Hannah Schoonmaker, M.MFT, LMFT-A
supervised by Jeffrey Emery, M.MFT, LMFT-S
5189 Texas Ave,
Abilene, TX 79605
682-214-8216 (mobile); 325-603-1725 (office)
888-843-6404 (fax)
www.mosaicwellnessonline.com

Client Intake Paperwork

Client name (printed): _____ Date: _____

Information, Policies & Procedures
Please read carefully!

This paperwork is intended to provide clients with important information regarding my professional services and business policies. This consent form will provide a clear framework for our work together and will facilitate our therapeutic relationship. Any questions or concerns regarding the contents of this agreement should be discussed with me prior to signing it.

Therapist Information

Professional Orientation: I offer therapy for couples, families, and individuals above the age of 18. I believe that therapy can be a stepping stone for you and your relationships in the direction of growth and fulfillment. I have regularly seen individuals, couples and families dealing with depression, anxiety, PTSD, career decisions, marital or couple concerns, grief, and suicidal ideation.

Educational / Training Background: I have a Bachelor of Science in Kinesiology from Abilene Christian University and a Master's in Marriage and Family Therapy from ACU Online. I am a Licensed Marriage and Family Therapy Associate.

Client Rights

1. You have the right to ask questions about any procedures used during therapy; if you wish, I will explain my approach and methods to you.
2. You have the right to decide not to receive therapeutic assistance from me; if you wish I will refer you to other qualified professionals whose services you may prefer.
3. You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued. I ask that you contact me by phone or in person before you make such a decision.
4. You have the right to expect that I will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, all of which could greatly compromise our work together.
5. Therapy involves a partnership between therapist and client(s). As your therapist, I will contribute my knowledge, skills and a willingness to do my best.

_____ Client Initials

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Client Rights (cont.)

Confidentiality: One of the most important client rights involves confidentiality: within the limits of the law, information shared by you during therapy will be kept private and will not be revealed to any other person or agency without your written permission. As your therapist, I am legally prohibited from revealing to another person that you are engaged in therapy with me. Nor can I reveal what you have said to me in any way that identifies you without your permission. However, in the following instances, your right to confidentiality must be set aside as required by the law or my professional standards.

Limits of Confidentiality:

1) If I become aware of or suspect any physical or sexual abuse, emotional cruelty, or neglect of a child or an elderly adult or dependent adult, I am required by law to report such to the appropriate protective services.
2) If I have reason to believe that a client poses an unavoidable and imminent danger of violence or harm to any other person, I may warn the intended victim and notify the proper authorities.
3) If you, as a client, reveal a serious intent to harm yourself, I am ethically bound to do what I can to help keep and maintain your safety, which may involve notifying others who may be of assistance.
4) If a judge orders my testimony or, in the context of a legal proceeding, you raise your own psychological state as an issue, I may be required to release confidential information to the court.

In all the above situations, it is my responsibility to release only that information which may be necessary to appropriately carry out my responsibilities. Your confidentiality still remains an ethical priority.

Legal Action: If legal actions occur in which I am requested or subpoenaed to provide testimony (such as a custody case), you will be responsible to pay me directly, in advance, for providing the following services: (a) time spent preparing for the court, (b) time spent for transportation to/from court, and (c) time spent appearing/testifying in court. Charges for legal services will be billed at **$200 per hour**, with a minimum of one hour billed, regardless of whether I actually testify in the court proceedings. This fee is NOT reimbursable by your insurance or any other Third Party Payer and is therefore the full legal responsibility of you, the client, and/or the client's parent or legal guardian.

_____ Client Initials

Appointments: Your appointment time is reserved especially for you. Therapy sessions are normally 45-60 minutes in length. **Cancellations must be made at least 24 hours in advance; otherwise, you are responsible for up to a $25 late cancellation or no-show fee**. After 2 missed appointments, you will be required to pay in advance for your next scheduled appointments. Regular attendance is recommended to ensure continuity and to enhance the effectiveness of therapy.
I am happy to provide therapy hours in the evenings, but I am especially protective of those hours, as they represent time beyond normal daytime working hours for both myself and my clients. If it happens that there are several occurrences of missed evening appointments, I reserve the right to restrict scheduling to weekday hours.

