A Peace of Mind Therapy, LLC
Dale Heppe, LMHC 10915

INTAKE FORM

Please provide the following information and answer the questions below prior to your first session. Information you provide here is protected as confidential information. A minimum of 24-hour notice is required for all cancellations. No shows and same day cancellations are not covered by insurance/EAP/MOS.

Name _____ **Birth Date** _____/_____/_____
(Last) (First) (Middle initial) **SSN# (for billing)** _____/_____/_____

Address _____ **Phone** _____

_____ **May we leave message?** _____ _____
Yes No

Email _____

Name of parent/guardian/sponsor

_____ **Sponsor Birth Date** _____/_____/_____
(Last) (First) (Middle initial) **SSN# (for billing)** _____/_____/_____

Address _____ **Phone** _____

_____ **May we leave message?** _____ _____
Yes No

Email _____

Please list any children/age _____

_____

Status

___Never Married ___Domestic Partnership ___Married ___Student

___Separated ___Divorced ___Widowed ___ Retired

Referred by _____

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

_____ No

_____ Yes _____

Are you currently taking any prescription medication?

_____ _____

_____ _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? Please list any specific health problems you are currently experiencing
   ___Poor ___Unsatisfactory ___Satisfactory ___Good ___Very Good

   _____ _____

   _____ _____

2. How would you rate your current sleeping habits?
   ___Poor ___Unsatisfactory ___Satisfactory ___Good ___Very Good

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 _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
   _____ No
   _____ Yes _____

7. Are you currently experiencing any chronic pain?
   _____ No
   _____ Yes _____

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

9. How often do you engage recreational drug use?

   ___Daily ___Weekly ___Monthly ___Infrequently ___Never

10. Are you currently in a romantic relationship? _____ Yes _____ No

11. On a scale of 1-10, how would you rate your relationship? _____

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

_____ _____

_____ _____

FAMILY MENTAL HEALTH HISTORY

Please identify if there is a family history of any of the following. How are they related?

Alcohol 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	_____
Substance Abuse	____ Yes ____ No	_____
Suicide Attempts	____ Yes ____ No	_____

OTHER

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

_____ _____

_____ _____

What do you consider to be some of your weaknesses?

_____ _____

_____ _____

What do you consider to be some of your strengths?

_____ _____

_____ _____

Do you consider yourself to be spiritual or religious? _____ Yes _____ No

Are you currently employed? _____ Yes _____ No

Do you enjoy your work? Is there anything stressful about your current work?

_____ _____

_____ _____

Use space below for any additional concerns

Dale Heppe is a trauma and crisis specialist. As such, he receives calls to assist within the community. We will make all efforts to contact and reschedule you asap.

850.481.8189(O) apeaceofmindtherapy@gmail.com 850.303.7077(C)

A Peace of Mind Therapy, LLC

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Client Informed Consent

This form is provided in order to help you understand several important things about your counselor's professional status and qualifications, your professional relationship with your counselor, and your rights as a client. Please read all information carefully. Feel free to ask questions about anything you do not understand.

Counseling Relationship: During the time we work together, we will usually meet weekly for 45-50-minute sessions. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Please do not invite me to a social event, bring gifts, ask to barter or exchange services, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling relationship. You will be best served if our interactions address your concerns exclusively.

I conduct all counseling sessions in English or with a translator for whom you arrange and pay. I do not discriminate on the basis of race, gender, religion, national origin, sexual orientation, or physical disability. If significant differences, such as in culture or belief system, exists between us, I will work to understand those differences. Unless you prefer otherwise, I will call you by your first name; please call me Dale.

Effects of Counseling: Although I expect you to benefit from counseling, I cannot guarantee any specific results. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or understanding of yourself. You may feel distressed, usually only temporarily, by some of the things you learn about yourself or some of the changes you make. In particular, one risk of couples counseling is the possibility of exercising the divorce option. Although the exact nature of changes resulting from counseling cannot be predicted, I intend to work with you to achieve the best possible results for you. If you are dissatisfied with me at any time, I ask that you address these concerns with me, and if we cannot come to a solution you are happy with, I can refer you to another counselor. If you need to reach me outside of the counseling session, please leave a message at 850-303-7077, and I will get back to you as soon as possible. **If it is an emergency, please call 911.**

