

INTAKE

Date _____

Name(1) _____ Name(2) _____

Address _____ Address _____

Home phone# _____ Home phone# _____

Work _____ Cell _____ Work _____ Cell _____

Email _____ Email _____

May I notify you about future services? May I notify you about future services?

Yes _____ No _____ Yes _____ No _____

Soc.Sec.# _____ Soc.Sec.# _____

Birthdate _____ Age _____ Birthdate _____ Age _____

M.Status:M ___ Yrs ___ Single ___ Sep ___ D ___ M. Status: M ___ Yrs ___ Single ___ Sep ___ Div ___

Occupation _____ Occupation _____

Employer _____ Employer _____

Time employed _____ Time employed _____

Insurance Co _____ Insurance Co _____

Policy type (HMO, PPO) _____ Policy type (HMO, PPO) _____

Subscriber _____ Subscriber _____

ID# _____ ID# _____

Group# _____ Group# _____

Deductible _____ Copay _____ Deductible _____ Copay _____

Children? Yes _____ No _____ Children? Yes _____ No _____

Names: Names:

1. _____ Age _____ 1. _____ Age _____

2. _____ Age _____ 2. _____ Age _____

3. _____ Age _____ 3. _____ Age _____

4. _____ Age _____ 4. _____ Age _____

Others in home _____ Others in home _____

(relationship) _____ (relationship) _____

(initials) _____ (date) _____

(initials) _____ (date) _____

Medical History(1)_____

Medical History(2)_____

Hospitalizations_____

Hospitalizations_____

Current Issues_____

Current Issues_____

Meds_____

Meds_____

Prescriber_____

Phone#_____

PCP_____

Prescriber_____

Phone#_____

PCP_____

Previous therapy and date(s):

Previous therapy and date(s):

Current therapy and therapist:

Current therapy and therapist:

Phone#_____

Phone#_____

Person who referred you to me:

Phone#_____

May I contact them?_____

Person who referred you to me:

Phone#_____

May I contact them?_____

May I contact above health providers?

Yes_____ No_____

May I contact above health providers?

Yes_____ No_____

(initials)_____ (date)_____

(initials)_____ (date)_____

Pursuant to the Regulations of the Board of Mental Health Practice in New Hampshire, all mental health professionals licensed by the Board must provide their clients with the following basic information. I encourage you to discuss any items with me if you have any questions:

Credentials

- MSW - Fordham University Graduate School of Social Service, 1977
- Certificate - Portsmouth Psychotherapy Institute, 1983
- Certificate - Fowler Wainwright International Assoc. of Coaching, 2010
- Licensure - New Hampshire, LICSW #202
Massachusetts, LICSW #105981
- Certification - American Board of Examiners in Clinical Social Work,
"Board Certified Diplomate," (BCD) #14332

Professional Associations

- National Association of Social Workers (NASW)
- American Clinical Social Work Association (ACSWA)
- American Association of Marriage and Family Therapists (AAMFT)
- Maine Association of Marriage and Family Therapists (MEAMFT)
- New Hampshire Psychological Association (NHPA)
- GoodTherapy.Org
- International Association of Coaching (IAC)

Scope of Practice

I provide individual and couples therapy, specializing in couples therapy.
I provide Discernment Counseling to couples on the brink of divorce.
I provide consultation, coaching and training to individuals, couples and groups.
Couplespeak™ is a division of my practice which provides relationship tools and products live, and online.
I work with adolescents age 14 and older, and adults of all ages.
I do not provide any services to the following populations:
adult perpetrators of sexual abuse, violent offenders, or clients with active or untreated psychotic disorders.

(initials)_____ (date)_____

(initials)_____ (date)_____

Supervision / Consultation

As part of maintaining a valid license, I am required to regularly discuss cases with colleagues for the purpose of addressing clinical issues which arise in the course of treatment, to broaden my perspective, and to maximize my clinical effectiveness and professional growth. I also obtain formal supervision on cases when I believe it is necessary. In these situations I do not disclose the identity of my clients. My colleagues, and any formal consultant are legally bound to confidentiality as well.

I also adhere to licensure requirements regarding continuing education to enhance and expand my clinical skills.

Code of Ethics

As a Licensed Independent Clinical Social Worker, I am governed by the Code of Ethics of the National Association of Social Workers (NASW). Copies of the Code are available at all times in my waiting room, and also available upon request.

