CLEMSON CREATIVE COUNSELING

Client Intake Form

(Please print)

Date: _____ Referred by_____ May we thank them for the referral? Yes ____ No ____

Identification

Name: _____ Date of Birth: _____ Age: _____

Marital status: _____ Male____Female ____ If client is a minor, resides with: Father_____ Mother_____Both _____

Address: _____

City:_____State:_____Zip: _____

Contact Information

Ok to leave a message?

Home Phone: _____ Yes____No ____

Work Phone: _____ Yes____No ____

Cell Phone: _____ Yes____No ____

Email: _____ Yes____No ____

Responsible Party *(Person responsible for payment if different from above)*

Name:_____Relationship: _____

Address: _____

City:_____State:_____Zip: _____

Marital History

Spouse's Name	Years Married	Relational Issues?

Children

Name	Age	Gender	School & Grade	Behavioral or Adjustment Problems?	Quality of Relationship

Client:_____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Address: _____

Note: This will only be used in the event of a medical or psychological emergency in our offices.

Medical Care

Please list all Physicians you see regularly

_____	_____	_____
Name	Phone	Reason
_____	_____	_____
Name	Phone	Reason

Medication:_____Dosage:_____Reason:_____Date Started: _____

Medication:_____Dosage:_____Reason:_____Date Started: _____

Serious accidents, illnesses, or hospitalizations (please list):

_____	_____
Incident	Year
_____	_____
Incident	Year

Health Issues

Appetite: Good____Average_____Poor ____

Sleep: Good____Average____Poor ____

Alcohol:_____drink(s) per _____

Tobacco: Yes____No ____

Recreational Drugs: Yes____No ____

High Blood Pressure: Yes____No ____

Thyroid problems: Yes____No ____

Diabetes: Yes____No ____

Any current medical problems? (Please list) _____

Employment

Current Occupation: _____

How long? _____ Any issues with work? _____

Previous Occupation(s):_____

How long? _____ Any issues with work? _____

Client:_____

Family of Origin

Relative	Name	Age	Illness?	Education	Occupation	Quality of Relationship
Father						
Mother						
Step-Father						
Step-Mother						
Sibling						
Sibling						

Reasons for Seeking Counseling:

_____

How have you attempted to solve the problems that have brought you to therapy?

_____

Previous Counseling Experience

Therapist's Name	Clinic/Office Name	When/How Long?	City, State	Reason(s)

What was helpful about these experiences? What was unhelpful?

_____

_____

Client:_____

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PAYMENT AGREEMENT

Professional fees are based on $150/individual and $175/couples for a standard 50-minute session. If needed, additional psychological assessments, consultations and reports will be discussed with you during your session and price will be given at that time. Brief professional services are billed at $25 per 15 minutes, or any part thereof, including telephone conversations. Fees will be periodically adjusted, and clients will be notified in advance of the adjustment.

Professional fees will be assessed at the rate of $200 per hour, or any part thereof, for any services related to litigation, defense or other court related or case related activities. Such activities include interviews, evaluations, research, reports, correspondence, testimony, communication with attorneys, travel, and on-site time. In case of overnight travel, the maximum daily rate will be $800. Incidental expenses for professional services, such as, but not limited to, cost of travel, lodging, meals, will be billed to the client or his/her attorney.

Payment in full is expected at the time or in advance of services rendered. Statements will be provided for filing insurance claims for reimbursement. Nonpayment of fees will result in elimination of professional services and collection activity for amounts owed.

Since professional services are available only through prior scheduling, sessions canceled less than 24 hours in advance are charged at the full rate of the scheduled service.

Any variation from this payment agreement will require a separate, written agreement

I have read this agreement and agree to its terms.

_____

Client/Legal Guardian

_____/_____/_____

Date

Credit Card Authorization Form

PLEASE READ: Form must be filled out by client *(or guardian if a minor)* to cover fee for canceled sessions with less than 24 hour notice.

Client(s) Name(s) _____

CreditCard#: _____

NameonCreditCard: _____

Expiration Date: _____

Card Verification Code: _____

Billing Address: _____

Zip Code: _____

I agree that the credit card listed above may be charged for the therapy sessions and/or assessments of the client(s) named and for therapy sessions canceled with less than 24 hours' notice. This form and my credit card information will be held in my confidential client file until all billing has been completed and then destroyed promptly at the end of that time period.

_____ _____

Signature Date

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INFORMATION, AUTHORIZATION, & CONSENT TO TREATMENT

I am very pleased that you have selected me to be your therapist, and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with me is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

Background Information

The following information regarding my educational background and experience as a therapist is an ethical requirement of my profession. If you have any questions, please feel free to ask.