Fees: In return for a previously agreed upon fee of $150.00 per session, I agree to provide counseling services for you. If the fee represents a hardship to you, please let me know. The fee for each session will be due and must be paid either before or immediately after the session (unless previous arrangements have been made). Cash, Credit Card or personal checks made out to "A Peace of Mind Therapy, LLC" are acceptable for payment. I am a provider for several insurance companies and will file the claim on your behalf, but you are still responsible for the fee if the insurance company refuses to pay any or part of the amount owed unless other arrangements have been made prior to the session. **Our office policy requires for a minimum of a 24-hour notice of cancellation to avoid a "no show" fee of $150 being applied to the account. Insurance does not cover same day cancellations or no shows. It is your responsibility as the patient to pay**.

Confidentiality: Discussion between the two of us, and even the fact that you are counseling with me, is confidential. For that reason, if I see you in public, I will protect your confidentiality by greeting you only if you greet me first. However, exceptions to confidentiality do exist. These conditions include, but are not limited to, the following situations: a) you and your legal representation direct or consent in writing that I release your records; b) I am consulting with another mental health professional about how to best serve you, in which case I

will not use your name or will use your first name only; c) I learn that you are involved in abuse, neglect, or exploitation of a child, elderly, or disabled person or a patient in a mental health facility; d) I learn that you are infected with a potential life-threatening illness that could be transmitted to a specific uninformed person; e) you disclose sexual contact with another mental health professional with whom you had a professional therapeutic relationship. In that case I must file a complaint and have a right to confidentiality in the filing of the complaint; f) I am testifying in a child custody or visitation case involving you; g) I am testifying in a lawsuit in which your mental health is an issue; h) You have been charged with a crime; i) You bring a negligence suit against me; j) I am ordered by a Court to disclose information; or k) I am otherwise required by law to disclose information.

In the event that I believe you are in danger, physically or emotionally, to yourself or another person, you specifically consent for me to warn the person and to contact the following, in addition to any medical and/or law enforcement personnel:

Name_____ Telephone Number_____

If at any time you have any question regarding confidentiality, you should bring them to my attention. By signing this information and consent form, you are giving you consent to me to share confidential information with all persons mandated by law, with agency or mental health professional who referred you, and with my supervisor and you are also releasing me and holding me harmless from any departure from your right of confidentiality that may result.

Records: All of our communication becomes part of the clinical record, which is maintained in the form of paper files. Records are property of A Peace of Mind Therapy, and stored in a lockable file cabinet. Adult client records are destroyed seven years after the file closed. Minor client records are destroyed seven years after the client's 18th birthday.

Consent to Treatment: By your signature below, you are indicating; 1) that you voluntarily agree to receive mental health assessment and mental health care, treatment, or services, and that you authorize me to provide such assessment and care, treatment, or services as I consider necessary and advisable; 2) that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may at any time stop such care, treatment, or services that you receive through me; 3) that you have read and understood this statement and have had ample opportunity to ask questions about, and seek clarification of, anything unclear to you; and 4) that I provide you with a copy of this statement. By your signature, you verify the accuracy of this document and acknowledge your commitment to its specifications.

Print Name	Signature	Date
Street Address	City, State Zip code	Phone Number

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

CREDIT CARD GUARANTEE

[ ] UNINSURED PATIENTS

Patients who are uninsured or whose insurance does not cover the cost of mental health counseling because of high deductibles or other limitations are personally responsible for payment. Any balance not paid by the end of the week will be automatically charged to your designated card below. This procedure will enable you to spread out your payments if you wish and make them smaller while keeping your account current.

[ ] INSURANCE ASSIGNMENT

Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 90 days for payment. Please remember, however, that you are ultimately responsible for payment. On Day 90, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. Any payments made on these claims thereafter will be immediately refunded to you.

A Peace of Mind Therapy is committed to providing all our patients with exceptional care. When a patient cancels without giving a 24-hour notice in accordance with our office policy, they prevent another patient from being seen. **Insurance does not cover same day cancellations or no-show fee's ($150), this falls on the responsibility of you as the patient.**

I agree to the above terms and authorize you to charge any payment not paid by the end of each week to the credit card below.

_____ _____

SIGNATURE DATE

CREDIT CARD ____ VISA _____MC _____DISCOVER

CARDHOLDER'S NAME _____

BILLING ADDRESS _____

_____

CARD# _____ _____ _____

EXP. DATE 3 DIGIT CID#