Mental Health Bill of Rights

Pursuant to the N.H. Bill of Rights, clients have certain rights. A copy of the Mental Health Bill of Rights is posted in my waiting room. Please review it, and let me know if you have any questions. Copies are available upon request.

Conflicts of Interest

New Hampshire is a small state. From time to time, actual or potential conflicts of interest may arise. If I become aware of a potential conflict of interest in providing treatment to you, I may be required to refer you to another therapist. Regardless of the existence of a conflict of interest, you can be assured that any information will remain confidential.

Electronic Communications

Some insurance companies require that I, or my billing service send billing and other information by fax or email. I can't guarantee the confidentiality of this.

(initials)_____ (date)_____

(initials)_____ (date)

*If you do not consent to electronic communications, please inform me immediately before beginning treatment, so that I can determine whether and how to proceed. I do not accept or respond to electronic mail communications about treatment issues.

Confidentiality

Under New Hampshire law, communications between a client and a licensed psychotherapist are privileged (confidential), and may not be disclosed without the specific authorization of the client, except under specific, limited circumstances required by law. (For details refer to attached HIPAA privacy material).

Couples Therapy, Family Therapy, and Discernment Counseling

Information that is shared by a member of a couple or family cannot be considered confidential from the other parties in that therapy.* Thus, there is no confidentiality between individuals in couples* or family treatment. Partners, by signing this, understand and agree that each will have access to the records of the other. Treatment of unmarried couples is not confidential between partners under New Hampshire law. Such treatment is the legal equivalent of group therapy, which is not privileged. Such couples agree, by signing this, not to disclose information to outside parties.

*** Open Secrets Policy**

In the course of couples therapy and Discernment Counseling, at intervals I meet with partners individually by request, circumstance, protocol, or clinical indication. Clients may share information with me that they may not have divulged to their partner for some compelling reason. Unless this information relates to the physical safety of the other, I will hold the “secret,” and work with the individual to explore the issues around divulging it. My goal is to maximize honesty between partners. By signing this however, partners recognize that “secrets” may arise, agree to defer to my professional judgment about eventual disclosure or not, and agree to release me from any liability regarding any “secrets” I may hold.

(initials)_____ (date)_____

(initials)_____ (date)_____

Sanctity of Treatment

It is critical for partners engaged in couples work to feel as emotionally safe as possible with me and each other during the process. In order to preserve this safety I make it a policy, to the best of my ability, to stay out of any eventual legal proceedings between partners, (as in the case of separation or divorce). In my experience, it is not therapeutically sound to “wear two hats,” or be in the role of psychotherapist, while positioning for a possible involvement in a legal process between partners. Furthermore, because of the systemic frame I embrace in viewing couples’ problems, it would not benefit either partner for me to be drawn into any eventual legal proceedings exploring culpability for the decline of the marriage or partnership.

By signing this, partners agree to preserve the sanctity of the therapy, and not use the psychotherapy record, (even though they have the legal right to do so), in any possible future legal proceedings with each other.

Minors

The treatment of a minor must be authorized by a parent of the minor. Although communications between a client and a licensed psychotherapist are confidential, either parent of the minor, (even a non-custodial parent), has the right to access and authorize release of the psychotherapy record. When a child turns 18, the control of treatment, and treatment records reverts to the child.

Maintaining Professional Boundaries

Based upon my own ethics, professional ethics, and state law, I will maintain appropriate professional boundaries with current and past clients. New Hampshire state law requires that you, as a client, have the right to report inappropriate actions by any health-related professional to the Board of Examiners at (603) 226-3599. Please do not hesitate to raise any concerns you may have regarding this issue.

(initials)_____ (date)_____

(initials)_____ (date)_____

Limits of Availability and Emergency Coverage

My office hours vary based upon the time of year, and the scheduling needs of my clients. I am generally available for sessions Tuesdays through Fridays.

Tuesday through Thursday: noon until 8:00 or 9:00 PM

Friday: noon until 6:00 or 7:00 PM

I pick up voicemail messages periodically during the day and each evening, and can usually return a call within two days.

Even though **I am available by pager (603-248-1006)**, and I utilize colleagues to share on-call coverage in my extended absence, I do NOT provide formal emergency services. For emergencies requiring immediate attention, please contact your doctor or local hospital emergency department. You may also call the Crisis Hotline in N.H. at (800)273-TALK or in Maine at (207)282-6136 .

