**COURTNEY L SLATER, PHD**
**Licensed Psychologist**

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**Welcome to my practice.** Below you will find some information to read and some forms to fill out and sign. Please read this information carefully and do not hesitate to ask if you have any questions or if you would like to clarify anything.

First, tell me about yourself…

## Intake Questionnaire

Patient Name: _____ Preferred Name: _____

Today's Date: _____ Date of Birth: _____

Name of Parent or Guardian if under 18: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Voicemail message ok? ☐Y ☐N

Home Phone: _____ Voicemail message ok? ☐Y ☐N

Work Phone: _____ Voicemail message ok? ☐Y ☐N

Please indicate your relationship status: □Single □Married □Divorced □Separated □Widowed

If you are currently in a romantic relationship, for how long? _____

How would you rate your relationship, on a scale of 1-10 with 10 being the best? _____

List any children and ages: _____

Please tell me a little about yourself on these identity dimensions:

Gender: _____ Pronouns: _____ Sexuality: _____ Ability Status: _____

Ethnicity: _____ Religion/Spirituality: _____

What other cultural or identity issues are important to you? _____

_____

Level of Education Attained: _____ Occupation: _____

Name and Address of Employer: _____

Name and Relationship of Emergency Contact: _____

Phone of Emergency Contact: _____

Family Physician: _____ Phone: _____

How were you referred to Dr. Slater? _____

## Treatment History

Why are you seeking therapy at this time? _____

_____

_____

How severe would you rate your problem? ☐Mild ☐Moderate ☐Severe ☐Disabling

How long has this problem been troubling you? _____

Why are you seeking therapy *now* (has something happened in the last day or so that spurred you to make the phone call)? _____

Have any of your biological relatives ever had problems similar to those you are having?

☐Y ☐N If yes, please describe: _____

Will you be asking your therapist to complete disability forms? ☐Y ☐N

Please list any additional concerns you would like Dr. Slater to be aware of: _____

_____

Please list any previous counseling, hospitalization and/or substance abuse treatment:

| Provider | Facility/Address | Approximate Dates |
|---|---|---|
| | | |
| | | |
| | | |

_____ I have no previous psychiatric or psychological treatment

Current use of: ☐Caffeine ☐Cigarettes ☐Alcohol ☐Illegal Drugs

Past use of: ☐Caffeine ☐Cigarettes ☐Alcohol ☐Illegal Drugs

## Medical History

How would you rate your current physical health:

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

Please indicate health problems you have experienced or are currently experiencing:

☐Diabetes ☐Headaches/Migraines ☐Heart Disease ☐Hypertension ☐Cancer ☐Arthritis ☐Asthma

☐Epilepsy/Seizures ☐Thyroid Disease ☐Suicide Attempts ☐Head Trauma

☐Other _____

How many times per week do you exercise: _____

How would you rate your current sleeping habits?

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

Please list any sleep problems you are currently having:

_____

Please list any current difficulties you are having with your appetite or eating patterns:

_____

MEDICATIONS (list prescriptions, over-the-counter drugs, vitamins and supplements):

| Medication | Condition | Dose | Prescriber |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Personal History

Where were you born? _____

Where did you grow up?_____

Who lived in your home when you were growing up?

| Name | Relation | A few words to describe | Alive? Or cause & year of death |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are there any other conditions or problems in your family history? (e.g., substance use, health, violence, abuse, etc.) _____

_____

_____

_____

Are there any other important memories, family stories, or developmental issues that might be important? _____

_____

_____

_____

What are your aspirations? Where do you hope to be in a few years? _____

_____

_____

_____

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

_____

_____

_____

**Information about Policies.** Below you will find some essential information about psychotherapy policies. Please read and sign at the bottom to indicate that you have reviewed this information.

1. **Length and frequency of treatment.** Psychotherapy typically involves regular sessions, usually 45-minutes in length. Duration and frequency vary depending on the nature of your problem and your individual needs.
2. **Fee Policies.** My fee for an individual therapy session is $150. Payment is expected at the time of service in the form of cash or a check. All returned checks are subject to a $20.00 fee as well as any fees the bank applies. Balances unpaid for 90 days or more may be sent to a collection agency and all collection fees will be added to your account.
3. **Cancelations.** If you need to cancel an appointment, please tell me at least 24 hours ahead of time; otherwise you will be charged for the missed session. Please be aware that insurance carriers will not cover cancellation charges.
4. **Emergencies.** If you need to contact me by phone, please do not hesitate. When I am not available, please leave a message. I am usually able to return calls within the same day. You will not be charged for the phone call unless the phone call lasts more than 10 minutes. Phone sessions will be indicated as such on receipts and are not generally reimbursed by insurance. If you can not reach me in an emergency, you can find help by calling 911.
5. **Physician contact.** Physical and psychological symptoms often interact. I encourage you to seek medical consultation if warranted. In addition, medication may sometimes be helpful for psychological problems. When appropriate, I will refer clients for a medical evaluation.
6. **Freedom to withdraw.** You have the right to end therapy at any time. If you wish, I will give you the names of other qualified psychotherapists.
7. **Legal.** Dr. Slater does not participate in legal proceedings.
8. **Audio Taping:** In order to provide the best possible treatment, it is common for therapists to audio and/or videotape therapy sessions. It is also common for therapists to get consultation or supervision of their cases. By signing below, I willingly give consent to allow therapy sessions to be audio taped and listened to by a consultant. I understand that any consultant who listens to my therapy sessions, is under the same confidentiality requirements as my therapist. I understand the audio tapes of my sessions will be kept strictly confidential and will be taped over or destroyed once they have been used. I also understand that the purpose of allowing audio taping of my therapy sessions is to enhance the effectiveness of the therapy treatment I am receiving. I understand that I may withdraw this consent at any time.

