**CLIENT INTAKE FORM pg 1 of 12**

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

**Who referred you to us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we thank them? Y\_\_\_ N\_\_\_**

|  |  |
| --- | --- |
|  | **SELF** |
| **NAME** |  |
| **DOB** |  |
| **SSN** |  |
| **PHONE(S)** |  |
| **EMAIL** |  |
| **ADDRESS** |  |
| **EMPLOYER/OCCUPATION** |  |
| **EMERGENCY CONTACT NAME/NUMBER** |  |

Please describe why you are coming to therapy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What has already been done to address this?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to accomplish by coming in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Indicate on the scale how intense this problem is for you currently?

 Not At All Moderately Extremely

 **CLIENT INTAKE FORM pg 2 of 12**

 **FAMILY INFORMATION**

**IMMEDIATE FAMILY**

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** | **AGE** |  **SEX** | **RELATIONSHIP** |
|  |  |  |  |
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 **(Include yourself/yourselves & children below.)**

Have you ever placed a child for adoption? \_\_Y \_\_N If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a miscarriage or medical abortion? \_\_Y \_\_N

**FAMILY OF ORIGIN**

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** | **AGE** |  **SEX** | **RELATIONSHIP** |
|  |  |  |  |
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 **(List mother, father, siblings, step family)**

With whom do you currently live: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **CLIENT INTAKE FORM pg 3 of 12**

 **MEDICAL & PSYCHOTHERAPY HISTORY**

**Family Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you or anyone in your family is presently seeing a specialist (urologist, allergist, etc.), please provide the following information (use back of page if needed):

Specialist Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you or anyone in your family have been in therapy or counseling before, please list below:

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** | **WHEN** | **WITH WHOM?** | **WHAT FOR?** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Have you ever been hospitalized for psychiatric reasons? Y\_\_\_ N\_\_\_. Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please describe.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you or anyone in your family currently on medication? Y\_\_\_ N\_\_\_ If yes, list below

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NAME** | **MEDICATION** | **WHAT FOR?**  | **DOSAGE** | **PRESCRIBER** |
|  |  |  |  |  |
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|  |  |  |  |  |
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| --- | --- | --- | --- | --- | --- |
|  | **Abortion** |  | **Financial Troubles** |  | **Self-Esteem** |
|  | **Abuse – Emotional** |  | **Friendship Problems** |  | **Self Injury**  |
|  | **Abuse – Physical** |  | **Gambling** |  | **Sexual Abuse/Assault** |
|  | **Abuse – Verbal** |  | **Gender Identity** |  | **Sexual Arousal** |
|  | **Adoption** |  | **Grief** |  | **Sexual Compulsive Behaviors** |
|  | **Alcohol Use/Misuse** |  | **Guilt** |  | **Sexual Desire Differences** |
|  | **Anger** |  | **Health Concerns** |  | **Sexual Orientation** |
|  | **Anxiety/Nervousness** |  | **Hostility** |  | **Sexual Pain or Discomfort** |
|  | **Apathy** |  | **Impulsiveness** |  | **Sexual Performance** |
|  | **Career concerns** |  | **Infidelity/Cheating** |  | **Shyness** |
|  | **Childhood issues** |  | **Irritability** |  | **Sleep** |
|  | **Children/Family Planning** |  | **Lacking Love & Affection** |  | **Smoking/Tobacco Use** |
|  | **Concentration** |  | **Laziness** |  | **Spirituality** |
|  | **Communication** |  | **Legal Matters** |  | **Stress** |
|  | **Crying** |  | **Loneliness** |  | **Suicidal Thoughts, Plan or Intent** |
|  | **Debt** |  | **Loss of Interest in Activities** |  | **Temper Problems** |
|  | **Dependence** |  | **Loss of Interest in Sex** |  | **Terminal Illness** |
|  | **Depression** |  | **Mood Swings** |  | **Trauma** |
|  | **Disaster** |  | **Motivation** |  | **Violence or Threats of Violence** |
|  | **Divorce/Separation** |  | **Nightmares** |  | **Weight/Body Image** |
|  | **Domestic Violence** |  | **Obsessions/Compulsions** |  | **Work Issues** |
|  | **Drug Use/Misuse** |  | **Orgasm Issues** |  | **Other concerns or issues:** |
|  | **Eating Concerns** |  | **Panic or Anxiety Attacks** |  |  |
|  | **Education/School** |  | **Pornography Use** |  |  |
|  | **Fatigue**  |  | **Recent Loss** |  |  |
|  | **Fears or Phobias** |  | **Relationship Problems** |  |  |
|  |  |  |  |  |  |

 **CLIENT INTAKE FORM pg 4 of 12**

Please initial additional concerns:

**GENERAL INFORMATION AND CONSENT FOR THERAPY pg 5 of 12**

***for Amy Sander Montanez, D.Min., LPC, LMFT***

**DBA: Personal and Family Growth Associates, Inc.**

For best results and your own welfare, it is important that you understand what it means to be in psychotherapy. Please read the brief description below. If you have any questions or concerns, you are urged to talk about them. If you understand it and you chose to be in psychotherapy as described here, **INITIAL** each point and sign and date this form. Your signature represents an agreement between us.

