Helping Others Heal
Counseling to restore love and wholeness
1386 Old Freeport Road, Suite 3B, Pittsburgh, PA 15238
932 5th Avenue, Suite A, New Kensington, PA 15068
866-488-0493

Couple's Intake Form

Name: _____ Date of Birth: _____/____/_____

Social Security Number: _____-_____-_____ Gender: Male ___ Female ___

Name: _____ Date of Birth: ____/____/_____

Social Security Number: _____-_____-_____ Gender: Male ___ Female ___

Current Marital Status (please circle): Single Married Domestic Partnership

Divorced (number of divorces/years) __/____ Widowed (how many years) _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Email Address: _____

How did you hear about Helping Others Heal? _____

Employer Name & Phone Number: _____

Who is your emergency contact person? _____

Relationship to you/Phone Number: _____

Permission to share information with this person/other individual (please name)?: Yes No

Insurance Information

Name of Insurance Company: _____

Member Identification: _____ Group: _____

Who is the primary cardholder? _____

Consent for Treatment/Responsibilities in This Process:

As your therapist, it is my responsibility to inform you of the following; rates/insurance, session types, confidentiality and termination of therapy (voluntary and involuntary).

Rates: Intake session - $200.00; Couple/Family session - $200.00/hour; extended couple/family session - $300.00/90 minutes; NSF check - $40.00; late cancellation/missed session fee – I require 24 hours-notice for a cancellation) - $80. 00. I currently accept the following insurance providers: Blue Cross Blue Shield, Cigna, Optum/United Healthcare and UPMC. I am also authorized to provide video sessions (telehealth) by these insurance carriers. *Please note: most insurance providers DO NOT cover marriage and family counseling.* I need to collect your copayments at the time of service (a condition of the insurance companies listed). If for some reason your insurance claim is denied, you will be responsible for the entire balance owed. A credit authorization form is required to be on file to cover the cost of sessions, copayments, late cancels/missed appointments. Your signature on this form is your understanding of this policy. Good Faith Estimate: Couple's therapy using the Emotionally Focused Couple's Therapy model is typically 6-20 sessions in duration. Should there be a need to extend sessions beyond that timeframe, we will have a discussion to establish new time limits/treatment goals.

Confidentiality:

Standard confidentiality issues are well known but bear repeating. If I feel as though you are a danger to yourself, I must, in an effort to protect you, seek help through your emergency contacts or agencies, such as the police department or crisis units/hospitals. If you disclose to me that you have a desire to harm someone else and there is a clear intention and plan to do so, I must protect the life of that individual as well and call upon resources to help them. Please note that the law requires me to report any harm to a child or an elderly person disclosed to me. ***If you authorize your sessions to be paid through your insurance provider, they may ask for information regarding our sessions related to symptoms or diagnosis, your treatment planning goals (the purpose of you attending therapy sessions). the clinical notes/file and the dates that we met. Please note, if your record is requested, I must provide this information. Please decide whether you are more comfortable with self-pay in more sensitive circumstances.***

Limitations to confidentiality in couples/family sessions:

I am providing this written policy to help therapy participants understand that when I participate in couples or family counseling, that "treatment unit" (couple or family unit) is seen as the "client." It is standard procedure to engage in "break-out sessions" where I will see participants individually. Please note that I will use my clinical discretion/best judgment on whether the information shared with me individually will be discussed in the treatment unit. Should you desire for the information that you discuss to not be shared, it is advisable that you seek the help of an individual counselor to disclose those matters in that setting. This "no secrets" policy is beneficial because it will allow me to discern an appropriate treatment path that will benefit the unit. If I am not free to use my clinical judgment to share accordingly, I may be forced to terminate treatment with the couple or family. Again, this policy is being disclosed in written form pursuant to having a clear understanding and expectation of the role I must play in this counseling process.

Termination: Therapy has a natural end. This is normally agreed upon by the therapist and the client when progress has been made and all issues have been addressed. There are occasions, however, when this process is no longer a "good fit" for one or both parties (client or therapist) and I will refer you out so that you can connect with someone that is more suited to your needs. You have every right to inform me that you are not satisfied with my services and desire to cease the therapeutic process. Your file is closed after 60 days of not attending/scheduling sessions.

Signatures of Acknowledgment:

We, the members of the _____ (last name/s/ of the couple/family unit) acknowledge by individual signatures that they have read, discussed and understand the policies described in this form. The individual signatures also indicate that any questions or concerns have been discussed with ___Adrian S. Turner, M.A., LMFT_____ (therapist's name) and agree to the conditions being entered into with Helping Others Heal, LLC.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____