Jennifer Walrod, MSW, MPA, LCSW

Couples Therapy - Intake Questionnaire

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General Information:

Husband's Name__________________________Birthdate________Social Security #________________

Wife's Name______________________________Birthdate________Social Security #_______________

Street Address____

City________________________State____ Zip_______ Home phone________Cell phone___________

If we are trying to return your call or need to reschedule an appointment, when is the best time to reach you? __________At what number(s)?____

May a voice mail message or text message be left at the above number?_________________________
(Please indicate voice and/or text)

How many years have you been married?_______________ Previous Marriages?__________________

Relationship History and Background

(Please answer each question as completely and accurately as possible)

____

What are the things you like most about your relationship?

____
____
____
____
____

What are the things you most want to be different?

____
____

How often do you argue?

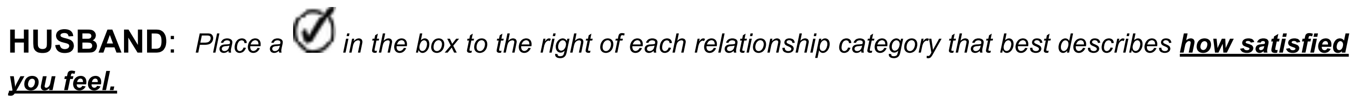
What do you most often argue about?

When you do argue, does someone end up leaving? Who? How long before they come back?

How long do you stay mad at each other?

Who is the first to attempt to make things better?

Do your arguments get physical?

HUSBAND: *Place a*  *in the box to the right of each relationship category that best describes* ***<u>how satisfied you feel.</u>***

	Very Dissatisfied	Moderately Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Moderately Satisfied	Very Satisfied	Check 3 Areas you most want to Change
Degree of Closeness, Openness, Confiding and Sharing							
Expression of Affection and Caring							
Satisfaction of Sexual Intimacy							
Handling Conflicts and Arguments							
Expression of Anger, Criticism or Blame							
Handling Family Finances							
Handling of Parenting Responsibilities							
Degree of Respect or Admiration of Partner							
Satisfaction with Your Role in the Relationship							
Satisfaction with Your Partner's Role in the Relationship							

WIFE: *Place a ☑ check in the box to the right of each relationship category that best describes* ***how satisfied you feel.***

	Very Dissatisfied	Moderately Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Moderately Satisfied	Very Satisfied	Check 3 Areas you most want to Change
Degree of Closeness, Openness, Confiding and Sharing							
Expression of Affection and Caring							
Satisfaction of Sexual Intimacy							
Handling Conflicts and Arguments							
Expression of Anger, Criticism or Blame							
Handling Family Finances							
Handling of Parenting Responsibilities							
Degree of Respect or Admiration of Partner							
Satisfaction with Your Role in the Relationship							
Satisfaction with Your Partner's Role in the Relationship							

Information and Consent to Treatment

Thank you for entrusting your therapeutic care to Jennifer Walrod, LCSW. Jennifer provides client-centered, confidential, psychotherapeutic counseling to individuals and couples. She will help individuals look at many aspects of their life; relational, physical, emotional, mental, and spiritual using professional clinical training. Jennifer promotes inner healing and wholeness according to the needs of each person, and believes in the dignity, value and worth of each individual life. She believe there is hope even in the most challenging life circumstances.

I acknowledge that I have received, have read (or have had read to me), and understand the privacy policy and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in treatment with Jennifer Walrod, LCSW.

- I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest.
- I agree to play an active role in this process
- I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.
- I have the right and responsibility to choose a therapist and treatment modality that best suits my needs and purposes.
- Once sessions begin, the duration and termination of therapy is something that should be a joint decision. Thoughts and feelings around wanting to stop therapy are important and encourage you to raise these concerns in counseling sessions.
- I am aware that I may stop my treatment with Jennifer Walrod, LCSW at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered).
- Records maintained by Jennifer Walrod, LCSW, PLLC are considered medical records and protected health information. She places a high value on confidentiality and will make every effort to ensure your privacy. Consultation with individuals or organizations regarding your treatment will require your written consent. There are, however, some exceptions and limitations to confidentiality as required by law. These specific situations are:

    1. Any known or reasonably suspected cases of ***child abuse or neglect.***
    2. Any known or suspected ***intentions of harming oneself (suicide****).*
    3. Any known or suspected ***intentions of harming others.***
    4. When written ***consent is given by the client*** to release information.
    5. When charges are brought against a counselor in response to a ***subpoena from a court of law or administrative agency.***

