family therapy. This means the therapist will alongside the client(s) in a supportive role disclose all information to all adult parties in therapy.
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| Client/Guardian Initials |

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| **Technology Agreement** |
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| I/we understand that although both the therapist and I/we take precautions to ensure the confidentiality of information transmitted through the use of computers, electronic mail, facsimile machines, cell phones, text messaging, voicemail and other electronic or computer technology a privacy breach can occur; I/we have been informed and understand the risks to privacy and limits to confidentiality by these forms of communication.EMAIL: I/we understand that should the therapist contact me/us via email, the intent of the email will be to communicate information for the client’s use only or to confirm/change an appointment.TEXTING: I/we understand that should I/we contact the therapist or should the therapist contact me/us via text messaging, the intent of the text will before the client’s use only or to confirm or change a scheduled appointment time.SOCIAL NETWORKING: Online social networking sites like that of Twitter, Instagram, LinkedIn, or Facebook are strictly prohibited as a means to communicate with my therapist. |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client/Guardian Initials |

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| **Professional Disclosure Information (HIPAA)** |
| Your initials below indicate that you have read the HIPAA agreement and agree to its terms and serves as acknowledgement that you have received the HIPAA notification form. Not abiding by these policies may lead to termination of our work together and/or referral to another professional.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client/Guardian Initials |

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**Therapist: Vonetta McClunie, MS, LCMFT(KS), LMFT(MO), BS, OTR/L**