

COUPLE INTAKE INFORMATION

Client A: _____ (First) (Middle Initial) (Last) Date of Birth: ____/____/____ Age: ____ Home Address: _____ (Street and Number) _____ (City) (State) (Zip) Relationship Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____	Client B: _____ (First) (Middle Initial) (Last) Date of Birth: ____/____/____ Age: ____ Home Address: _____ (Street and Number) _____ (City) (State) (Zip) Relationship Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____
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REFERRAL SOURCE

Name of referral source, or how you heard about Janna Cash Gilner/Transition Counseling Services, LLC:

May I send your referral a thank you? Yes No

CONTACT AUTHORIZATION

Messages for Client A: Please Call: <input type="checkbox"/> My Home <input type="checkbox"/> My Cell <input type="checkbox"/> My Work Number: _____ If unable to reach me you may: <input type="checkbox"/> leave a detailed message, as this is a private line <input type="checkbox"/> please leave a message asking me to return your call <input type="checkbox"/> do not leave a message The best time to reach me is (day) _____ between (time) _____ May I email you?* <input type="checkbox"/> Yes <input type="checkbox"/> No E-mail: _____	Messages for Client B: Please Call: <input type="checkbox"/> My Home <input type="checkbox"/> My Cell <input type="checkbox"/> My Work Number: _____ If unable to reach me you may: <input type="checkbox"/> leave a detailed message, as this is a private line <input type="checkbox"/> please leave a message asking me to return your call <input type="checkbox"/> do not leave a message The best time to reach me is (day) _____ between (time) _____ May I email you?* <input type="checkbox"/> Yes <input type="checkbox"/> No E-mail: _____
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**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Emergency Contact for Client A In case of emergency, contact: (name) _____ (phone #) _____ (relationship) _____	Emergency Contact for Client B In case of emergency, contact: (name) _____ (phone #) _____ (relationship) _____
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I authorize Janna Cash Gilner/Transition Counseling Services, LLC to waive my confidentiality and contact the above named person, if she deems an emergency exists. This person will be notified of the client's location, condition, and acknowledgment as a client of Janna Cash Gilner/Transition Counseling Services, LLC.

A signature is required to confirm and authorize your preferences listed on this form and consent regarding contacting your referral, how you are contacted, and for whom you have named as your emergency contact.

_____ Signature	_____ Date	_____ Signature	_____ Date
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BRIEF PERSONAL HISTORY

Coordination of Care:

Please check any current involvement with any of the following services:

- Child & Family Services Court or Legal Proceedings Other: _____

Please explain: _____

Please list any *previous* mental health services (psychotherapy, psychiatric services, hospitalizations, etc.) including the provider's name, type of service, city, diagnosis (if any), and date of services:

If in therapy before, what caused you to stop seeing that provider, or specifically, what were you looking for that you did not receive:

Please list any *current* mental health providers (psychiatrist, therapist, etc) and any current medication(s), and condition or diagnosis given:

Please list any *current* medical conditions that you receive treatment or medication(s) for and Physician's name:

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you (father, grandmother, uncle, etc).

- Client A: Over Activity Suicide Attempts Explosive Anger
 Drug Abuse Legal Problems Eating Disorders
 Marital Problems Developmental Disability Obsessive Compulsive Behavior
 Domestic Violence Emotional Problems Bipolar Disorder
 Alcoholism Significant Loss Schizophrenia
 Learning Problems Anxiety Schizoaffective Disorder
 Suicide Depression Delusions/Paranoia

Any other significant family history:

- Client B: Over Activity Suicide Attempts Explosive Anger
 Drug Abuse Legal Problems Eating Disorders
 Marital Problems Developmental Disability Obsessive Compulsive Behavior
 Domestic Violence Emotional Problems Bipolar Disorder
 Alcoholism Significant Loss Schizophrenia
 Learning Problems Anxiety Schizoaffective Disorder
 Suicide Depression Delusions/Paranoia

Any other significant family history:

HISTORY OF CONCERNS/GOALS

Our reason for seeking counseling:

Describe your difficulty/struggle and for how long it has been an issue:

Is there a history of similar problems in your families? If yes, please describe.

If not noted elsewhere, please add any worries/concerns you have about your therapy services.

What changes are you hoping for?

We will know that our goals have been reached, when the following things have changed for the better:

INFORMED CONSENT & COUNSELING AGREEMENT

Signatures below indicate that you have received, read, and understand the practice policies of Janna Cash Gilner/Transition Counseling Services, LLC, and agree to abide by the outlined policies.

CONSENT FOR TREATMENT

I voluntarily consent to services provided by Janna Cash Gilner, which may include assessment and referral recommendations as deemed necessary. I understand that during treatment, things may, at times, feel worse before they get better. Sometimes relationships with family/friends may change as a result of thinking and behaving differently, and this may cause stress. As changes take place, there are shifts in various parts of a person's life. I understand that this is part of the change process and I consent for treatment.

Signature	Date	Signature	Date
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FINANCIAL POLICIES

Clinical Fees:

The fee for a 60-minute session is \$80 and is due at the beginning of each session. Any phone conversation, between sessions, lasting longer than 15 minutes, will be billed as a session. Forms of payment accepted are cash, check, or credit card. Regardless of payment choice, a current credit card must be kept on file. Receipts are available by request. Occasionally, there are extra or altered charges. In your case, the fee per session will be \$_____.

Cancellation Policy:

Appointments canceled with less than 24-hour notice will be charged \$40. A \$40 fee will also be charged if you do not show to a scheduled appointment without notice. Appointments missed due to inclement weather or other major problems will not be charged.