I received my bachelor's degree from Clemson University in 1989 and my master's degree in 1997 from The University of South Carolina. I have practiced in both group practices and hospice settings. I am a member of the American Association of Christian Counselors, and I am in the Focus on the Family Preferred Counselors Network. I'm licensed in the State of South Carolina as a Licensed Independent Social Worker-Clinical Practice, License #13363. Finally, I have specialized training in EMDR, Attachment and Emotionally Focused Couples Therapy.

Theoretical Views & Client Participation

It is my belief that as people become more aware and accepting of themselves, they are more capable of finding a sense of peace and contentment in their lives. However, self-awareness and self-acceptance are goals that may take a long time to achieve. Some clients need only a few sessions to achieve these goals, whereas others may require months or even years of therapy. As a client, you are in complete control, and you may end your relationship with me at any point.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things you and I talk about both during and between sessions. This also means avoiding any mind-altering substances like alcohol or non-prescription drugs for at least eight hours prior to your therapy sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is my policy to only see clients who I believe have the capacity to resolve their own problems with my assistance. It is my intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without me. I also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, I will direct you to other resources that will be of assistance to you. Your personal development is my number one priority. I encourage you to let me know if you feel that terminating therapy or transferring to another therapist is necessary at any time. My goal is to facilitate healing and growth, and I am very committed to helping you in whatever way seems to produce maximum benefit. I truly hope we can talk about any of these decisions. If at any point you are unable to keep your appointments or I don't hear from you for one month, I will need to close your chart. However, as long as I still have space in my schedule, reopening your chart and resuming treatment is always an option.

Confidentiality & Records

Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be kept in a file stored in a locked cabinet in my locked office. Additionally, I will always keep everything you say to me completely confidential, with the following exceptions: (1) you direct me to tell someone else and you sign a "Release of Information" form; (2) I determine that you are a danger to yourself or to others; (3) you report information about the abuse of a child, an elderly person, or a disabled individual who may require protection; or (4) I am ordered by a judge to disclose information. In the latter case, my license does provide me with the ability to uphold what is legally termed "privileged communication." Privileged communication is your right as a client to have a confidential relationship with a therapist. If for some unusual reason a judge were to order the disclosure of your private information, this order can be appealed. I cannot guarantee that the appeal will be sustained, but I will do everything in my power to keep what you say confidential.

Client:_____

Please note that in couple's counseling, I do not agree to keep secrets. Information revealed in any context may be discussed with either partner.

Professional Relationship

Our relationship has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other way, we would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between the therapist's interests and the client's interests, and then the client's (your) interests might not be put first. In order to offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature.

Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change.

There is another dual relationship that therapists are ethically required to avoid. This is providing therapy while also providing a legal opinion. These are considered mutually exclusive unless you hire a therapist specifically for a legal opinion, which is considered "forensic" work and not therapy. My passion is not in forensic work but in providing you with the best therapeutic care possible. Therefore, by signing this document, you acknowledge that I will be providing therapy only and not forensic services. You also understand that this means I will not participate in custody evaluations, depositions, court proceedings, or any other forensic activities.

You should also know that therapists are required to keep the identity of their clients confidential. For your confidentiality, I will not address you in public unless you speak to me first. I must also decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In sum, it is my ethical duty as a therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Statement Regarding Ethics, Client Welfare & Safety

I assure you that my services will be rendered in a professional manner consistent with the ethical standards of the National Association of Social Workers. If at any time you feel that I am not performing in an ethical or professional manner, I ask that you please let me know immediately. If we are unable to resolve your concern, I will provide you with information to contact the professional licensing board that governs my profession.

Due to the very nature of psychotherapy, as much as I would like to guarantee specific results regarding your therapeutic goals, I am unable to do so. However, with your participation, we will work to achieve the best possible results for you. Please also be aware that changes made in therapy may affect other people in your life. For example, an increase in your assertiveness may not always be welcomed by others. It is my intention to help you manage changes in your interpersonal relationships as they arise, but it is important for you to be aware of this possibility nonetheless.

Additionally, at times people find that they feel somewhat worse when they first start therapy before they begin to feel better. This may occur as you begin discussing certain sensitive areas of your life. However, a topic usually isn't sensitive unless it needs attention. Therefore, discovering the discomfort is actually a success. Once you and I are able to target your specific treatment needs and the particular modalities that work the best for you, help is generally on the way.

For the safety of all my clients and others in the building, I maintain a zero-tolerance weapons policy. No weapon of any kind is permitted on the premises, including guns, explosives, ammunition, knives, swords, razor blades, pepper spray, garrotes, or anything that could be harmful to yourself or others. I reserve the right to contact law enforcement officials and/or terminate treatment with any client who violates my weapons policy.

TeleMental Health Statement

TeleMental Health is defined as follows:

"TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers."

TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. Therefore, I have completed specialized training in TeleMental Health. I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline:

It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided me with that phone number, I may contact you on this line from my own landline in my office or from my cell phone, typically only regarding setting up an appointment if needed. If this is not an acceptable way to contact you, please let me know. Telephone conversations (other than just setting up appointments) may be billed at my hourly rate.

Cell phones:

In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you, typically only regarding setting up an appointment if needed. Telephone conversations (other than just setting up appointments) may be billed at my hourly rate. Additionally, I keep your phone number in my cell phone, but it is listed by your first name and last initial only and my phone is password protected. If this is a problem, please let me know, and we will discuss our options.

Text Messaging:

Text messaging is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text because it is a quick way to convey information. **Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment scheduling.** Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy.

Email:

Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. If you do choose to bring up any therapeutic content via email, your confidentiality could be at risk. Please carefully consider any information that you choose to send via email. You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.

I also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this to me via email because I may not see it in a timely matter. Instead, please see below under "Emergency Procedures."

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:

It is my policy not to accept "friend" or "connection" requests from any current or former client on my **personal** social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of our relationship.

Client:_____

Recommendations to Websites or Applications (Apps):

During the course of our treatment, I may recommend that you visit certain websites for pertinent information or self-help. I may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment.

Electronic Transfer of PHI for Certain Credit Card Transactions:

I utilize Square as the company that processes your credit card information. This company may send the credit card-holder a text or an email receipt indicating that you used that credit card for my services, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit card-holder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill. The name on the charge will appear as Dawn Sturkey LISW-CP.

Your Responsibilities for Confidentiality & TeleMental Health

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any TeleMental Health sessions.

Limitations of TeleMental Health Therapy Services

TeleMental Health services should not be viewed as a complete substitute for therapy conducted in my office, unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, and it involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see a tear in your eye. Or, if audio quality is lacking, I might not hear the crack in your voice that I could easily pick up if you were in my office.

There may also be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction.

Please know that I have the utmost respect and positive regard for you and your wellbeing. I would never do or say anything intentionally to hurt you in any way, and I strongly encourage you to let me know if something I've done or said has upset you. I invite you to keep our communication open at all times to reduce any possible harm.

Consent to TeleMental Health Services

Please check the TeleMental Health services you are authorizing me to utilize for your treatment or administrative purposes. Together, we will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment just by notifying me in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to my practice, and I will be utilizing that technology unless otherwise negotiated by you.

- ☐ Texting
- ☐ Email
- ☐ Recommendations to Websites or Apps

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Communication Response Time

My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. I will return phone calls, texts, and emails within a business day. However, I do not return communications on weekends or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

In Case of an Emergency

If you have a mental health emergency, I encourage you not to wait for communication back from me. Clemson Creative Counseling does not operate as a crisis center, and I am only available during office hours. Please do one or more of the following:

- Call Suicide and Crisis Lifeline at 988.
- Call 911.
- Go to the emergency room of your choice.

Our Agreement to Enter into a Therapeutic Relationship

Please print, date, and sign your name below indicating that you have read and understand the contents of this "Information, Authorization and Consent to Treatment" form **as well as the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices"** provided to you separately. Your signature also indicates that you agree to the policies of your relationship with me, and you are authorizing me to begin treatment with you.

I am sincerely looking forward to facilitating you on your journey toward healing and growth. If you have any questions about any part of this document, please ask.

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

If Applicable:

_____ _____

Parent's or Legal Guardian's Name (Please Print) **Date**

_____

Parent's or Legal Guardian's Signature

The signature of the Therapist below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

_____ _____

Therapist's Signature **Date**

Client:_____

CLEMSON CREATIVE COUNSELING

The Health Insurance Portability and Accountability Act (HIPAA) establishes patient rights and protections associated with the use of protected health information. HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care providers. Providers and health care agencies are required to provide patients a notification of their privacy rights as it relates to their health care records.

This Patient Notification of Privacy Rights informs you of your rights. Please carefully read this Patient Notification, which can be found on the Clemson Creative Counseling website under Helpful Forms. It is important that you know and understand the patient protections HIPAA affords you as a patient.

In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship; therefore, we will do all we can do to protect the privacy of your mental health records. Please contact your counselor if you have questions regarding matters discussed in this Patient Notification. Please print, sign, and date this form below to acknowledge that you have familiarized yourself with Clemson Creative Counseling Confidentiality/HIPAA practices.

I, _____, acknowledge that I have been able to review The Clemson Creative Counseling Patient Notification of Privacy Rights on the website or have read the physical copy provided in the office. My signature below indicates that I had opportunity to review this document prior to signing it.

_____ _____

Client Signature Date