ANGIE DAVENPORT COUNSELING
118 Public Square, Gallatin, TN 37066

Minor Intake Form

Name _____ **Prefers to be called** _____
Gender: Male / Female **Birth Date** _____ /_____ /_____ **Age** _____ **Grade** _____
School _____ **Home Phone** _____-_____-_____
Address _____

Reason for coming to counseling _____
_____

Parent / Guardian Information

Name _____ **Occupation** _____ **Employer** _____
Relationship to client: Birth Parent / Step Parent / Adoptive Parent / Legal Guardian
Home/Cell phone _____/_____/_____ May we leave a message? _____ yes _____ no

Name _____ **Occupation** _____ **Employer** _____
Relationship to client: Birth Parent / Step Parent / Adoptive Parent / Legal Guardian
Home/Cell phone _____/_____/_____ May we leave a message? _____ yes _____ no

Name _____ **Occupation** _____ **Employer** _____
Relationship to client: Birth Parent / Step Parent / Adoptive Parent / Legal Guardian
Home/Cell phone _____/_____/_____ May we leave a message? _____ yes _____ no

Name _____ **Occupation** _____ **Employer** _____
Relationship to client: Birth Parent / Step Parent / Adoptive Parent / Legal Guardian
Home/Cell phone _____/_____/_____ May we leave a message? _____ yes _____no
_____

If biological parents are divorced, please answer the following:
Year of divorce _____Which parent is the primary residential parent? _____
Is there a parenting plan in place? _____ yes* _____ no *please provide a copy
Who has non-emergency health care decision making? Mother / Father / Joint
What is parenting time schedule? _____
Has either parent remarried? Mother: _____ yes* _____ no *If yes, year of remarriage _____
Has either parent remarried? Father: _____ yes* _____ no *If yes, year of remarriage _____

Please list any siblings this minor has in order of their births:

Name	Age	Relationship to Client	Active part in life
		biological / adoptive / half / step / foster	Y / N
		biological / adoptive / half / step / foster	Y / N
		biological / adoptive / half / step / foster	Y / N

ANGIE DAVENPORT COUNSELING
118 PUBLIC SQUARE, GALLATIN, TN 36066

Medical / Counseling History

Name of Doctor _____ Phone_____
For what medical problems is the child being treated currently? _____

_____

Please list all medications currently being taken:

Medication	Dosage	Frequency	Prescribed for ...	Date began

Has the minor received counseling before? _____ yes _____ no **Seen a psychiatrist?** yes / no

Age	Duration	Counselor's Name	Reason for Counseling	Outcome

Has the minor ever been hospitalized for a psychological problem? _____ yes _____ no
Has the minor ever received inpatient treatment for an addiction? _____ yes _____ no
Has the minor ever: considered suicide? ____yes ____no **attempted suicide?** ____ yes____ no
self-harmed? _____ yes _____no

What do you hope to achieve through this counseling experience? _____

_____

By whom was this child referred for counseling? _____

I certify that the information contained herein is complete and accurate, to the best of my knowledge. I voluntarily consent to the treatment that my child/teenager will receive at Angie Davenport Counseling.

_____ _____ / _____ / _____
(Signature) (Date)

ANGIE DAVENPORT COUNSELING
118 Public Square, Gallatin, TN 37066

AUTHORIZATION TO COUNSEL MINOR CHILDREN

I (We), _____ _____
give my (our) permission to [Name of Parent(s) or Guardian]

___Angie Davenport, LMFT_____ to see my (our) son/daughter,
(Counselor)
_____ for counseling with and/or
(Name of Minor Child)
without me being present in the same session. I (We) understand that we are the holder of confidential privilege – the right to withhold disclosure or private counseling information about my child. However, in the interest of developing a trust relationship between the counselor and my (our) child(ren), I (we) give the counselor permission to reveal or withhold information which, in her clinical judgment, is necessary to protect my (our) minor child. The only exception to this discretion would be in the case of:

_____

_____

Please initial

- I(We) have legal custody of the child and have authorization to provide counseling for the child named above. Yes _____ No _____

- Does another person or party have the authority to provide consent for medical and mental health treatment? Yes _____ No_____

- Is the consent of this other person or party required for treatment to begin?

