

KATIE MATHESON, MFT

Client Information Form

Client's Full Name _____

Date of Birth _____

Parents' Names _____

Address _____

Client's Phone Number _____

Parents' Phone Numbers _____

Client's Email Address _____

Parents' Email Addresses _____

Social Security _____

How did you hear about my practice? (circle one)

My Website Psychology Today Network Therapy Good Therapy

Other _____

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Adult Individual Intake

Name_____ Age_____ Date_____

Reason for Seeking Treatment at this time:

Previous Therapies? If so, when and with whom, and what was helpful?

Employment Status:

Medical Problems/Medications:

Use of alcohol and or substances (frequency):

On a scale of 1-10, rate your most common mood/state of mind (1-worst, 10-best):

What are 3 goals you have for the process of therapy?

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Couples Intake

Name and age of both _____

Date _____

Years married/together _____

Reason for seeking treatment at this time:

Past therapies? If so, when and with whom? What helped?

Employment statuses:

Children?

Use of alcohol and or any substances (frequency):

Legal problems:

Medical problems/Medications:

Goals for therapy:

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Adolescent Intake Form

Client Name & Age _____

Date of Intake _____

Before you answer these questions, it is important for you to know that everything you write will be kept confidential. This means I will not share this information with ANYONE--including your parents--unless you or someone else is in serious danger of being hurt, or unless I have your signed permission to share a piece of information with a specified person.

What do you think made you or your parents seek counseling? Why do you think you/they chose now? (Did something happen?)

What are some things you would like to talk with me about?

Is there anything you are/have been struggling with? (Describe or circle below)

anger sadness anxiety low self-esteem body image/weight

school home life friends boyfriend/girlfriend stress about college

sports identity loss embarrassment

other:

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What do you like to do?

What are you good doing?

Who can you talk to about a problem?

What do you want to do when you are an adult?

What is something not many people know about you?

What is something most people know about you?

Have you ever thought of hurting yourself or tried to hurt yourself? If so, what did you do, and did you tell anyone?

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If you had to pick 3 goals for yourself, what would they be?

- 1.
- 2.
- 3.

Tell me a little more about yourself and your family. What is your life like at home?
Is there anything you would change in your life if you could?

Do you have any questions for me about counseling?

Thanks for your help, I look forward to meeting you!

Katie

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Parent Intake Form

Parent
Names _____

Date of
Intake _____

What brings you into therapy? Why specifically at this point in time (was there an incident that led you here?)

Describe your marriage/relationship history?

What is your work schedule like? Spouse's employment/schedule?

How would you describe your parenting style/relationship with your child?

What are your main concerns as a parent?

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How often do you drink alcohol, smoke, or use any other substances? Has a substance ever been a problem in your life?

Do you have any current or past medical problems?

Are you currently on any medications? History of medication?

Have you ever been to Therapy before? If so, what worked for you and what did not?

What are 3 goals you have for yourself for the process of Therapy with me?

1.

2.

3.

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Parental Consent to Treatment of Minor Form

I _____, (parent or legal guardian's name) as a parent or legal guardian of _____, (minor's name) consent to treatment with Katie Matheson, Marriage & Family Therapist. I understand the nature of the therapeutic relationship is that it may be terminated at any time as parent or therapist see fit, unless treatment is court-ordered or legally mandated.

X _____ SIGNATURE

X _____ DATE

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Informed Consent Form

I _____, have been informed of office policies regarding fee, scheduling, cancellation and confidentiality. Upon entering into a therapeutic relationship with above therapist, I am taking responsibility for my self and my well-being by moving in the direction of change and or understanding. The nature of such a relationship is that myself or above therapist may decide to end it on his or her own accord, however, a discussion and evaluation of termination is strongly recommended. By signing this document, I am acknowledging my part in the counseling process on this day of _____.

(Month, Day, Year)

Client Name: _____

Client Signature: _____

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Release of Information Form

I, _____, (client/parent name) consent for therapeutic information to be released regarding _____, (client name) to _____, (3rd party name) for treatment purposes only.

This information is to be released from _____ to _____ (dates)

OR

This information may be shared in an ongoing manner between Katie Matheson and _____ (3rd party name) throughout the duration of treatment.

X _____ DATE

X _____ SIGNATURE(S)

X _____

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Client No Harm Contract Form

I _____, promise I will not do anything to harm myself between now and the next time I see my therapist. If I think that I want to do something that might harm myself, I will call my therapist at 949-542-2121, or a crisis hotline at 1-800-999-9999.

Print Name _____

Signature _____

Date _____

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Notice of Privacy Practices

This notice describes how information about you as a patient of this practice may be used and disclosed, and how to access your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

My patient medical records are kept confidential, secure and out of reach by unauthorized persons. All reports, consultations and correspondence are reviewed by me prior to being filed in the medical records. A written release signed and dated by the patient/guardian must be obtained prior to the release of medical record information. My practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. Confidentiality laws are complicated, but I must provide you with the following important information.

THE FOLLOWING CIRCUMSTANCES MAY REQUIRE ME TO USE OR DISCLOSE YOUR HEALTH INFORMATION:

TO PROVIDE TREATMENT: I will use your health information within my office to provide you with the best health care possible. This may include administrative and clinical office procedures to schedule and coordinate care between doctors, and business office staff. In addition, we may share your health information with referring physicians, specialists, clinical laboratories, pharmacies or other health care personnel providing your treatment. To provide you with the best of care, I confer with colleagues and other professionals in some situations. The confidentiality of your health and treatment information is safeguarded, unless I have your specific consent.

TO OBTAIN PAYMENT: Your health information may be included with an invoice used to collect payment or reimbursement for treatment you received in my office. Any statements sent to you include a diagnosis, dates of service and service rendered. At times these invoices may be submitted electronically.

TO CONDUCT HEALTH CARE OPERATIONS: Your health information may be used during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

COMMUNICATIONS: I may contact you to remind you of a scheduled appointment or that it is time for you to contact me to make an appointment. These communications may include letters, e-mails or telephone reminders. I may share your health information with those you tell me will be helping you with any related medical, psychological or other treatments, medications or payment assistance. You can request that my practice communicate with you about your health and related issues in a particular manner or at certain locations. For instance, you may request that I contact you at home, rather than at work. I will try to accommodate reasonable requests.

AS REQUIRED BY LAW: I may disclose your health information to public health authorities and health oversight agencies that are authorized by law to collection information, when required to do so by a law enforcement official, lawsuits and similar proceedings in response to a court or administrative

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order, when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.

YOU ARE ENTITLED TO RECEIVE A COPY OF THIS NOTICE

I, _____, have had full opportunity to read and consider the contents of this Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, billing and accounting services and health care operations.

SIGNATURE(S): _____

DATE: _____