Cathy Swan, LCSW
1832 Snake River Rd., Suite E
Katy, TX 77449
(832) 278-8511
cswan@swancounseling.life

Intake

Please provide the following information. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Please bring this completed and signed form to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

Name of Child/Adolescent: _____

Name of Parent/Guardian: _____

Birth Date: _____ Age: _____ Gender Identification: _____

Address: _____

Parent Cell #: _____ Message OK? Y / N Text OK? Y / N

Home #: _____ Message OK? Y / N

Work #: _____ Message OK? Y / N

Emergency Contact: _____
(Name/Relationship) (Number)

Email: _____ OK to email? Y / N

How did you hear about Swan Counseling? _____

Intake - Continued

Is your child/adolescent currently receiving psychotherapy elsewhere? Yes / No

Have they previously seen a therapist? Yes / No

_____

(Name of Therapist) (When)

Are they currently prescribed psychiatric medications? Yes / No

If yes, please list: _____

If no, have they previously been prescribed psychiatric medications? Yes / No

If yes, please list: _____

HEALTH AND SOCIAL INFORMATION

1. How do you describe their current physical health? (Please Circle)

   Poor Unsatisfactory Satisfactory Good Very Good

2. Please list any history of hospitalizations, major illnesses, or health concerns:

   _____

3. To your knowledge, are they having any problems with their sleep habits? Y / N

   - ☐ Sleeping too much
   - ☐ Sleeping too little
   - ☐ Poor quality sleep
   - ☐ Disturbing Dreams
   - ☐ Other _____

4. Do they drink alcohol? If so, how often? _____

5. Do they engage in recreational drug use? If so, how often? _____

6. Do they use tobacco? If so, how often? _____

7. To your knowledge, do they have thoughts of suicide and/or self-harm? (Circle One)

   Currently Frequently Sometimes Rarely Never

Intake – Continued

8. To your knowledge, do they have thoughts of hurting or killing others? (Circle One)

   Currently Frequently Sometimes Rarely Never

9. Have they ever been hospitalized in a psychiatric facility? Yes / No

   If yes, please provide name of hospital, when they were hospitalized, and why: _____

   _____

   _____

10. Are they currently in a romantic relationship? Yes / No

11. In the last year, have they experienced any significant life changes or stressors? If so, Please describe: _____

    _____

    _____

12. Self-Care: Please list any ways they practice self-care: _____

    _____

Have they ever experienced:

Extreme depressed mood: Yes / No
Extreme elevated mood: Yes / No
Mood Swings: Yes / No
Panic Attacks: Yes / No
Phobias: Yes / No
Hallucinations: Yes / No
Unexplained Memory Lapses: Yes / No
Alcohol/Substance Abuse: Yes / No
Frequent Body Complaints: Yes / No
Eating Disorder: Yes / No
Body Image Issues: Yes / No
Repetitive Thoughts/Behaviors: Yes / No

Intake - Continued

OCCUPATIONAL INFORMATION:

Are they currently employed? Yes / No

If yes, who is their current employer / position? _____

How long have they worked there? _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or other relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g. Brother, Mom, Paternal Uncle, etc.)

Depression: _____

Anxiety: _____

Panic Attacks: _____

Bipolar Disorder (I or II): _____

Schizophrenia: _____

Abuse/Neglect/Domestic Violence: _____

Trauma: _____

Different Learning Abilities: _____

ADD /ADHD: _____

Alcohol / Substance Abuse: _____

Eating Disorders: _____

Suicide Attempt(s) (Indicate if Completion): _____

Homicidal Ideation: _____

Intake - Continued

What made you decide to bring your child/adolescent for therapy? _____

_____

_____

_____

What do you want them to get out of their time in therapy? _____

_____

_____

_____

What do you want me to know that hasn't been addressed in this form? _____

_____

_____

_____

_____ _____

Parent/Guardian Signature Date

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Therapeutic Relationship Agreement

FEES & PAYMENTS

Payment for services is due at the end of each session. Fees may change over time, but you will be informed of any potential rate increases well in advance. Fees for services are as follows:

50-minute individual session – $120.00
90-minute group therapy session – $50.00

CANCELLATIONS

There is no charge for appointments cancelled or rescheduled at least 24 hours in advance. With shorter notice, you are agreeing to pay for the time you reserved. The fee for cancellations within less than 24 hours or no-shows is $60.00. Emergencies are handled on a case-by-case basis, and should be discussed with me at your earliest convenience.

If you are going to be late for your session, please call me to let me know. After 20 minutes past your session start time, if I have not heard from you, I will assume you are not attending and I cannot guarantee that I will still be here when you arrive.

