ALLISON SPLAUN, PH.D.

ADULT, CHILD, AND FAMILY THERAPY

408 EAST MARKET ST., SUITE 201B #1, CHARLOTTESVILLE, VA 22902

(434) 989 – 9240

Confidential Client Intake Packet
Demographics

Date: _____ Date of Birth: _____ Current Age: _____

Name: _____ What you would like to be called: _____

Social Security Number: _____

Street Address: _____Ok to send mail? □Yes □No

City/State/Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____ Email address: _____

Which method of contact do you prefer? _____
Do I have permission to leave a detailed message at your preferred method of contact? □ Yes □ No

Occupation: _____ Employer: _____

Emergency Contact
Name: _____ Phone Number: _____
Relationship to client: _____

If client is a minor:
Legal Guardian: _____ Relationship to client: _____

Name of person referring you: _____ May I thank them? □ Yes □ No

Financial Information:
Name of person responsible for the account: _____
(only complete the remainder of this section if the financially responsible party is not the client)
Relationship to client: _____
Street Address: _____ City/State/Zip Code: _____
Phone number: _____ Email address: _____

ALLISON SPLAUN, PH.D.

ADULT, CHILD, AND FAMILY THERAPY

408 EAST MARKET ST., SUITE 201B #1, CHARLOTTESVILLE, VA 22902

(434) 989 – 9240

Background Information

Gender: _____ **Sexual Orientation: _____**

Relationship Status: Single Partnered Married Separated Divorced Widowed

Ages of children (if applicable): _____

Who resides in your household? _____

_____

Highest Educational Degree Obtained/Subject: _____

Current reason for seeking therapy: _____

_____

_____

_____

Please circle any issues that are of concern to you:

Relationship Issues	Depression	Anxiety	Self-esteem Issues	Social Life
Suicidal Thoughts	Eating	Self-Harm	Alcohol/ Drug Use	Work/ School
Sex or Sexuality	Spiritual Life	Finances	Legal Involvement	Sexual Orientation
Parenting	Trauma	Insomnia	Aggression/Irritability	Grief
Gender Transition	Caregiving			

Other issues of concern?_____

Please circle any significant changes over the last three years:

Deaths Births Illnesses/ Injuries Job Change Change in Relationship Status Relocation

Please explain any of the above or identify other significant changes:

_____

_____

Have you been in counseling previously? □ Yes □ No

If so, please fill out the following (if more than three episodes, please use the back of the page):

Problem(s)	Dates of treatment	Was it helpful?
1.		
2.		
3.		

ALLISON SPLAUN, PH.D.

ADULT, CHILD, AND FAMILY THERAPY

408 EAST MARKET ST., SUITE 201B #1, CHARLOTTESVILLE, VA 22902

(434) 989 – 9240

Have you been hospitalized for psychiatric/psychological reasons in the past? □Yes □No

If yes, please fill out the following (if more than three episodes, use the back of the page):

Reason for hospitalization	**Location of hospitalization**	**Dates of hospitalization**
1.		
2.		
3.		

Do you have any previous suicide attempts, self-harming behaviors, or violent behaviors? If so, indicate age, circumstances, and whether it led to hospitalization or legal troubles: _____

_____

_____

Circle any medical problems that apply to you:

Epilepsy Insomnia Asthma Diabetes Sleep Apnea Stroke Headaches
High blood pressure Kidney Problems Migraines Cardiac Problems
Chronic Pain Chronic Fatigue

Other medical problems:

_____

What medications (including vitamins or herbal supplements) do you currently take?

Medication	Amount & Frequency	Reason	Who prescribes it?
1.			
2.			
3.			
4.			
5.			

Have you ever taken medications for psychological conditions such as depression or anxiety? □ Yes □ No

If yes, please fill out the following:

Medication	Dates of Use	Reason	How much it helped?
1.			
2.			
3.			
4.			
5.			

Is there any other information that may be helpful in my work with you? _____

_____

_____

ALLISON SPLAUN, PH.D.

