Living Fluent

INTAKE PACKET

Please complete the following packet and give it to your therapist during your first session. The packet includes these documents:

New Client Information

HIPAA Acknowledgement

Consent for Telehealth and Telecoaching services

Release of Information Form

Fee Agreements

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First Name:_____Middle Initial:_____Last Name: _____
Date of Birth: _____
Sex: M F
Marital Status:_____
Address:_____
City:_____State:_____Zip Code: _____
Phone Number: _____
Email Address: _____
Referring Physician Name (Optional): _____
Referring Physician Phone Number & NPI (Optional) : _____

MENTAL HEALTH HISTORY/STATUS:
What problems are you seeking help for?

_____
_____
_____
_____
_____
_____

Have you ever been hospitalized for psychiatric reasons? Yes:_____No: _____
If yes, When and where? _____

Have you ever had outpatient treatment by a psychiatrist? Yes:_____No:_____
If yes, when and where? _____

Have you ever received counseling or psychotherapy in the past? Yes:_____No:_____
If yes, when and where? _____

Please list any psychiatric medications you are taking or have taken (include dates and amounts taken):

Medication:_____
Medication:_____
Medication:_____
Medication:_____
Medication: _____
Medication: _____

Are you comfortable with or seeking the integration of faith, spirituality, sacred literature within therapeutic sessions?_____

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CONFIDENTIALITY

Generally speaking, the information provided by and to a client during therapy and/or coaching sessions is confidential. If the information is confidential, the therapist or coach cannot be forced to disclose the information without the client's consent. Living Fluent therapists, coaches, and office personnel will not inform others that you are in therapy or coaching and the content of sessions/meetings will remain confidential. The only time this confidentiality may be broken is if one or more of the following exceptions/conditions apply:

- If you pose physical danger to yourself or others
- If you disclose that you or another person has physically or sexually abused a child, an incompetent or a disabled person, or an elderly person.
- If you disclose that a child, an incompetent or a disabled person, or an elderly person is suffering due to neglect.

If any of the above are disclosed in session, we are mandated by law to report such information to the appropriate State agency.

Additionally, it is important to know and understand that your information may be shared with other Living Fluent therapists, coaches, and/or administrators for the purposes of case consultation, supervision, billing, and other administrative functions. By your signature below you authorize and release your therapist and/or coach to provide this information to Living Fluent as a whole.

It is possible that you and your therapist or coach may run into each other in a public place. Should this occur, the therapist or coach must protect confidentiality by not acknowledging you unless you first acknowledge your therapist or coach. If you approach your therapist or coach, contact should be brief and no session material should be discussed so confidentiality can be maintained.

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TECHNOLOGY

By your signature below, you authorize Living Fluent to contact you by phone using the number you provide at intake. If this is not a safe number to leave messages at, please let your counselor/coach know in writing or note this on the intake packet itself. Your therapist or coach may call you using a VOIP (internet based voice over IP phone) or a cell phone both of which may not be completely confidential because of potential technology issues.

Email is not the most confidential mode of communication. If you choose to use email to send information to Living Fluent or to a therapist or coach, you do so knowing that this information is at risk, and that your counselor may respond via email.

Text messaging is a popular form of communication. If you choose to text your therapist or coach, this information is at risk as this is not a confidential mode of communication.

Lastly, some sessions may be conducted via teleconference. Living Fluent uses an encrypted site, but as with all technological forms of communication, confidentiality cannot be guaranteed.

At Living Fluent, some therapists or coaches accept text messages and some do not. Please clarify how you would like to communicate with your therapist or coach.

Address client will be at during telehealth sessions (required):

_____

_____

_____

_____

Non-911 local emergency contact number (police, medical, etc.) (required):

_____

_____

_____

_____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
EMERGENCY CONTACT

I,_____hereby authorize Living Fluent Counseling and Coaching Services ("Provider") to receive from and/or disclose to:

Name of Emergency Contact:

_____

the following protected health information:

Information related to a medical or other life-threatening emergency experienced by client.

Emergency contact information:

Home Phone:

Cell Phone:

Relationship to Client:

I understand that I have a right to receive a copy of this authorization, and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective. Revocation does not apply to information disclosed previous to effective date of revocation. I authorize the disclosure of the health information described above for the following purpose:
The specific uses and limitations on the uses of my health information by Recipient are as follows: I understand that Provider cannot condition treatment upon me signing this authorization.

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that the Federal Privacy Rule may no longer protect such information, although the re- disclosure of such information may be protected by applicable Texas law.

Provider is authorized to disclose the protected health information specifically listed above until:

_____(authorization expiration date).

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PAYMENT

Session fees are all listed on the website by appointment.

Living Fluent accepts cash or credit card payments at this time. All clients must make full payment at the time of service. We keep a method of payment on file to make this process easier.

All payments are due at the time of service unless prior arrangements have been made.

SESSIONS

Sessions are normally from 45-50 minutes in length though this may vary based on your individual treatment plan that you develop with your therapist or coach.

Please arrive promptly for sessions. Sessions will end at the designated time regardless of when it was started. Therapists are only required to wait 15 minutes past the scheduled time for an appointment before a no-show appointment can be billed.

CANCELLATIONS

We understand that you may need to cancel an appointment. It is helpful for us to know if you will not be coming, so we ask that you give us 24 hour notice for any change or cancellation. Any late cancellation (less than 24 hour notice), change, or missed appointment will be charged $50. Late cancellations for team counseling sessions involving more than one provider will be charged $100.

Name on Credit Card: _____
Credit Card Number: _____
Expiration Date:_____/_____Security Code (3 Digits for Visa, 4 Digits for AMEX): _____
Zip Code for Card on File: _____

AGREEMENT

I understand that, consistent with the HIPAA requirements, consent to treatment and consent to release information will expire after twelve months and I may revoke such consent at will anytime during services, although revocation is not retroactive.

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I have been informed of and read the preceding information and agree to it.

I UNDERSTAND DR. BRANDON HONEYCUTT IS NOT A STATE LICENSED COUNSELOR BUT PROVIDES NATIONALLY BOARD CERTIFIED PASTORAL COUNSELING, MARRIAGE AND FAMILY THERAPY, AND CERTIFIED COMMUNICATIONS TRAINING.

If you have any questions or would like additional information, please feel free to ask.

ATTESTING THAT I UNDERSTAND THE ABOVE AND AGREE TO THERAPY OR COACHING UNDER THE ABOVE LIST OF DISCLOSURES I HAVE SIGNED BELOW:

CLIENT
SIGNATURE _____ DATE_____

SIGNATURE OF SPOUSE IF
FAMILY/MARITAL COUNSELING_____ DATE_____

SIGNATURE OF PARENT OR
GUARDIAN IF CLIENT IS A MINOR_____ DATE_____

THERAPIST and/or COACH_____ DATE_____