1. Psychotherapy is a special kind of health care service. The goals of psychotherapy are to help you better understand yourself and others, to help you solve problems that may be limiting your life satisfaction, and to help you better cope with the feelings and challenges that you encounter in your daily life. **\_\_\_\_I understand.**

2. The most common form of psychotherapy involves your talking about your feelings, your problems or concerns, and your experience of yourself and your situation. Other common methods involve using your imagination, keeping personal records of your experiences, and trying new or different ways of thinking, acting, or feeling. These methods may be used within treatment sessions or you may be asked to do them at home. **\_\_\_\_ I understand.**

3. To better understand you, many psychotherapists use a variety of tests or measures of your current abilities and styles of experiencing. These measures are important in choosing the treatment methods best suited to you, and they are also helpful in estimating your progress. **\_\_\_\_I understand.**

4. The length of psychotherapy often depends upon your individual needs and the rate of your progress. Many therapists use periodic reviews as a means of evaluating your needs, progress, and satisfaction. **\_\_\_\_ I understand.**

5. Most people benefit from psychotherapy. The most common benefits include improvements in self-awareness, self-esteem, self-confidence, hope, feeling understood, relationships with other people, emotional expressiveness, and taking an active and responsible role in one’s life. There are also some risks to being in psychotherapy. The most common risks are temporary periods of emotional distress related to changes in your life situation and your relationship with yourself and others (including your therapist). Psychological damage caused by psychotherapy is rare, but you should be aware that it could happen. The most common causes of such damage are poor communication or unethical conduct. If you feel that you are not making reasonable progress or that you are being harmed by your involvement in psychotherapy, you should discuss this with your therapist. If you feel that your therapist has attempted to violate you in any way -- financially, physically, sexually, or otherwise -- you should so inform the state agency responsible for professional licensing.

 **\_\_\_\_ I understand.**

6. You always have the right to choose whether or not to continue in psychotherapy. If you feel that you might work better with a different therapist, your present therapist should be able to offer you information on possible referrals. Local mental health agencies are listed in the phone book and they may also offer helpful information. The most common alternatives to psychotherapy are self-help and support groups, bibliotherapy (therapeutic reading), and different forms of religious counseling**.**

 **\_\_\_\_ I understand.**

7. The information communicated in therapy must be kept confidential by your therapist unless you grant permission to release it. The only exceptions to this protection of your privacy are dictated by state laws. **\_\_\_\_ I understand.**

**GENERAL INFORMATION AND CONSENT FOR THERAPY pg 6 of 12**

***for Amy Sander Montanez, D.Min., LPC, LMFT***

**DBA: Personal and Family Growth Associates, Inc.**

 **Confidential information may be released WITHOUT your permission if:**

 You threaten to harm yourself or someone else and your threat is believed to be serious your therapist is ethically and in some instances legally obligated to take whatever action seem necessary to protect you or others from harm.

1. There is suspected child abuse or neglect. Therapists are obligated by law to report this to the appropriate state agency. This law also applies if you report that you have reason to believe another person is abusing or neglecting a child.
* You are in court-ordered therapy and the court wishes to receive some type of report or evaluation.
1. You are involved in litigation of any kind and inform the court of the services you receive here (MAKING YOUR MENTAL HEALTH AN ISSUE BEFORE THE COURT), you may be waiving your right to keep your records confidential.
2. You lodge a formal complaint against me or make me a party to a legal action.
3. You use insurance to reimburse for fees (please see Release of information Form for Insurance Purposes).
4. You do not pay your bill and billing information is forwarded to a collection agent.

8. Our “no secrets policy” is intended to inform you that when working with a couple or family, the couple or the family is the “client.” Any information learned while treating any individual member of the couple or family may be deemed relevant or even essential to the treatment of the “client” and may be shared.

 **\_\_\_\_ I understand.**

9. I understand that my therapeutic relationship is with **Amy Sander Montanez, DBA: Personal and**

**Growth Associates, Inc.** Although the location is at 1703 Richland Street and other independent therapists practice at this location, I agree to hold harmless any other service provider at this location.

