Rhonna W. Phillips
Counseling & Therapy Services, LLC

In advance of your INITIAL Family INTAKE APPOINTMENT each participant age 14 or more, please follow these steps, for yourself. Scroll down to print and complete the forms you need. Plan for 45 minutes or more to complete it all. This will benefit you by saving our time for discussion and is intended to be more convenient for you. I should receive one set per every participant that is attending.

If you are being seen remotely, I need everything returned to me by noon, two business days before our appt. Otherwise, the appt may have to be postponed.

If being seen in my office, you can bring it all with you when you come. If you haven't done all your paperwork in advance, you will need to complete yours during your appointment time and this will limit our discussion time.

All of the information is important; either to me or required by law or ethical codes to be provided to you. I do apologize for the quantity. I will be reviewing all of it. The information provides me a basis to begin to understand each of your upbringings, backgrounds & the foundations for your personal values, which you may have brought to your family relationships.

Also, during our appointment time, I will personally ask you some of my Family Assessment questions. These will pertain to the nature of your concerns, your roles and responsibilities, your communication, and problem solving and/or dispute resolution styles. Be watching for me to separately send to the appt initiator my Payment & Rate Agreement and consent form/s for Release of Information.

PSYCHOSOCIAL HISTORY & INTAKE

1. **FAMILY INTAKE form -** appt initiator do this, one for all.

2. Each participant of concern does one of these for self:
   - *For Child - if person of concern is age 13 or less.
   - *For Adolescent - if person of concern is age 14-18.
   - *For Adult - if person of concern is age 19 or more

3. **HOW CONFIDENTIALITY WORKS -** Each, do your own.

4. **HIPAA -** Each participant does their own.

5. Driving **DIRECTIONS -** post Pandemic, only if appt at office.

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6. **USE OF TECHNOLOGY in Counseling -** this form can be shared (appt initiator to do) but ONLY if all attendees are in the same location during your Virtual and Remote counseling sessions, every time. Otherwise, each participant is to do their own.

I very much look forward to our Intake appt and working to assist you!

Rhonna W. Phillips, MA

Licensed Professional Counselor & Supervisor,
Licensed Marriage and Family Therapist,
Collaborative Practitioner,
Qualified Family & Domestic Relations Mediator

2-2021

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PSYCHOSOCIAL HISTORY FOR FAMILY INTAKE ASSESSMENT
If any dependent may be the subject of our focus, please have him/her complete the CHILD or ADOLESCENT INTAKE ASSESSMENT also .
Date of Intake appt: _____

Who is initiating service _____Role _____
DOB _____ Age ___ Home Phone _____ Cell Phone _____
Address: _____
Current problem as the adult/s sees it "_____
_____
_____"

Current Problem as the Child/ren or Teens see it "_____
_____
_____"

Those who are to be present for the initial session:
1. _____2. _____
3. _____4. _____
5. _____6. _____

How are the above stated problems affecting others in your household or family? _____
_____
_____

Current Household members:
Names, Adult Roles (biological parent or step, other)
Siblings (biological, (1/2), step) & Ages & Date of merger

1._____
2. _____
3. _____
4. _____
5. _____
6. _____

If Divorced, describe non-Custodial parent & those Household members:
1. _____
2. _____
3. _____
4. _____
5. _____

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Others, closely involved ie: Grandparents, signif. others. Describe:
1. _____
2. _____
3. _____
4. _____

? DHR contact: _____ Ph: _____
? GAL contact: _____ Ph: _____
Regular visitation schedules, court orders….
1. _____
2. _____
3. _____
4. _____ **has Legal Custody of** _____
5. _____ **has physical custody of** _____

Any absent biological parent? Name _____ relation _____
Address _____ Phone _____
If child is subject of session/s and custody is split, are you willing to provide a copy of the court order re the Custody and Roles? Yes/No_____

Mental Illness in any family members (Hospitalizations, RX, Depression, Anxiety, Suicide/attempts, Substance Abuse, Psychosis, Counseling..)
Biological Mother/side: _____
Biological Father/side: _____
Step Mother/side: _____
Step Father/side: _____

Legal Problems in any family members of current or related households
_____

OFFICE NOTES: _____
_____

Dx Impr_____ PLAN: _____
HMWK: _____ RTC: _____

_____ _____
Rhonna W. Phillips, MA **Date**
Licensed Professional Counselor & Supervisor
Licensed Marriage and Family Therapist
Collaborative Practitioner
Qualified Family & Domestic Relations Mediator **Rev. 05-2016**

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PSYCHOSOCIAL HISTORY for a CHILD age 13 or less and INTAKE ASSESSMENT
Primary Caregiver is to do Part A. The Child, if able, is to do Part B.

Intake appt Date _____

Child/Adolescent's legal name _____
Goes by _____ DOB _____ Age _____ Grade _____
Identified Gender: _____ Any culture specific needs or adaptations for services needed? _____

Child primarily lives w/ _____ Phone: _____
Primary address:_____
Legal Custodian _____
Your name/role: _____
Your Home phone _____Cell Phone _____

If in custody of one, has a copy of the court order, pertinent to the orders around custody, services, access, payment, participation and decision making re minor child been made available to Rhonna yet? Yes_____ No _____ Is the primary custodian willing to provide this? _____
Are you willing for Rhonna to contact the non custodial parent? _____

Secondary Address _____
Second or non custodian parent: _____
Home phone _____Cell Phone _____

Child's School _____ town _____ FT/PT
Homeschool: _____ Other regular activities _____

Child's siblings birth order: Name/Age, Gender, Biological/Step/or Half, Parent.
1st _____
2nd _____
3rd _____
4th _____
5th _____
6th _____

Your primary concerns about the child: "_____
_____
_____"

