Whitney Barrell, LCSW
1308 s. 1700 e. suite 209 SLC, Utah 84108
p.385.355.4355
whitneybarrell@gmail.com
www.whitneybarrellcounseling.com

Intake Form

Please provide the following information, what you provide here is protected as confidential information. *If the client is your child, please fill out the questions that are pertinent to your child.*

GENERAL INFORMATION

Client's name: _____

Name of parent or legal guardian (if under 18 years of age)

_____

Client's Date of Birth: _____ Age: _____ Gender: (circle) Male Female

Please list any children/siblings and their ages:

Please list any family members or others living in the home:

Client's address: _____ City_____
State:_____ Zip Code:_____

Home Phone: _____

Cell/Other Phone: _____

Referred by (if any):

Have you/your child previously received any type of mental health services?
No Yes, previous therapist/practitioner:

Are you/your child currently taking any prescription medications?
If yes, please list:
Medication Name: _____ How Long? _____

Medication Name: _____ How Long? _____

Have you/your child ever been prescribed psychiatric medication *in the past*?
If yes, please list:
Medication Name: _____ Dates: _____

Health and Mental Health Information

1. How would you rate you/your child's current physical health? (circle)
Very Good Good Satisfactory Unsatisfactory Poor

Please list any specific health problems you/your child are currently experiencing.

2. How would you rate you/your child's sleeping habits? (circle)
Very Good Good Satisfactory Unsatisfactory Poor

Please list any specific sleep problems you/your child are currently experiencing:

3. Please list any difficulties you/your child experiences with appetite or eating patterns.

4. Are you/your child experiencing chronic pain? If yes, for how long?

5. Has alcohol ever impacted you/your child's ability to function?

6. Has the use of recreational drugs ever impacted you/your child's ability to function?

7. Have you/your child ever been a victim of physical abuse/neglect? No Yes

8. Have you/your child ever been a victim of sexual abuse? No Yes

9. Have you/your child ever experienced trauma? No Yes

10. Did you/your child achieve developmental tasks on target? If no, please describe:

ADDITIONAL INFORMATION

1. Are you/your child currently employed? If yes, please describe your current position.

2. What do you consider to be some of you/your child's strengths?

3. What do you consider to be some of you/your child's weaknesses?

4. What would you/your child like to accomplish during your time in therapy?

5. How motivated do you feel about the change you/your child would like to make? (circle, 10 is most motivated)

1 2 3 4 5 6 7 8 9 10

FAMILY MENTAL HEALTH HISTORY

In this section, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (ex. Father, grandmother, uncle, etc)

			Family Member
Alcohol/Substance Abuse	No	Yes	_____
Anxiety/Panic/OCD	No	Yes	_____
ADD/ADHD	No	Yes	_____
Bi-polar Disorder	No	Yes	_____
Depression	No	Yes	_____
Domestic Violence	No	Yes	_____
Eating Disorders	No	Yes	_____
Schizophrenia	No	Yes	_____
Suicide Attempts	No	Yes	_____

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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 and 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 and 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 client's' records. Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes and summaries.

Email and Text:
Although you may use email and text to communicate with me, be aware the confidentiality using these means cannot be guaranteed.

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

_____
Client's Signature (Client's Parent/Guardian if under 18 years of age)

_____Today's Date

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Professional Service Agreement

My goal is to provide you with the best service possible, I look forward to working with you to improve your life and relationships. A variety of evidence based treatment methods will be used to provide relief, and to improve coping and problem solving skills. By signing you are consenting to treatment for yourself or your child.

FEES AND BILLING: Therapy sessions are 45-50 minutes each. Each therapy session is billed at $125.00. If you fail to arrive to the appointment on time, the session will still end at the allotted time and will be billed as a complete session. Payment is due in full at the end of each session by cash, check, debit card or credit card. *Checks are preferable, due to the fees for processing credit*. If applicable and as a convenience to you, we can bill your primary insurance company for each session. Secondary insurance billing is not provided. You are responsible for paying all co-payments, co-insurance, deductibles and insurance denials. Collections: All delinquent accounts will be charged an interest rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay collection fees. The undersigned further agrees to pay court costs and reasonable attorney's fees in addition to the collection fee. You authorize us to call you at any number you provide or at any number at which we reasonably believe we can contact you, including calls to mobile, cellular, or similar devices for any lawful purpose. You agree to any fee(s) or charge(s) that you may incur for incoming calls from us, and /or outgoing calls to us, to or from any such number, without reimbursement from us.

COURT POLICY: Please be advised that Whitney Barrell, LCSW does not participate in person, by phone or in writing in any court related matter that the client of Whitney Barrell, LCSW may be a party to or become a party to in any way. Whitney Barrell, LCSW does not write letters regarding their client's treatment to any entity, including court. Whitney Barrell, LCSW at no time will offer an opinion or recommendation in any court matter, especially as it relates to custody. Whitney Barrell, LCSW is licensed as a therapist and does not function in the role as a custody evaluator and therefore cannot practice out of the scope of her license. If a court order is served and is requesting that Whitney Barrell, LCSW be present in person and or there is a request for records, the client's consent will be requested before turning over confidential information. When obtaining this consent, the client will be told exactly what has been requested by court and there is no guarantee that the information will be kept confidential. This includes a client's mental health history; current status and inclusive records and may not be in the best interest of the client. The therapist - client relationship does not render the therapist as an advocate. The therapist will withhold any opportunity to engage in a dual relationship with the client.