**\_\_\_\_ I understand.**

10. On occasion, a client will request that I release client record information under circumstances that I feel may be harmful to them. Confidentiality laws do not allow me to do so without a court order. This will also apply to a personal request from you or your attorney. **\_\_\_\_ I understand.**

Your signature below indicates that you have read and understood the above description of psychotherapy. Your signature also indicates that you are now consenting to be in psychotherapy with the understanding that you retain the right to review and revise this decision at later points in time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature Date**

South Carolina provides the consumer the opportunity to file inquiries with its Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists. Board offices may be reached at: **South Carolina Board of Examiners, P.O. Box 11329, Columbia, SC 29211-1329.**

 **POLICY, FEES, PAYMENT, INSURANCE AND SCHEDULING pg 7 of 12**

***for Amy Sander Montanez, D.Min., LPC, LMFT***

***DBA: Personal and Family Growth Associates, Inc.***

The fee for a 50-55 minute session is $150.00 unless your therapist indicates otherwise. Please plan to pay the full fee after each session unless otherwise arranged in advance. You will not be billed. However, a copy of your charges and payment record will be made available upon your request. You may pay with credit card, cash or check made out to your therapist (or the business name). If you pay by check, your check will be deposited into your therapist’s account and by nature of its traveling to the bank and being handled by bank professionals, confidentiality cannot be guaranteed. If you are paying by a credit card left on file, you will be notified before a transaction is made.

Your appointment time is reserved for you alone. Without sufficient prior notice, it cannot be given to anyone else. **You will be charged the full fee for any missed appointments unless you provide cancellation notice 24 hours in advance or advise us in the event of an emergency.** Appointments will be scheduled after sessions or you can call the office at 803-254-5650, and leave a message for your therapist.

Most therapists do not charge for brief telephone contacts; however, you will be charged for telephone sessions, written evaluations, official letters, court appearances, or meetings with collateral contacts.

We do not file with insurance companies but will be glad to provide whatever information your particular plan requires so that you may file for reimbursement. Companies often require that a diagnosis be assigned before they will pay. If you find that this is necessary with your plan, you will be advised of a diagnosis code for insurance purposes.

Insurance companies and policies differ greatly in their choices of what types of providers and mental services are covered. There are sometimes confusing and seemingly arbitrary restrictions on reimbursements. With your permission, your therapist will attempt to provide to you whatever documentation of your services your company requires. If you are relying on your coverage to pay for therapy, you should get direct confirmation from the insurance company that they will pay out-of-network mental health benefits and what percentage they will reimburse. **You are responsible for the full fee at time of service. \*\*Please be aware that using insurance to cover mental health fees is an automatic agreement to Release of Information to your insurance company.**

I have read “Policy, Fees, Payment, Insurance, and Scheduling” and understand my responsibilities as stated. I understand that I am responsible for payment whether or not my health insurance covers treatment.

Further, I understand that although the location of service is at Wholistic Therapy and Coaching Center of the Midlands, this is not the service provider and I agree to hold harmless any other service provider at this location.

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Person responsible for payment if different:**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

 Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **General Consent for Communication Guidelines pg 8 of 12**

***for Amy Sander Montanez, D.Min., LPC, LMFT***

**DBA: Personal and Family Growth Associates, Inc.**

***Because the nature of communications and technology continues to evolve, it is important that we are clear about how we will and will not communicate with each other outside of the therapy hour.***

Please **initial** all statements below*.*

**THERAPY:**

**Phone Sessions:**

I am only able to conduct therapy sessions via phone in states where I am licensed, which currently is only in South Carolina. Before I conduct phone sessions with you, you must call your insurance (if you are filing) to get approval for telephone sessions. My general rule is that all therapy is done in person unless we have a clear contract that indicates we will talk on the phone. I understand: yes\_\_\_\_\_\_

**Skype Sessions:**

Skype or other video telecommunication methods such as Face Time are not considered a confidential form of therapy. Therefore I do not conduct therapy session via the Internet.

I understand: yes\_\_\_\_\_

**Texting:**

Our office uses landlines for the sake of your security and confidentiality. We do not use texting as a form of therapeutic communication. I understand: yes\_\_\_\_\_

**Email:**

Our email is encrypted. Email is not to be used to communicate emergency or therapeutic information. If you do send information via email, know that it is confidential within our office. However, all communication via the Internet is not considered secure and also becomes a part of your permanent file.