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DEVELOPMENT:
How was the Pregnancy:_____ Full term Y/N _____
Baby's weight at birth _____

What age did this Toddler achieve these developmental milestones? Crawling _____, Sitting Up _____, Walking _____, Putting words together _____, Potty trained _____. Did he/she have any unusual behaviors? Spinning_____, Hand flapping _____, repeating words _____, referring to others as "I" _____, excessive use of other senses ie: Smelling and Tasting _____. Any other odd behaviors? _____. At what age did he/she begin sleeping in own room _____ or by self _____. Did he/she attend Pre-School or Day Care? _____ _____

As a baby did he/she have any of these problems? Disliking to be held or touched _____, Eating _____, Over sensitivity to Light /Noise /temperature? _____, Restlessness _____, Sleeping _____, To be comforted/was fussy _____, Colic _____, Head banging _____, Difficulty bonding _____ Giving eye contact _____, Responding to smiles _____ Other _____.
Was there Substance Use or Abuse during this child's conception or pregnancy? Y/N _____

EDUCATION:
Attended Elementary School age _____
Any problems with Behavior, Learning, or Social relationships? _____ _____.
Any evaluations done for Academic concerns? _____ were Special Education Services or an IEP provided? _____What adult was the primary participant? _____ Did he /she suspect learning problems? _____
Has any adult close to this child ever commented on or asked about or suggested any condition that might be impacting your child? _____

MEDICAL/MENTAL HEALTH HISTORY:
Primary Care Dr _____ Phone _____
Chronic conditions _____ past Head Injury Y/N_____,
Major surgeries _____.

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Y/N: Ever been to Psychiatric Hospital ____, Psychiatrist ____, prescribed Mental Health Rx _____, attended Counseling _____, Other _____.

Medicine on now:
_____ for _____ Dr. _____ ph _____
_____ for _____ Dr. _____ ph _____
_____ for _____ Dr. _____ ph _____
_____ for _____ Dr. _____ ph _____

Has this child witnessed any traumatic events? _____
MV accidents _____, damage to his/her or a known home _____, frightening storms _____, harm to a close loved one _____, loss of a close loved one including pets_____, multiple moves _____, isolation _____, nutritional deprivation _____, lack of access to books or toys or learning or creating or free play _____, homelessness _____, close call or serious injury _____, significant illness or medical condition or imposing treatments _____, Pain _____, In the house at same time as parent arguments _____, adult threats of leaving _____, adult threats of taking the child away from the home or other parent _____, or parent conflict that became physical _____, have the Police ever come to a place where the child has been _____, parent legal conflicts _____, witnessed a parent harmed by self (alcohol or drugs...) or by others (assault, handcuffed, arrested.....)_____

Describe any Suicidal, Self Injurious, or Homicidal behavior you suspect or are aware of for your child, past or present _____
_____.

Does this child spend time in any locations where weapons exist? _____

LEGAL:
Alternative School ____, CHINS ____, Charges _____ Jail _____ Court Date _____
Biological parents divorced y/n. Please provide a copy of the court order showing custody and visitation orders. Provided y/n _____

Thank you for sharing this important information about your loved one. Please ask the child to complete part B & bring/submit both A & B for our first session. Each section will provide me valuable insight into the problem, and I will be better able to help your child as quickly as possible.

_____ _____
Your signature Date

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PSYCHOSOCIAL HISTORY FOR CHILD and INTAKE ASSESSMENT
To be completed by the Child, Part B
Date _____

Name you go by _____
Gender identity: _____
How shall I reach you?:
Phone _____ Text: Yes/No
Mail _____
Email _____
Other _____
Contact in case of emergency _____ ,
is your _____ Lives _____
@ phone _____

What is your concern? "_____"

Why did you agree to this appointment? _____

What problems are you experiencing? When started?
Emotions _____

Thoughts _____

Attitude _____

Behavior _____

Attention _____

Relationships _____

Other _____

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Using a severity scale for problems: 1 (best) – 10 (worst):

How unhappy are you _____ How stressed are you? _____
Check which situations are a part of this: School ____ Home or parents _____ Other family_____ Other adults _____ Friends/peers _____ (male or female) Health/Medical problems _____ Other _____
What do you think led to or caused this problem?_____
_____.

Office Note: _____

Have you experienced any unkind treatment? _____
Verbal _____, Emotional _____, Physical _____ Sexual _____
Office Note: _____.

How have you Coped? Sleeping _____, Ignoring _____, Avoiding _____, Skipping School or Work _____, Running Away _____, Pushing people away _____, Praying _____, Stating your Feelings & Needs _____, Yelling _____, Arguing _____, Refusing to Cooperate _____, Talking to: friends, other family, siblings, or other adults _____, Focusing on Activities _____, Diving into wk or school or other _____ Doing Alcohol or Drugs _____, Acting Out _____, Being Sexually Promiscuous _____, Binge Eating _____, Restricting Eating/Foods _____, Purging _____, Exercising _____ (excessive?), Self Harm_____, Suicide Attempts ____, Threatening to assault/harm others _____, Other _____
_____

_____ _____
Your signature Date

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PSYCHOSOCIAL HISTORY FOR CHILD INTAKE ASSESSMENT
Part C for Staff

OFFICE NOTES:

_____

_____

_____

_____

_____

Dimensional description of client presentation:

_____

_____

Internalizing/Externalizing factors: _____

Psycho-social & contextual factors: _____

ICD 10 CM Z codes: _____ _____

Diagnostic impression or see Sx Assessment: _____

_____

PLAN: _____

HMWK: _____

RTC: _____

_____ _____
Rhonna W. Phillips, MA **Date**
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Licensed Marriage and Family Therapist
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Rhonna W. Phillips
Counseling & Therapy Services, LLC