Please Note: Two no-shows/cancellations without at least 24 hours notice will result in the scheduled appointment time being released to other clients.

COMMUNICATION

The best way to reach me is by phone, at (832) 278-8511. Please note that **I do not return calls from Caller ID**. If you would like me to return your call, you need to leave me a message.

Unscheduled phone calls in between sessions will be billed at a pro-rated session fee of $120.00 per hour, for any calls lasting longer than ten minutes (this ***does not include*** regular calls for scheduling/administrative purposes). There is no charge for calls lasting less than ten minutes.

I only communicate with clients via email or text message for scheduling purposes. **Please do not email or text me other content, as I cannot guarantee who could potentially gain access to it.**

Therapeutic Relationship Agreement - Continued

Additionally, I cannot accept any requests to be connected with clients on social media sites such as Facebook, Instagram, or LinkedIn. Please review the *Digital Media Policy* for detailed policies and reasons regarding limits to digital communication options.

INSURANCE

Currently I am an in-network provider with the following insurance companies: Blue Cross Blue Shield, United Healthcare, Aetna, Cigna, and Medicare. Because all plans, coverage, and deductibles are different, please **contact your insurance provider with specific questions about your eligibility and mental health benefits.** If you have a different insurance carrier, you can contact them directly to obtain information regarding your out-of-network mental health benefits.

EMERGENCIES

I cannot promise to be available at all times. I do not provide emergency services like 24-hour coverage. I typically do not answer the phone when I am in session with another client. Phone messages will be responded to as quickly as possible. Phone calls received between 6:00 PM and 9:00 AM, and on weekends and holidays, will be returned the next **business** day.

If you are experiencing a clinical emergency and are unable to reach me, please immediately call the 24-hour telephone counseling line, Crisis Intervention of Houston, at **(713) 533-4500.**

If the matter is urgent and you feel like your safety is at risk, especially if you are feeling suicidal, please call 911 or go directly to the nearest emergency room.

CONFIDENTIALITY

Texas state law and the ethics of my profession require that anything you say in the context of our therapeutic relationship remain confidential; however, the *Notice of Privacy Practices* explains the times and situations in which the law may require me to break some portion of our confidentiality.

I participate in professional consultation and supervision groups and at times we discuss specific cases. I protect my clients' confidentiality at those times by concealing their identities (for example, I do not use names, professions or other specific identifying information).

I require written authorization from you, outside of the times required by law, or through supervision or consultation, to discuss with anyone or disclose in any way your personal information. This includes speaking with other doctors, such as a psychiatrist, your family members, lawyers or insurance professionals. **Please note**: if you are 18 years of age or older, regardless of who pays for your therapy, I need a signed release to speak to anyone (including parents) about your treatment.

Therapeutic Relationship Agreement – Continued

CLIENT LITIGATION

I will not voluntarily participate in any litigation or custody dispute in which the client is involved. This includes communication with the client's attorney, as well as documentation such as letters, reports, and affidavits. **I will not voluntarily provide testimony**. Should I be ordered by a court of law to appear as a witness in an action involving the client, the client agrees to reimburse me for any time spent out of the office, for preparation, and travel. The client or client's attorney will billed at a rate of $500/hour, door to door. A retainer fee of $1,000 is required prior to court appearances. This will be applied to the actual charges, with charges over $1,000 being billed to the client and any overpayment being reimbursed. **This payment must be made by cashier's check.** The client also agrees to release me from duty as their therapist and terminate our therapeutic relationship.

TERMINATION OF SERVICES

Ideally, the decision to terminate therapy should be a mutual one between the client and the therapist. However, there may be times when I discover that I am not the best-equipped therapist to address certain situations. Additionally, a client may choose to end therapy at any time for a variety of reasons. In either situation, to the best of my ability, I will assist you in finding another therapist to best meet your needs.

OUR AGREEMENT

The therapy process exists to serve you in a manner that is comfortable and appropriate to you. I am working in your interest, and my role is to help you identify and reach your goals. I encourage you at any time to discuss with me any feelings, concerns, or thoughts regarding the methods or policies of your therapy.

I have read and understand the above information and agree to these conditions.

