

# Talk Therapy 2 Me, LLC.

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## **CLIENT INTAKE FORM AND CONSENT TO TREAT**

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

The questions below are designed for me to get to know your perspective, current state and vision so that I can be the catalyst to support you in a positive and holistic therapeutic approach. I look forward to helping you co-create the life you desire and join you in your healing journey by peeling away layers, uncovering, and discovering.

### **DEMOGRAPHICS:**

Name:	Address:	Phone# (home, cell, work)

Date of Birth:	Gender:	Marital Status:	Race:

Children's Name and Ages:	Spouse (if applicable)

Occupation:	Monthly Income
	\$

Email Address:	SSN

Emergency Contact Name	Phone #	Relationship

Primary Care Physician Name and Phone #	Medications

Educational Level:	Spirituality/Religion

How did you hear about my services? \_\_\_\_\_

**GOALS:**

1. What are the biggest changes you want to make in your life? \_\_\_\_\_  
\_\_\_\_\_.
2. What one thing do you want more of in your life right now? \_\_\_\_\_  
\_\_\_\_\_.
3. What one thing do you want less of in your life right now? \_\_\_\_\_  
\_\_\_\_\_.

**BACKGROUND:**

1. What are your primary stressors? (What stresses you out?)


2. Level of stress currently from 1-10 (1=low, 10=high) \_\_\_\_\_

3. Describe yourself: (energetic, assertive, personable, hot tempered, etc.)


4. Interest and Hobbies:

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5. Prior Counseling and when? \_\_\_\_\_

6. Rate your current quality of health:

**Physical:** \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Neutral \_\_\_\_\_ Poor \_\_\_\_\_ of Serious Concern  
**Mental:** \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Neutral \_\_\_\_\_ Poor \_\_\_\_\_ of Serious Concern  
**Emotional:** \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Neutral \_\_\_\_\_ Poor \_\_\_\_\_ of Serious Concern  
**Relational:** \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Neutral \_\_\_\_\_ Poor \_\_\_\_\_ of Serious Concern  
**Social:** \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Neutral \_\_\_\_\_ Poor \_\_\_\_\_ of Serious Concern  
**Spiritual:** \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Neutral \_\_\_\_\_ Poor \_\_\_\_\_ of Serious Concern  
**Financial:** \_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Neutral \_\_\_\_\_ Poor \_\_\_\_\_ of Serious Concern

7. Why are you seeking counseling? (check all that apply)

Career Counseling	Personal development:	Personal Finances:
Seeking Balance:	Relationship building:	Seeking Self-care:
Spirituality:	Finding purpose:	Goal Setting:
Self-discovery:	Parenting:	Anger Management:
Mood:	Substance Use/Abuse:	Anxiety:
Depression:	Legal/Mandated:	Suicidal Ideation:
Sleep Disturbance:	Couples Counseling:	Trauma:
Family Counseling:	Other: (specify)	

## **CONSENT TO TREATMENT:**

I (print name) \_\_\_\_\_ grant permission for psychotherapy services for myself/my relationship/my family. I understand that my therapist is committed to applicable ethical codes and subject to State and Federal Laws.

I agree to an hourly (45-50 minutes) fee of \$\_\_\_\_\_ which is my personal responsibility to pay. The fee is payable by Cash, Ivy Pay, Venmo, or Cashapp: \$talktherapy2me and payable before each session. Missing or rescheduling sessions is strongly discouraged.

Responsible Party who will be paying the per session fee for services \_\_\_\_\_  
(leave blank if same as the client).

\_\_\_\_\_(initials here) 24 hour notice is required for cancellations with a surcharge of \$50 and I understand that I am responsible for the full fee if I fail to cancel within 24 hours of my scheduled session.

\_\_\_\_\_(initials here) I understand that if I have not made or kept an appointment for 4 weeks or longer, even without explicit notice of termination, therapy will be considered inactive and terminated. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By providing my initials above, I agree to the stated terms and stipulations regarding the services I receive from this therapist.

### Insurance Information

<b>Employer:</b>	<b>Employer address:</b>
<b>Primary Insurance:</b>	<b>Policy Holder Name:</b>
<b>ID#:</b>	<b>Policyholder Date of Birth:</b>
<b>Authorization #:</b>	<b>Policy/Group #:</b>
<b>Client Name:</b>	<b>Relationship to Client:</b>

## Electronic Communication Policy

Neither regular email nor texting is a secure form of communication, and your privacy cannot be guaranteed. If you choose to use email, ensure you are using a secure, encrypted HIPAA compliant email service. Your email records will be retained and may be considered part of your medical record for legal purposes. It is appropriate to communicate via email for making or changing appointments and for occasional, brief questions between sessions. If cancelling an appointment with short notice, please call (813) 699-0074 and leave a voicemail.

Email should not be used for emergencies. If it is a life-threatening emergency, call 911 or go to a hospital emergency room.

### Please initial one of the options below:

\_\_\_\_\_ YES, I want to communicate with my therapist electronically through the secure, encrypted HIPAA compliant email service.

Client e-mail:

\_\_\_\_\_

\_\_\_\_\_ I am willing to communicate regarding appointment setting ONLY at the following email address: \_\_\_\_\_

\_\_\_\_\_ NO, I do not want to communicate with my therapist electronically.

It is our policy to protect the effectiveness of the therapeutic relationship by refraining from outside social (dual) relationships including electronic forms such as:

- Facebook
- Linked-in
- Any social networking site
- Online chatting

YOUR SIGNATURE BELOW INDICATES THAT YOU UNDERSTAND AND AGREE TO ALL THE ABOVE TERMS AND CONDITIONS.

\_\_\_\_\_  
Client or Legal Guardian Signature

\_\_\_\_\_  
Date

## Permission to Video/Audio Tape Counseling Sessions

To continue to improve my counseling skills, and obtain assistance when working with you, I would like to record our sessions. If you are comfortable with this, I need your written permission. Our work in counseling will not be affected by whether you consent and you are free to say no. If at any time you change your mind, we can stop the recording.

I give my Therapist permission to record our counseling sessions for the following use(s). Circle the adjacent number and initial the option(s) agreeable to you.

- 1) For my Therapist to review outside of sessions\_\_\_\_\_
- 2) For myself to review our sessions\_\_\_\_\_
- 3) For my Therapist's use in meeting with a supervisor or peer consultant\_\_\_\_\_
- 4) For my Therapists' use in supervision groups that include several other therapists\_\_\_\_\_
- 5) For my Therapist's use in teaching or professional training workshops\_\_\_\_\_
- 6) For research purposes\_\_\_\_\_
- 7) All of the above\_\_\_\_\_

I understand that my confidentiality will be protected at all times. If a supervisor, peer consultant, supervisee, or researcher knows me in any way whatsoever, they will not view or listen to the recording and will keep my confidentiality as per standard professional guidelines. I need only to ask to receive a copy of any sessions which have been recorded.

Client: \_\_\_\_\_  
(print)

Client: \_\_\_\_\_  
(signature)

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