PSYCHOSOCIAL HISTORY and INTAKE & ASSESSMENT

for INDIVIDUAL Adolescent age 14-18yo

Client Name: _____ Intake date: _____

Preferred or nickname: _____ DOB: _____ Age: _____

Address: _____ City _____ State: ___ Zip _____

Cell Phone: _____ Home Phone: _____ IDs Gender as: _____

Ethnicity as: _____ Country born in: _____

Highest Grade/degree completed: _____ Major:_____

Current School: _____ for _____

Military service? You or close relative? _____

Current Job: _____ Co: _____ How long? ____

Currently living with? _____ Referred by: _____

Problem? "_____"

Event that triggered appt: _____

Attach separate notes if you prefer to write more detail. If your counseling is CONJOINT, only submit what you're willing to share with other session members.

SOCIAL & INTIMATE RELATIONSHIPs: IN THE PAST: 1st Significant intimate rel:

Year met _____ You were Age _____ Location _____

Year dated _____ You were Age _____ Yr moved in together _____ Age _____

Year married _____ Partner was age ____ You were age ____ # yrs married _____

If Divorced, how long/yrs _____ Why did the rel end? _____

Biological Children of this relationship	Stepchildren of this relationship
Names/Gender/Age:	Names/Gender/Age:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Which of these children visit w/you now? _____

Any that do not, why?_____

Second Sig intimate relationship or Marriage:

Year met _____ You were Age _____ Location: _____

Year dated _____ You were Age _____ Yr moved in together _____ Age _____

Year married _____ Partner was age ____ You were age ____ # yrs married _____

If Divorced, how long/yrs _____ Why did the rel end? _____

Biological Children of this relationship Stepchildren of this relationship

Names/Gender/Age: Names/Gender/Age:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Which of these children visit w/you now? _____

Any that do not, why?_____

Current intimate relationship status:

Dating, Girl/Boyfriend, Partner, Live together, Married. How long _____

Year met _____ You were age_____ Location _____

Year dated _____ You were age _____ Yr moved in together _____ Age _____

Year married _____ Partner was age _____ Your age _____ # yrs married _____

If Divorced, how long/yrs _____ Why did the rel end? _____

Biological Children of this relationship Stepchildren of this relationship

Names/Gender/Age: Names/Gender/Age:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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Which of these children visit w/you now? _____

Any that do not, why?_____

Other PAST Significant Intimate Relationships effecting issues now? _____

_____

Age 1st sexually active ____ Sexual identity _____ # sex partners in past 6 mos ____

Happiest memory of any intimate relationship _____

Worst memory of any intimate relationship's _____

Any: Domestic Violence (incl psychological abuse, phys and sexual abuse) Y/N __

Legal Probs Y/N _____ Past or current Lawsuits Y/N _____

Arrests Y/N _____ DUI Y/N Outcome _____

Court Dates _____ Name of Lawyer_____

Court orders _____ Name of Probation officer _____

_____

$ Concerns Y/N _____ Child Support paid & current or unpaid _____

Attach additional notes if needed, to explain above.

Self harm: your own thoughts or actions: _____

significant other's thoughts or actions _____

_____

Suicidal: your own thoughts or actions: _____

significant other's thoughts or actions _____

_____

Homicidal: your own thoughts or actions: _____

significant other's thoughts or actions _____

_____

Weapons you have access to? _____

Pistol/s, Rifles, Shotguns, ammo, Hunting knives, Dangerous pills, Other: _

_____

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Counseling & Therapy Services, LLC

Office use: N/A, Ideation ___ Plan___ Access ___ Attempts ___ Intent _____

Current Risk: Low, Medium, High-Warn _____

FAMILY OF ORIGIN:

Who is your Support system is: _____

Religion: Raised_____ Current Religion: _____ Attend: _____

Parents Married _____ yrs, If Divorced you were age _____ You lived w/ _____

Mother remarried? _____ Relationship w/ 1st Step Fa was: _____
_____ Rel w/ 2nd Step Fa was: _____
_____ Rel w/ 3rd StepFa was: _____

_____

Father Remarried? _____ Relationship w/1st Step Mo was: _____
_____ Rel w/ 2nd Step Mo was: _____
_____ Rel w/ 3rd Step Mo was: _____

_____

Contact w/ non custodial parent was: _____
Sibling Birth Oder:

	Name	Age	Gender	Biological/Step/or Half	Parent:
1st					
2nd					
3rd					
4th					
5th					
6th					

Happiest memory of childhood _____

Worst memory of childhood _____

_____

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Counseling & Therapy Services, LLC

History of Abuse: Verbal Y/N Emotional Y/N Physical Y/N Sexual Y/N Explain:

_____

_____

Family's mental health Hx :Depress, Anxiety, Subst Abuse, Suicide Attmpts, Hosp

Mother: _____ Maternal Grandparents:_____

Aunts/Uncles: _____ Cousins: _____

Father: _____ Paternal Grandparents:_____

Aunts/Uncles:_____ Cousins: _____

Siblings: _____ Kids: _____

_____

MENTAL/ HEALTH TREATMENT:

Past or present treatment by a Psychiatric Dr. Y/N:

Dr. _____ for _____ Yr _____

Dr. _____ for _____ Yr _____

If any more or any Residential treatment or Psychiatric hospitalizations please list, by date, on separate paper

Mental health Counselors: Current, name _____ Since_____ for _____ If considering a change why? _____

Past: Counselor name _____ Age/Year_____ how long _____ for _____

Counselor _____ Age/ Year_____ how long _____ for __

_____

Medical Conditions current: _____ Past chronic conditions _____ Hosp: _____ Surgeries: _____

Past Medication: _____ for_____ by Dr. _____.

