Initial Intake for Megan Pollock Therapy

Last Name:	First Name:	Date of Birth:
Home Address:		
City:	Zip Code:	Social Security Number:
Home Phone:	Work Phone:	Cell Phone:
E-mail:	Preferred Contact Method:	Permission to leave message:
Marital Status:	Spouse Name:	Length of Relationship:
Children:	Ages:	Genders:
Responsible Party:	Relationship:	Contact:
Emergency Contact:	Number:	Relationship:
Employer:	Occupation:	Length of Employment:
Referred by:	Contact:	Permission to contact:

Current Health Issues:		
Current Medications:		
History of Therapy/Counseling:	Whom:	Phone:
History of Hospitalization:	Why:	When:

Check Any of the Following That May Apply to You:

- ☐ Headache
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ No Appetite
- ☐ Over-Eating
- ☐ Stomach Trouble
- ☐ Bowel Disturbances
- ☐ Always Tired/Sleepy
- ☐ Unable To Relax
- ☐ Insomnia
- ☐ Recurrent Dreams
- ☐ Nightmares
- ☐ Hallucinations
- ☐ Other

- ☐ Inferiority Feelings
- ☐ Feel Tense
- ☐ Feel Panicky
- ☐ Fears and Phobias
- ☐ Obsessions
- ☐ Depressed
- ☐ Suicidal Ideas
- ☐ Take Tranquilizers
- ☐ Alcoholism
- ☐ Dangerous Drugs
- ☐ Allergy
- ☐ Asthma
- ☐ Sexual Problems

- ☐ Shy With People
- ☐ Can't Make Friends
- ☐ Afraid Of People
- ☐ Home Conditions Bad
- ☐ Unable To Have A Good Time
- ☐ Always Worried About Something
- ☐ Don't Like Weekends/Vacations
- ☐ Can't Make Decisions
- ☐ Over-Ambitious
- ☐ Financial Problems
- ☐ Gambling
- ☐ Job Problems
- ☐ Can't Keep A Job

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Please state why you decided to come for counseling/therapy
How long has this been a problem for you
What are you hoping to gain from counseling/therapy

Risks and Benefits: Psychotherapy can have both risks and benefits. The therapy process may include discussions of your personal challenges and difficulties, which can elicit uncomfortable feelings such as sadness, guilt, anger and frustration. However, therapy has been shown to have many benefits. It can often lead to better interpersonal relationships, improved work/academic performance, solutions to specific problems, and an increased capacity to manage intense feelings. But, there is no assurance of these benefits. Therapy requires active involvement in order to work towards growth.

Knowing the risks and benefits, I consent to treatment with Megan Pollock for the purpose of psychotherapy and acknowledge that I may discontinue services at any time in the future.

Signature Date

Cancellation Policy: A full fee is charged for missed appointments, no show and cancellations with less than a full 24 hour notice. Consideration is given for illness and emergencies.

Signature Date

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:

Duty to Warn and Protect When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

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.

Minors/Guardianship Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records, unless there certain circumstances that the release of confidential information may be harmful to the minor, as determined by the therapist, or the Court or Child's Attorney holds the Privilege.

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

Signature Date

NOTICE OF PRIVACY PRACTICES

1. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

2. **How we may use and disclose your health information.** We use health information for treatment, to get paid for the treatment, for administrative purposes, and to evaluate the quality of care that you received. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax or other methods. We may use or disclose your health information without your authorization for several reasons. If you sign an authorization to disclose information, you can later revoke it to stop any future disclosures.

3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. You may request that we limit disclosure to family members, other relatives, caregivers, or close personal friends who may or may not be involved in your care. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe that your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

4. **Our Legal duty.** We are required by law to protect the privacy of your health information provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of the receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice. You can also request a copy of our notice at any time.

5. **Privacy Complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact us. You may send a written complaint to the U.S. Department of Health and Human Services. We can provide you whit the appropriate address.

Acknowledgment of receipt of Notice of Privacy Practices

Signature:_____

Printed Name:_____

Date:_____