Rebekah H Bragan, MMFT
604 N High St . Ste 3
Columbia . TN 38401
www.rebekahhbragan.com

COUPLES 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.

PARTNER A

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

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: ( ) -

Voicemail? Yes No **Text?** Yes No Emergency Person: _____

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

OCCUPATIONAL INFORMATION:

Are you currently employed? No Yes Employer: _____

Job Title: _____ Length at current Job: _____

HEALTH & SOCIAL INFORMATION

1. How is your physical health at present? Poor Fair OK Good Excellent
2. How regularly do you use alcohol? Daily Weekly Monthly Rarely Never
3. Do you engage recreational drug use? Daily Weekly Monthly Rarely Never
4. Are you currently in a romantic relationship? No Yes how long? _____

Quality of your relationship: Poor Fair OK Good Excellent

5. Is there anything in your relationship you would like to mention that may require special consideration or sensitivity from your counselor? (i.e. LGBTQ, Gender Identity, Sexual Trauma, Religious Trauma/Purity Culture, Sexual Behaviors or non-traditional relationship parameters such as polyamory, open marriage, etc.) _____

_____

_____

SYMPTOM RATING SCALE: (rate each symptom: 0=lowest/None 5=High/Worst)

Emotional Symptoms

Anger	0 1 2 3 4 5	Anxiety	0 1 2 3 4 5	Mood Shifts	0 1 2 3 4 5
Irritability	0 1 2 3 4 5	Depression	0 1 2 3 4 5	Helplessness	0 1 2 3 4 5
Hopelessness	0 1 2 3 4 5	Frustration	0 1 2 3 4 5	Crying Spells	0 1 2 3 4 5
Emotionless	0 1 2 3 4 5	Fear	0 1 2 3 4 5	OTHER: _____	
Worry	0 1 2 3 4 5	Guilty	0 1 2 3 4 5		

Mental Symptoms

Trouble Concentrating	0 1 2 3 4 5	Inattention	0 1 2 3 4 5
Difficulty Making Decisions	0 1 2 3 4 5	Distractibility	0 1 2 3 4 5
Repeated Neg. Thoughts	0 1 2 3 4 5	Memory Problems	0 1 2 3 4 5
Paranoid Thinking/Behavior	0 1 2 3 4 5	Racing Thoughts	0 1 2 3 4 5

Behavioral Symptoms

Hyperactivity	0 1 2 3 4 5	Purging/vomit	0 1 2 3 4 5	Alcohol Use	0 1 2 3 4 5
Impulsivity	0 1 2 3 4 5	Disordered Eating	0 1 2 3 4 5	Drug Use	0 1 2 3 4 5
Arguing	0 1 2 3 4 5	Suicidal Thoughts	0 1 2 3 4 5	Fighting/Aggression	0 1 2 3 4 5
Disorganized	0 1 2 3 4 5	Self-Injury	0 1 2 3 4 5	Lying/Deceitfulness	0 1 2 3 4 5
Binge/Over Eating	0 1 2 3 4 5	Withdrawal	0 1 2 3 4 5	Avoiding School/Job	0 1 2 3 4 5

Physical Symptoms

Appetite Increase/decrease	0 1 2 3 4 5	Severe Headaches	0 1 2 3 4 5
Sleep Difficulties	0 1 2 3 4 5	Muscle Tension	0 1 2 3 4 5
Increased Heart Rate	0 1 2 3 4 5	Body Pain/Numbness	0 1 2 3 4 5
Sweating/Chills	0 1 2 3 4 5	Other: _____	
Stomach or Gut Issues	0 1 2 3 4 5		

CURRENT MEDICATIONS:

Name:	Dose:	Treatment of:	Prescriber:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Counselor Notes: _____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?

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

Other significant familial information that might impact your mental health treatment?

_____

_____

GOALS & TREATMENT PLANNING:

☆What do you consider to be your personal strengths?

☆What are some effective coping/self-care 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.

PARTNER B

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

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

Address: _____

_____
(City) (State) (Zip)

Marital Status:

Never Married Partnered Married Separated Divorced Widowed

Spouse: _____
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BOTH PARTNERS REVIEW

DUTY TO WARN & 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.

