Matters of the Heart Counseling
Joanna Dixon, LMFT
& Student Interns
243 Old Shackle Island Road
Hendersonville, TN 37075

INTAKE FORM

Please provide the following information for my records. Leave blank any question you would rather not answer. Information you provide is held to the same standards of confidentiality as our therapy.

Name: _____
(Last) (First) (MI)

Parent/Legal Guardians: _____

Birth Date: _____/_____/_____ **Age:** _____ **Gender:** ☐ Male ☐ Female

Address: _____

_____
(City) (State) (Zip)

Marital Status:
☐Never Married ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed

Spouse: _____
(Last) (First) (Middle Initial)

Children's
Names and Ages: _____ _____

_____ _____

Primary Phone: ( ) - Emergency Phone: ( ) -

Voice Message? ☐ Yes ☐ No Emergency Person: _____
Text Message? ☐ Yes ☐ No

E-mail: _____ **Please be aware that email might not be confidential.*

OCCUPATIONAL INFORMATION:

Are you currently employed? ☐ No ☐ Yes Employer: _____

Job Title: _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, sleep issues, etc.):

_____

3. How many times per week do you exercise? _____

4. Have you experienced significant weight change in the last 2 months? □ No □ Yes _____

5. How regularly do you use alcohol? □ Daily □ Weekly □Monthly □Rarely □Never

6. Do you engage recreational drug use? □Daily □ Weekly □Monthly □Rarely □Never
Type(s):_____

7. Have you had suicidal thoughts in the past 12 months? ***How Recent?** _____
Frequency: □ Daily □ Weekly □ Monthly □ Sometimes □ Never

8. Are you currently in a romantic relationship? □ No □ Yes, how long? _____
Quality of your relationship: Poor Fair OK Good (other) _____

9. In the last year, have you experienced any significant life changes or stressors?

_____

1. MENTAL HEALTH HISTORY:

Have you ever experienced:

Extreme depressed mood	yes/no
Rapid Speech	yes/no
Extreme Anxiety	yes/no
Panic Attacks	yes/no
Phobias	yes/no
Sleep Disturbances	yes/no
Hallucinations	yes/no
Unexplained memory lapses	yes/no
Alcohol/Substance Abuse	yes/no
Eating Disorder	yes/no
Body Image Problems	yes/no
Repetitive Thoughts (e.g., Obsessions)	yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	yes/no
Homicidal Thoughts	yes/no
Suicide Thoughts	yes/no
Suicide Attempt	yes/no

Current Medication(s):_____

_____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty		**Family Member**
Depression	yes/no	_____
Bipolar Disorder	yes/no	_____
Anxiety Disorders	yes/no	_____
Panic Attacks	yes/no	_____
Schizophrenia	yes/no	_____
Alcohol/Substance Abuse	yes/no	_____
Eating Disorders	yes/no	_____
Learning Disabilities	yes/no	_____
Trauma History	yes/no	_____
Suicide Attempts	yes/no	_____

OTHER INFORMATION:

☆What do you consider to be your personal strengths?

☆What are some effective coping strategies you have learned? (exercise, journaling, etc..)

☆What are your goals for therapy?

Please use this space to provide any other necessary information you would like to share for the purpose of treatment.

_____

_____

_____

SOCIAL MEDIA CLAUSE

Per the AAMFT (American Association for Marriage and Family Therapists), the use of social media by way of Facebook, Instagram, Twitter, and other outlets, for therapists and their clientele to connect is prohibited for a minimum of 2 years post the termination of the therapeutic relationship, and is then up to the therapist's discretion. This serves to protect the integrity of the therapeutic relationship.

LIMITS OF CONFIDENTIALITY

All information disclosed within sessions or consultations is held strictly confidential and may not be revealed to anyone without a written release of information, except where disclosure is permitted or required by law. Disclosure is required in the following circumstances:

1. When there is a reasonable suspicion of child abuse or neglect, or abuse to a dependent or elder adult,
2. When the patient presents an imminent danger to self,
3. When the patient presents an imminent danger to others,
4. If a judge determines that our discussions are not confidential, a judge may request specific information.