_____ for _____ by Dr. _____.

_____ for _____ by Dr. _____.

_____ for _____ by Dr. _____.

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Current Medication, Herbs & Supplements, include contraception:

_____ for _____ dose: _____ by Dr. _____

_____ for _____ dose: _____ by Dr. _____

_____ for _____ dose: _____ by Dr. _____

_____ for _____ dose: _____ by Dr. _____

Allergic to any RX? _____

Alcohol use: Add separate page if additional space is needed

Beer: # per day _____, # days per week _____

Wine: # per day _____, # days per week _____

Hard Liquor: # per day _____, # days per week _____

Last Marijuana use _____ Get high # x per day _____ # x per week _____

Substances that you use socially/ recreationally: _____

Substances you abuse: _____ # per day _____ # per wk _____

Have you or anyone close to you ever been concerned about your Alcohol or substance use? _____ Tobacco use: # per day _____

Any other important information to share: _____

_____

OFFICE NOTES: Potential Tx Goals: _____

_____

_____

_____

Plan _____

HMWK _____ RTC _____

_____ _____

Rhonna W. Phillips, MA Date

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Rev. 02-2021

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Counseling & Therapy Services, LLC

PSYCHOSOCIAL HISTORY and INTAKE & ASSESSMENT

for INDIVIDUAL Adult age 19yo +

Client Name: _____ Intake date: _____

Preferred or nickname: _____ DOB: _____ Age: _____

Address: _____ City _____ State: ___ Zip _____

Cell Phone: _____ Home Phone: _____ IDs Gender as: _____

Ethnicity as: _____ Country born in: _____

Highest Grade/degree completed: _____ Major:_____

Current School: _____ for _____

Military service? You or close relative? _____

Current Job: _____ Co: _____ How long? ____

Currently living with? _____ Referred by: _____

Problem? "_____"

Event that triggered appt: _____

Attach separate notes if you prefer to write more detail. If your counseling is CONJOINT, only submit what you're willing to share with other session members.

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Year married _____ Partner was age ____ You were age ____ # yrs married _____

If Divorced, how long/yrs _____ Why did the rel end? _____

Biological Children of this relationship	Stepchildren of this relationship
Names/Gender/Age:	Names/Gender/Age:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Which of these children visit w/you now? _____

Any that do not, why?_____

Second Sig intimate relationship or Marriage:

Year met _____ You were Age _____ Location: _____

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If Divorced, how long/yrs _____ Why did the rel end? _____

Biological Children of this relationship Stepchildren of this relationship

Names/Gender/Age: Names/Gender/Age:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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Any that do not, why?_____

Current intimate relationship status:

Dating, Girl/Boyfriend, Partner, Live together, Married. How long _____

Year met _____ You were age_____ Location _____

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Year married _____ Partner was age _____ Your age _____ # yrs married _____

If Divorced, how long/yrs _____ Why did the rel end? _____

Biological Children of this relationship Stepchildren of this relationship

Names/Gender/Age: Names/Gender/Age:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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Which of these children visit w/you now? _____

Any that do not, why?_____

Other PAST Significant Intimate Relationships effecting issues now? _____

_____

Age 1st sexually active ____ Sexual identity _____ # sex partners in past 6 mos ____

Happiest memory of any intimate relationship _____

Worst memory of any intimate relationship's _____

Any: Domestic Violence (incl psychological abuse, phys and sexual abuse) Y/N __

Legal Probs Y/N _____ Past or current Lawsuits Y/N _____

Arrests Y/N _____ DUI Y/N Outcome _____

Court Dates _____ Name of Lawyer_____

Court orders _____ Name of Probation officer _____

_____

$ Concerns Y/N _____ Child Support paid & current or unpaid _____

Attach additional notes if needed, to explain above.

Self harm: your own thoughts or actions: _____

significant other's thoughts or actions _____

_____

Suicidal: your own thoughts or actions: _____

significant other's thoughts or actions _____

_____

Homicidal: your own thoughts or actions: _____

significant other's thoughts or actions _____

_____

Weapons you have access to? _____

Pistol/s, Rifles, Shotguns, ammo, Hunting knives, Dangerous pills, Other: _

_____

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Office use: N/A, Ideation ___ Plan___ Access ___ Attempts ___ Intent _____

Current Risk: Low, Medium, High-Warn _____

FAMILY OF ORIGIN:

Who is your Support system is: _____

Religion: Raised_____ Current Religion: _____ Attend: _____

Parents Married _____ yrs, If Divorced you were age _____ You lived w/ _____

Mother remarried? _____ Relationship w/ 1st Step Fa was: _____
_____ Rel w/ 2nd Step Fa was: _____
_____ Rel w/ 3rd StepFa was: _____

_____

Father Remarried? _____ Relationship w/1st Step Mo was: _____
_____ Rel w/ 2nd Step Mo was: _____
_____ Rel w/ 3rd Step Mo was: _____

_____

Contact w/ non custodial parent was: _____
Sibling Birth Oder:

	Name	Age	Gender	Biological/Step/or Half	Parent:
1st					
2nd					
3rd					
4th					
5th					
6th					

Happiest memory of childhood _____

Worst memory of childhood _____

_____

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History of Abuse: Verbal Y/N Emotional Y/N Physical Y/N Sexual Y/N Explain:

_____

_____

Family's mental health Hx :Depress, Anxiety, Subst Abuse, Suicide Attmpts, Hosp

Mother: _____ Maternal Grandparents:_____

Aunts/Uncles: _____ Cousins: _____

Father: _____ Paternal Grandparents:_____

Aunts/Uncles:_____ Cousins: _____

Siblings: _____ Kids: _____

_____

MENTAL/ HEALTH TREATMENT:

Past or present treatment by a Psychiatric Dr. Y/N:

Dr. _____ for _____ Yr _____

Dr. _____ for _____ Yr _____

If any more or any Residential treatment or Psychiatric hospitalizations please list, by date, on separate paper

Mental health Counselors: Current, name _____ Since_____ for _____ If considering a change why? _____

Past: Counselor name _____ Age/Year_____ how long _____ for _____

Counselor _____ Age/ Year_____ how long _____ for __

_____

Medical Conditions current: _____ Past chronic conditions _____ Hosp: _____ Surgeries: _____

Past Medication: _____ for_____ by Dr. _____.

