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Client Information

Name _____ Birthday _____

Address_____

Phone numbers: (home)_____ (cell) _____
(ok to call? Y N) (ok to call? Y N)

email address: _____(ok to email? Y N) Male □ Female □

Marital Status: Single Married Separated Divorced Children's names/ages:_____

Occupation: _____ _____

Employer: _____ _____

Highest level of education: _____ Religious preference: _____

Person to contact in case of emergency: _____ Relationship:_____

Home phone : _____ Work phone: _____

Minor Client Information

(only to be completed for clients under 18 years of age)

Siblings (names/ages): _____

Parental Marital Status: Single Married Separated Divorced Custodial arrangement: _____

Father's Name: _____ Age: _____

Address: _____

Phone number :_____ okay to call? Y N

Occupation : _____ Employer:_____

Email : _____Religious preference_____

Father's marital status: Married Engaged Divorced Separated Live with partner other: _____

Mother's Name: _____ Age: _____

Address: _____

Phone number : _____ okay to call? Y N

Occupation : _____ Employer:_____

Email : _____Religious preference_____

Mother's marital status: Married Engaged Divorced Separated Live with partner other: _____

Medical information

Physician's Name _____ Phone number _____

Relevant health history:(hospitalizations, surgeries, major illnesses or conditions) _____

_____

List any medications you are currently taking: _____

_____

Information related to counseling

Who may I thank for your referral? _____

Have you ever consulted a counselor before? Yes No With whom? _____

Are you currently in counseling elsewhere? Yes No With whom? _____

Outcome and/or Diagnosis :_____

Have you ever considered suicide? Yes No Have you ever attempted suicide? Yes No

Do you have an addiction? Yes No Uncertain (Explain on reverse side)

Have you had any previous trauma? Yes No Uncertain (Explain on reverse side)

What concern has caused you to seek counseling at this time?

_____

_____

_____

_____

_____

What has been done about your concern up to this point?

_____

_____

_____

_____

Has anyone in your family experienced similar problems?

_____

_____

For each concern explained above, what changes/improvements will be signs of progress?

_____

_____

_____

Practice Policies

Benefits and Risks of Counseling

Research has shown that therapy is beneficial for a wide variety of problems. The majority of people who receive counseling make significant improvements. However, it should be understood that some people do not report themselves as significantly improved at the end of treatment and a small percent report that they feel worse after receiving treatment. Therefore, as with any treatment, whether it is psychological or medical, therapy should only be entered with proper consideration. A client always has the right to inquire and choose treatment modalities as well as terminate counseling at any time.

Confidentiality

Therapists have an ethical and moral obligation to keep information revealed in sessions confidential. The release of information regarding services is controlled by the client. In an emergency situation when there is imminent danger to the client or another person, the counselor may breach confidentiality. In addition, the Tennessee Law requires that suspected child or dependent adult/elder abuse be reported to the Department of Human Services. Otherwise, your counselor will only release information regarding your treatment if she has your written permission.

Limitations to confidentiality only apply in the following circumstances, where disclosure is required by law:

1. if I present an imminent threat of harm to myself or to others,
2. when there is an indication of abuse of a child or dependent adult,
3. if I become gravely disabled, and
4. by court subpoena.

When working with minors, Rooted Counselors generally will not share the content of sessions with parents/guardians, though they reserve the right to disclose information due to their clinical judgment, such as safety purposes or if therapeutic judgment warrants sharing content for the welfare and health of the minor. Due to Tennessee State Law, a release form from a minor client age 16 and up will be required prior to disclosure to a parent /guardian.

Professional Consultation

In order to enhance your counseling and therapeutic experience, and to maintain the highest standards of care and accountability, collaborative consultations may take place within a professional context. Such consultation is typically provided with protection of client's identity.

Fee Policy **FEE FOR SERVICE: $_____ Client Initials: _____**

All intakes are up to 75 minutes and cost $175.00. The fee for a 50-minute therapy session varies depending on the therapist and will be discussed prior to the intake session and written above. There will be a $15.00 fee for returned checks. Rooted Counseling **does not** bill for sessions, and payments are due by the end of the day of the session.
Clients will be charged in full for appointments not cancelled 24 hours prior to their appointment.

Credit Card Policy

Rooted Counseling keeps a credit card on file for each client in order to ensure on-time payment and payments for late cancels or missed sessions. Please see page 6 for more information.

Professional Services

Rooted Counselors are available for counseling appointments at scheduled times throughout the week between the hours of 9am – 8pm (availability varies depending on therapist). Each therapist will provide his or her clients with a phone number and email to use for contact between sessions. If a client is unable to reach their therapist or counselor, and they are in crisis and feeling suicidal, overwhelmed, or unsafe, they should call the Crisis Help Line at 615-726-0125, the YWCA Domestic Violence Center at 615-242-1199, or go to their nearest emergency room.

