CASSANDRA'S COUNSELING INC. INTAKE INFORMATION

cazglmhc@gmail.com
(727)-505-0959

Fax: (727) 863-1343

Read the following information and complete pages 4-6 (I keep these). You can keep the other pages. Thank you, Cassandra

If you need information on how to sign pdf, please go to http://www.labnol.org/software/sign-pdf-documents/9333/

Confidentiality and Hippa

I understand that all documents pertaining to my counseling are stored on an online system and are not shared in any way with other person or agency, other than as deemed necessary by insurance or required by the court of law. I agree to the terms of service available to me at http://www.hhs.gov/ocr/hipaa/ , or I can contact them at 1-866-627-7748

Personal Agreements

I understand that I may be asked to do certain "homework exercises" such as reading, visualization, changing behaviors, and otherwise acting in my own best interest. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling.

I further understand that much of the work done will be to resolve issues and will depend on my honesty and willingness to do the things I need to do to move forward even if it is painful and difficult.

I understand that whatever I say in a session is strictly confidential and will not be released to anyone without my consent unless I am violating codes of abuse, harm to myself or others, or a legal situation demands the information be released.

I agree to take personal responsibility for my counseling and will make payments prior to counseling session. I will pay any outstanding balances promptly and will discuss any fee concerns with my counselor. I understand that I will be referred to other community services if I am no longer able to pay for services.

I understand that if I miss two sessions that my counselor may consider that I am no longer interested in the therapeutic process and I will be referred to community services which may better suit my needs.

I understand that the counseling process is a personal process and is about making my own personal changes. I understand that that I am responsible for my change and not the change of someone else.

Extras

By special request I will set up **phone counseling** or **Skype**.

I may send you **homework assignments** online, but **no** counseling will be conducted online without prior arrangements and going through secure channels.

Short phone calls may be necessary, but if you desire phone counseling, then pre-payment arrangements must be made.

Letters, if you require a letter for medical or legal situations, a fee of 40.00 will be charged in advance.

Court appearance 300.00 per appearance within 50.00 miles, anything that is further will require fee adjustments.

Updates: Stay updated on classes, activities, and Mindfulness and set-up appointments online. Information will be sent out via e-mail sent out once or twice a month. You can unsubscribe anytime.

Keeping Appointments

I will do my best to be your guide and teacher. **YOU** are the most important part. Please understand this is how I make my living, if you do not show up, I do not get paid. Therefore, I have to set up limits for appointments.

As a commitment to my treatment, I understand that I will pay a fee for appointments not canceled with 24 hours notice. The rate is $30 per missed session.

CASSANDRA'S COUNSELING INC.

Statement of Client Rights and Responsibilities

*I have the right to be treated with courtesy, respect and privacy for my individuality.

*I am responsible for participating in decisions regarding my treatment plan, understanding my behavioral health problems, and developing mutually agreed upon treatment goals.

*I am responsible for following my treatment plan. My choice is voluntary and I understand that I may terminate my counseling at any time without follow-up.

*I am responsible for keeping and paying for all appointments. In the event that I cannot keep an appointment, I will give 24 hour notice, or be responsible for a missed session fee of 35.00.

*I am responsible for keeping my counselor up to date on any changes to my person, such as telephone number, address, relationship status, health issues, medication addition or changes, substance abuse or other addiction issues, or any other issue that could have a significant impact on my treatment.

*I am responsible for my treatment and I agree to be honest with my counselor and myself and dedicate myself to making positive changes in my thoughts, feelings and actions.

*I understand that confidentiality of records of information collected about me will be held or released in accordance with state laws regarding confidentiality of such records of information.

*I understand that I will need to sign a release for any parties that I choose to share therapeutic information with, other than those mandated by a court of law.

*I understand I will pay a fee of 3.00 per copy for any information requested from my file.

*I have read and received a copy of this Statement of Client Rights and Responsibilities.

My Commitment to you:

As your therapist/counselor, you confide in me by sharing your life and growth with me. I will have high regard for you as a person. I will bring the best that I know from my study and experience. I will bring you the highest of my insight, wisdom, and spiritual guidance.
I will keep a holistic perspective in our work together because I believe that the Physical, Spiritual, and Soul (mind, will, emotions) all work together to form the wholly healthy person.

You can expect truth from me even when you may not want to hear it. I will always have compassion and empathy for you in all that we do. I value you as a person in need of care. I will do my best to honor that. Let's begin the journey.

Insurance Clients:

Insured Name:_____

Today's Date_____

Social Security Number (required by insurance companies)_____

Date of birth_____

Insurance Company:_____ ID#_____

Group#_____ Co-Pay or Deductible_____

Authorization #_____

Number of sessions allowed:_____

Child or Spouse Client Information:

Name:_____

Age:_____ Birthdate_____

Social Security:_____

Clients Without Insurance

Name of responsible person if different than client

Today's Date_____

Age_____ Birth date_____

Full Address_____

_____

Home Phone_____Cell_____ OK to leave message at Home or Cell

If not an Insurance client your agreed payment per session will be: 70.00 (unless another agreement has made for payment of_____ per session.

General Information

How would you like to be contacted? **Phone** or **E-mail**?

***E-mail** (for homework and reminder e-mail)_____

How were you referred to Cassandra's Counseling?_____

Previous Counseling? YES NO Where?_____

Primary Care Physician (who is your doctor?)_____

Phone:_____

Please list any medical conditions you are being treated for:_____

Allergies:_____

Please List any medications you are taking:

Medication_____ Dose_____ How often?_____

Medication_____ Dose_____ How often?_____

Medication_____ Dose_____ How often?_____

****Will it be necessary for me to be in touch with your doctor regarding your treatment**? **YES NO**

PLEASE LIST ANY OTHER PEOPLE WHO WILL BE INVOLVED IN YOUR THERAPUTIC PROCESS, other than those listed above:

Name:_____-

Relation:_____

Name:_____-

Relation:_____

CASSANDRA'S COUNSELING INC.

Name:_____-

Relation:_____

EMERGENCY CONTACT

NAME_____

PHONE_____

ADDRESS_____

Please note any other information you would like me to know:
Such as:

Suicidal or homicidal thoughts or intents and when and how often?_____

Depression/Anxiety or both a problem and for how long?_____

Substance Abuse when and how often?_____

Uncontrolled anger or abusive behavior toward self or others?_____

Anything else?

By signing below, I acknowledge that I have read and understand the information presented to me by Cassandra's Counseling Inc. and that I agree to abide by the terms and have received a full copy of the agreement.

**Signature:_____

I would like to receive updates via e-mail **YES **NO**

Cassandra Gadouas LMHC

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