Beatrice Kerr, MSW, LCSW

Initial Therapy Intake Form

Client Name:		Age:		Birth Date:	
Address:					
City:		State:		Zip:	
Home Phone:		Work (optional):			
Cell Phone:		Email:			

Occupation:		Employer:	

If client is a minor, name of responsible adult:

Emergency Contact:				Phone:	
Address:					
City:		State:		Zip:	
Relationship of emergency contact:					

May we say who we are if we phone you at:			May we leave a message?	
Home:	Yes ☐	No ☐	Yes ☐	No ☐
Work:	Yes ☐	No ☐	Yes ☐	No ☐
Cell Phone:	Yes ☐	No ☐	Yes ☐	No ☐

REASON FOR COMING TO THERAPY

Please describe the problem(s) that you want help with:	
How has this problem affected your life in the following areas?	
Family:	
Work/School:	
Social:	
Health:	
How long have you had this problem?	
Have you had counseling/therapy in the past? ☐ Yes ☐ No If so, where/when/duration?	
What was helpful about the counseling?	
What was not helpful about the counseling?	

CURRENT FAMILY SITUATION

Who currently lives in your home?
Current marital status:
Current family stressors:

FAMILY HISTORY

Who raised you?	
If there were changes, please list and indicate the age you were when these changes occurred:	
# of siblings_____# brothers_____ # sisters_____	In rank order from oldest to youngest, what is your place in the order?
Which members of your family are you close to?	
Are there any family members who are a problem for you?	
Please indicate other people in your life that provide support for you:	
Please list any problems that family members have/have had and indicate relationship:	
Arrests/convictions	
Alcoholism	
Depression	
Violence	
Other mental/emotional problems	

Check any of the following that apply to your childhood/adolescence:

☐ Happy childhood ☐ Unhappy childhood ☐ School problems ☐ Medical problems

☐ Family problems ☐ Alcohol use ☐ Drug use ☐ Arrests/convictions

EDUCATIONAL HISTORY:

Yrs. Completed:

Problems:

Strengths:

WORK HISTORY:

Usual occupation:

Are you currently employed: ☐ Yes ☐ No

Length of time:

If you have changed jobs during the last five years, give duration of employment and reason for leaving job:

PHYSICAL AND MENTAL HEALTH:

How would you rate your current health?

Very poor 1 2 3 4 5 6 7 8 9 10 Very good

List current health/emotional problems for which you are receiving treatment:

List medical/emotional problems you have experienced in the past

Physicians currently receiving treatment from:

Name	Phone number	Fax number	Reason For Treatment

List any medications currently prescribed:

Current Medications/Dosages	Prescribing Doctor	Reason

Past medications/effectiveness:

Indicate any of the following that apply to you:

	Current	Past		Current	Past
Thoughts of suicide	☐	☐	Hurting yourself deliberately	☐	☐
Plan for suicide	☐	☐	Thougths of hurting someone else	☐	☐
Suicide attempt	☐	☐	Plan for hurting someone else	☐	☐

What is your current use of alcohol/drugs?

Have you had problems with alcohol use in the past? ☐ Yes ☐ No

Do you have a history of drug use? ☐ Yes ☐ No

If yes, please detail type/usage/frequency:

Have you been arrested for alcohol/drug related offenses? ☐ Yes ☐ No

Have you had treatment for drug abuse/dependency? ☐ Yes ☐ No

Where/When?

SOCIAL OUTLETS/ACTIVITIES/SUPPORTS

(note specifics, frequencies, increases /decreases in involvement)

Exercise
Religion/Spiritual Affiliation
Social Activities/Interests

Check any of the following that may apply to you (client):

	Depression		Inferiority Feelings		Traumatic event
	Anxiety		Feeling “blue”		Avoidance of associations with traumatic event
	Troubling thoughts		Unable to relax		Afraid of people
	Under-eating		Fears and phobias		Panic Attacks
	Over-eating		Obsessions		Self-harm behaviors
	Bowel disturbances		Suicidal thoughts		Racing thoughts
	Stomach trouble		Isolation		Hyper vigilance
	Always tired		Alcohol problem		Problems concentrating
	Difficulties sleeping		Drug problem		Flashbacks
	Legal problems		Loved one alcohol or drug problem		Nightmares
	Financial problems		spiritual distress		Heightened Startle Response
	Health problems		Grief/loss		Difficulties with intimacy/sex relations
	Work problems		Anger management		Sexual abuse/assault Survivor
	School problems		Feelings of guilt/shame		Other:
	Marital stressors		Conflict with parent/child		Other:

What do you wish to achieve through the process of therapy?