_____ for _____ by Dr. _____.

_____ for _____ by Dr. _____.

_____ for _____ by Dr. _____.

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Counseling & Therapy Services, LLC

Current Medication, Herbs & Supplements, include contraception:

_____ for _____ dose: _____ by Dr. _____

_____ for _____ dose: _____ by Dr. _____

_____ for _____ dose: _____ by Dr. _____

_____ for _____ dose: _____ by Dr. _____

Allergic to any RX? _____

Alcohol use: Add separate page if additional space is needed

Beer: # per day _____, # days per week _____

Wine: # per day _____, # days per week _____

Hard Liquor: # per day _____, # days per week _____

Last Marijuana use _____ Get high # x per day _____ # x per week _____

Substances that you use socially/ recreationally: _____

Substances you abuse: _____ # per day _____ # per wk _____

Have you or anyone close to you ever been concerned about your Alcohol or substance use? _____ Tobacco use: # per day _____

Any other important information to share: _____

_____

OFFICE NOTES: Potential Tx Goals: _____

_____

_____

_____

Plan _____

HMWK _____ RTC _____

_____ _____

Rhonna W. Phillips, MA Date

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Rev. 02-2021

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205-356-9834 • P.O. Box 26387 Birmingham AL 35260-0387

Rhonna W. Phillips
Counseling & Therapy Services, LLC

CONFIDENTIALITY: How it Works and INFORMED CONSENT

Name: _____

Your expectations of confidentiality are a critical part of how Counseling can be helpful. Therefore, it is important for you to fully understand what level of privacy to expect and also what the legal limitations are.

In AL, from the age of 14 and up you are entitled to access medical/mental health treatment at your will and without the notification or consent of any parent, guardian or custodian. At age 14 & up, it is your choice to Request or Consent to Release any Information about your treatment. You can limit what is released and you can revoke your consent at any time. For multiple participants, ie Family or Couple's Counseling, all participants must be in agreement or I can only release a summary that is specific to the requestor only! Any communications must be available to all participants; this means I will not be the keeper of secrets. For Couples, be aware, AL does have some legal restriction of your use of a LMFT's testimony in an Alimony or Divorce action.

Your privacy is important to me. I will refer to you by your first name. I will not acknowledge you in public unless you initiate this. The outer office remains locked. My office door is locked and your files are kept in my locked cabinet. If I must transport files they will be in a locked briefcase and locked car. After services are ended, your files are kept locked for 7 years (adults) and 10 years for kids. Technology I use, like my computer and work cell phone are password protected. My computer is encrypted. Even so, privacy cannot be guaranteed. No audio or video recording devices will be allowed or used at any time, by any participant, unless there has been written permission by all participants, in advance. If you see any potential for privacy leaks please make me aware so I can do my best to resolve these immediately.

If your treatment causes me to seek professional consultation, I will use every precaution so as to not give any identifying information. If I am incapacitated my confidential Records' Custodian and Emergency Clinical Coordinator designee is Angel Jernigan, LPC 205-538-4710. Be sure to have this information for your future reference.

It is critical that you understand the circumstances in which, BY LAW, I AM REQUIRED TO REPORT limited information that you disclose to me.

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1. If there is suspicion of ABUSE of vulnerable persons such as children, the elderly (60yo +), the disabled… I must notify The Department of Human Resources (DHR) or the Police.

2. If you are in clear danger & imminent risk of committing SUICIDE or seriously harming yourself.

3. If you are in clear danger & imminent risk of seriously harming or KILLING another person. I have a DUTY TO WARN. For both #2 and #3 the Police and/or Emergency Medical Services (EMS) would be notified, unless you agree to have your designee transport you immediately & voluntarily to the Hospital for Psychiatric assessment. If you have a communicable DISEASE that can be fatal, and you intend to put a person at this risk, I have a duty to report it to the local Health Authorities & to warn the person at risk of harm. AL Health Depts. have an anonymous partner notification program.

4. I must provide the records or testimony ordered, if a Judge orders me, or in situations like: client mental health hospitalizations, court ordered assessments, any civil, criminal, or disciplinary DEFENSE of ME that involves your mental or emotional condition, or if a victim of sexual assault or family violence died, I may have no choice. Clients being treated with Substance Abuse disorders have special protections of those records, EXCEPT if they commit a crime on the premises (and it is a federally funded program like TASK or Beacon Addiction Ctr.)

Client's Emergency contact is:

_____ Hm: _____ C: _____

_____ _____
Client acknowledges as understood Date

Rhonna W. Phillips, MA
Licensed Professional Counselor & Supervisor
Licensed Marriage and Family Therapist
Collaborative Practitioner
Qualified Family & Domestic Relations Mediator Rev. 10-2019

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HIPAA Notice of Privacy Practices and Client Rights

The Health Insurance Portability and Accountability Act of 1996, was effective as of 4/14/03 & updated Sept 2013. See www.hhs.gov. It applies to your "Protected Health Information" (PHI). This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Notice of Privacy Practices:

This provider is required to maintain the privacy of your PHI and only releases your information in accordance with state and federal laws and the ethical codes of the Counseling & Marriage & Family Therapy professions. This notice describes the policies related to the use and disclosure of your PHI for the purposes of providing services. This includes TREATMENT, COLLECTING PAYMENT, and CONDUCTING OPERATIONS including inquiries & scheduling appointments.