Insurance:

I do not accept insurance payment and do not bill insurance companies directly. Your counseling services may be eligible for reimbursement through out-of-network benefits. If you choose to seek reimbursement, it is your responsibility to contact your insurance provider to inquire about reimbursement for out-of-network counseling services. I can provide you with a receipt at the end of each session, which you can submit to your insurance company for out-of-network coverage/reimbursement. You are responsible for filing claims.

Signature	Date	Signature	Date
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CLINICAL EMERGENCIES

In the event of an emergency or emotional crisis, and you are unable to reach me by phone, or I am out of town, then you are directed to call 911 or go to your nearest hospital emergency room. Once you are safe, you are directed to contact me.

Signature	Date	Signature	Date
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LIMITS OF 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. State law and professional code of ethics mandate exceptions. Noted exceptions are as follows.

- Duty to Warn – When a client discloses intentions or a plan to harm another person, the counselor is required to warn the intended victim and report this information to legal authorities.
- Duty to Protect – In cases in which the client discloses or implies a plan for suicide, the professional counselor is required to notify legal authorities and make reasonable attempts to notify the emergency contact, family, or a friend of the client.
- Abuse of Children of Dependent/Vulnerable Adults – If an adult client states or suggests that he or she is abusing a child (or dependent/vulnerable adult), has recently abused a child (or dependent/vulnerable adult), or a child (or dependent/vulnerable adult), is in danger of abuse, the professional counselor is required to report this information to the appropriate social service and/or legal authorities. This also applies in cases where the client is the minor child (or dependent/vulnerable adult) who discloses or suggests that he or she has been abused or is in danger of abuse. The counselor is also required to report reasonable suspicion of abuse.
- Prenatal Exposure to Controlled Substances – Professional Counselors are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
- Minors/Guardianship – Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.
- Court Proceedings – If you are involved in a court proceeding, your Professional Counselor will not release information without the written authorization of you or your legally appointed representative, or a court order.

The following are noted exceptions within policy of Janna Cash Gilner/Transition Counseling Services, LLC:

- 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, but is not limited to types of services, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.
- Written Request for Release of Information – You may complete a form which requests a Professional Counselor to disclose information regarding your records to a third party.
- Crime Committed Against Staff or Property – In cases of crime, this professional counselor reserves the right to disclose names to authorities if charges are required.
- Legal Disputes – If a client makes claims against the professional counselor, the counselor will be required to disclose information about the client that is pertinent to the counselor's defense.
- Unpaid Balance – Should the client accrue unpaid balances which require creditors, the professional counselor will disclose information required to collect balances due.

You must check the statements below and a signature is required.

- I agree to the above limits of confidentiality and understand their meanings and ramifications.
- I also confirm that I have been given access to a copy of my HIPPA Authorizations and Client Rights.

Signature

Date

Signature

Date

QUALIFICATIONS

Janna Cash Gilner, MA, LPC:

- Has a Masters in Counseling.
- Is licensed in the State of Kansas as a Licensed Professional Counselor.
- Adheres to the Code of Ethics set forth by the American Counseling Association.
- Has received a Certificate in Play Therapy.
- Cannot prescribe medication.
- Does not provide medical or legal advice.

SUPERVISION NOTIFICATION & AUTHORIZATION

Janna is under supervision seeking advanced licensure to become a Licensed Clinical Professional Counselor. Janna is providing counseling services under the supervision of Melanie L. Davis, PhD, Licensed Psychologist. Melanie Davis, PhD, Licensed Psychologist

8012 State Line Road, Suite 102
Prairie Village, KS 66208
Phone: 913-461-4610
Website: www.drmelaniedavis.com

This requires you consent to the use of audio or video recordings, case consultation, live consultation, or observation via remote video for the purposes of supervision, and access to your client file. All areas of supervision are treated with the same ethical concern as confidential records and any recordings are erased following supervisory use and are not a part of the client file.

Signature

Date

Signature

Date

WAIVER OF MEDICAL/PSYCHIATRIC CONSULTATION

I understand that under the provisions of Kansas Law, KSA 65-6404 (b) (3), my counselor is required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that is causing or contributing to any observed symptoms of a mental disorder:

Printed Names of Adults:

In the event that I or my minor child(ren) do not have a primary care physician or psychiatrist, I acknowledge that my counselor has recommended that I seek medical consultation.

By signing below I am indicating that I waive my right to such consultation and that I do not wish for my counselor to contact my(our) physicians(s). I am also aware that this waiver will become part of my client record.

Signature

Date

Signature

Date

If I choose not to waive this consultation by signing this form, my counselor will request that I complete a separate Release of Information form in order to complete the above-mentioned consultation.

CREDIT/DEBIT CARD CHARGE AUTHORIZATION

Regardless of payment choice, a current credit card must be kept on file.

Forms of payment accepted: cash, check, or credit/debit card (Visa, MasterCard, American Express, Discover).

My signature below authorizes Janna Cash Gilner, MA, LPC/Transition Counseling Services, LLC to charge my credit/debit card for late cancellation or no show fees and unpaid balances due.

Fees:

- \$80 per 60-minute session
- \$40 for late cancellation or no show

CLIENT'S NAME: _____

CARD TYPE: <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD <input type="checkbox"/> AMERICAN EXPRESS <input type="checkbox"/> DISCOVER
PRINT NAME AS IT APPEARS ON THE CARD: _____
BILLING ADDRESS: _____ _____
CARD #: _____
EXP. DATE: _____ 3-DIGIT SECURITY CODE: _____
CARDHOLDER'S SIGNATURE: _____
DATE: _____