_____ initials **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.

_____ initials **Prenatal Exposure to Controlled Substances**
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

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

_____ initials **Insurance Providers** (when applicable)
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 any ramifications should risk be reported.

_____ _____
Client signature (parent/guardian if under 16) Date

CONSENT FOR TREATMENT

I, _____, **(client)** hereby consent to treatment by way of counseling with _____**(counselor)** 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.

Additionally, each client may have a face sheet that is kept on file with this practice, that is behind double lock, and includes your name, contact information, reason for treatment, and any safety plans created. This is in case of emergency should something happen to this counselor and their identified *In Case of Emergency* counseling partner will contact you to make alternative counseling plans.

I recognize that a copy of the **HIPAA Privacy Policies** for treatment has been made available online with the printable paperwork for me to print and keep for my own records.

_____ _____
Client/Guardian Signature (if client is under 16) Date

FINANCIAL AGREEMENT:

This practice is committed to providing you with the best possible care. In order to achieve these goals, your assistance & your understanding of our payment policy is needed.

Payment for service is due at the time services are rendered *unless* payment arrangements have been agreed upon *in advance*. This practice accepts most credit cards, HSA's (Health Savings Accounts), cash, check and Venmo, though a small fee may be charged with credit transactions. 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 counselor's home life. Your appointment time cannot be filled with other clientele *unless the appropriate notice has been given*. For this reason, it is asked that you make every effort to provide at least a **24-hour advance notice** by your counselor's provided best contact (email/call/text).

It is understood that crisis situations occur and circumstances can conflict with your ability to keep your appointment, and this counselor will consider the circumstances carefully. In most situations, when the appropriate amount of time has not been given to cancel, you may anticipate that **the full fee** will be applied to the card you choose to keep on file with this counselor. *This measure has been created out of necessity to ensure a mutual respect is established for one another's time.*

PAYMENT:

*Insurance: While this practice does not currently accept Insurance, it 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. Please be aware that by submitting a superbill to your insurance, a diagnosis is required and will reflect on your permanent history which may impact insurance renewals or changes as the diagnosis will be considered a "pre-existing condition."*

As counselors advance in their profession and gain licensure, specializations, etc, their rates may increase. While you are an active client, the rate with which you enter counseling, as posted in the space below, will remain the same, and will continue to be grandfathered in at the identified rate. (Unless otherwise discussed in writing with said therapist for any long-term clients). Once your file is closed, either through successful completion of treatment goals, termination of services, or a lapse in treatment exceeding 3 months, you will be required to complete NEW paperwork and will re-enter with the counselor at their present rate of services.

This provider has created a payment scale. The rates at this office range from $125-$250/ Therapeutic Hour. For details about your counselor's rates, please visit the website at www.rebekahhbragan.com or contact your counselor directly for current fees.

_____
initials

As a professional courtesy, this provider acknowledges unforeseeable circumstances, and may extend grace for regular clients who have consistent attendance history. Should late canceling and rescheduling appointments 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 require payment of the **full fee for counseling services.** This will be automatically charged to the card you keep on file. It is important to note that most counselors have a waiting list of clients who would be able to coordinate their schedule to accept a canceled appointment should an adequate notice be given.

_____ 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.

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.

My Identified session fee is: _____/therapeutic hour (50-60 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 counselor's expectation for my financial commitment and have read and agree to the Financial Agreement.

Signed: _____*Date:* _____

Counselor Signature: _____*Date:*_____

_____

Thank you for being on this journey with me, and as always, I hope that you feel as though this space is safe, warm, and inviting to walk through some of life's most vulnerable trials you are facing. I value each of you and hope it is felt each time you enter this space.

Should you have any concern about this document or working with this provider, please contact Rebekah at rhbragan.counseling@gmail.com so we may work together to provide you with an alternative arrangement or referral to some local colleagues in the community, should there be the need.

Sincerely,

Rebekah H Bragan, MMFT
under the supervision of Joanna Dixon, LMFT #1070