I understand: yes \_\_\_\_\_

**COMMUNICATIONS**:

May our office manager and I call you **at home**? yes \_\_\_\_\_ no \_\_\_\_

May we leave a message at this number? yes \_\_\_\_\_ no \_\_\_\_\_

**General Consent for Communication Guidelines pg 9 of 12**

***for Amy Sander Montanez, D.Min., LPC, LMFT***

**DBA: Personal and Family Growth Associates, Inc.**

**COMMUNICATIONS continued**:

May our office manager and I call you **at work**? yes \_\_\_\_\_ no \_\_\_\_\_\_

May we leave a message at this number? yes \_\_\_\_\_ no \_\_\_\_\_

May our office manager and I call you on your **cell phone**? yes \_\_\_\_\_ no\_\_\_\_

May we leave a message at this number? yes \_\_\_\_\_ no \_\_\_\_\_

May I email you to schedule appointments and send you reminders? yes \_\_\_\_\_\_ no \_\_\_\_\_\_

Would you prefer to be emailed rather than called to schedule appointments and for reminders of scheduled appointment? yes \_\_\_\_\_\_\_ no \_\_\_\_\_\_\_

Please note that if I call you after hours on my cell phone, I cannot guarantee that the phone line is secure and confidential. The same is true if you call me on your cell phone at my office.

I understand: yes\_\_\_\_\_\_

If the location service is engaged on my smart phone, it may identify my location on social media:

 I understand: yes\_\_\_\_\_

**Facebook**:

I will not accept Facebook Friend Requests from you or send them to you while you are an active client. Wholistic Therapy and Coaching Center and I have professional Facebook pages. Please use our pages for your own education. As you know, if you “like” our pages or comment or leave a review, your name may show up on our pages. I understand: yes \_\_\_\_\_

**Newsletter:**

Dr. Montanez periodically sends out a newsletter called *Connections* through MailChimp. It provides useful information about what she is doing and what’s happening with the Wholistic Therapy and Coaching Center and the community. May we add you to our list? yes \_\_\_ no \_\_\_

**I have read and understand the above guidelines for communication and consent to follow them:**

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

 **General Consent for Telemental Health Communication pg 10 of 12**

***for Amy Sander Montanez, D.Min., LPC, LMFT***

**DBA: Personal and Family Growth Associates, Inc.**

***Because the nature of communications and technology continues to evolve, it is important that we are clear about how we will and will not communicate with each other outside of the therapy hour.***

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (name of client) hereby consent to participate in telemental health with Amy Montanez as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care 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:

1. I understand that 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.

2. I understand that there are risk 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 emergencies.

3. I understand that 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.

4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5. I understand that 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.

6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at \_\_\_\_\_\_\_\_\_\_\_\_\_\_***(phone number)*** to discuss since we may have to re-schedule.

7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

**Emergency Protocols:** I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

**In case of an emergency, my location is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**and my emergency contact person’s name, address, phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**I have read and understand the above guidelines for communication and consent to follow them:**

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

**NO SURPRISES ACT**

 **GOOD FAITH ESTIMATE pg 11 of 12**

**PROVIDER:**

***Amy Sander Montanez, D.Min., LPC, LMFT***

***DBA: Personal and Family Growth Associates, Inc.***

***1703 Richland Street, Columbia, SC 29201***

***LPC # 613, LMFT # 1306***

***Tax ID # 57-0892959 NPI # 1467598714***

**PATIENT:**

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

**DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

As an uninsured or self-pay client, you are entitled to receive this Good Faith Estimate of what the charges could be for psychotherapy services provided to you. **The fee for every 50-55 minute session (whether in-person or via telehealth) is $150.00.** While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend and your individual circumstances. This estimate is not a contract and does not obligate you to obtain any services from this provider. All of this information is also in your in-take package on the Policy, Fees, Payment, Insurance & Scheduling form.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

If you receive a bill that is at least $400 more than this Good Faith Estimate, you have a right to initiate a dispute resolution process. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **NOTICE OF PRIVACY PRACTICES pg 12 of 12**

**This Notice Describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.**

 The Health Insurance Portability & Accountability Act of 1996 (HIP AA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIP AA provides penalties for covered entities that misuse personal health information. As required by HIP AA, we have prepared this explanation of I how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

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| ***Treatment*** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy.***Payment*** means such activities as obtaining reimbursement for services confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.***Health Care Operations*** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.In addition, your confidential information may be used to remind you of an appointment (by phone, email or mail) or provide you with information about treatment options or other health related services. We will use and disclose your PROTECTED HEALTH INFORMATION (PHI) when we are required to do so by federal, state or local law. We may disclose your PHI to public health authorities that are authorized by law to  | collect information: to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made anEffort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PHI when serious threat to your health and safety or the heath and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request except to the extent that we have already take actions relying on your authorization.  | You have certain rights in regards to your PHI, which you can exercise by presenting a written request to our office at the address below.You have the right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relative, close personal friend, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.You have the right to request to receive confidential communications of PHI from us by alterative means or at alternative locations.You have the right to request an amendment to your PHI. You have the right to obtain a paper copy of this notice for us upon request. We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. |

 Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a claim.

For more information about HIPAA or to file a complaint: US Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, S.W.

Washington, DC 20201 Toll free 877-696-6775.

***Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***