How were you referred to Beatrice Kerr?

Upon my signature below, I hereby attest that all the information furnished is true and correct. By signing, I agree to be responsible for all fees that my insurance does not cover. I agree to receive therapy services from Beatrice Kerr.

_____ _____

Signature Date

Beatrice Kerr has my permission to provide services to the above-named child. I will attend sessions with and for my child as requested.

_____ _____

Signature Date

Center For Family Counseling

Welcome and thank you for choosing Beatrice Kerr, LCSW as your primary supportive therapy provider. It is my sincere desire to assist you as you take steps to improve your circumstances and increase the amount of contentment and overall wellness you find in life. Therapy may be a new experience for you and the information below will provide you with the basics of what to expect as you embark on this journey and set the foundation for your therapeutic work in our practice. I highly recommend that you keep a therapy notebook to chart your growth progress and maintain your healing work. Many clients find it helpful to bring their notebook to their sessions.

Informed Consent to Psychotherapy and Office Policies

Please Read the following carefully and ask Beatrice Kerr for specifications about any element you do not fully understand.

Qualifications

Beatrice Kerr received her Masters of Social Work degree from Virginia Commonwealth University and is a Licensed Clinical Social Worker. She is a Certified Bereavement Facilitator, Certified Clinical Trauma Professional, and has received extensive training in EMDR. Beatrice has over 24 years of experience as a grief counselor and hospice social worker. Ms. Kerr began working private practitioner in 2010. Ms. Kerr is committed to trauma-informed care and employs several evidenced-based approaches including, internal family systems, cognitive behavioral therapy, EMDR, emotionally focused therapy and mindfulness.

Beatrice Kerr works best with people who are ready to move through the issues in which they feel, “stuck” so they can use their energy in more positive and productive ways. She values education and seeks to educate her clients about the therapeutic process and the internal and external resources that are available to them. She expects her clients to be active participants in the therapeutic relationship and encourages them to question and explore all of the resources and options available to them throughout their treatment.

Process, Benefits, and Risks of Psychotherapy

Participating in therapy can provide a number of benefits to you. These benefits include reducing or eliminating psychological symptoms, improving interpersonal relationships, as well as resolving the specific concerns that led you to seek therapy.

Benefits may also include increased comfort in social, work and family settings, increased capacity for intimacy, decreased negative ideation, decreased self-defeating behaviors and improved abilities to become goal oriented. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your active involvement, honesty and openness in order to change your thoughts, feelings and/or behaviors. Much of the value of therapy comes from using the skills, ideas, tasks and suggestions discussed during the sessions in your every day life. I will ask you for your feedback and views on your therapy and will expect you to respond openly and honestly. During the therapeutic process discomfort may be experienced by

remembering or talking about unpleasant events, feelings or thoughts. These discussions may evoke strong feelings of anger, sadness, worry, fear, . . etc, or you may experience an increase in symptoms associated with anxiety, depression, or insomnia. I may challenge some of your assumptions and perceptions or propose different ways of viewing, thinking about or handling situations. These challenges may evoke feelings of anger, upset, hurt, disappointment or resentment. Attempting to resolve the issues that prompted you to seek therapy may result in changes that were not originally intended. Psychotherapy may initiate decisions about changing behaviors, employment, substance use, schooling, housing or relationships.
Sometimes a decision that is positive for one family member is viewed negatively by another family member. During the course of psychotherapy things can get better or worse. Often they will get worse before they get better. Change can be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

During the course of therapy, I am likely to draw on various theoretical approaches according to the problem presented and my assessment of what will be most beneficial to you. These approaches include cognitive/behavioral, EMDR, internal family systems, and psycho-education. If you have any questions about the
procedures employed during the course of your treatment (i.e. their risks, my expertise in using them, or the treatment plan) please ask and I will answer you to the best of my ability. You also have the right to know about other treatments for you condition. If you could benefit from any treatment that I do not provide, I will assist you in obtaining those treatments through appropriate referrals.

