INITIAL INTAKE FOR MEGAN POLLOCK THERAPY

Today's Date: ____ / _____ / 20____

Last Name:	First Name:	Preferred Pronouns:	Date of Birth:
Home Address:			
City:	Zip Code:	Length @ address:	
Home Phone:	Work Phone:	Cell Phone:	
E-mail:	Preferred Contact Method:	Permission to leave message:	
Employment Status:	Employer & Occupation:	Length of Employment:	
Relationship(s) Status:	Other's Name(s):	Length of Relationship(s):	
Other(s) Employment Status:	Occupation:	Length of Employment:	
Children:	Birth Month(s)/Year(s)	Gender(s):	

Referred by:	Contact:	Permission to contact:
Responsible Party (Last, First, MI):	Relationship:	Phone:
Responsible Party Address:		
City:	Zip Code:	Social Security Number:
Employer:	Occupation:	Length of Employment:

Current Health Issues:		
Current Medications:		
History of Therapy/Counseling:	Whom:	Purpose & Length:
History of Hospitalization:	Why:	When:

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. Noted exceptions are as follows:

Duty to Warn & 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 & 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, unless there certain circumstances that the release of confidential information may be harmful to the minor, as determined by the therapist, or the Court or Child's Attorney holds the Privilege.

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

Signature	_____	Guardian if client is under 18	_____
Printed Name	_____	Printed Name	_____
Date	_____	Date	_____

Risks and Benefits: The therapy process may include discussions of your personal challenges and difficulties, which can elicit uncomfortable feelings such as sadness, guilt, anger and frustration. However, therapy has been shown to have many benefits which may include: better interpersonal relationships, improved work/academic performance, solutions to specific problems, and an increased capacity to manage intense feelings.

Therapy requires active involvement in order to work towards growth. Knowing that there are risks and that there are no guarantees of benefits and outcomes, I consent to treatment with Megan Pollock for the purpose of psychotherapy and acknowledge that I may discontinue services at any time in the future.

Signature	_____	Guardian if client is under 18	_____
Printed Name	_____	Printed Name	_____
Date	_____	Date	_____

Cancellation Policy: A full fee is charged for missed appointments, no show and cancellations with less than a full 24 hour notice. Consideration is given for illness and emergencies.

Signature	_____	Guardian if client is under 18	_____
Printed Name	_____	Printed Name	_____
Date	_____	Date	_____

Contact Between Sessions: It is expected that things may arise between scheduled sessions that would lead to communication. For those reasons, Megan Pollock Therapy provides multiple methods of contact (phone with voicemail, texting, and email) for client access and safety. Every reasonable attempt is made to return contact in a swift and timely manner. Confidentiality cannot be guaranteed to be secure nor error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. Additionally, this contact is not intended, nor appropriate, as a substitute for therapy sessions. For those reasons, Megan Pollock Therapy reserves the right to bill clients for contact between sessions in excess of 10 minutes.

Signature	_____	Guardian if client is under 18	_____
Printed Name	_____	Printed Name	_____
Date	_____	Date	_____

Check Any of the Following That May Apply to You:

☐ Headache	☐ Inferiority Feelings	☐ Shy With People	☐ Financial Problems
☐ Dizziness	☐ Unable To Relax	☐ Can't Make Friends	☐ Gambling
☐ No Appetite	☐ Feel Tense	☐ Afraid Of People	☐ Job Problems
☐ Over-Eating	☐ Feel Panicky	☐ Home Conditions Bad	☐ Can't Keep A Job
☐ Stomach Trouble	☐ Fears and Phobias	☐ Unable To Have A Good Time	☐ Take Tranquilizers
☐ Bowel Disturbances	☐ Obsessions	☐ Always Worried About Something	☐ Alcoholism
☐ Always Tired/Sleepy	☐ Depressed	☐ Don't Like Weekends/Vacations	☐ Dangerous Drugs
☐ Insomnia	☐ Suicidal Ideas	☐ Can't Make Decisions	☐ Allergy
☐ Recurrent Dreams	☐ Hallucinations	☐ Over-Ambitious	☐ Asthma
☐ Nightmares	☐ Sexual Problems	☐ Relationship Problems	☐ Fainting Spells