Scheduling and communication: Once we have established you as a client, you may choose to schedule via phone to our office, via an online scheduling procedure, or text messaging. You may be sent an automated text reminder of your appointment time. Emails, texting, social media and similar forms of communication have some advantages but are inherently hard to secure. Any information transmitted through those formats can compromise your privacy. Please restrict this communication to scheduling purposes and do not use emails, faxes or texting for emergencies.

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Client Rights (cont.)

Records and Administrative Services: I may take notes during session and may also produce other notes and records regarding treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Should you request a copy of my records, such a request must be made in writing. I reserve the right, under Texas law, to provide a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. I will maintain a client's records for seven years following termination of therapy. If the client is a minor, records will be maintained for 10 years after that minor's eighteenth birthday. However, after 7-10 years, your records may be destroyed in a manner that preserves your confidentiality. Records requests may incur administrative fees, as reasonable.

Professional Fees and Payments:

- First session (intake): $70
- Second and subsequent sessions: $65
- Legal Action (see pg 2): $200 per hour
- Late Cancel & No Show fee (see pg 2): $25 per occurrence
- **Responsibility**: You, the client, (legal guardians in the case of minors) are responsible for payment of services. When a Third Party fails to make timely payments, payments will be expected from the client and/or legal guardian in the case of a minor child. Third Party payers include: divorced parents, divorced or separated spouses, insurance companies.
- **Insurance**: I am unable to accept insurance at this time.

Consent For Services:

Thank you for reviewing this information. Your signature below indicates you have read and understand and will comply with the policies and procedures of my practice.

_____ _____

Client Signature(s) Date

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Client Consent for Use and Disclosure Of Protected Health Information (PHI)

I, _____,
Client Name (Printed)

hereby give my consent for Hannah N. Schoonmaker, M.MFT, LMFT-A to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). By signing this form, the therapist may use PHI to carry out treatment and/or arrange for payment of treatment and/or consult with other providers about my treatment.

The Notice of Privacy Practice explains in more detail how my PHI can be used and disclosed. I have the right to read and review the NPP prior to signing this document (see page 2). By signing below, I attest that I have read it.

I may request that my PHI be restricted in certain cases, how it is used and disclosed to carry out my TPO; however, Hannah N. Schoonmaker, M.MFT, LMFT-A is not required to agree to my request, but if she does, he is bound by this agreement. I may revoke my consent (in writing) except to the extent that the disclosures have already been made in reliance on my prior consent. If I do not sign this consent form or later revoke it, Hannah N. Schoonmaker, M.MFT, LMFT-A may decline to provide treatment to me.

Hannah N. Schoonmaker, M.MFT, LMFT-A reserves the right to revise its Notice of Privacy Practices at anytime. A revised NPP may be obtained by forwarding a written request to privacy officer, Deborah Emery, at the above address.

_____ _____
Client Name (Printed) Date

_____ _____
Signature of Client Client Date of Birth

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Adult Intake Form pg. 1

Name: _____ Date: _____

Social Security #: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ Zip: _____

Telephone: Cell: _____ Work: _____ Other: _____

Email: _____ Employer: _____

In case of an emergency, who may I contact on your behalf?

Name: _____ Relationship to you: _____

Phone Number: _____ Address: _____

May we contact your physician to coordinate services ? Y / N Physician: _____

Please list any medications currently being taken:

Medication	Dosage	Treating

Who referred you to our office? _____

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Household Information

Name	Date of Birth	Age	Relationship to you

Highest Level of Education (circle): High School Some College College Degree Graduate School Other
If you are currently a student, what are you studying? _____
If you received a college degree, what was your field of study? _____
Relationship Status (Circle all that apply): Single Married Divorced Separated Widowed Remarried Cohabitating

Current Partner's Name: _____ Partner's Occupation : _____ Length of Relationship: _____

How satisfied are you with your current relationship? (on a scale from 0-10)

(very unsatisfied) 1 2 3 4 5 6 7 8 9 10 (very satisfied)

What is your occupation? _____ Avg Hours Worked / Week: _____ Do you enjoy your occupation? Y / N