Some specific psychotherapeutic interventions I may suggest, such as EMDR or guided imagery, can potentially elicit feelings, thoughts or experiences that do not necessarily reflect literal reality or historical accuracy. Such techniques can produce both accurate and inaccurate information and may or may not increase recall. Only through independent corroborative evidence one may know the accuracy of the internal experiences evoked by these techniques. Although we may retain the gist and relevant details of significant events of our lives, memory works in ways that distortions can be brought into our recall. Emotionally arousing internal experiences, which could be experienced as memories, can be quite inaccurate (detail reconstruction, source misattribution, dating and identification errors, and filling in the gaps often happens). If the historical truth becomes important at any given point in therapy (e.g. a lawsuit), you will be encouraged to seek corroborative evidence for you
internal experiences; and I will refer you for psychological testing to screen for any personality traits that may predispose you to distorting memories. As suggestive influences may contribute to memory distortion, I will try to minimize any suggestive influence in therapy and will want to review other potential suggestive influences to which you may have been exposed in order to better experience your own internal reality. Finally, without corroboration, a testimony of childhood abuse will be challenged in an adversarial legal system. Undertaking such an endeavor may work at cross-purposes with psychotherapy and we may decide to terminate treatment.

I consult regularly with other health professionals regarding my clients in order to increase the effectiveness of the services I provide. I do not use names or other identifying information during these consultations in order to assure that full confidentiality is maintained. I may not inform you of these consultations unless you request it in writing. After the first initial sessions, or at any point during our work together, if either one of us decides that I am not effective in helping you reach your therapeutic goals, treatment can be terminated. In the event of termination, I will provide you with referrals to other therapists should you wish to continue treatment.

If at any time you wish to seek another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified. With your written consent, I will provide him/her with the information needed for proper assessment/ evaluation. You have the right to terminate therapy at any time. If you choose to end treatment, I will offer to provide you with the names of other professionals who are qualified to work with your issues. Therapy never involves sexual or business relationships or any dual relationship that impairs my objectivity, clinical judgment or therapeutic effectiveness.

Confidentiality

The laws and standards of the Social Work profession require that I keep treatment records. All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where law requires disclosure. Law, in the following circumstances,may require disclosure:

1. Where there is reasonable suspicion of child or elder abuse or neglect
2. Where a client presents a danger to him/herself or to another person
3. A client is gravely disabled

The intent of such requirements is that a therapist has a legal and ethical responsibility to take action to protect endangered individuals from harm when the therapist's judgment indicates that danger exists. It is my policy to fully disclose these matters with my clients before any action is taken, unless there is a compelling reason not to do so. Regarding the above circumstances, only information necessary to expedite the resolution of the emergency is revealed. Therefore, if there is an emergency during our work together or the possibility of you injuring yourself or someone else, I am obligated to do whatever I can within the limits of the law to assure your safety and the safety of others. For this purpose, I may contact the person you have listed as an emergency contact on the intake sheet, notify the potential victim, contact the police or seek hospitalization when necessary.

Disclosure may also be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to

obtain the psychotherapy records and/or my testimony. If you are involved in legal proceedings, lawyers from either side can subpoena your records or a judge may order my testimony if it is determined that the issues demand it. In family therapy or when different family members are seen individually, confidentiality may not apply among family members. I will use my clinical judgment about revealing information.

Disclosure of confidential information may be required by your health insurance carrier for HMO/PPO/ MCO/EAP in order to process your claims. Only the minimum necessary information will be provided to your insurance as permitted by law. This information is called the Protected Health Information (PHI) as determined by the HIPAA Privacy Rule. It includes the psychotherapy session start and stop times, their dates, the modalities and frequencies of treatment provided, results of clinical tests, and any summary of diagnosis, symptoms, functional status, treatment plan, prognosis, and progress to date. I have no control or knowledge over what insurance companies do with the PHI information I submit. Upon request, I will provide you with a copy of the information submitted. The confidential nature of your personal information provided through electronic means cannot be guaranteed, therefore, you can request that the information be sent through the mail.

Client Rights:

HIPAA provides you with several rights regarding your PHI record and disclosures of protected health information. These rights include:

1. The right to request that I amend your record
2. The right to request restrictions on what information from your PHI record is disclosed to others
3. The right to request an accounting of most disclosures of PHI that you have neither consented to nor authorized
4. The right to determine the location to which protected information disclosures are sent
5. The right to have any complaints you make about my policies and procedures documented in your record
6. The right to a paper copy of this agreement, the attached Notice form and my privacy policies and procedures.
7. The right to revoke your consent to send information to your insurance company effective on the date I receive the revocation in writing.

I am happy to discuss any of these rights with you.

As a client, you have the right to review or receive a summary of your psychotherapy record at any time, except in limited legal or emergency circumstances. In such circumstances, I may provide you with a summary of your records, and will be available to review them with you to provide clarification and support. Per your written request, I also will provide the records or its summary to an appropriate professional of your choice. You will be charged an appropriate fee for any professional time spent in responding to an information request regarding you or your treatment.

