**Skowronski Counseling**

**Kristen Skowronski, M.S., LMFT-Associate**

10655 Six Pines Dr., Suite 150

The Woodlands, TX 77380

Phone: 346-370-0028

Email: kskowronski@skimft.com

**Intake Form and Consent**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent(s)/Guardian(s) Names (if client is a minor)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (Name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you find Skowronski Counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate below how we may contact you and whether we can leave a message:

Home Phone May I leave a message? \_\_ Yes \_\_ No

Cell Phone May I leave a voice message? \_\_ Yes \_\_ No

Send a text message? \_\_ Yes \_\_ No

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I send an email? \_\_Yes \_\_ No

**Psychological Services:** Throughout our time together we will be targeting and working towards your goal(s) for therapy. Psychotherapy calls for an active effort on your part as well. I will work with you in facilitating movement towards your goals, however, in order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. During this process there are both possible benefits and risks that may occur. During sessions it is possible that you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. In the case of couples and family therapy, family members or partners may experience these types of feelings together. Therapy has also been shown to have many possible benefits leading to improved relationships, increased ability to deal effectively with stress, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience, and it is important that we discuss any questions, discomfort, or concerns you have regarding the psychotherapy process. I will consistently assess your treatment goals and progress with you. If your situation fails to improve or deteriorates, I will discuss with you changes that may be necessary for the sessions and/or provide referrals to another professional.

**Confidentiality:** The law protects the privacy of communications between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form. While I will maintain confidentiality with my clients, there are some instances in which I am obligated by law and/or professional ethics to report to the correct authorities. These include**:**

**Child Abuse/Neglect:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.

**Abuse/Neglect of the Elderly and Disabled:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.

**Sexual Misconduct by a Therapist:** I am required to report any incidents of sexual misconduct by a current or former therapist to the offending therapist’s licensing authority.

**Regulatory Oversight:** If a complaint is filed against a therapist with a regulatory authority, they have the authority to subpoena confidential mental health information relevant to that complaint.

**Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case. If a complaint is filed against myself with a regulatory authority, I hold the right to subpoena confidential mental health information relevant to that complaint.

**Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.

**Worker’s Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer’s insurance carrier.

I may seek out consultation with other mental health professionals about your case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don’t object, I will not tell you about these consultations unless I feel that it is important for our work together. I will note all consultations in your Clinical Record.

I also have contracts with some business services, such as a billing service, electronic claims processing service, and email services. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. A copy of these agreements will be made available for your inspection on request.

In the case of family or couple sessions all notes of sessions are kept in a combined file and will require all adult participants’ authorization to release information contained in this file. Occasionally only some members of the family (or perhaps only one) are present for a session. It is my policy to keep information confidential outside the family, however, to share information between family members where that seems both practical and likely to be helpful, in my professional judgment. If you have any questions about this policy, please discuss this with me. In the event that a breach of data occurs I will contact any clients that I believe have been affected and notify them of the information that may have been reached.

**Minors and Parents:** Clients under 18 years of age and their parents should be aware that the law may allow parents to examine their child’s treatment records at any time. However, I ask that you as a parent be aware that privacy in therapy is often crucial to successful progress. Although I will provide records as the law requires if requested, I ask that parents participate in a session first so that we can have an open dialogue with all parties involved rather than have the minor feel that their privacy was violated and possibly hinder their progress in therapy. I will provide the parents with general information about the progress of treatment and attendance. In the case of a child custody order, I will require a copy of the most recent custody order decree indicating parental rights or guardianship for my records before initiating treatment.

**Supervision:** As an LMFT Associate, I am under supervision provided by Dr. Leonard Bohanon. If you have any concerns or complaints he can be contacted anytime by phone or email.

Phone: (832) 628-5253 Email: leonard@drbohanon.com

Complaints can also be made to the Behavioral Health Executive Council. Please ask me for the information or see the posted information in the waiting room.

**Payment for Service:** My rate for a standard 50-minute session ranges from $80-150. My policy is for my clients to choose their own rate within this range. Think of how much you can afford consistently and decide on a number within this range that fits best to your personal budget. My hope is to make therapy more affordable and accessible for everyone. Finances should not prevent you from receiving services! If my regular rates would hinder you from obtaining therapy, please bring this to my attention so that we can find the best fit for you. I request that clients pay fees or charges at the end of each session unless other arrangements have been made in advance. I accept most credit/debit cards, checks, and cash.

I am not currently in-network with any insurance. However, I can provide you with a "super bill" with my full fee of $150 per session in a document that you can send to your insurance company to request out-of-network reimbursement. You (not your insurance company) are responsible for full payment of fees. I recommend that you contact your insurance company in advance of your appointment to verify your benefits coverage.

My agreed upon rate is \_\_\_\_\_\_\_\_

**Legal Service:** I do not provide legal testimony services. If compelled to provide those legal testimony services, there are additional fees which are substantially higher than my fees for clinical services. My fee is $300 per hour with a minimum of 5 billable hours payable in advance.

**Emergencies:** If there is an emergency, please call 911, contact local authorities, or direct yourself to the nearest hospital. I am not always available, and you will get the best possible care in those instances at a hospital. If a non-emergency incident has come up during the week that cannot wait until your next appointment, you may give me a call so that we can set another session. If I am not immediately available, I will return your call as quickly as possible. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

**Appointments and Contact:** When you make an appointment, that time is reserved for you. Please make every effort to be on time for scheduled appointments. If you must cancel an appointment or will be more than a few minutes late, please provide as much notice as you can. I try my best to respond within 24 hours of contact. Please keep in mind that in order to protect your confidentiality phone messages and emails should be kept to scheduling matters only.

**Social Media:** I do not communicate with any of my clients through social media. I do not accept Friend or Contact requests from current or former clients on social media. If I discover that I have accidentally established an online relationship with you, I will cancel that relationship. I believe that including clients as social networking contacts may not only compromise client confidentiality and our respective privacy, but also blur the boundaries of our professional relationship. I have a website that you are free to access that is used for professional information about me and my practice.

**ACKNOWLEDGEMENT**

I understand and accept those policies and practices. This practice is hereby granted consent to contact me as specified above, and for the use and disclosure of my health information as described in those policies for Treatment, Payment and Health Care Operations. I hereby consent to evaluation and treatment for myself and/or my dependent(s) specified on the Personal Data Record.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Client or Authorized Representative Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature