



Welcome! Let me take a minute to provide you with some professional information about myself. I am a Licensed Marriage and Family Therapist in Nevada (#01435) and California (#94047). My Master of Science is in Marriage & Family Therapy from Vanguard University and my undergraduate degree is from New York University. I provide mental health counseling for individuals, families, couples, adolescents and children. Please complete the following forms; the information you provide below will be helpful in determining the best course of action for your current needs.

**Client Information**

Name \_\_\_\_\_ Date \_\_\_\_\_

Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_ Referred By/Website \_\_\_\_\_

Highest Level of Education \_\_\_\_\_ Occupation \_\_\_\_\_ Income (Sliding Scale) \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Number \_\_\_\_\_ Relationship \_\_\_\_\_

**Second Party Information (Parent, Legal Guardian, Etc.)**

Name \_\_\_\_\_ Date \_\_\_\_\_

Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_

Highest Level of Education \_\_\_\_\_ Occupation \_\_\_\_\_ Household Income \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Number \_\_\_\_\_ Relationship \_\_\_\_\_

**Payment Information (Credit Card)**

Name as it appears on card \_\_\_\_\_ Zip code (billing address) \_\_\_\_\_

Credit Card number \_\_\_\_\_ Expiration \_\_\_\_\_ Vcode \_\_\_\_\_

Signature authorizing payment for each Session or cancellation without 24 hour notice to be billed on card \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

**Background Information**

**Immediate Family Members (Use back of sheet if space is needed)**

Name	Relationship	Age	Living In Home Y/N

Have you had any treatment with a psychiatrist, psychologist or therapist in the past? \_\_\_\_Yes \_\_\_\_No

If yes, Psychiatrist/therapist/practitioner \_\_\_\_\_ Was it Helpful? \_\_\_\_Yes \_\_\_\_No

Current Prescription Medications \_\_\_\_\_

Religious Affiliations or Church \_\_\_\_\_ Do you want Spiritual/religious issues to be a part of your therapy?  
\_\_\_\_ Yes \_\_\_\_ No

Briefly explain why you are seeking counseling today: \_\_\_\_\_

Please describe any complaints associated with the problem: \_\_\_\_\_

When did the problem start? \_\_\_\_\_ How long do you think it will take to resolve these problems? \_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_

Are you currently at risk of harming yourself or someone else? \_\_\_\_Yes \_\_\_\_No \_\_\_\_Unsure

Have you attempted to harm yourself in the past? (Please list dates) \_\_\_\_\_

Following is a list of common obstacles that often lead people to seek counseling. Please check all that apply:

- |   |  |  |                                     |
|---|--|--|-------------------------------------|
| <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Communication     | <input type="checkbox"/> Self Esteem         | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Addiction            | <input type="checkbox"/> Grief             | <input type="checkbox"/> Eating Problems     | <input type="checkbox"/> Insomnia   |
| <input type="checkbox"/> Alcohol              | <input type="checkbox"/> Drugs             | <input type="checkbox"/> Weight              | <input type="checkbox"/> Stress     |
| <input type="checkbox"/> Smoking              | <input type="checkbox"/> Gambling          | <input type="checkbox"/> Work Problems       | <input type="checkbox"/> Shyness    |
| <input type="checkbox"/> Relationships        | <input type="checkbox"/> Sexuality         | <input type="checkbox"/> Panic Attacks       | <input type="checkbox"/> Guilt      |
| <input type="checkbox"/> Phobia (Please List) | <input type="checkbox"/> Abuse             | <input type="checkbox"/> Trauma              | <input type="checkbox"/> Anger      |
| <input type="checkbox"/> Suicide Attempts     | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Self-Harm (Cutting) | <input type="checkbox"/> Pain       |
| <input type="checkbox"/> Low Motivation       | <input type="checkbox"/> Sexual Problems   | <input type="checkbox"/> Social Withdrawal   | <input type="checkbox"/> School     |

Is there a family history of any of the following? Please List Family Member in space provided (father, mother etc..)

- |                  |                         |                         |                 |
|------------------|-------------------------|-------------------------|-----------------|
| _____ Alcoholism | _____ Drug Use          | _____ Depression        | _____ Anxiety   |
| _____ Suicide    | _____ Attempted Suicide | _____ Medical Problems  | _____ Psychosis |
| _____ OCD        | _____ Eating Disorder   | _____ Domestic Violence | _____ Abuse     |

In the past 2 weeks have you engaged in any of the following?