ADULT, CHILD, AND FAMILY THERAPY

408 EAST MARKET ST., SUITE 201B #1, CHARLOTTESVILLE, VA 22902

(434) 989 – 9240

Informed Consent

Welcome to my private practice! This document contains important information about my business practices and professional services. Please read it carefully and we can discuss any questions you have at any time. After reviewing this information, please sign this form, which will constitute an agreement between us.

Services provided:
Our first few sessions will be an evaluation of your needs. By the end of the evaluation, I will offer you some initial impressions of what our work will include and will recommend a course of treatment, which we can discuss. This evaluation will be a time for each of us to decide whether we are a good match to work together. Please carefully consider whether you feel comfortable working with me or whether you would like to request modifications in the recommended treatment approach (requests will be considered whenever possible). It is very important that you feel comfortable with the therapy provider that you select, so please do not hesitate to discuss any questions you may have as they arise throughout the treatment. If you prefer to work with someone else or get a second opinion, I will be happy to help you find another qualified mental health provider. Additionally, there may be occasions when after the evaluation period, I determine that another provider or clinic could better meet your needs. I will be sure to make this clear and provide referrals as soon as possible should this be the case.

Because therapy can involve discussing challenging aspects of your life, you may experience uncomfortable feelings such as sadness, anxiety, frustration, or anger. However, extensive research has demonstrated that therapy has significant benefits, typically leading to less distress, better relationships, improved understanding of oneself, and increased clarity of ones' goals and needs. My approach is an integrative one that is based largely in psychodynamic theory, but I also commonly integrate cognitive-behavioral techniques.

Assessment Measures:
Prior to each session, I request that clients self-administer (in a secure online system or a paper form) a routine outcome monitoring questionnaire (the OQ-45.2 for adults, the YOQ-30.2SR for youth ages 18 and younger, as well as a parent report version, the YOQ-30.2PR). I will also intermittently administer a second measure, the ASC. The primary purpose of administering these measures is to track your progress over the course of treatment. We will intermittently look at the results together and use them as an opportunity for targeting our therapy on the areas that are most challenging, as well as celebrating successes. This measure is optional and may be discontinued at any time, though most clients find it useful and research has shown that this type of outcome monitoring helps to maximize the effectiveness of therapy, as well as provide the therapist with important feedback. Your data will be maintained in a confidential online system, consistent with other treatment records. Aggregate data may be utilized for advertising purposes, though no individual names or personal information will be available (for example, I may choose in the future to publish overall trends, for example, X percentage of patients tend to experience relief from their symptoms in X length of time). Please feel free to bring up any questions about this as they arise.

Confidentiality:
As a general rule, all communications between a client and a psychologist are strictly

confidential and are protected by law. I will only release information about our work (including the fact that you are my patient) to others with your written permission. However, there are a few important exceptions:

In many legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if they determine that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a clients' treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency.

Additionally, if I believe a client is threatening serious bodily harm to another person, I am required to take protective actions. These actions may include notifying the potential victim(s), contacting the police, or seeking hospitalization for the client. If the client threatens to harm him or herself, I may be obligated to seek hospitalization for him or her, to contact family members, or to contact others (such as legal authorities) who can help provide protection.

These situations have rarely occurred in my practice. If such a situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case to ensure that I am providing the best care possible. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally and ethically bound to keep the information confidential.

In case I am suddenly unable to continue to provide professional services or to maintain client records due to incapacitation or death, I have designated a colleague who is a licensed psychologist as my professional executor. If I die or become incapacitated, my professional executor will be given access to all of my client records and may contact you directly to inform you of my death or incapacity; to provide access to your records; to provide psychological services if needed; and/or to facilitate continued care with another qualified professional if needed. If you have any questions or concerns about this professional executor arrangement, I will be glad to discuss them with you.

Please do not hesitate to discuss any questions or concerns that you may have about issues surrounding confidentiality throughout your treatment.