  Yes ____ No _____

- Please provide any documentation concerning this authority to consent for treatment.

_____ _____/_____/_____
(Parent/Guardian Signature) (date)

_____ _____/_____/_____
(Parent/Guardian Signature) (date)

_____ _____/_____/_____
(Counselor Signature) (date)

ANGIE DAVENPORT COUNSELING
118 PUBLIC SQUARE, GALLATIN, TN 36066

GENERAL COUNSELING INFORMATION

Credentials

Angie Davenport holds a Masters in Marriage & Family Therapy and is licensed by the state of Tennessee as a Marital & Family Therapist, license #808. She is also a clinical member of the American Association for Marriage & Family Therapy.

Risks in Counseling

Counseling may be tremendously beneficial, while at the same time, there are some risks. These risks include the experience of intense and unwanted feelings, including sadness, fear, anger, guilt, or anxiety. It is important to remember that these feeling may be natural and normal and are an important part of the counseling process. Other risks may include recalling unpleasant life events; facing unpleasant thoughts and beliefs; increased awareness of feelings, values and experiences; alteration of an individual's thinking; changes in relationships, and calling into question some or many of your beliefs and values. Your counselor will be available to discuss any of your assumptions, problems or these possible side effects of your work together.

Client Rights

-You have the right to ask questions about any part of the counseling session.
-You have the right to end the counseling process at any time without moral, legal, or financial obligations other than those already accrued.
-You have the right to review information in your files at any time with proper notification and in consultation with your counselor.
-You have the right to request a release of the information in your counseling files to any person or agency you designate.

Termination

Termination of counseling may occur at any time and may be initiated by either the client or the counselor.

Clients Who Are Dependents

If you are requesting my services as the guardian or parent of a child or of a dependent adult, the same general principles as above will apply. However, it is important that your child be able to trust me as his/her counselor completely. That being true, I keep confidential what the child says in the same way that I keep confidential what an adult says. As the parent/guardian you have the right and responsibility to question and understand the nature of my progress with your child, and I must use my discretion as to what is an appropriate disclosure. In general, I will not release specific information that the child provides to me; however, I feel it is appropriate to discuss your child's progress in broader terms and value your participation in their counseling experience. You will be asked to sign a consent form allowing me to counsel your minor child.

I welcome you to Angie Davenport Counseling and look forward to our work together.
Please note: No unauthorized audio or video recording is allowed.

Client Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

-I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, my legal duties, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect.
-I reserve the right to change my privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before I make a significant change in my privacy practices, I will change this Notice and make the new Notice available upon request.
-You may request a copy of my Notice at any time. For more information about my privacy practices or for additional copies of this Notice, please contact me using the information listed at the end of this Notice.

-Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA (The Health Insurance Portability and Accountability Act) and state law very clearly defines what kind of information is to be included in your "designated medical record" as well as some material known as "Psychotherapy Notes," which is not available to outside sources and in some cases, not to the client.
-HIPAA provides privacy protections about your personal health information, which is called "protected health information" which could personally identify you. PHI consists of three (3) components: treatment, payment, and health care operations.
TREATMENT refers to activities provided by a counselor to coordinate your health care.
PAYMENT refers to cases where reimbursement is sought from an outside source. Since I do not file insurance this situation would be extremely rare.
HEALTH CARE OPERATIONS refers to activities that relate to the operation of the office.
-The use of your protected health information refers to activities that Angie Davenport Counseling conducts for scheduling appointments, keeping records and other tasks within Angie Davenport Counseling related to your care. DISCLOSURES refers to activities you authorize which occur outside of Angie Davenport Counseling such as sending your protected health information to other parties such as your primary care physician or in the case of children to the school guidance counselor.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING AUTHORIZATION