- |                                      |                 |                         |
|--------------------------------------|-----------------|-------------------------|
| <input type="checkbox"/> Alcohol     | Frequency _____ | Your Strengths _____    |
| <input type="checkbox"/> Marijuana   | Frequency _____ | Your Weakness _____     |
| <input type="checkbox"/> Drugs       | Frequency _____ | Your pets & names _____ |
| <input type="checkbox"/> Other _____ | Frequency _____ | Your Hobbies _____      |

Explain how you cope with stress: \_\_\_\_\_

What do you like to do with your free time? \_\_\_\_\_

Are you currently in a romantic Relationship? \_\_\_\_ If yes, for how long? \_\_\_\_

On a scale of 1-10, how would you rate your relationship? \_\_\_\_ If there is areas you would like improvement what are they? \_\_\_\_\_

What stressful life events have your experienced recently? \_\_\_\_\_

Is there anything else that you feel is important for me to know? \_\_\_\_\_



**Client Rights**

1. You have the right to receive information concerning the methods of therapy employed, the techniques used, the duration of therapy and the fee structure for services provided. If services are not appropriate, referrals to other qualified professionals will be provided.
2. You have the right to refuse or terminate treatment at any time.
3. You have the right to seek a second opinion, if needed I can provide you with the names of other qualified professionals.
4. You have the right to know that in a professional psychotherapeutic relationship sexual intimacy between therapist and client is never appropriate.
5. Therapy is a professional relationship. It is extremely important that you and I both believe the relationship is the right fit in order to provide you with the greatest benefit possible. Because I value and appreciate your commitment to therapy, if at any time I believe you would greater benefit from seeking the services of another professional, I will inform you immediately and provide referrals.

\_\_\_\_\_ Initials

**Confidentiality**

The therapeutic relationship is confidential and protected by ethical standards of practice and Nevada statutes. Any information obtained in the therapeutic setting cannot be released without your prior written consent except in the following situations according to Nevada State Regulations:

- a. Cases of suspected child or elder abuse or neglect.
- b. Cases of potential harm to self or others or a need for immediate hospitalization – medical/mental health concerns
- c. Cases of legal claims or defense required by state or federal law or court ordered by a judge.
- d. Cases under investigation by a board of examiners as part of an investigation or hearing.
- e. If you are under the age of 18 in the State of Nevada, parents have access to information in regard to their child's medical records.

It is my policy to maintain confidentiality throughout the therapeutic process; therefore, I will not acknowledge clients in a public area unless first approached by client.

\_\_\_\_\_ Initials

**Fees and Cancellation Policy**

Sessions are 50 minutes long. The charge per session is \$175.00 or sliding scale fee of \_\_\_\_\_ is due at the time of service. Please give a 24-hour cancellation notice to avoid a fee for the missed appointment and to allow others to receive help in your place.

\_\_\_\_\_ Initials

**Emergencies**

*I understand that Kana Nootenboom is not a 24-hour crisis intervention provider. If I am faced with a mental health emergency I agree to call 911 or go to my local emergency room.*

\_\_\_\_\_ Initials

**Insurance Billing**

I do not accept insurance. If you have PPO insurance I will give you a superbill (receipt) at the end of the month which you can submit to your insurance for possible reimbursement and/or to go towards your deductible. I understand that I am responsible for contacting my insurance company for information about my insurance coverage .

\_\_\_\_\_ Initials

**Electronic Communications**

Though I do my best to protect your confidentiality of electronic messages, please note that I cannot guarantee confidentiality under circumstances that include use of Internet (VSee, Skype, Facetime), cellular phone or text message.

\_\_\_\_\_ Initials

*I authorize Kana Nootenboom to send Email and or text messages regarding appointments*

\_\_\_\_\_ Initials

If you are wanting teletherapy through VSEE (app like Skype but Hippa compliant) or by phone, please fill out the Teletherapy intake and consent form.

***I have read and fully understand the nature and limits of the above statements and agree to participate in counseling under these conditions.***

Signature \_\_\_\_\_ Date \_\_\_\_\_

# HIPPA Privacy Statement

## I. Uses and Disclosure for Treatment, Payment, and Health Care Operations

Las Vegas Counseling Center may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. We are required by law to maintain the privacy of HI and to provide you with our legal duties and privacy practices with respect to PHI> we are required to abide by the terms of this notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the Revised Notice of Privacy Practices by sending you a copy in the mail upon request at your next appointment.

## II. Uses and Disclosures Requiring Authorization

We may use of disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when we asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing psychotherapy notes. “Psychotherapy notes” are notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

## III. Uses and Disclosures with Neither Consent Nor Authorization.

We may use of disclose PHI without your consent or authorization in the following circumstances: (1) Child Abuse/Neglect; (2) Elder Abuse/Neglect; (3) Health Oversight (Nevada Licensing Board requesting records); (4) Judicial or Administrative Proceedings (Judge Court Order); (5) Serious Threat to Health or Safety to self or others; (6) Workers Compensation (if you file a claim)

Client Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

(If a child or adolescent under age 18, parent or legal guardian must sign)