Center For Family Counseling

Availability and Emergency Procedures

If you need to contact me between sessions, please leave a message on my voice mail at 540-361-1556. I check my messages daily and will return your call as soon as I am available. Calls received after 5pm on Friday may not be returned until Monday.

At certain times during the treatment process we may recognize a benefit to putting in a time-limited option of your contacting me outside of office hours for a 5-minute skills intervention. Please recognize this is only during specific time periods that we designate in our treatment process and means that if you receive my voice mail you are to leave a message and I will return the call as soon as I am available. These time-limited calls are not meant for emergency purposes, are not intended to and should not be used outside of our stated agreement in the treatment process. If you need to talk to someone right away, you can call Emergency Services at 540-373-6876, Snowden at 540-741-3900, the police at 911 or go to the nearest emergency room. If an emergency situation arises in which you are being harmed or are in danger of harming yourself or someone else, please call 911.

I will be away from the office at various times throughout the year. During these times, if you would need to see a mental health professional, I will provide you with the name of a qualified therapist that you can contact.

Please be aware that electronic communications including texts and e-mail are not HIPPA compliant. Please limit this form of communication to appointment scheduling.

Payments and Insurance Reimbursement:

I am currently in-network for many major insurance companies. You are expected to pay the standard copay or your full fee of $120 for a 60-minute intake session and $110 per each 45-minute follow-up session at the beginning of each session unless other arrangements have been made. It is your responsibility to obtain the appropriate reimbursement from your insurance company that I do not contract with if you choose to do so. Insurance companies do not reimburse all issues/conditions/problems that are the focus of treatment. It is your responsibility to verify the specifics of your coverage. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, release of records, longer sessions, travel time, etc. will be charged at the rate of $110 per 45-minutes unless indicated and agreed otherwise. In the event that I am subpoenaed to court, my rates are $200 per hour including travel time. The fees will be billed to the person on whose behalf I am summoned.

Please notify me if any problem arises during the course of therapy regarding your ability to make timely payments. It is important to evaluate your financial resources in terms of covering treatment fees. If you should encounter financial difficulties that interfere with your ability to pay for services rendered, it is important to notify me as

soon as possible. I will provide you with a few sessions to focus on terminating our therapeutic work together and will make reasonable efforts to find a referral whose fees are more affordable to you. If your account is overdue (unpaid) and there is no agreement on a payment plan, I can use legal means (court, collection agency, etc.) to obtain payment. Should your account be referred for collection, you will be responsible for all of the collection costs including attorney's fees and court costs. There will be a $30 fee for returned checks from the bank. Please be aware that if you choose to pay me by check, your confidentiality may be compromised as the bank teller handling the transaction may see my name on the check.

Electronic Communications
I will only use email communication and text messaging with your verbal permission (this will be documented in treatment notes) and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with this office should be limited to things like setting and changing appointments, billing matters and other related issues. Do not use PHI (personal health information such as name, date of birth, etc.) when using electronic communication, because access to electronic information is not assumed to be protected or private. Please do not use e-mail or texting for treatment-related issues.

I do not communicate with, or contact, any clients through social media platforms like Twitter and Facebook. In addition, electronic relationship status will be canceled if a clinician discovers that an online relationship has been accidentally established. This is because these types of casual social contacts can create significant security risks for you. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it during the next scheduled session.
I will not use web searches to gather information about you without your permission, because this constitutes a violation of your privacy rights.

Cancellation
Since the scheduling of an appointment involves the reservation of time especially for you, a fee of $50 will be charged for sessions missed without 24-business hour notice of cancellation. Insurance companies do not reimburse for missed appointments. I value the importance of keeping scheduled appointments in order to maintain the movement of the therapeutic process. Therefore, if I need to cancel an appointment with you, I will only do so when it is important and will do my best to reschedule it within the same week.

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I have reviewed the information in this agreement and I fully understand it, I accept it and I agree to abide by its terms during our professional relationship. I have had my questions answered to my satisfaction. Based on the terms of this agreement, I consent to participate in an evaluation and treatment with Beatrice
Kerr, LCSW. I understand that this agreement can be withdrawn at any time.
YOUR SIGNATURE BELOW ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client signature_____Date _____

I authorize permission for Beatrice Kerr, LCSW to contact my insurance company,as necessary to pursue and/or inquire regarding said services. I authorize the release of any medical or other information necessary to process claims for insurance payment. I also authorize payment of benefits to the supplier of services accepting assignment of benefits.

Client signature_____Date _____