Insurance Billing, Session Fees and Financial Policies

- I understand that the intake diagnostic fee is $180 with subsequent session fees at $145/per clinical hour.
- It is often helpful to conduct a 90 minutes session with couples at a fee of $180. If you choose to bill insurance, Jennifer will bill one partner's insurance for the first 45 minutes and the second partner for the remaining 45 minutes.
- If insurance is billed, you are responsible for co-pay amounts at the time of service. If you are paying "out of pocket" a 15% deduction will be applied.
- These fees also apply to the preparation of assessment reports, court appearances, consultations, or meetings you have authorized as part of your therapeutic process. If payment for the services I receive is not made, Jennifer, though reluctantly, may stop my treatment.
- I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged $75 for that appointment.

"No Secrets" Policy for Couples Therapy

During the course of work with a couple, Jennifer may see an individual for one or more sessions. If you are involved in one or more of such sessions, please understand that generally these sessions are confidential in the sense that she will not release any confidential information to a third party without your consent. However, Jennifer may need to share information learned in an individual session with the other partner, if she is to effectively serve the unit being treated. She will use her best judgment as to whether, when, and to what extent she will make disclosures to the treatment unit, and will also, if appropriate, first give the individual the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be confidential you might want to consult with an individual therapist.

The "no secrets" policy is intended to allow Jennifer to continue to treat the couple by preventing a conflict of interest where an individual's interests may not be consistent with the interests of the couple being treated. If she is not free to exercise clinical judgment regarding the need to bring this information to the family or the couple during their therapy, she might be placed in a situation where treatment of the couple or the family will need to be terminated. This policy is intended to prevent the need for such a termination.

We, ____(couple), acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Jennifer Walrod and that we enter couple/family therapy in agreement with this policy.

Consent for Video Recording and Consultation

In order to provide the best possible therapy treatment to you, it is common for Jennifer Walrod, LCSW, to video record her sessions with couples for the purpose of her own personal review as well as consultation with an advanced practitioner. This practice of recording has been shown to provide the best outcomes for couples and is considered best practice. Video recordings are not part of your medical record and will permanently deleted after review.

By signing below, I give my consent to allow my therapy sessions with Jennifer Walrod, LCSW to be observed through video recordings by an EFT supervisor, therapist, team of therapists, or therapist-in-training. Because of the lack of supervisor-level EFT therapists in Montana, I consent to have this consultation occur via a tele-heath, HIPPA compliant platform.

I understand that any supervisor, therapist, or therapist-in-training who observes my therapy session is under the same confidentiality requirements as my therapist. Furthermore, I understand that if by chance any supervisor, therapist, or therapist-in-training knows me socially, he/she will immediately leave the supervision session and will not observe, seek, or be given any information about my case. I also understand that the purpose of allowing observation of my therapy sessions is to enhance the effectiveness of the therapy treatment I am receiving. I understand that I may withdraw this consent at any time and that I will be notified if any live observation or recording is going to occur before my session.

Assignment of Benefits and Release

The **HIPPA Notice of Privacy Practices and Authorization to Disclose Limited Mental Health Information** provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I acknowledge receipt of this document and my signature below indicates that I understand and consent to treatment under these conditions.

We acknowledge and authorize Jennifer Walrod, LCSW, PLLC to use and disclose my individual identifiable health information for the purpose of providing treatment to us, receiving payment from responsible parties for behavioral health care services rendered and / or engaging in behavioral health care operations. Our signature below allows Jennifer Walrod, LCSW, PLLC to receive all benefits which are or shall become payable from any third party payer. I authorize and direct all third party payers to pay all benefits directly to Jennifer Walrod, LCSW, PLLC.

We understand that I have the right to request a restriction on the use or disclosure of my Health information. We further understand that we have the right to revoke this consent, in writing. We understand that we have the right to request a restriction on the use or disclosure of my Health information. I further understand that I have the right to revoke this consent, in writing.

We acknowledge receiving a copy of the HIPPA Notice of Privacy Practices from Jennifer Walrod, LCSW, PLLC which provides a description of the uses and disclosures of protected health information.

With our signature we acknowledge we have read, understand, and agree to the nature of counseling services; our rights, responsibilities, HIPPA Notice of Privacy Practices, video recording and hereby consent to treatment with Jennifer Walrod, LCSW.

____ _________________________

Signature of patient Date

____

Printed name

____ _________________________

Signature of patient Date

____

Printed name

PLEASE SUBMIT PAYMENT AT TIME OF SERVICE