Sara Fackelman, Ph.D., LMHC #8688, CAP

aTransLifeMatters

3825 Henderson Blvd. #405, Tampa, FL 33629 • 3530 - 1st Avenue North, #117, St. Petersburg, FL 33713
813-716-4264 • www.atranslifematters.com • sara@atranslifematters.com

Consent to Receive Services

Please initial that you have read and understand the following:

_____ I am giving consent to receive psychotherapy from Sara Fackelman, Ph.D., LMHC.

_____ I have received a copy of *Understanding Your Health Records.*

_____ I have received a copy of *Client Rights and Responsibilities.*

_____ I understand that when I schedule an appointment I am reserving a period of time. Therefore, I will be charged a $50.00 cancellation fee if I cancel my appointment without 24 hours' notice. I understand I will be charged the full appointment fee if I do not show for an appointment without giving notice.

_____ I understand that my personal information may be transferred electronically (i.e., online billing, email, fax machine).

YES NO You can email me about upcoming groups, workshops, seminars, appointment reminders.

My email address is: _____

IF YOU ARE FILING A CLAIM WITH YOUR INSURANCE, PLEASE READ & INITIAL:

_____ I understand that it is my responsibility to know what my insurance benefits pay for, how many sessions are covered under my plan, what services are not covered, what my deductible may be, and what my co-payments/co-insurance will be. I understand that I am to pay for services when rendered and I do not hold Sara Fackelman, Ph.D., LMHC, CAP responsible for the outcomes of my filed claims.

_____ _____

Client or client representative to sign & date Witness sign & date

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LESBIAN, GAY, BI, TRANS, TWO-SPIRIT, INTERSEX, OR QUEER

Please provide the following information and answer the questions below.
Please note: Information provided here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years old):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ / _____ / _____ Age: _____

Gender: M ___ F ___ MtF ___ FtM ___ GenderQueer/Fluid/Neutrosis ___ Other ___

Marital Status: Never Married ___ Separated ___ Divorced ___ Domestic Partnership ___ Married ___

Please list any children/age: _____

_____

Address: _____
(Number and Street)

_____
City State Zip

Home Phone: ( ) _____ May we leave a message? ___ Y ___ N

Cell/Other Phone: ( ) _____ May we leave a message? ___ Y ___ N

Email: _____ May we email you? ___ Y ___ N

*Please note: Email correspondence is not considered to be a confidential media of communication. Neither is Facebook. Please do NOT ask me to friend you.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

____Y ____ N / If Yes, who was your previous therapist? _____

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CLIENT RIGHTS FORM

1. I understand that I have the right to decide not to enter therapy (although, depending on my situation there may be legal or other consequences for not entering or completing therapy), not to participate in any particular type of therapy, and to terminate therapy at any time. If I wish to terminate therapy here and continue therapy elsewhere, I will be given a list of providers with whom I can continue. **Initials:** _____

2. I understand that I have the right to a safe environment during therapy, free from physical, sexual, and emotional abuse. **Initials:** _____

3. I understand that I have the right to complete and accurate information about my treatment plan, goals, methods, potential risks and benefits, and progress. **Initials:** _____

4. I understand that I have the right to information about the professional capabilities and limitations of any clinician(s) involved in my therapy, including their certification/licensure, education and training, experience, specialization, and supervision. I have the right to be treated only by persons who are trained and qualified to provide the treatment I receive. **Initials:** _____

5. I understand that I have the right to written information about fees, payment methods, co-payments, length and duration of sessions and treatment. **Initials:** _____

6. I understand that my confidentiality will be protected and information regarding my treatment will not be disclosed to any person or agency without my written permission except under circumstances where the law requires such information to be disclosed. I understand that I have the right to know the limits of confidentiality, the situations in which a therapist or agency is legally required to disclose information about my case to outside agencies, and the types of information which must be disclosed. **Initials:** _____

7. I understand that I have the right to know if my therapist will discuss my case with supervisors or peers. I understand that no portion of my therapy may be recorded in audio or video form without my informed written consent, and that if I consent to have any portion of my therapy recorded, I have the right to know who will see or hear the recording(s), for what purpose(s) the recording(s) will be used, and when and how the recording(s) will be erased or destroyed. **Initials:** _____

8. I understand that I have the right to request a summary of my treatment, including diagnosis, progress in treatment, prognosis, and discharge status. **Initials:** _____

9. I understand that I have the right to request the release of my clinical information to any agency or person I chose. **Initials:** _____

Client/Guardian's Name: _____

Client Guardian's Signature: _____ Date: ____ /____ /____

Therapist's Name: _____

Therapist's Signature: _____ Date: ____ /____ /____

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CONSENT FOR TREATMENT

1. I have been fully informed of my rights as a client of this agency, the extent and limits of confidentiality in therapy, and the goals associated with this therapy. With that knowledge, I request and consent to receive therapy from qualified personnel of this agency. **Initials:** _____