Each contact or visit to this office generates a written note. This practitioner does not use electronic medical records. We do use Word to type notes, internet based email, website appointment and payment services, and cell phone communication services upon your initiation. The hard copy records are stored in the mental health/medical file under your name. It is the property of this provider. This file compiles a record of your symptoms, assessment, diagnosis, treatment, plan for future treatment, payments and any correspondence including other mental/health records received by this provider.

initial **X**_____

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The file for you is used for: Planning your care & treatment, legal documentation, to contact you when needed
A communication tool to coordinate care among your health professionals
A third party payer, to verify the services billed were provided & payment can be retrieved
A tool for educating health professionals
A source of data for medical research which has privacy protocols
A source of information when public health officials require it ie: preventing disease, reporting adverse reactions to Rx, reporting abuse, neglect, domestic violence, preventing or reducing serious threat to anyone's health or safety
Use of data for planning and marketing of services
A tool for improving care and services
Verification of compliance with the HIPAA law

According to HIPAA law your information may be disclosed to provide, manage or coordinate your care and services. This can include mental and/or health care professionals, consultants, specialists, and referral sources. It can also include law enforcement/government officials (like the Police or FBI) for your or others' health & safety, worker's compensation, disability determination, related to organ/tissue donation, medical examiner or funeral directors if deceased, or response to legal actions like court orders. Refer to "How Confidentiality Works" for further information on AL Counselor & Therapist professional ethics and mandated disclosures by this practice.

initial **X**_____

Rhonna W. Phillips
Counseling & Therapy Services, LLC

Your PHI may be disclosed for processing payment, reimbursement for services (including any 3rd party payer/insurance company verification of coverage or processing of claims), billing or collections of fees, including legal actions.

Your information may be used to manually or electronically to conduct the business of healthcare operations i.e.: Compliance w/laws or regulations, disaster/emergency situations, licensure, contract services for the office or your treatment, treatment alternatives, business associates, administration, quality improvement, inquiries for services, or management of your appointments. Only the reasonably minimum necessary amount of your PHI will be disclosed. You may have some choices in how we use or share this information. We never sell or market your PHI or fundraise with identifiable PHI. You will be notified if a known breach of information occurs that may have affected the security of your PHI.

Client Rights:
You can request communications by alternate means or locations & reasonable requests will be accommodated. You can choose someone to act in your behalf ie: Medical Power of Attorney or Legal Guardian. We will verify their authority.

You authorize this provider to contact you for routine purposes via:
Email: _____
Cell/ok to lv msg: _____ Hm/ok to lv msg: _____ Wk/ok to lv msg:_____
Texting: Ok or NO; Other technology: _____
If you initiate contact w/me via any form you are authorizing use of that form & accepting its' inherent risks. I will NOT interact with you

via Social Media for your privacy protection.
If you are requesting an alternate mailing address be used for contacting you, please note it here: _____
You request to NOT be contacted at _____

This provider is required to provide you with this notice, abide by it, and notify you of any changes. A written copy will be available, in writing, at this providers' office.

You have a right to inspect and/or copy your PHI usually within 30 days & in electronic version if it's in that format. This can be limited according to this provider's judgment of potential clinical contraindications. You would be notified of this. You do not have rights to clinical psychotherapy notes. This provider may provide you a summary instead. Charges apply.

You have a right to add to or correct your PHI. The request must be in writing & explain why. Any denial will be given to you in writing within 60 days from receipt of the request. This request can be denied. You can put any disagreement in writing. This would all be added to the record & does not delete the original documentation.

You can obtain a list of who has received any disclosures about your PHI and why for six years from the start of your treatment with this provider. This accounting would apply only to disclosures other than about your treatment, payment, provider operations, or those you requested. One list per year is free otherwise the charges are based on the cost.

initial **X**_____

Rhonna W. Phillips
Counseling & Therapy Services, LLC

You can, in writing, request restriction on certain treatment, payment, or operations uses or disclosures of your PHI ie: disaster relief, provision of mental health care, marketing. We are not required and if this provider is unable to agree to your request you will be notified.

You can request, if you pay in full out of pocket, that we not share PHI with your health insurer for purpose of our payment or operations.

You have the right to release your PHI to family, friends, or your other health care providers, and can revoke a prior authorization for use or disclosure of your PHI. Each must be in writing. Revocation cannot apply to that which was already authorized and/or released.

If you have any concerns you can contact this provider; we will work for resolution. You have the right to file a complaint. There will be no retaliation for a complaint. Contact the Office of Civil Rights: U.S. Dept of Health & Human Services 200 Independence Ave. S.W. Room 509F HHH Bldg Washington, D.C. 20201; 1-877-696-6775; www.hhs.gov/ocr/privacy/hipaa/complaints.

Remember, the above activities can be case management labor and those services can be charged according to the time costs. I have received in writing, read & understand this HIPAA notice.

_____ _____

Client Signature Date

Rhonna W. Phillips, MA
Licensed Professional Counselor & Supervisor,
Licensed Marriage and Family Therapist, Collaborative Practitioner,
Qualified Family & Domestic Relations Mediator **Rev. 05-2016**

Rhonna W. Phillips
Counseling & Therapy Services, LLC

Please don't rely on GPS; you will likely be left lost in my parking lot.

DIRECTIONS:

From I-65 Heading South:
Take the Alford Avenue Exit.
Turn Left and cross over interstate bridge.