-Tennessee requires authorization and consent for treatment, payment, and healthcare operations. HIPPA does nothing to change this requirement by law in Tennessee. With your consent Angie Davenport Counseling may disclose personal health information for the purposes of treatment, payment, and healthcare operations. You have signed this general consent to care and authorization to conduct services associated with this care.
-Additionally, if you ever want Angie Davenport Counseling to send any of your protected health information to anyone outside Angie Davenport Counseling, you will always sign a specific **authorization to release** information to this outside party. A copy of the authorization form is available upon request. The requirement of you signing an additional authorization form is an added protection to help insure that your protected health information is kept strictly confidential.
-There is a **third, special authorization** provision potentially relevant to the privacy of your records: psychotherapy notes. In recognition of the importance of the confidentiality of conversations between the counselor and the client in treatment settings, HIPAA permits keeping **"psychotherapy notes"** separate from the overall "designated medical record". "Psychotherapy notes" are not the same as your "progress notes" which provide general information about your care and progress each time you have an appointment at Angie Davenport Counseling. Any time that psychotherapy notes are requested this will require an additional authorization for their release.
-You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done.

BUSINESS ASSOCIATES DISCLOSURES

HIPAA requires that Angie Davenport Counseling train and monitor the conduct of those performing ancillary administrative services. These business associates would include my assistant. My assistant only has access to the information that pertains to financial arrangements and information related to establishing and maintaining contact with the client and scheduling. The counselor is the only person who has access to the protected health information. In compliance with HIPAA, my assistant has signed a confidentiality agreement stipulating that protecting your mental health information is an absolute condition for employment. She is also trained in HIPPA privacy practices.

ANGIE DAVENPORT COUNSELING
118 PUBLIC SQUARE, GALLATIN, TN 36066

USES AND DISCLOSURES NOT REQUIRING CONSENT OR AUTHORIZATION

By law, protected health information may be released without your consent or authorization for the following: Suspected Child abuse, Suspected sexual abuse of a child, Suspected abuse of a disabled or elderly adult, Court order, Serious threat of harm to client or others – "Duty to Warn" law, and/or Workers Compensation claims – All of your protected health information is automatically subject to review by your employer and/or insurer(s).

Client's Rights and Angie Davenport Counseling Duties

You have a right to the following:
The right to request restrictions on certain uses and disclosures of your protected health information which your counselor may or may not agree to but if the counselor does, such restrictions shall apply unless our agreement is changed in writing;
The right to receive confidential communication by alternative means & locations;
The right to inspect and copy your protected health information in your designated medical record set for as long as protected health information is maintained in the record except in cases where it would not be in your best interest as determined by the counselor.
The right to amend material in your protected health information, although counselor may deny an improper request and/or respond to any amendment(s) you make to your record;
The right to an accounting of non-authorized disclosures of your protected health information;
The right to a paper copy of notices/information from your counselor, even if you have previously requested electronic transmission of notices/information;
The right to revoke your authorization of your protected health information except to the extent that action has already been taken.

Client Confidentiality Policy

Angie Davenport strives to provide each client with the highest quality of counseling services, including a level of confidentiality that makes the counseling experience safe and comforting to the client. Counseling session information will not be released without your prior consent or the one who has the legal authority to consent on your behalf. There are national and state laws that define necessary **limits to that confidentiality**. Angie Davenport is committed to conforming to these laws that require a counselor to report **any suspicions of abuse of a child or incapacitated adult and threats of homicide or suicide**. In addition, occasionally judges will subpoena a counselor for testimony or order the release of confidential information in court proceedings. In these instances, the client is notified of the subpoena and/or court order, and every effort is made to protect confidential information. All Client records will be stored in a locked filing cabinet and secured. Access to the Client record is limited to the Counselor. Information contained within the file shall never be released to anyone without your consent except where limited by law.
If you understand these disclosure statements and desire to proceed with the counseling relationship, please indicate this below with your signature and today's date. If you have any questions, please feel free to ask.

_____

Client printed name & signature **Date**

_____

Parent if Minor- printed name & signature **Date**

ANGIE DAVENPORT COUNSELING
118 Public Square, Gallatin, TN 37066

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides client protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of client records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout our country are now required to provide clients with a notification of their privacy rights as it relates to their health care records.

Please read this document as it is important that you know what client protections HIPAA affords all of us. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, I am required to secure your signature indicating that you have received this "Client Notification of Privacy Rights" document. Thank you for choosing my services here at Angie Davenport Counseling.