Non-Secure Communication Policy

Email Confidentiality Agreement
When communicating via email, it is important to remember that confidentiality is limited. By signing below, the client is saying that they have considered and understand the limitation of confidentiality and agree that the client is responsible for keeping their email account private to the extent that they desire for it to be private.

Text Messaging Agreement
Rooted Counselors are not permitted to counsel clients via text message. Any therapeutic processing should be reserved for sessions and/or phone consultation. By signing below, the client is agreeing that they have considered and understand the limits of confidentiality and agree that the client is responsible for keeping their text messages private to the extent that they desire them to be private.

Phone Sessions
In some circumstances, phone counseling sessions are scheduled. All phone time (scheduled or unscheduled) is billed at a per-minute rate based on the fee of your therapist, starting after 5 minutes. Insurance companies do not reimburse phone counseling sessions.

Professional Boundaries
Rooted Counselors avoid any other relationships with their clients outside of the therapeutic relationship, such as personal relationship, business relationship, or similar. Beyond confidentiality requirements, professional boundaries also play a role in respecting the privacy of Rooted clients outside of therapy. For example, if a client sees their therapist in a public setting, the therapist will not initiate communication with their client.

Social Media
Counselors at Rooted Counseling are prohibited from engaging in a personal virtual relationship with individuals with whom they have a current counseling relationship (e.g., through social and other media) – ACA Code of Ethics A.5.e.

I give permission for the therapist to correspond with me via email or text messaging. Yes ____No____

I understand that email and/or text messaging is not necessarily secure _____ (initials)

Phone Number: _____

Email: _____

Signature of Responsible Party(ies):_____**Date:** _____

If for any reason you are in need of immediate help and cannot get in touch with your therapist, please call the mobile crisis hotline at 615-244-7444.

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Informed Consent

Courtney McInturff, M.S., LPC-MHSP (temp.), NCC

Courtney McInturff graduated with a Master's Degree in Clinical Mental Health Counseling from the University of Tennessee in Knoxville. During her time in Knoxville, Courtney provided individual, group, and family counseling at Richard Yoakley Alternative School and Kingston Academy, a Psychiatric Residential Treatment Facility to at-risk children and adolescents.

Courtney has secured a LPC-MHSP temporary license in the state of Tennessee, which will be upgraded upon completion of her clinical hours under the supervision of Ashley Colclasure (License no. 2732).

As a part of the supervision process, Courtney will meet on a regular basis with her supervisor to discuss cases in order to provide the utmost care for her clients.

The information that clients share will be held in confidence; however, there are important exceptions to this rule which include:

1. Courtney's supervisor needs to be aware of the nature of the issue to provide the best care to the client
2. The client requests in writing that Courtney share information with a specified person,
3. If there is foreseeable risk to the client or any identifiable person
4. If there is any report of child or elder abuse or neglect, and/or a court-order or subpoena.

By signing this document, you agree to and understand all of the information and guidelines presented in this disclosure statement and any questions have been answered. You as the client, parent, or guardian understand your rights, and your signature indicates that you are consenting to counseling from the date this document is signed.

Do you have any questions about fees, confidentiality, or other matters? Yes_____ No_____
Do you agree with the conditions of provisions of these Practice Policies? Yes _____ No_____
I have read, understand, and accept the policies stated above.

Client Signature	Date
Guardian's Signature if client is a minor	Date
Guardian's Signature if client is a minor	Date

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Credit Card Information:

Cancellation Policy
Clients will be charged for appointments not cancelled 24 hours prior to their appointment time.

- If you are choosing to turn in receipts for insurance reimbursement, the missed/cancelled sessions will not be counted as a treatment session, so you will not be reimbursed for the session
- All clients are required to keep a credit card on file to pay for those cancelled/missed sessions.
- Late cancellations, no shows, and or no calls will be charged in full (plus 3.5% convenience fee) for the treatment sessions missed on the day of the scheduled session.
- These sessions will be charged the day of the session using the credit card number provided below.

Credit Card Policy
In addition to payment in cash or check, clients may choose to keep a credit card on file to pay for sessions.

A 3.5% convenience fee will be added to the session fee for all credit card transactions.

Type of Credit Card:
☐ Visa
☐ MasterCard
☐ AMEX

Name on Card: _____
Billing Zip Code: _____
Email for receipts: _____

Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration Date: ☐☐/☐☐ CCV code: _____

Would you like to use this credit card to pay for all sessions? YES NO

I authorize Rooted Counseling to make charges to my credit card for payment of counseling services when I do not provide cash or check for those sessions. I understand the cancellation policy and give Rooted Counseling Permission to charge any missed or cancelled session on the credit card listed above.

_____
Signature Date