If the patient is a minor, you acknowledge that your child's records are confidential except in the above stated exceptions. Please be aware that submitting mental health claims to your insurance company carries a certain amount of risk to confidentiality, privacy, and to future capacity to obtain health or life insurance, or even a job. I receive regular professional consultation. In such cases, neither your name, nor any identifying information about you is revealed.

Duty to Warn and Protect

_____ initials 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

_____ initials 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.

Prenatal Exposure to Controlled Substances

_____ initials Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

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

Insurance Providers (when applicable)

_____ initials 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.

_____ _____

Client signature (parent/guardian if under 18) Date

CONSENT FOR TREATMENT:

I, _____, hereby consent to treatment by way of counseling with Joanna F. Dixon, LMFT on this date & beyond. I understand that all efforts made by this counselor to assist in the meeting the goals set forth for treatment will be given with the best or intentions and out of the best interest of myself and all others involved in the counseling process. If at any time I feel that counseling services are not meeting my expectations, I can request a referral to an alternative provider that might better meet my goals for treatment without any bias or discrimination.

_____ _____
Patient signature Date

_____ _____
(Both Parents or legal guardian for minor) Date

I have been given a copy of the **HIPAA Privacy Policies** for treatment.
(separate page to be printed out and kept by client)

_____ _____
Patient signature (Parent or guardian for minor) Date

FINANCIAL AGREEMENT:

I am committed to providing you with the best possible care. In order to achieve these goals, I need your assistance & your understanding of my payment policy.

Payment for service is due at the time services are rendered *unless* payment arrangements have been agreed upon *in advance*. I accept Visa, MasterCard, Discover, and AmExpress through SQUARE payment. When paying with cash or check, you will receive a $5 discount, as there will be no processing fee. Please note that any returned checks will have a service charge of $25 per check to cover the counselor's bank fees.

Session Attendance:
It is important to understand that a session missed is also a session that cannot be booked for other clients, and time away from the therapist's family. Your appointment time cannot be filled with other clientele unless the appropriate notice has been given. For this reason, I ask that you make every effort to provide at least a **24 hour advance notice** by phone (call/text).

I understand that crisis situations occur and circumstance can conflict with your ability to keep your appointment, and, therefore, the first occurrence is forgiven, with no fee. After that time, **the full fee** will be applied to the card you choose to keep on file with this counselor and a receipt will be given via email. *This measure has been created out of necessity to ensure a mutual respect is established for one another's time.*

Your signature below signifies that you have read the information, understand, and agree to it as the responsible party.

_____ _____
Patient signature (Parent or guardian for minor) Date

Payment Arrangements

Updated August 2019

While this practice does not currently accept Insurance, we can work with you and your insurance company or Health Savings Account to provide receipts and ICD-10 codes, which can be submitted to **some** plans for reimbursement.

Options	60 minute session fee	90 minute session fee
Joanna Dixon's Licensed Supervisor Counseling Rate	$125	$185
Keiara Marsh & Nicole Heckel. Pre-Licensed Counseling Rate	$65	$85
Student Intern Rate	$35	$55
$5 discount for payment by cash/check		

This practice requires that ALL clients provide a valid credit/debit card to keep on file to assist in preventing missed sessions that are unable to be filled by other clients.

_____ initials

As a professional courtesy, we acknowledge unforeseeable circumstances, and will extend grace for said situations, however, should this become a pattern, you will be given alternative referral options for comparable therapists in the area, as this might inhibit the quality of the therapeutic alliance.

_____ initials

Sessions missed without the required 24 hour notice prior to scheduled session will be shown grace **for the first occurrence**, and **full fee for occurrences there after.** This will be automatically charged to the card you keep on file.

_____ initials

With limited availability and high demand, missed sessions without adequate cancellation time, has little tolerance in this practice. Should your card require being run more than 3 times for missed sessions, it will then be **mutually understood** that the therapeutic process is ineffective and therefore requires a referral outside of this practice.

My Identified session fee is: _____/therapeutic hour (50 minutes)

Credit/Debit Card to keep on file for phone sessions, payment use, and potential no shows is:

Card #_____ Expiration: _____ CVV#: _____

Card billing zip code: _____ Name on the card: _____

Preferred Email address/cell number for receipt: _____

By signing below, I recognize that I have read and understand this therapist's expectation for my financial commitment and have read and agree to the Financial Agreement.

Signed: _____ *Date:* _____

Therapist Signature: _____ *Date:* _____