Other: _____

_____

Please state why you decided to come for counseling/therapy at this time

_____

_____

How long has this been a problem for you

_____

What are you hoping to gain from counseling/therapy

_____

_____

Payment Information Current rates of service are $165 for each 55-minute session unless other arrangement is made. Payment is expected at the time of service unless other arrangement is made. For other services, rates will be discussed at the time of service. Rates may be changed, and clients will be notified of any changes no less than one month prior to change. (Please initial one of the following options):

____ **Private Payment** I do not intend to use mental health insurance to pay for my services at Megan Pollock Therapy. I understand that I am responsible for full payment of for services at each visit.

____ **Out-of-Network Insurance** I intend to use out-of-network insurance benefits to cover my services at Megan Pollock Therapy. I understand that I am responsible for full payment for services at each visit and will use clinic receipt to seek reimbursement from my insurance company. I recognize that insurance companies vary in the percentages of reimbursement provided. I recognize that it is my responsibility to secure this preauthorization

____ **In-Network Insurance** I intend to use in-network insurance coverage benefits to cover my services at Megan Pollock Therapy. I understand that it is my responsibility for the co-payment and/or co-insurance amount for my visit at the time of service. I authorize Megan Pollock Therapy to apply for benefits on my behalf for services rendered to me. I request that payment from my insurance company, if any, be made to Megan Pollock Therapy, unless otherwise indicated on the claim. I authorize the release of any necessary information, including medical information, for this or any related claim, to my insurance carrier. In making this assignment, I understand that I am financially responsible for any charges not paid under this insurance policy. I further understand that Megan Pollock Therapy will not file for secondary insurance on my behalf.

If you plan on using in-network insurance, **please complete and provide a copy of insurance card**:

Insurance Co: _____ Policy Holder's Name (as appears on card): _____

Relationship to Policy Holder: _____ Deductible Amount: _____ Co-Payment Amount: _____

By signing, you indicate that Megan Pollock Therapy has your consent to communicate about your treatment with the above insurance company.

Signature _____ Guardian if client is under 18 _____

Printed Name _____ Printed Name _____

Date _____ Date _____

Megan Pollock Therapy • 5959 W Loop South, Ste 410 • Bellaire, TX 77401 • (281) 974-2726

Email & Texting Policies & Permissions

INTRODUCTION: Electronic mail and texting are not safe/confidential forms of communication. (E.g., emails or texts may be sent to the wrong person, others in your home or office environment may see messages intended only for you, third parties may have or store email, etc.). This office works to protect your sensitive personal data by sending you email and/or texts *only with your permission*, and only for administrative purposes.

A. **EMAIL: Choose to Receive or Not Receive Emails**

Knowing that email is not secure, I (your name) _____
(**initial one**) ____ **do** ____ **do not** give permission to Ms. Pollock to send me emails for administrative purposes, such as billing, setting appointments, occasional appointment and generic homework reminders, workshop announcements, etc. I know that I may change this permission at any time.

The private email address I would like Ms. Pollock to use is:

_____

B. **TEXTS: Choose to Receive or Not Receive Texts**

Knowing that texts are not secure, I (your name) _____
(**initial one**) ____ **do** ____ **do not** give permission to Ms. Pollock to send me texts for administrative purposes, such as billing, setting appointments, occasional appointment and generic homework reminders, workshop announcements, etc. I know that I may change this permission at any time.

The phone number for texts I would like Ms. Pollock to use is:

_____

Signed: _____ Date: _____

Note: Unless changed prior, these permissions will expire 2 years after your last therapy session with Ms. Pollock

If you wish to send Ms. Pollock email and/or texts containing personal potentially sensitive information, you may do so. However, please indicate that you are aware of the risks.

I have been informed by Ms. Pollock of the risks I may incur should I choose to send private, personal information via non-secure email and/or texts.

Signed: _____ Date: _____

REVIEW OF HIPAA PRIVACY RULE AND NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Acknowledgment of receipt of Notice of **HIPAA PRIVACY RULE AND NOTICE**

Signature	_____	Guardian if client is under 18	_____
Printed Name	_____	Printed Name	_____
Date	_____	Date	_____