From I-65 Heading North:
Take the Alford Avenue Exit.
Turn right.

A Shell station will be on your right.
Just beyond the Shell station, turn left into the second office park parking lot.

Follow the building signs to building # 1320.
It will be the 3rd building on the far right side of the parking lot.

Parking Note: Because of the slope of the parking lot, please use caution when opening or closing your car door. It can potentially cause personal injury or damage to other cars.

To enter the office waiting area use the left doorway to suite 101. 1320 Alford Avenue Suite 101 Hoover, AL 35226

Rev 12-2019

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Rhonna W. Phillips
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Use of Technology for Counseling
like Video-conferencing or Cell phone, Email, or Text

If you are a new client, using technology for our session/s, **please be sure all the documents requested, have been completed and sent to me so I have them IN ADVANCE OF our first session.**

All clients: Please read all the information below. Use this to make your preparations to be ready for your session via technology. **At our appt time watch for contact from me.**

_____ For **Video-Conferencing.** I am glad you are able and/or willing to use my **confidential, simple to use, software "Doxy.Me"** for our appt which I use in a **HIPAA compliant** way.

Watch for an email from me, in it will have the link to click on. **Scroll down to see the diagram below, note step two. It is that easy.** You might need to turn on your video screen and/or microphone.

_____For Cell Phone use: I will call you at the agreed #.
_____For Email: watch for an email from me at our appt time.
_____For text: Watch for a text from me at our appt time.
_____For other: _____

If we run into any tech problems, like it keeps crashing… because the internet is overloaded…. our **backup plan** will be to use the phone. Use your discretion, as to how much you want to trust any technology, for your privacy. Keep in mind, all forms of technology have their risks, because of hackers and voyeurs. I'm using the best tools I know, in the most protective ways, **but I**

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cannot guarantee your privacy. We each have a responsibility to minimize any risks, if possible.

Most of you have already **prepaid $$$.$$ for your appt**. Thank you. No further action is required. For those who were due to pay in office, please send my payment to my email via PayPal or Venmo (RPhillips@BirminghamCounselor.com) or mail me a check (PO Box 26387 Bham AL 35260). If you intend to file with your Insurance, knowing I am NOT In-Network, please also know that Counseling via distance/technology may not be covered at all.

In order to see and hear and get as much out of the session as you could in person, please ensure you are set up in a **private, quiet, comfortable spot** to sit for the 50 or 80 minute session. If you have earbuds/phones use them. For video, sit where you/all can see the screen straight on and it can be stationary. Be sure **light is in front of you** and not behind you glaring, and the site line behind you is free from visual distractions.

Before we start, I will need to see your photo identification to **verify your identity, to verify your location, if you have privacy, and if you are ready to begin.** During our session I may refer to your file and I will **take notes, documenting our technology based session and our locations,** and retain the information securely. You can request to update your information at any time. If we need to pause, for privacy, state the code word **"groceries"**.

I must have an emergency contact # for each location of any video session, at all times.

Rhonna W. Phillips
Counseling & Therapy Services, LLC

#1. Current home address: _____
Current emergency contact at home: _____
Ph #: _____ _____

#2. Current work address: _____
Current emergency contact at work: _____
Ph #: _____ _____

#3. Other location for Tech based Counseling: _____
Emergency contact name this loc: _____
Ph #: _____ _____

#4. Other location for Tech based Counseling: _____
Emergency contact name this loc: _____
Ph #: _____ _____

If **an emergency** occurs during our session, for immediate purposes, use the Doxy.Me text tool or you can call or text me on my cell phone 205-356-9834. Less prompt, but an option, is to leave a cell phone voice message or email me.

If I observe signs of potentially life threatening distress, significant out of character behavior/symptoms of a more severe condition, or you confirm an immediate need, I will contact your pre-designated emergency contact for your location. If I don't know where you are, 911 won't find you either. So, **yes, I really must have this info:**

Non 911 emergency #'s (like County Sheriff or Municipal Police):
for your residence: _____
for your work: _____
Other locations for video sessions:

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205-356-9834 • P.O. Box 26387 Birmingham AL 35260-0387

Other: _____ **Ph #:** _____
Other: _____ **Ph #:** _____
Other: _____ **Ph #:** _____

Rhonna's Office location: 1320 Alford Ave Suite 101 Hoover AL 35226. For mailing, use PO Box.

Because technology will limit our use of visual & auditory cues, there is greater **chance for misunderstandings**. Please check and verify before concluding and reacting. Please share with me, informally, at any time, or on my evaluation form, any feedback or suggestions you may have.

We may **cease to use technology based tools for your counseling appt if**: connection or quality problems can't be resolved, if you don't like it, if your privacy can't be secured, if I am not able to retrieve information I need or to be effective communicating with you. Differences in aptitude for technology can affect comfort and even roles. Speech, language, auditory, visual, or attention problems can all be a barrier to progress via technology. Either of us may choose to cease its' use, for any reason. Once the circumstances for use of technology is over, we will resume face to face, in office sessions with me; elsewhere if referral is needed.

Our use of technology is only for our professional use, to provide accessible mental health services**. I do not use social media nor my personal accounts with clients** (like Facebook, LinkedIn, Twitter, Skype….). These are tools that others can possibly view or participate in. This is for YOUR privacy and protection.

Rhonna W. Phillips
Counseling & Therapy Services, LLC

Once you have reviewed the instructions below, if you have any questions or concerns, please just call me and we'll address it. Your signature affirms your understanding and acceptance of the privacy risks with the use of technology for counseling. You may withdraw your consent at any time, if you choose to.

