**Empowered Healing, LLC**

Nicole Peluso, MA, LPC, NCC, CCTP

Licensed Professional Counselor

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**Informed Consent**

Welcome to my private practice! I am so happy to have you here with me. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them during our initial session!

**QUALIFICATIONS**

I am a Licensed Professional Counselor (LPC) of the State of New Jersey with a Master’s Degree in Mental Health Counseling. I am also a Certified Clinical Trauma Professional (CCTP). Ongoing professional development includes attending conferences, keeping up with continuing education, and being greatly involved with the American Counseling Association and New Jersey College Counseling Association. I also consult with colleagues and supervisors as well as being active in increasing my personal growth and awareness.

**NATURE OF COUNSELING**

I approach counseling from an integrative, eclectic perspective utilizing modalities such as Client-Centered, Mindfulness Based Cognitive Therapy, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Mindfulness, and Solution-Focused Therapy. Techniques include active listening, non-judgmental stance, rapport building, homework when necessary, role-playing, psychoeducation. I recognize that each individual has unique experiences and stories to be told; therapy should be tailored to that individual. I consider the client’s needs and goals for therapy as a foundation.

# PSYCHOLOGICAL SERVICES

Psychotherapy can have benefits and risks. Psychotherapy has been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. On the other hand, therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. There are no guarantees as to what you will experience.

**YOUR RESPONSIBILITIES AS A CLIENT**

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 45 minutes. If you are late, we will end on time and not run over into the next person's session. If you miss a session **without** canceling, you will be charged a full session fee of $150.00.

# BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. I will provide an insurance receipt if you choose to utilize your out of network benefits. My fee is **$150.00**. This is subject to change and further sessions may result in a sliding scale fee or at a regular rate. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Form of payment includes: cash, check, Venmo, PayPal, Zelle.

## CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. If the patient threatens to harm himself/herself, I am obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action. If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient’s treatment.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have. 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:

**LIMITS TO CONFIDENTIALITY**

**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.

**Prenatal Exposure to Controlled Substances**

Mental Health care professionals are required to report admit ted prenatal exposure to controlled substances that are potentially harmful.

**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.

# MINORS

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from the parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our sessions together, unless I feel there is a high risk you will seriously hurt yourself or someone else.

In this case, I will notify my concern. I will provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objectives you may have with what I am prepared to discuss.

**CONTACTING ME**

I will make every effort to return your call/email on the same day you make it, with the exceptions of weekends, holidays, and very late in the evenings. If I will be unavailable for an extended time, I will make you aware ahead of time. Please call me if you are to cancel an appointment as I do not always check my email. Emails and texting are not to be utilized as a source of psychotherapy. They are to be utilized for communication purposes only.

**EMERGENCIES**

If you have an emergency outside of our session, please contact your psychiatrist and/or go to your local emergency room. 911 is an option in serious emergencies.

**HOTLINES**

Suicide Prevention Lifeline: 1-800-273-8255. New Jersey Hopeline: 1-855-654-6735

# CLIENT CONSENT TO PSYCHOTHERAPY

When you sign this document, it will represent an agreement between us. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. I have read this statement, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I am aware that sessions are pro bono at this time and I agree that this may be subject to change in the future. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me.

**CLIENT SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GUARDIAN SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**No Show, Late Cancellation, and Payment Policy**

In the case of non-emergency situations, if you fail to cancel a scheduled appointment within 24hours, you will be charged a full session fee of $150.00 for your missed appointment.

A full session fee of $150.00 is charged for missed appointments**.** A bill will be sent directly to all clients who do not show up for or cancel an appointment.

In addition to:

1. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges (unless out of network benefits are being used).

2. I understand that the therapy session will last 45 minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time.

By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

Thank you for your consideration regarding this important matter.

**Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Teletherapy Consent Form**

**Definition of Services:** I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to engage in teletherapy with ***Nicole Peluso, MA, LPC, NCC, CCTP.****.* Teletherapy is a form of psychological service that is provided via internet technology, which can include consultation, psychotherapy sessions, transfer of medical data if necessary, emails between client and therapist, telephone conversations, video, or data communications.

I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually, if applicable. Teletherapy has the same purpose as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face sessions.