Court Policy & Fees

Please be advised that should Whitney Barrell, LCSW be ordered by court to write a letter to the court, the time shall be billed to the client at $125 per hour.

Please be advised that should Whitney Barrell, LCSW be court ordered to appear in court, the fee stipulation is as follows, which will be charged to the client whose attorney sent the order.

- $1,000 per day
- $200 per hour for preparation

Whitney Barrell, LCSW will **NOT** be ON-CALL at anytime. Should a case be trailed, or continued, the therapist will be paid in full for each day. All court fees must be received by cashier's check 7 days prior to the court date. Should the court, calendar the hearing for another date, Whitney Barrell, LCSW must be re-issued a new subpoena with the new court hearing date.

By signing and dating below, you understand and agree to the above stated court policy and stipulation, including but not limited to the fee structure for all related court matters.

CANCELLATION POLICY: If you are unable to make your scheduled appointment, I request that you cancel at least 24 hours in advance so that another client may be scheduled at that time. If 24 hour notice is not given, you will be charged a late cancellation service fee of $40.00. If you fail to inform me at all and do not show for your appointment, you will be charged the full session amount, which is either $125 or the insurance contracted rate, typically $70-120. Thank you for your consideration regarding this important matter.

IN CASE OF EMERGENCY: In the event of an emotional, behavioral crisis call the University of Utah Neuropsychiatric Institute at 801-587-3000 call 911 or go to the nearest emergency room. PLEASE BE ADVISED THAT WHITNEY BARRELL, LCSW DOES NOT PROVIDE 24 HOUR CRISIS SERVICES. I have read, understand and agree to the information and policies as stated above, and I give consent for treatment with Whitney Barrell, LCSW.

Client Name: _____ Date:_____

Parent Name: _____

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Patient Privacy Policy (H.I.P.P.A.)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO IT. PLEASE REVIEW IT CAREFULLY.

1.Your medical records are used to provide treatment, bill and receive payments, and conduct health care operations. Examples of these activities include but are not limited: review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal uses outlined above except when required by law or authorized by the patient or legal representative.

2. Federal and State laws require abuse, neglect, domestic violence, and threats of violence to be reported to Social Services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative, UNLESS disclosure increases risk of further harm.

3. Disclosed information will be limited to the minimum necessary. You may request an accounting for any uses or disclosures other than those described in sections 1 and 2.

4. You or your legal representative may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identifying the person authorized to request the release, specifying the information you want disclosed, the name and address of the entity you want the information released to, the purpose and the expiration of the authorization. Any authorization provided may be revoked in writing at any time. Psychotherapy notes are not part of your medical record. We have 30 days to respond to a disclosure request, and 60 days to respond if the record is stored off site.

5. You may request corrections to your record.

6. A request for disclosure may be denied under the following circumstance; disclosure would likely endanger the life or physical safety of you or another person; if the requested information references other persons, except the healthcare provider, or if release to a legal representative would likely result in harm.

7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request a review of the denial. This review will be conducted by another licensed healthcare provider, appointed by the original reviewer,who was not involved in the original decision to deny access. A review will be concluded within 30 days.

8. You may request that we restrict uses and disclosures outlined in Section 1, however, we are not required to agree to these restrictions. If an agreement is made to restrict use or disclosure, we will be bound by such restriction until revoked by you or by your legal representative orally or in writing except, when the disclosure is required by law, or in an emergency situation. We may also revoke such restrictions, but information gathered while the restriction was in place will remain restricted by such agreement.

9.If you wish to complain about privacy related issues, you may contact Whitney Barrell, LCSW. You may also contact the Secretary of the Department of Health and Human Services, Huber H. Humphrey Building, 200 Independence Avenue SW, Washington D.C., 20201. In any case, there will not be any retaliation against you or your legal representative for filing a complaint.

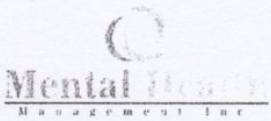
10. If there is a privacy breach, you have a right to be notified. If your are a self pay client you must sign a release for your insurance company to have access to your PHI. You have the right to opt out of any fundraising communication. Disclosures for the purposes of marketing and sale of PHI require your authorization.

11. This agreement may be modified or amended as required by law or in the course of health care operations. I have read and understand this privacy notice, and I understand my rights concerning the use and disclosure of protected healthcare information.

Signature:_____ Date:_____

Provider Name:_____

Patient Information



Patient Information

Patient Name:			
Home Address:			
City:	State:	Zip:	Email:
Home Phone:	Cell Phone:	Work Phone:	
Date of Birth:	Social Security #:	Sex: M F	
Emergency Contact:	Contact Phone #:	Primary Physician:	

Insurance Information

Primary Insurance:			Policyholder Name:
Company Address:			Policyholder Date Of Birth:
City:	State:	Zip:	Subscriber I. D. #:
Company Phone:			Group #:
Employer:			Social Security #:

Secondary Insurance:			Policyholder Name:
Company Address:			Policyholder Date Of Birth:
City:	State:	Zip:	Subscriber I. D. #:
Company Phone:			Group #:
Employer:			Social Security #:

Responsible Party Information

Information about the person responsible for paying the patient portion of the bill(leave blank if same as the client).

Responsible Party:	Date of Birth		Home Phone:
Street Address:			Work Phone:
City:	State:	Zip:	Cell Phone:

Patient Signature:_____ Date:_____