_x_____ _x_____
Client 1. signature Date

_x_____ _x_____
Client 2. signature Date

_x_____ _x_____
Client 3. signature Date

_x_____ _x_____
Client 4. signature Date

_____ _____

Rhonna W. Phillips, MA **Date**
Licensed Professional Counselor & Supervisor
Licensed Marriage and Family Therapist
Collaborative Practitioner
Qualified Family & Domestic Relations Mediator

Scroll down for:

Flyer to help clients have their first video session with Rhonna:

GETTING STARTED FOR PATIENTS

How to check in for your video visit

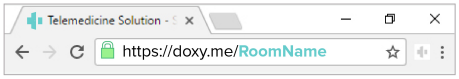
1 Use a computer or device with camera/microphone

PC and Mac
Chrome | Firefox | Safari

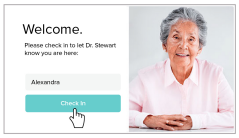
Android
Chrome

iOS
Safari

2 Enter your clinician's doxy.me web address into the browser

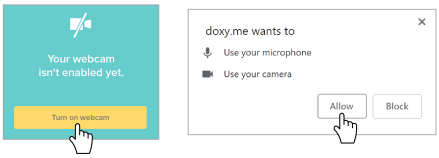


3 Type in your name and click check in



- Secure
- No software to download
- HIPAA compliant
- No registration needed

4 Allow your browser to use your webcam and microphone



5 Your care provider will start your visit

Call Tips

- Have a good internet connection
- Restart your device before the visit
- Use the Start Test button in the waiting room
- Need help? Send us a message https://doxy.me

Powered by doxy.me

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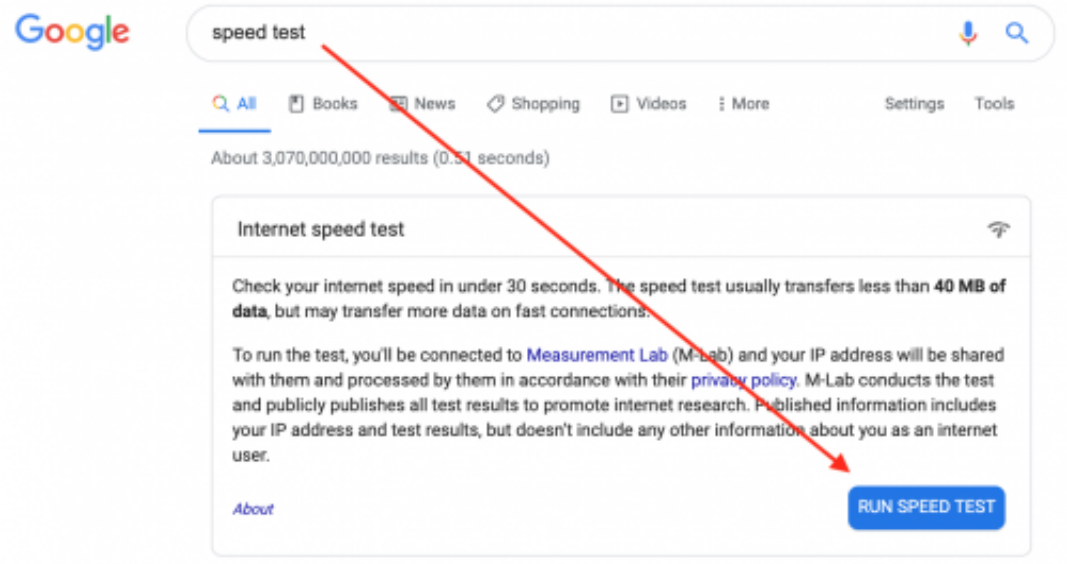
Doxy.Me: **CTO & Cofounder Dylan Turner 3445 Winton Place Suite 109 Rochester NY 14623 or support@doxy.me**

A strong, reliable internet connection is integral to an effective technology based mental health session, especially using video. If you're able to use a wired connection, this will provide you with the best possible experience through your internet provider.

If you're not able to use a wired connection, you can still use a wireless network for your online sessions. However, you'll want to be sure that you're using Wi-Fi with a bandwidth (speed) of at least 10 MBPS on download and upload. If your bandwidth is any slower, your video will lag and cut out causing a negative experience for both you and your clients. To check your internet speed, type "speed test" into a Google search and click this button:



This will run short tests for both your download and upload speeds, which will take about 30 seconds overall. When complete, you'll be shown your results:

If either of your tests returns a speed lower than 10 Mbps, contact your Internet Service Provider (ISP) to ask about available options to improve your connection. This will likely require upgrading your service to a higher-level package but may be worth it in the long run.

Rhonna's training for technology use in Counseling:

6/25-26/2015 (15 hours) Distance Counseling Training by The Telehealth Certification Institute, Ray Barrett, LPC, LMHC. NBCC ACEP# 6693.

2/22/2020 (3 hours) Technology in Marriage and Family Therapy by AL Association Marriage and Family Therapy Network, Scott Ketring, PhD, LMFT, Sponsored by AAMFT NBCC ACEP# 5209.

4/10-4/11/2020 (15 hours) Certificate in Technology Assisted Services by AL Association Marriage and Family Therapy Network, Tony Watkins, LMFT and Dale Bertram, LMFT, Sponsored by AAMFT; NBCC ACEP# 5209.

Licensure:

LPC-S #1643/466 AL Board of Examiners in Counseling 205-458-8716.
LMFT #L230 AL Board of Examiners in Marriage and Family Therapy 334-395-7455.

Only clients who are physically located in AL may receive services by Rhonna whose licenses only cover AL. The use of technology, unfortunately, does not provide an exception to this current law.

Tele- Mental Health Informed Consent Rev 6-10-2020
with ongoing construction and updating.