I understand that I have the following rights with respect to teletherapy:

**Client’s Rights, Risks, and Responsibilities:**

1. I, the client, needs to be a resident of New Jersey. This is a legal requirement for licensed professional counselors counseling in New Jersey. **Please note: with COVID, laws and regulations have temporarily broadened teletherapy services to other states. This is subject to change in the future.**

2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care.

3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received.

4. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

5. There is a risk that services could be disrupted or distorted by unforeseen technical problems. If there are technical difficulties, I will be contacted via telephone by my therapist to continue session.

6. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services.

7. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in future, my therapist will recommend more appropriate services.

8. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychological treatment provider to do the same on their end.

9. Photography, Recording, or Screen Captures: You are asked to not record or capture your sessions (e.g., audio/video recording, screenshots, or photos) in any way without written consent of my therapist.

10. (If applicable) Insurance Coverage for Telehealth: You are responsible for verifying your insurance coverage for telehealth services and informing your therapist of any necessary authorizations. Any services not covered are the client’s financial responsibility.

11. Email/text/phone contacts between sessions should be used for scheduling and brief questions only. Please send all email to empoweredhealingllc@gmail.com for secure communication.

**I have read, understand and agree to the information provided above regarding telehealth:**

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

**Informed consent for in-person services during covid-19 public health crisis**

This document contains important information about our decision to resume/begin in-person therapy in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

**Decision to Meet Face-to-Face** We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone’s well-being. If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate.

**Risks of Opting for In-Person Services** You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

**Your Responsibility to Minimize Your Exposure** To obtain services in person, you agree to take certain precautions which will help keep everyone safe from exposure, sickness. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement.

Initial each to indicate that you understand and agree to these actions:

You will only keep your in-person appointment if you are symptom free. If you had COVID-19, I will need clearance / note / results confirming you are negative. \_\_\_

If you suspect you may have COVID-19, we will cancel scheduled sessions and I will need clearance / note / results confirming you are negative before we continue in-person sessions. \_\_\_

You will wash your hands or use alcohol-based hand sanitizer when you enter the office. \_\_\_

You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands). \_\_\_

You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. \_\_\_

You will take steps between appointments to minimize your exposure to COVID. \_\_\_

 If you are exposed to other people who are infected, you will immediately let me know and we will resume teletherapy. \_\_\_

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

**My Commitment to Minimize Exposure**

I have taken steps to reduce the risk of spreading the coronavirus within the office. Please let me know if you have questions about these efforts.

**Office Safety Precautions in Effect** I am taking the following precautions to protect my clients and help slow the spread of the coronavirus. Office seating in the waiting room and in the office has been arranged for appropriate physical distancing. I will wear a mask. I will maintain safe distancing at 6ft. Restroom soap dispensers are maintained and everyone is encouraged to wash their hands. Hand sanitizer that contains at least 60% alcohol is available in the office. Physical contact is not permitted. Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis. Common areas are thoroughly disinfected at the end of each day. I will disinfect in between sessions.

**If You or I Are Sick**

You understand that I am committed to keeping you, me, and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office. We can follow up with services by telehealth as appropriate. If I test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

**Intake Form**

*Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.*

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(First) (Last) (Middle Initial)**

Name of parent/guardian (if under 18 years):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(First) (Last) (Middle Initial)**

**Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birth Date: \_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_**

**Sex at birth:** □ **Male** □ **Female**

**Sexual Orientation:** □ **Heterosexual** □ **Bisexual** □ **Gay** □ **Lesbian** □ **Asexual**  □ **Transgender** □ **Questioning**

□ **Prefer not to answer** □ **Other**

**Preferred Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status:** □ **Never Married** □ **Partnership** □ **Married**  □ **Separated** □ **Divorced** □ **Widowed**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Street and Number)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(City) (State) (Zip)**

**Cell/Other Phone: ( ) May I leave a message?** □**Yes** □**No**

**E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I email you?** □**Yes** □**No**

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

If there is an emergency during our session, or I become concerned about your safety, I am required by law and by the rules of my profession to contact someone close to you (i.e. relative, spouse, close friend). I am also required to contact this person, or the authorities, if I become concerned about you harming someone else.

Please write down the name and contact information for your emergency contact person.