Electronic communications

At times clients may choose to use email to discuss scheduling. Because email cannot be guaranteed to be a secure means of communication, it is recommended that email not be utilized for confidential or personal information. Should you choose to disclose this information by email, there is no guarantee that it can be kept strictly confidential.

Payments are accepted by credit card either through my online billing system. Every effort will

be made to ensure the confidentiality of these transactions (e.g. although payments will go from you to me, they should not be labeled in a way that indicates the payments are for psychotherapy). However, it is possible that third parties may be able to determine that these payments are for therapy. If this is a concern, you may discuss this with me or you may wish to consider paying by cash or check.

Telephone Access and Emergencies
Although I am not always immediately available by telephone, you may always leave me a confidential voicemail. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are unable to reach me and are having a psychiatric emergency (particularly if you are considering harming yourself or someone else), contact the nearest emergency room and ask for the psychiatrist on call or call 911. If I will be unavailable for an extended time, I will always provide you with the name of a colleague to contact in advance of my absence.

Records
The laws and standards of my profession require that I keep treatment records for a minimum of seven years. I typically keep basic records, including the date and times of our sessions, the type of service provided, and general information about the content of our sessions. The records are kept on an encrypted, password-protected computer hard drive, on third party record keeping software that fully encrypts and password protects all information and is compliant with HIPPA laws, and/or in a locked file cabinet. These records are considered confidential by law and ethics.

Clients Under Age 18
If you are under eighteen years of age, please be aware that the law provides your parents the right to examine your treatment records. It is my policy to request an agreement from parents not to seek access of your records. If they agree, I will provide them only with general information about our work together unless I feel there is a high risk that you will seriously harm yourself or someone else, or if I suspect someone is harming you. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you if possible and will do my best to handle any objections you have.

Fees
The fee for an initial evaluation session is $180 and typically lasts 60 – 75 minutes. The fee for a 50 minute psychotherapy session is $130. On January 1 of each year, I raise my rates by $5. In addition to charging for regular appointments, I charge this hourly fee (prorated for shorter periods) for other professional services, including telephone conversations lasting longer than 5 minutes, attendance at school visits or legal proceedings, and preparations of records.

Cancellation Fees
If you are unable to attend a scheduled initial evaluation appointment or a scheduled psychotherapy session, you must provide notice by email or telephone by noon the day prior to the appointment. If you cancel a session after noon the day prior to the appointment or do not attend a scheduled appointment, you will be charged the full fee for the session. You are free to leave therapy at any time and have no moral, legal, or financial obligation to complete a certain number of sessions. However, please inform me if you are choosing to cease therapy to avoid

late cancellation charges.

Payment

My psychotherapy practice is a "self-pay" practice. You may choose to make payments by check or cash at the time of the services provided. Alternatively, you may provide credit card information to be stored on my secure online practice management software. You will be charged immediately after each scheduled session (including sessions attended and late cancellation fees).

If fees will present a significant hardship for you or your family, it is your responsibility to discuss this with me to determine if other arrangements can be made ahead of time. If you accrue a balance for any reason, therapy sessions will cease until you have paid the full balance. If you have not paid as agreed upon for more than 60 days, I have the option of using legal means to secure the payment (the only information I would release in this case would be your name, the nature of the services provided, and the amount due).

Billing Insurance

I do not participate on any managed care panels or belong to any insurance provider networks. However, if clients request it, at the end of each month, I will provide you with a receipt for services that you may use to file a claim for reimbursement with your insurance carrier. It is your responsibility to find out if your insurance carrier will cover these mental health services provided by an out-of-network psychologist. The receipt will provide the necessary information with which to determine if such a service is covered (e.g. your diagnosis, the dates of our sessions, and a summary of treatment if requested).

Agreement

Your signature below indicates that you have read the information in this document, wish to receive psychotherapy with Allison Splaun, Ph.D., and agree to abide by the terms laid out above during our professional relationship.

Client: _____ _____

Print Name Signature

Date Signed: _____

Guarantor (if client is under 18, indigent, or assigned a legal guardian):

_____ _____

Print Name Signature

Date Signed: _____