



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

Couples Intake Paperwork

Name (printed): _____

Date: _____

Name (printed): _____

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 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
_____	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 and your partner during therapy will be kept private and will not be revealed to any other person or agency without your and your partner's written permission. As your therapist, I am legally prohibited from revealing to another person that you and/or your partner are engaged in therapy with me. Nor can I reveal what you and/or your partner 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 and your partner's 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

_____ 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 and/or your partner request a copy of my records, such a request must be made in writing by both partners. 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 your records for seven years following termination of therapy. 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.



Due to the nature of couples therapy and information shared from both individuals, release of records is only done with consent from both individuals. Without written consent from both individuals, I am unable to release any information unless otherwise indicated.

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 and your partner are responsible for payment of services. Payment will be taken at the time of each scheduled session. In the case of having separate finances, it is up to you and your partner to determine the payment for services. If one partner defaults on payment, it is the responsibility of the other partner to pay for any past due services. When a Third Party fails to make timely payments, payments will be expected from the client. 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

Client Signature(s)

Date



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

I, _____, and
Client Name (Printed)

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 (NPP) 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

Client Name (Printed)

Date

Signature of Client

Client Date of Birth





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Intake Form

To be filled out individually

Partner #1 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

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? _____



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Partner #1 pg. 2

Relationship Status (Circle all that apply): Single Married Divorced Separated Widowed Remarried Cohabiting

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 the problem that led you to come to couples therapy? _____

How long have you and your partner been together? In what form (e.g., dating, living together, married)? _____

What initially attracted you to your partner? _____

How long has it been since things were good between the two of you? _____

What do you usually do when there is a conflict between the two of you? _____

What does your partner usually do? _____

What strengths do you have when resolving conflict? _____

What would you say are your partner's strengths in resolving conflict? _____

How open are you to expressing your innermost thoughts and emotions with your partner? (on a scale from 0-10)

(totally closed) 1 2 3 4 5 6 7 8 9 10 (totally open)

When do you feel the most unhappy or frustrated in your relationship? _____

When do you feel the most content in your relationship? _____

Describe your level of commitment to your relationship? (on a scale from 0-10)

(not at all) 1 2 3 4 5 6 7 8 9 10 (extremely)

Are you currently seeing another therapist? Y / N			
If YES, please indicate the therapist's name:			
Have you been in individual therapy in the past? Y / N		Have you been in couples 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 <i>helpful</i> to your situation?			
Was there anything previous therapist(s) provided that was <i>unhelpful</i> to your situation?			

Is there anything else you would like me to know about you or your partner?



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Intake Form

To be filled out individually

Partner #2 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

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? _____



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Partner #2 pg. 2

Relationship Status (Circle all that apply): Single Married Divorced Separated Widowed Remarried Cohabiting

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 the problem that led you to come to couples therapy? _____

How long have you and your partner been together? In what form (e.g., dating, living together, married)? _____

What initially attracted you to your partner? _____

How long has it been since things were good between the two of you? _____

What do you usually do when there is a conflict between the two of you? _____

What does your partner usually do? _____

What strengths do you have when resolving conflict? _____

What would you say are your partner's strengths in resolving conflict? _____

How open are you to expressing your innermost thoughts and emotions with your partner? (on a scale from 0-10)

(totally closed) 1 2 3 4 5 6 7 8 9 10 (totally open)

When do you feel the most unhappy or frustrated in your relationship? _____

When do you feel the most content in your relationship? _____

Describe your level of commitment to your relationship? (on a scale from 0-10)

(not at all) 1 2 3 4 5 6 7 8 9 10 (extremely)

Are you currently seeing another therapist? Y / N			
If YES, please indicate the therapist's name:			
Have you been in individual therapy in the past? Y / N		Have you been in couples 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 <i>helpful</i> to your situation?			
Was there anything previous therapist(s) provided that was <i>unhelpful</i> to your situation?			

Is there anything else you would like me to know about you or your partner?