WESTCHASE OFFICE: Elan Wellness Center, 12197 W. Linebaugh Avenue, Tampa, FL 33626
ST. PETERSBURG OFFICE: Docs Outside the Box! 8950 Dr. MLK St. N, St Petersburg, FL 33716

Kimberly Acheson
MSW, LCSW
License #10560

Confidential Client Intake Summary Form

Date: _____
Name: _____
Address: _____
Best phone contact to reach you at: _____
Email _____
Age: _____ Date of birth: _____
Employer (or school, if student) _____
Occupation _____
Insurance Company _____
Member ID Number _____
If EAP/SAP, Authorization # _____
Relationship Status: __Single __Married __Divorced __Widowed
If separated, how long had you been together: _____
If married, how long have you been married: _____
Current Household Family: Do you have children? _____
Names / Age _____
_____
Others living in home: name, relationship _____
_____
How many times have you been married? _____
Brief description of why you're seeking counseling: _____
_____
_____
_____
_____
Counseling history: approximately how many visits with a therapist?
__1 - 4 __5 - 10 __11 - 30 __1 year or more __2 years or more
How was previous therapy helpful or not helpful? _____
_____
_____
Current medications/dosage: _____
_____
Previous medications, dosages, dates, why stopped _____
_____
Relationship to Your Parents __Biological __Adopted __Step-child
Mothers Age: _____ Father's Age: _____
Number of Brothers: _____ Number of sisters: _____
Briefly describe your relationship with your father: _____
_____
Briefly describe your relationship with your mother: _____
_____
List family members with mental health past: _____
_____

History of trauma or abuse
Neglect/Physical abuse/Sexual abuse _____
_____
Rape or assault _____
Accidents/natural disasters/childhood losses: _____
_____
Medical history:
Do you have any significant health/medical issues? __Yes __No
If yes what is/are the health issue(s) and are you limited in any way?
_____
_____
Abuse history: Have you ever been physically, emotionally, or sexually abused? __Yes __No. If yes, briefly explain (who, what and when):
_____
_____
Do you have people that you can turn to for support? Yes___ No___
If yes, who? _____
What do you hope to achieve or accomplish through counseling?
_____
What have you tried that has been helpful? _____
What current issues or problems do you hope to deal with initially?
_____
_____
Areas of Concern or Stress: (use an x for current concerns; circle past concerns) __Personal/Relational __Anxiety/worry __Stress
__Panic attacks __Fear __Restlessness __Anger __Frustration
__Confusion __Shyness __Feeling inadequate __Disorganized
__Difficulty making decision __Loneliness __Guilt __Shame
__General unhappiness __Depression __Grief __Crying spells
__Boredom __Mood swings __Suicidal thoughts __Headaches
__Thoughts of hurting others __Unwanted thoughts/rituals
__Problems at work __Relationship problems __Aches or pains
__Concern about sexual identity/preference __Financial concerns
__Concern about sexual function __Low energy __Nightmares
__Memory lapses, blank periods __Unable to concentrate
__Abdominal problems __Fatigue __Unwanted memories or images
__Cutting, burning or other self-harm __Sudden impulses
__Difficulty coping with daily demands __Difficulty trusting others
__Secrets I'm afraid to tell anyone __Physical problems or pain
__Disturbing fears I think about __Communication difficulties
__Inability to stop doing certain things __Peculiar or wierd experiences
__Hearing voices/things others don't hear __Depending too much on others
__Feeling different from others __Alcohol or drug abuse problem
__Restrict food __Binge/purge __Excessive means to control weight

Consent for Treatment Form

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OUTPATIENT SERVICES CONTRACT Welcome to my practice. I am governed by various laws and regulations and by the code of ethics of my profession. The ethics code requires that I make you aware of specific office policies and how these procedures may impact you. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

COUNSELING SERVICES Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Sometimes counseling services are provided primarily to prevent further deterioration of your mental or emotional status which is considered maintenance treatment. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. Under certain circumstances I may recommend a psychiatric consult; conjoint marital/couple, conjoint parent/child sessions and/or group psychotherapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to refer you to another mental health professional for a second opinion.

MEETINGS I normally conduct an evaluation that will last from 1 to 2 sessions. During this time, we can both decide whether I am the best person to provide the services you need in order to meet your treatment goals. If you decide to continue treatment, I will usually schedule one 60-minute session per week at a time we agree upon.

PROFESSIONAL FEES My hourly fee is $90.00. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you request of me.

BILLING AND PAYMENTS You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. If you wish to pay by check, please make it payable to: Kimberly Acheson.

INSURANCE REIMBURSEMENT In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. You should be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide them with additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This record will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do once it is in their hands. In some cases, they may share information with a national medical information databank. Once I have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself (private pay) to avoid the problems described above.

CONTACTING ME I am often not immediately available by telephone. My telephone is answered by an answering service voice mail that I monitor periodically throughout the day. I will make every effort to return your call the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. Telephone calls are offered as a professional courtesy and this service does not constitute an emergency service. I am not responsible for your behaviors or decisions occurring outside the consultation room at any given time, whether before or after a telephone call or consultation. If you are unable to reach me and feel that you can't wait for me to return your call, contact 911, your family physician or the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

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MINORS If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle objections you may have with what I am prepared to discuss.

CONFIDENTIALITY In general, the privacy of all communications between a client and a LCSW psychotherapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person or disabled person is being abused, I must file a report with the appropriate state agency. If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police and seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or contact family members or others who can help provide protection. I will take any threats seriously whether I am informed by you or someone you know. Therefore, please use discretion when providing my contact information to a third party. You should be aware that when counseling services are sought by third parties such as employers, lawyers, or the courts, disclosure of some information is required by law. You should also be aware that disclosure of requested information to third parties, when mandated by law, could potentially have an adverse affect on your life. These situations have rarely occurred in my practice. I will make every effort to discuss it with you before taking any action, unless I believe that notifying you may put you or your health in jeopardy.

TERMINATION Your participation in psychotherapy is voluntary and you have the right to withdraw from treatment without adversity at any time. I would recommend that when termination is considered, you discuss this with me, so that we can create a plan for termination to minimize any possible negative effects.

Your signature below indicates that you have read the information in this document, were provided accurate information, and agree to abide by the terms during our professional relationship.

_____
Print Name of Client above line

_____ _____
Signature of Client Date

_____ _____
Additional Client Signature (Spouse/Partner/Friend/Family Member) Date

_____ _____
Signature of Parent/Legal Guardian/ Foster Parent/ Conservator/Other Date

_____ _____
Signature of Psychotherapist - Kimberly Acheson Date