2. I understand that the staff of this agency my not disclose information about my therapy to anyone outside this agency without my written consent, except as required by law to comply with a court order, to prevent suicide/self-harm or harm to others, or to stop and prevent abuse of a child, senior, or disabled person. However, I also understand that my participation in treatment may require my written consent to allow staff of this agency to provide some information about my therapy to a referring agency and/or an insurance company or other payer, and that if this is the case, the form provided for my written consent for this disclosure with state what specific types of information will be disclosed. **Initials:** _____

3. I understand that my therapist may work with me at this agency, in my home, or in other settings based on his/her professional judgement. I further understand that my therapy may involve my participation in individual, couple, family, and/or group counseling, and may involve homework assignments for me to do outside of my therapy sessions. I agree to participate actively in my therapy, to cooperate with my therapist, and to complete required homework assignments or other activities included in my therapy. **Initials:** _____

Client/Guardian's Name: _____

Client Guardian's Signature: _____ Date: ____ /____ /____

Agency Representative Name: _____

Agency Representative Signature: _____ Date: ____ /____ /____

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DISCLOSURE OF CONFIDENTIAL INFORMATION

We are required to disclose confidential information if any of the following conditions exist*:

1. You are a danger to yourself or to others.
2. You see treatment to avoid detection or apprehension or enable anyone to commit a crime.
3. Your therapist was appointed by the courts to evaluate you.
4. Your contact with your therapist is for the purpose of determining sanity in a criminal proceeding.
5. Your contact is for the purpose of establishing your competence.
6. The contact is one in which your psychotherapist must file a report to a public employer or as to information required to be recorded in a public office, if such report or record is open to public inspection.
7. You are under the age of 16 years and are the victim of a crime.
8. You are a minor and your psychotherapist reasonably suspects you are the victim of child abuse.
9. You are a person over the age of 65 and your psychotherapist believes you are the victim of physical abuse. Your therapist may disclose information if you are the victim of emotional abuse.
10. You die and the communication is important to decide an issue concerning a deed or conveyance, will, or other writing executed by you affecting as interest in property.
11. You file suit against your therapist for breach of duty and have claimed mental/emotional damages as part of the suit.
12. You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.
13. You waive your rights to privilege or give consent to limited disclosure by your therapist.
14. Your insurance company paying for services has the right to review all records.

* If you have any questions about these limitations, please discuss them with your therapist.

_____

SIGNATURE *DATE*

I am consenting to my (or my dependant) receiving outpatient treatment.

_____

SIGNATURE *DATE*

RELEASE OF INFORMATION

I authorize _____ to contact my primary care physician (name) _____ regarding an appointment being made for follow-up, as well as information pertaining to psychological and emotional function.

_____

SIGNATURE *DATE*

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Client's Name: _____
First Name Middle Name Last Name

2. Date of Birth: ____/____/____ **3.** Date authorization initiated: ____/____/____
Month/Day/Year Month/Day/Year

4. Authorization Initiated by:

_____
Name (client, provider, or other)

5. Information to be released:

☐ Authorization for Psychotherapy Notes ONLY. (Important: if this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

☐ Other (describe information in detail):

_____

_____

6. Purpose of Disclosure: The reason I am authorizing release is:

☐ My request

☐ Other (describe):

_____

_____

7. Person(s) Authorized to Make the Disclosure:

_____
Name(s)

8. Person(s) Authorized to Receive the Disclosure:

_____
Name(s)

9. This Authorization will expire on _____ / _____ / _____ or upon the happening of the following event:

_____
Describe event (if applicable)

Authorization and Signature: I authorize the release of my confidential protected health information as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and that the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization my be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my protected health information.

_____
Signature of Patient Date

_____
Signature of Personal Representative Relationship to Patient Date

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HEALTH INFORMATION

1. Are you currently taking any prescription medication? Yes ☐ No ☐

Please list: _____

_____

2. Have you ever been prescribed psychiatric medication? Yes ☐ No ☐

Please list and provide dates: _____

_____

3. How would you rate your current physical health?

Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good ☐

Please list any specific health problems you are currently experiencing: _____

_____

_____

4. How would you rate your current sleeping habits?

Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good ☐

Please list any specific sleep problems you are currently experiencing: _____

_____

5. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

_____

6. Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

7. Are you currently experiencing overwhelming sadness, grief, or depression? Yes ☐ No ☐

If yes, for approximately how long? _____

_____

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HEALTH INFORMATION CONTINUED

8. Are you currently experiencing anxiety, panic attacks, or have any phobias? Yes ☐ No ☐

If yes, when did you begin experiencing this? _____

_____

9. Are you currently experiencing any chronic pain? Yes ☐ No ☐

If yes, please describe: _____

_____

10. Do you drink alcohol more than once a week? Yes ☐ No ☐

11. How often do you engage in recreational drug use?

Never ☐ Infrequently ☐ Monthly ☐ Weekly ☐ Daily ☐

12. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

13. In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	PLEASE CIRCLE		RELATIONSHIP/FAMILY MEMBER
Alcohol/Substance Abuse	Yes	No	_____
Anxiety	Yes	No	_____
Depression	Yes	No	_____
Domestic Violence	Yes	No	_____
Eating Disorders	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____
Suicide Attempts	Yes	No	_____