_____ _____

Parent/Guardian Signature Date

Cathy Swan, LCSW
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Consent to Treat a Minor (Adolescent or Child)

In order for me to treat a minor child (under 18 years of age), I must have the written consent of the child's parent(s) or legal guardian(s). Please indicate your consent for me to treat your child by signing the following statement:

I, _____ state that I have the legal right to authorize Cathy
(Parent/Guardian Name)

Swan, LCSW, to provide mental health services to _____
(Client Name)

_____ _____
Parent/Guardian Signature Date

Waiver of Right to Full Disclosure
(Optional but Recommended)

As a rule, parents or legal guardians have a right to complete access of all information concerning the adolescent or child involved in therapy with me. However, experience suggests that in order for most child and/or adolescent clients to feel comfortable in therapy, it is beneficial to offer them the opportunity to talk with the therapist and to know that what they tell the therapist will not get back to their parents (except in cases of imminent danger to the client or others, or where the therapist considers the information to be so serious that the parents' ultimate responsibility for the child's welfare dictates that the parents be kept informed). I ask that you consider this issue in the therapy with your child. If you are willing to agree to this express waiver of your right to full disclosure, I ask that you do the following: a) indicate your agreement by signing the form below, and b) that you will allow us to keep our discussions confidential and not insist that I relate all that your child tells me back to you.

_____ _____
Parent/Guardian Signature Date

Consent for Services - Continued

I, Cathy Swan, LCSW, have discussed the issues above with the client's parent or guardian. My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Therapist's Signature Date

A photocopy of this document will be available, at your request, for your records and reference.

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Receipt of Privacy Practices

Client Name: _____

Parent/Guardian Name(s): _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Swan Counseling's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Cathy Swan, LCSW.

_____ _____
Signature of Parent/Guardian Date

❑ Client Declines to Acknowledge Receipt:

_____ _____
Signature of Staff Member Date

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Client Information for Insurance

(One person to be identified if using insurance)

Client Name: _____ Date: _____

Parent/Guardian Name: _____

Health Insurance: *Please bring your insurance card(s) with you to your appointment.*

Company: _____

Insurance Phone: _____

Name of Primary insured & their DOB: _____

ID: _____ Group: _____

If you have EAP sessions authorized, please complete the following:

Number of approved sessions: _____

Approval/Authorization Number: _____

I authorize the release of any medical information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

_____ _____

Signature **Date**

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Authorization to Charge Credit/Debit Card for Services

Name of Client: _____

I authorize Swan Counseling and Cathy Swan, LCSW, to keep my signature on file and to charge my Visa, MasterCard, or American Express account for recurring charges. These charges will include fees for no-shows and cancellations with less than 24 hours notice. I understand that Cathy Swan, LCSW, will attempt to contact me prior to charging my card under the circumstances of a no-show or late cancellation. If Cathy Swan, LCSW, is unable to reach me, I understand that she will charge my card.

I understand that this form will be renewed in January of each calendar year and is valid for one calendar year unless I cancel the authorization in writing.

Cardholder Name: _____

Billing Address for the Credit/Debit Card: _____
Street

_____
City, State, Zip

Type of Card: _____ Card #: _____

Expiration Date: _____ Security Code: _____

_____ _____
Cardholder Signature Date

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Digital Media Policy

Social Media Sites

I do not accept any requests to be connected with clients on social media sites such as Facebook, or Instagram. Adding you as a connection on these sites would compromise your confidentiality and our respective privacy. It would also blur the boundaries of the therapeutic relationship.

Interacting through Digital Media

Please do not use text messaging to contact me. Texting is not secure and there is a good chance I will not read these messages in a timely manner. Engaging with me in this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact me between sessions, the best way to do so is by phone. Direct email is second best, but only for quick administrative issues such as changing appointment times. See the Email section below for more information regarding email interactions.

Email

I prefer to use email only to arrange or modify appointments. Please do not email any other content, as email is not completely secure or confidential. Additionally, I do not check email frequently enough to respond in a timely manner to any personal or potentially life-threatening information. If you choose to communicate with me by email, be aware that all emails are retained in logs of Internet Service Providers (ISPs). You should also know that any emails I receive from you, and any responses that I send to you, by law become a part of your medical record.

Business Review Sites

You may find my psychotherapy practice on sites such as Yelp or Healthgrades. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is ***not*** a request by me for a testimonial, rating, or endorsement from you as my client. The social work ethics standards suggest that social workers should not solicit testimonials from clients or other persons who because of their particular circumstances may be vulnerable to undue influence.

Digital Media Policy - Continued

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I can only respond to any feedback (whether it is positive or negative) on these sites in a session with you, and cannot reply online. I also cannot discuss anyone else's comments on these sites, as that would be a violation of their confidentiality.

Please be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it. I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit.

None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and the ethical standards of my profession prohibit me from requesting testimonials. But you are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provided to you, in any forum of your choosing.

If you feel I have done something harmful or unethical and you do not feel comfortable discussing it with me, you can always contact the Texas Board of Social Work Examiners, which oversees licensing, and they will review the services I have provided. To do so, you can visit the Texas State Board of Social Worker Examiners website at www.dshs.state.tx.us/socialwork or call (512) 719-3521 or (800) 232-3162.

_____ _____

Parent/Guardian Signature Date