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(First) (Last) (Middle Initial)**

**Cell/Other Phone: ( ) Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you previously received any type of mental health services (psychotherapy, psychiatric services, hospitalization, etc.)?**

□ **No**

□ **Yes, previous therapist/practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently taking any prescribed psychiatric medication?**

□ **Yes**

□ **No**

**Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Are you currently experiencing suicidal thoughts?**

□ **Yes**

□ **No**

**If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Are you currently experiencing homicidal thoughts?**

□ **Yes**

□ **No**

**If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Are you currently engaging in self-harm behaviors?**

□ **Yes**

□ **No**

**If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**GENERAL HEALTH AND MENTAL HEALTH INFORMATION**

**1.** **How would you rate your current physical health? (Please circle)**

 **Poor Unsatisfactory Satisfactory Good Very good**

**Please list any specific health problems you are currently experiencing:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. How would you rate your current sleeping habits? (Please circle)**

 **Poor Unsatisfactory Satisfactory Good Very good**

**Please list any specific sleep problems you are currently experiencing:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. How many times per week do you generally exercise? \_\_\_\_\_\_\_\_\_\_**

**4. Please list any difficulties you experience with your appetite or eating patterns.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5. Are you currently experiencing overwhelming sadness, grief or depression?**

□ **No**

□ **Yes**

If yes, for approximately how long? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**6. Are you currently experiencing anxiety, panic attacks or have any phobias?**

□ **No**

□ **Yes**

If yes, when did you begin experiencing this? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**7. Are you currently experiencing any chronic pain?**

□ **No**

□ **Yes**

If yes, please describe? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**8.** **Do you drink alcohol more than once a week?** □ **No** □ **Yes**

**9. How often do you engage recreational drug use?**

□ **Daily** □ **Weekly** □ **Monthly** □ **Infrequently** □ **Never**

**10. Do you have a history of alcohol / drug use?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**11. What significant life changes or stressful events have you experienced recently?**

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**FAMILY MENTAL HEALTH HISTORY**

*In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (father, grandmother, uncle, etc.).*

**Please Circle List Family Member**

Alcohol/Substance Abuse yes/no

Anxiety yes/no

Depression yes/no

Domestic Violence yes/no

Eating Disorders yes/no

Obesity yes/no

Obsessive Compulsive Behavior yes/no

Schizophrenia yes/no

Suicide Attempts yes/no\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL INFORMATION**

**1. Are you currently employed?** □ **No** □ **Yes**

If yes, what is your current employment situation?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. Do you consider yourself to be spiritual or religious?** □ **No** □ **Yes**

If yes, describe your faith or belief:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guardian Signature:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:**   **\_\_\_\_\_\_\_\_\_**

**Boundaries**

In therapy, you and I will work together on how to set boundaries with others! However, it is also important to practice honoring boundaries that others may set for themselves!

**Here are some boundaries that are important to me:**

* Last minute rescheduling ***may*** result in waiting until the next week to schedule a session due to full bookings.
* Last minute cancelling ***will*** result in your session fee of $150.00.
	+ A charge will be sent via how you pay for sessions.
* No show / no cancellation ***will*** result in your session fee of $150.00.
	+ A charge will be sent via how you pay for sessions.
* My business hours are:
	+ Monday – Thursday, 9am-7pm (7pm last session scheduled)
	+ Friday, 9am-5pm (5pm last session scheduled)
	+ Saturday & Sunday = ***closed***
* Emailing and texting are to be used ***only*** to schedule, reschedule, cancel, or ask questions regarding session/therapy.
	+ Emails are ***not*** monitored on the weekends.
	+ Emails, texting, and Instagram are ***not*** to be utilized for venting or therapy.
* Due to confidentiality and ethical reasons, I cannot befriend you back on Instagram or any social media platform.
* I will get back to you within the same day of you reaching out to me during the hours I am available and open.
	+ I will not be available on the days that my business is closed.
	+ I will not be available late at night.
	+ If there is an emergency, please contact these hotlines or in emergent situations, call 911 or go to the nearest emergency room:
		- Hotlines are ***free***, ***confidential,*** and available ***24/7:***
			* National Suicide Prevention: 1-800-273-8255
			* NJ Hopeline: 1-855-654-6735
			* The Trevor Project: 1-866-488-7386
			* RAINN: 1-800-656-4673
			* National Domestic Violence Hotline: 1-800-799-7233
			* Crisis Text Line: Text HOME to 741741

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paperwork complete, thank you!