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ADDITIONAL INFORMATION

1. Are you currently employed? Yes ☐ No ☐

If yes, what is your current employment situation? _____

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? Yes ☐ No ☐

If yes, please describe your faith or belief:

_____

3. What do consider to be some of your strengths?

_____

_____

_____

_____

3. What do consider to be some of your weaknesses?

_____

_____

_____

_____

4. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

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MEDICAL HISTORY

1. Does anyone in your family have a history of chronic physical or mental health concerns? Yes ☐ No ☐

If yes, why? _____

_____

2. Do you have any chronic physical or mental health conditions? Yes ☐ No ☐

If yes, what are they? _____

_____

3. Have you ever been diagnosed with a physical or mental health condition? Yes ☐ No ☐

If yes, when and what is the diagnosis? _____

_____

4. HIV is a big concern for a lot of people. Can you tell me in what ways this may be true for you?

_____

_____

5. Have you ever been hospitalized? Yes ☐ No ☐

If yes, when and what for? _____

_____

6. Are you currently taking any medication (including illicitly obtained hormones, vitamins, or herbal supplements) and if so, what is the name, dose, and length of time you have been taking it?

_____

_____

7. Have you ever had any injuries or surgeries? Yes ☐ No ☐

If yes, what are they? _____

_____

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SOCIAL CONCERNS

1. Do you have any concerns about body image? Yes ☐ No ☐

If yes, what are they? _____

_____

2. Do you have any concerns about aging? Yes ☐ No ☐

If yes, what are they? _____

_____

3. Do body image pressures and ageism in the lesbian, gay, bi, transgender, two-spirit, intersex and/or queer communities (LGBTTIQ) affect you?

Yes ☐ No ☐

If yes, how? _____

_____

4. What are your social supports?

_____

_____

5. When you are under stress, who do you turn to for help?

_____

_____

6. Do you have any concerns relating to work, school, or community involvement?

_____

_____

7. Do you feel connected to any particular communities, e.g., the transgender community, cultural community, lesbian, gay, bisexual community, youth group, senior's groups, hearing, or sight impaired?

_____

_____

8. What are your hobbies or social interests?

_____

_____

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GENDER CONCERNS

1. Do you have any concerns relating to your gender? Yes ☐ No ☐

If yes, what are they? _____

2. Do you have any questions relating to your gender? Yes ☐ No ☐

If yes, what are they? _____

3. How do you feel about being transgender?

4. Are there any cultural or religious conflicts for you as a transgender person? Yes ☐ No ☐

5. Have you ever pursued any changes to your appearance or body to bring it closer to your sense of self?

Yes ☐ No ☐ _____

6. Do you have any concerns relating to question 5 now? Yes ☐ No ☐

7. Have you ever sought to change your body through hormones/surgery? Yes ☐ No ☐

8. Are there any kinds of supports you feel might be helpful as a transgender person?

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SEXUALITY CONCERNS

1. Do you identify in a particular way in terms of your sexual orientation? Yes ☐ No ☐

Explain: _____

2. Are you attracted to men ☐ women ☐ both ☐ transgender people ☐ ?

3. At about what age did you realize you were _____?
What has it been like for you after coming out/transitioning to yourself and to others?

4. Are you currently involved with anyone romantically? If yes, how do you feel about your relationship?

5. Have you ever had any concerns about relationships or sexuality in the past?

6. Any current concerns?

7. How open are you about your sexual orientation/gender identity? At work? At home? At school? With new acquaintances?

8. Can you tell me about any particular problems you have faced because of discrimination based on your sexual orientation/gender identity?

9. Have you ever had any concerns about sexual abuse or sexual assault?

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ALCOHOL & DRUG HISTORY

1. Do you smoke and if so how much per day? Yes ☐ No ☐

2. Do you use alcohol and/or other drugs to cope with any of the issues we mentioned in the concerns sections? Yes ☐ No ☐

Comments: _____

3. If applicable, has anyone expressed concern about, or objected to, your use of drugs and/or alcohol?

Yes ☐ No ☐ Whom? _____

4. Are mental health concerns related to any of the issues we mentioned?

Yes ☐ No ☐ Not at all ☐ A little ☐ Somewhat ☐ A lot ☐

If yes, in what ways? _____

5. Do you have concerns about drugs and alcohol now? Yes ☐ No ☐

If yes, what are they? _____

FAMILY HISTORY

1. People define "family" in many ways. Who do you define as being in your family?

2. How would you characterize your relationships with your family members when you were a child and now?

3. Tell me about your family. Has your sexual orientation/gender identity affected your relationship with your family? Do you have support from your family?

4. Do you have any concerns relating to your family?