PHILIP LANE, MSW, LCSW

PL Therapy, LLC
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Client Intake Form

Name:____

Home Address:____

____

Phone Number:____

Email Address:____

Date of Birth:____

Sex:______________ Marital Status:_____________________________

Emergency Contact:____

Reason for Seeking Therapy:____

____

____

____

Please circle one: **I have** / **have not** had therapy in the past.

I do / **do not** take psychiatric medications. If yes, please list:

____

I hereby certify that I have read this therapist's disclosure agreement as well as all other documents provided. I understand the contents of these documents and agree to the terms set forth therein.

Client Signature:____ Date:___________________

Payment Agreement

Payment for psychotherapy sessions is due at time of services. Payment may be rendered via cash, personal check, or electronic payment method such as Venmo, PayPal, or Zelle. A receipt can be provided upon request. Non-payment will result in report to a credit agency. If you are paying through a sliding scale agreement, your signature below confirms your agreement to the payment amount negotiated. If you are unable to keep a scheduled appointment, please make notice at least 24 hours prior to your appointment, otherwise you may be subject to a cancellation fee of $25.00.

I, ____, agree the terms above.
Client Name

Client Signature:____ Date:_________________

Clinician Signature:_______________________________________ Date:__________________

Confirmation of Receipt of HIPPA Notice of Privacy Practices

Your signature below confirms that you have been given a copy of the Notice of Privacy Practices, explaining your rights regarding your medical records under HIPPA (Health Information Portability Act). Please feel free to inquire about any questions you might have regarding these rights.

Client Signature:____ Date:_______________________

Print Client Name:_______________________________________

NOTICE OF PRIVACY PRACTICES AND CLIENTS' RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective 3/16/2022, information related to your private medical information will be released only in accordance with state and federal laws and the ethics of the social work profession.

Use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

Treatment: Your health information may be used and disclosed in order to provide, manage, or coordinate care with consultants and/or referral sources.

Payment: Your health information may be used and disclosed in order to verify insurance and coverage and to process claims and collect fees.

Healthcare Operations: Your health information may be used and disclosed in order to review treatment procedures, review business activities, provide staff training, and comply with licensing activities.

Other Uses and Disclosures Without Your Consent: Your health information may be used and disclosed in the case of mandated reporting, emergencies, criminal damage, appointment scheduling, treatment alternatives, and as required by law.

Client Rights:
You have a right to request where we contact you.

You have a right to release your medical records as well as a right to revoke release in writing.

You have a right to inspect and copy your medical billing records.

You have a right to add information or amend your medical records.

You have a right to accounting of disclosures with the exception of disclosure for treatment, payment or healthcare operations, disclosures pursuant to a signed release, disclosure made to client, disclosures for national security or law enforcement.

You have a right to request restrictions on uses and disclosures of your healthcare information in writing.

You have a right to grievance. Please contact me first and, if not satisfied, contact the U.S. Dept. of Health and Human Services. You have the right to not be retaliated against for filing a grievance.

You have a right to receive changes in policy.

My signature below indicates that I understand and accept the above:

Client Signature:____ Date:_____________

Clinician Signature:____ Date:_____________

Telemental Health Informed Consent

Please fill out if utilizing teletherapy.

I, ___________________________________(name of client) hereby consent to participate in telemental health as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical healthcare services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

-We will use a secure platform for our telemental health sessions in order to maintain privacy and confidentiality.

-I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

-There are risks and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and or breaches of confidentiality by unauthorized persons, and or limited ability to respond to emergency situations.

-There will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

-If I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis, that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

-If technical difficulties occur, resulting in service interruptions, and we are unable to reconnect within ten minutes, please call your therapist on the cell number provided since we may have to reschedule.

-My therapist, as a mandated reporter, may need to contact the appropriate authorities in the case of an emergency.

Client Signature:____ Date:__________________