**I have read and understood the preceding statements. I have had an opportunity to ask questions about them and I agree to enter a professional psychotherapy relationship with Dr. Courtney L. Slater.**

Name: _____

Signature: _____ Today's Date: _____

## Important Information About Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

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**Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

**Insurance Providers** (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

*I agree to the above limits of confidentiality and understand their meanings and ramifications.*

_____

Patient Name Printed

_____

Patient Signature (Client's Parent/Guardian if under 18)

_____

Today's Date

## Use of Email

I, _____ understand that communicating with my therapist through email is NOT a confidential means of communication. Communicating through email has several risks, which include, but are not limited to, the following:

- The email could fail to be received and that confidentiality could be breached
- An email could fail to be received if it is sent to the wrong email address or if it is just not noticed by the therapist
- Confidentiality could be breached in transit by hackers or Internet service providers and at either end by others who had access to the account or computer.

By signing below, I am stating that I understand that email is not confidential and I have been informed of the issues of confidentiality with email. Additionally, I am agreeing to release my rights to confidentiality when I communicate with my therapist through email.

_____ _____
Patient Name Date

_____ _____
Psychologist's signature Date

## HIPAA "Notice of Privacy Practices"

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As a rule, I will disclose no information obtained from your contact with me, or the fact that you are my patient, except with your written consent. However, there are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by my own choice, [some because of policies in this office/agency,], and some required by law. If you wish to receive mental health services from me, then under the Federal HIPAA regulations, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

**I. Uses and Disclosures Requiring Authorization or Consent**

HIPAA allows health care providers to use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes. **In my own practice however, I do not disclose information routinely in these circumstances, so this will require your permission in advance, either through your consent at the onset of our relationship** (by signing the attached general consent form), **or through your written authorization at the time the need for disclosure arises.** You may revoke your permission to release PHI, in writing, at any time, by contacting me. If there is an emergency and I cannot ask your permission, I am allowed to share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you. Mental Health Medical Records is the term used for my formal record of the services provided to you, and these contain the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. (Under HIPAA Regulations, such notes are given a greater degree of protection than the PHI or formal

record, because they are considered my own private communication. However, Pennsylvania law does not protect such records from subpoena.)

**II. Possible Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances by policy, or if legally required:

· **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Pennsylvania law to report the matter immediately to the Pennsylvania Department of Public Welfare.

· **Adult Abuse Reporting:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Pennsylvania law to immediately make a report and provide relevant information to the Pennsylvania Department of Health.

· **Health Oversight:** Pennsylvania law requires that I report misconduct by a health care provider of my own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report that you are in treatment if I believe that your condition places the public at risk. Pennsylvania Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.

· **Court Proceedings:** If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without your written authorization, or if a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court.

· **Serious Threat to Health or Safety:** Under Pennsylvania law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.

· **Workers Compensation:** If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

**III. Definitions**

To help clarify the terms, here are some definitions:

· **"PHI" (Protected Health Information**) refers to information in your health record that could identify you.

· **"Treatment, Payment and Health Care Operations"** --Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of a disclosure related to treatment would be when I consult with another health care provider, such as your PCP or psychiatrist. --Payment is when I obtain reimbursement for your healthcare. Examples of disclosure for payment purposes are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. --Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. **NOTE:** In this office, my colleagues do not have access to my records and your records are kept in a locked filing cabinet.

· **"Use"** applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

· **"Disclosure"** applies to activities outside of my office, such as releasing, transferring or providing access to information about you to other parties.

· **"Consent"** is a general permission that allows me to use and disclose your health care information for routine purposes of treatment, payment and operations. For example, under the law, you must sign this consent form before I can begin to see you for therapy or provide other mental health services.

·**"Authorization"** is required by law and involves your written permission to use and disclose information not covered by the consent form. There are a few cases (see above) in which I am allowed, even required, to use and disclose your information without your consent or authorization. I will keep a record of disclosures, and this will be available to you.

**IV. Patient's Rights and Provider's Duties:**

· **Right to Request Restrictions-**You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is

involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

· **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations --** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· **Right to an Accounting of Disclosures -** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process

**.** · **Right to Inspect and Copy** - In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

· **Right to Amend** - If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· **Right to a copy of this notice -** You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

PATIENT NAME:_____

SIGNATURE:_____ EFFECTIVE DATE: _____