How would you describe your sexual identity? _____

How would you describe your gender identity? _____

What are your preferred pronouns? (she/her; he/him; they/them)_____

How would you describe your racial/ethnic identity? _____

How would you describe your spiritual beliefs? _____

Average number of hours you sleep each night: _____ How long does it typically take you to fall asleep? _____ mins _____ hrs

Do you frequently wake up in the night? Y / N If YES, how often? _____ times per night

How would you rate your overall sleep at the present time? (on a scale from 0-10)

(poor) 1 2 3 4 5 6 7 8 9 10 (excellent)

Do you exercise on a regular basis? Y / N If YES, how often? _____ times per week
If YES, briefly describe your activity: _____

How would you rate your overall diet at the present time? (on a scale from 0-10)

(poor) 1 2 3 4 5 6 7 8 9 10 (excellent)

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Do you drink alcoholic beverages? Y / N If YES, how many? _____ Daily _____ Weekly

Would you describe your drinking habits as problematic? Y / N Does anyone else describe your drinking as being a problem? Y / N

Do you smoke cigarettes/vape? Y / N If YES, how much/often do you smoke/vape: _____

If YES, when did you start smoking/vaping? _____ Have you ever tried to quit? Y / N

Have you in the past or currently: Used/Abused/Experimented with Illegal drugs? Y / N

If YES, briefly explain: _____ If YES, time since last use: _____

Have you ever attempted/seriously contemplated suicide? Y / N Have you ever self-harmed? Y / N

If YES, describe briefly and indicate dates: _____

Are you currently experiencing self-harming or suicidal thoughts? Y / N

Have you ever had a hospitalization due to psychological symptoms? Y / N

If YES, describe briefly and indicate dates: _____

_____

Therapy Experiences and Expectations:

re you currently seeing another therapist? Y / N

If YES, please indicate the therapist's name:

Have you been in therapy in the past? Y / N

If YES, please fill out the following on your previous counseling experience(s):

Therapist	Location	Dates	Reason for Therapy

Was there anything previous therapist(s) provided that was *helpful* to your situation?
Was there anything previous therapist(s) provided that was *unhelpful* to your situation?

Please briefly describe your reason(s) for seeking therapy at this time:

What goals do you wish to accomplish during the therapy process?

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SYMPTOM CHECKLIST: PLEASE PUT AN [X] BY ANY OF THE ITEMS THAT APPLY TO YOU.

Situations
__ Parenting
__ Children
__ Marriage
__ Divorce
__ Separation
__ Dating
__ Premarital counseling
__ Sexual problems
__ Stress
__ School/education
__ Career choices/goals
__ Finances
__ Legal concerns
__ Religion
__ My past

Relationship Issues
__ Relationship with parents
__ Relationship with friends
__ Relationship with in-laws
__ Feeling lonely or isolated
__ Feeling inferior to others
__ Feeling a lot of conflict

Feelings
__ Nervous
__ Angry
__ Irritable
__ Guilty
__ Shamed
__ Depressed
__ Sad
__ Fearful
__ Shy
__ Anxious
__ Worried
__ Hopeless
__ Numb/no feelings
__ Mood swings
__ Happy/elated
__ Worthless

Thinking
__ Blaming others
__ Difficulty acknowledging problems
__ Poor concentration
__ Attention span problems
__ Short-term memory problems

Thinking (continued)
__ Nightmares
__ Flashbacks
__ Hearing voices
__ Seeing strange things
__ Obsessive/repetitive thoughts
__ Suicidal thinking

Physical complaints
__ Insomnia
__ Sleeping too much
__ Weight gain
__ Weight loss
__ Low energy/fatigue
__ Less interest in pleasure/fun
__ Alcohol use
__ Drug use
__ Headaches
__ Upset stomach
__ Ulcers
__ Allergies
__ Asthma
__ Body aches
__ Bedwetting/soiling

What do you consider to be your strengths? _____

What do you like most about yourself? _____

What are some effective coping strategies you have learned? _____

_____

_____

What are your best hopes for therapy? _____

_____

_____

Is there anything else you would like me to know? _____

_____