



kat mahone, lcpc
115 Annapolis Street
Annapolis, Maryland 21401
katmahone@gmail.com
410.280.1140

Initial Therapy Intake Form

Today's Date: _____

Name _____ Age _____ Date of Birth ____/____/____

Social Security # _____ Email _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell Phone _____

Please circle the number we should try first and share any special instructions for contacting you _____

May we say who we are if we phone your home? _____

Occupation _____ Employer _____

Marital Status _____ Name of Spouse/Partner _____

How Long Have Both of You Been Together? _____ Religion/Spiritual Beliefs _____

Children (names and age) _____

If Client is a Minor, Name of Responsible Adult _____

Emergency Contact/Relation to you _____ Phone _____

Address _____ City _____ State _____ Zip _____

Counseling Treatment History

What brings you to counseling today? _____

What do you hope to accomplish while working together? _____

Have you previously received or currently receive services from a counselor/mental health professional? _____

If yes, please share what worked and why you left treatment/date(s) of treatment:

Have you ever been hospitalized for emotional or drug/alcohol treatment? _____ If yes, please describe the circumstances: _____

Medical History

Do You Smoke? _____ How Much? _____ Do You Drink? _____ How Much? _____

Do You Use Drugs? _____ If yes, what kind? _____ How often? _____

Please list any medical conditions that you have or believe you might have

Last Medical Examination _____ Reason _____

Are You Presently Under a Doctor's Care? _____ If yes, Doctor's name: _____

Reason for Doctor's Care: _____

Are You Taking Any Medication? _____ If yes, what kind?

Name of Physician prescribing _____

Reason for Medication: _____

Have You Ever Been Hospitalized for a Physical Illness? _____ Describe: _____

Check Any of the Following That May Apply to You:

Headache	Inferiority Feelings	Shy With People
Dizziness	Feel Tense	Can't Make Friends
Fainting Spells	Feel Panicky	Afraid Of People
No Appetite	Fears and Phobias	Home Conditions Bad
Over-Eating	Obsessions	Unable To Have A Good Time
Stomach Trouble	Depressed	Always Worried About Something
Bowel Disturbances	Suicidal Ideas	Don't Like Weekends/Vacations
Always Tired	Take Tranquilizers	Can't Make Decisions
Always Sleepy	Alcoholism	Over-Ambitious
Unable To Relax	Dangerous Drugs	Financial Problems
Insomnia	Allergy	Gambling
Recurrent Dreams	Asthma	Job Problems
Nightmares	Sexuality Issues	Can't Keep A Job
Hallucinations	Sexual Problems	Other

Please share where you learned of our services: _____

Upon my signature below, I hereby attest that all the information furnished is true and correct.

Signed (Client)

Date

Signed (Parent – if client is under the age of 18)

Date



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Name of Client _____

Confidentiality Agreement

What You Should Know about Confidentiality in Therapy

I will treat what you tell me with great care. My professional ethics (that is, my profession's rules about moral matters) and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the “confidentiality” of therapy. But I cannot promise that everything you tell me will never be revealed to someone else. There are some times when the law requires me to tell things to others. There are also some other limits on our confidentiality. We need to discuss these, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don't tell me something as a “secret” that I cannot keep secret. These are very important issues, so please read these pages carefully and keep this copy. At our next meeting, we can discuss any questions you might have.

1. **When you or other persons are in physical danger**, the law requires me to tell others about it. Specifically:
 - a. If I come to believe that you are threatening serious harm to another person, I am required to try to protect that person. I may have to tell the person and the police, or perhaps try to have you put in a hospital.
 - b. If you seriously threaten or act in a way that is very likely to harm yourself, I may have to seek a hospital for you, or to call on your family members or others who can help protect you. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to.
 - c. In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life. I will try to get your permission first, and I will discuss this with you as soon as possible afterwards.
 - d. If I believe or suspect that you are abusing a child, an elderly person, or a disabled person I must file a report with a state agency. To “abuse” means to neglect, hurt, or sexually molest another person. I do not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics. You may also want to talk to your lawyer. In any of these situations, I would reveal only the information that is needed to protect you or the other person. I would not tell everything you have told me.

2. **In general, if you become involved in a court case or proceeding**, you can prevent me from testifying in court about what you have told me. This is called “privilege,” and it is your choice to prevent me from testifying or to allow me to do so. However, there are some situations where a judge or court may require me to testify:

- a. In child custody or adoption proceedings, where your fitness as a parent is questioned or in doubt.
 - b. In cases where your emotional or mental condition is important information for a court's decision.
 - c. During a malpractice case or an investigation of me or another therapist by a professional group.
 - d. In a civil commitment hearing to decide if you will be admitted to or continued in a psychiatric hospital.
 - e. When you are seeing me for court-ordered evaluations or treatment. In this case we need to discuss confidentiality fully, because you don't have to tell me what you don't want the court to find out through my report.
3. There are a few other things you must know about confidentiality and your treatment:
- a. I may sometimes consult (talk) with another professional about your treatment. This other person is also required by professional ethics to keep your information confidential. Likewise, when I am out of town or unavailable, another therapist will be available to help my clients. I must give him or her some information about my clients, like you.
 - b. I am required to keep records of your treatment, such as the notes I take when we meet. You have a right to review these records with me. If something in the record might seriously upset you, I may leave it out, but I will fully explain my reasons to you.
4. Here is what you need to know about confidentiality in regard to insurance and money matters:
- a. If you use your health insurance to pay a part of my fees, insurance companies require some information about our therapy. Insurers such as Blue Cross/Blue Shield or managed care organizations ask for much information about you and your symptoms, as well as a detailed treatment plan.
 - b. I usually give you my bill with any other forms needed, and ask you to send these to your insurance company to file a claim for your benefits. That way, you can see what the company will know about our therapy. It is against the law for insurers to release information about our office visits to anyone without your written permission. Although I believe the insurance company will act morally and legally, I cannot control who sees this information at the insurer's office. You cannot be required to release more information just to get payments.
 - c. If you have been sent to me by your employer's Employee Assistance Program, the program's staffers may require some information. Again, I believe that they will act morally and legally, but I cannot control who sees this information at their offices. If this is your situation, let us fully discuss my agreement with your employer or the program before we talk further.
 - d. If your account with me is unpaid and we have not arranged a payment plan, I can use legal means to get paid. The only information I will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due to me.
5. **Children and families create some special confidentiality questions.**
- a. When I treat children under the age of about 12, I must tell their parents or guardians whatever they ask me. As children grow more able to understand and choose, they assume legal rights. For those between the ages of 12 and 18, most of the details in things they tell me will be treated as confidential. However, parents or guardians do have the right to general information, including how therapy is going. They need to be able to make well-informed decisions about therapy. I may also have to tell parents or guardians some information about other family members that I am told. This is especially true if these others' actions put them or others in any danger.



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Fee Agreement and Cancellation Policy 2024

Financial Policy:

Office Visits: Fee payment for each session is due at the time of service unless arrangements are made. Fees are payable by credit card (MasterCard/Visa), cash or personal check. Personal checks are payable directly to Kat Mahone, LCPC. Session duration is 55 minutes.

The current fee is **\$225** per 55 minute hour and **\$350** for a 90 minute session.

Cancellations: Appointments must be cancelled at least 24 hours in advance of the scheduled appointment time. Failure to provide 24 hours notice will result in a “missed appointment” charge of the full fee for the time scheduled, which will be charged to your credit card. Late cancellations due to medical or other emergencies will not be considered at “missed appointments.” Other circumstances will be addressed individually and determined at the discretion of the therapist.

Telephone Conversations/Email Contact: Fees for brief conversations between the therapist and client are included in the fees paid for routine office visits. If frequent or prolonged telephone/email conversations are required (especially those of a therapeutic nature), a fee of **\$60** per 15 minutes will be charged unless other arrangements have been made. This fee also applies when the therapist finds it is necessary to respond to frequent or prolonged messages by voicemail and/or email from the client.

Private Insurance and Extended Health Benefits: Clients must pay the therapist and then claim repayments from their own insurance provider.

Income Tax Deductions: Fees for therapy may be deductible under medical expenses on your income tax return depending on your income and other deductions.

Receipts: Receipts will be given for all payments.

Increase in Fees: Clients will be given three months notice of any increase in fees.

You are encouraged to discuss the above financial matters with your therapist at any time. The payment of fees for counseling is part of the client/therapist relationship. As such it is as open for discussion as any other concern.

Agreement: My signature below is my agreement to pay a fee of **\$225** per clinical hour in full at the end of each session unless other arrangements have been made. I have read the above and understand the information and agreements stated. I consent to receive counseling services from Kat Mahone, LCPC according to the guidelines noted.

Print Name: _____ **Signature/Date:** _____



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Authorization for Release of Mental Health Information

Today's Date: _____

Name of Client _____ Date of Birth _____

Maiden or other name (if applicable) _____

I request and authorize Kat Mahone, LCPC to exchange / provide / receive the following information about my mental health treatment: **Treatment summary or progress / Diagnosis / Attendance / Other (specify)**

With the following person(s) or entities:

Name/Agency _____

Phone _____ Fax _____

Address: _____

City, State: _____ Zip code: _____

For the purpose of: _____

This authorization is subject to the following restrictions (if any): _____

Treatment information during the following time period or dates: _____

This "consent to release information" form is valid for one year, or as allowed by State law. You may revoke this release at any time in writing. Authorization expires: _____ (date). If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

I understand that I may revoke this authorization at any time by making a written request to my therapist, except to the extent that action already has been taken in reliance on this authorization. I understand I am entitled to receive a copy of this Authorization.

Signature (Client or authorized representative) _____ Date: _____

Relationship/authority (if signed by authorized representative): _____

Witness (only if client is unable to sign): _____ Date: _____

Therapist _____ Date: _____