I, _____(print your name) understand and have been provided a copy of the "Client Notification of Privacy Rights" document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights concerning these matters. I understand that I have the right to review this document before signing this acknowledgement form.

_____ _____/_____/_____
(Client Signature or Parent/Guardian Signature if Minor or Legal Charge) **(Date)**

If legal charge, describe representative authority: _____

ANGIE DAVENPORT COUNSELING
118 PUBLIC SQUARE, GALLATIN, TN 36066

Practice Policies

Fee Policy I am committed to offering the highest quality, professional counseling services. My fee for all types of counseling services is $100 per clinical-hour session. I request that cancellations be made 24 hours in advance; otherwise, you will be charged a $50 late cancellation/no-show fee. As a practice, I do not do phone calls nor email dialogue between sessions. If this occurs and takes more than 10 minutes of time, you will be billed $25 per 15 minutes. I take payment at the beginning of each appointment. If you do not have your payment at the beginning of session, we will have to reschedule to another time when you can make the payment. You will owe for that session as well as the rescheduled one. I do not accept insurance; however, I can provide you with documentation to file for yourself out of network. I do not testify unless required by a court order. Court appearances are billed at $200 per hour including travel time. Related calls and documentation are $100 per hour to prepare. All court related fees are to be paid 1 week prior to court proceedings.

Confidentiality Professional ethics and Tennessee State law indicate that confidential information is controlled by the client. This means that, as a general rule, information shared in sessions with a counselor will be held in confidence. There are two exceptions to this general rule, however. In the case of an emergency where the counselor believes the client is at risk of hurting himself/herself or another person, the counselor may breach the requirement of confidentiality. Secondly, Tennessee law requires that child abuse in any form (sexual, physical, emotional, neglect) be reported to the appropriate agency/authority. In communication, persons sometimes prefer to communicate via text messaging or email. I do accept this form of communication; however, it is important for the client to understand that email is not a secure mode of communication. The correspondence is at risk of being intercepted, can be monitored by email providers, and human error could result in someone else receiving the email other than the intended therapist. It is also important to note that text messaging carries the same level of risk. Text messages can be intercepted, stored on a device and later read by others, read by phone providers, or sent to non-intended individuals.

When working with minors, I will not share the content of sessions with parents/guardians, unless the content must be shared for safety reasons or if my professional judgment warrants sharing content for the welfare and health of the minor. I will discuss progress and treatment plan in general terms with parents/guardians. Parents are encouraged to be a very active part of the counseling process; be prepared to be in session with your child at times and to have "homework assignments" at times for your family.

Professional Services I am available for counseling appointments at select times throughout the week. The phone number that you can reach me on is 615-708-6160. You can also reach me by email at angiedavenportlmft@gmail.com. I do not do phone consultations. If you have an emergency, you may obtain assistance by calling the Crisis Help Line at 615-244-7444, the YW Domestic Violence Center at 615-242-1199, *911 or by going to your local hospital emergency room. For a crisis with minors you can call the mobile crisis line at 866-791-9222. I will be unable to respond to texts and emails in a timely manner; therefore, do not text or email me when you are in a crisis and feeling suicidal, overwhelmed, or unsafe. Please call the crisis line or go to your nearest emergency room in these instances. I am not a certified Custody Evaluator or an Expert Witness, as defined by the legal system. As a marriage and family therapist, I am not permitted to make any judgments on custody.

Benefits and Risks of Counseling Persons contemplating counseling should realize that they may make significant changes in their lives. People often modify their emotions, attitudes, and behaviors. They may also make changes in their marriages or significant relationships, such as with parents, friends, children, relatives etc. I cannot guarantee a specific outcome. Clients are ultimately responsible for their own growth.

Do you have any questions about fees, confidentiality, or other matters? Yes_____ No_____
Do you agree with the conditions and provisions of these Practice Policies? Yes_____ No_____
I give permission for the therapist to correspond with me via text messaging and/or email.
Yes_____ No_____ If specifying: email only____ text only_____
I agree to the fee payment of $100 per 50-60 minute session. Yes_____ No _____

_____ **Date:** _____
Signature of Client (Parent if Minor)