Cost of Professional Services

(see Fee Policy on next page)

(initials)_____ (date)_____

(initials)_____ (date)_____

FEE POLICY

- 1. Couples Therapy** 50 min: \$175. Extended (75 min): \$250.
*Prepayment for 10 sessions: 10% discount
Individual Therapy 50 min: \$150. *Prepayment for 10 sessions: 10% discount
Initial Consultation 90 min: \$250. *Advance deposit required for reservation
Discernment Counseling 2 hour initial: \$325. Subsequent 90 Min. Sessions: \$250.
Consultations: 60 min: \$180.
Requested Paperwork (letters, record prep, etc., 1 hr minimum): \$125.
- 2. Payment options:** I accept checks, cash, Visa, MC, Amex, Discover and debit cards.
- 3. Payment** is expected at the time of service. A \$20. charge will be applied for any returned checks.
- 4. Cancellation:** All clients will be charged for missed appointments unless they **CANCEL AT LEAST 48 HOURS IN ADVANCE**. If there is a late notice of cancellation, but I am available for a rescheduled session at any time **WITHIN THE SAME WEEK**, no charge will be applied for the missed session.
- 5. Snow policy:** Clients will be expected to attend sessions unless driving is hazardous, in which case no charge will be applied for late cancellations. Clients' discretion in assessing safety of road conditions will be honored.
- 6. Insurance:** Clients are responsible for obtaining and tracking information regarding details of benefits, prior authorizations, deductibles, copays, timing of treatment reports to authorize more sessions, and to track balances. I am considered "out of network" for all managed-care plans except Anthem Blue Cross Blue Shield. (I will clarify those details upon request). *It is the client's responsibility to obtain prior authorization for psychotherapy (necessary for most plans). Many plans only authorize a handful of sessions unless the therapy is "medically necessary." Treatment reports are periodically required to document this, and to authorize more sessions. For all plans except Anthem BCBS I charge the above noted fee for this paperwork. As insurance coverage for most therapy is limited, and usually unavailable for couples work, you will need to begin planning for the expense at the outset. I encourage you to discuss any concerns regarding the use of insurance with me.

Person responsible for payment _____ **Fee** _____ **Date** _____
Signature(s) _____

(initials) _____ (date) _____

(Initials) _____ (date) _____

Recommended Treatment

At the beginning of the therapeutic relationship, and throughout your therapy, as appropriate, I will discuss with you my recommendations for treatment, as well as realistic expectations for change, and the possible costs and benefits which may accompany this process. You are encouraged at all times to ask any questions, and share any concerns you may have about our work together, or about the policies as stated above.

By signing this, you are acknowledging that you have read, understood, and agree to the above terms and policies of treatment with me.

Name_____

Signature_____

Date_____

Name_____

Signature_____

Date_____

Permission given for treatment of:

Minor client_____

Signature of parent or guardian_____

Date_____

www.SusanLager.com

Couplesctr@gmail.com

118 Maplewood Ave. Bldg. A, Portsmouth, NH

Ph: 603-431-7131

Fax: 603-436-8003

Authorization To Release Information

(Fill out if you are currently, or recently have been in therapy elsewhere, or are involved with other healthcare professionals.)

Client Name _____ **d.o.b.** _____
Address _____

Client Name _____ **d.o.b.** _____
Address _____

I (we) hereby authorize Susan Lager to share information with the following person(s) or facilities, concerning diagnosis, treatment, prognosis, and recommendations, as well as other data pertinent to my (our) treatment, or that of my (our) child. This may be in the form of verbal discussions, or written reports, mailed or faxed.

1. Name _____ **Ph:** _____
Address _____ **State** _____

2. Name _____ **Ph:** _____
Address _____ **State** _____

I (we) also authorize the above named person(s) to discuss, or report in writing or fax to Ms. Lager any relevant history, treatment, diagnosis or similar information for the purpose of assisting with my (our) treatment, or the treatment of my child. I fully understand the nature of this information, and the authorization to release it is made voluntarily on my part. I understand that I may revoke this authorization at any time by written notice to Ms. Lager, but such revocation may not be retroactive. The expiration date of this authorization, if any, is _____.

Date _____ Signature of Client _____
Date _____ Signature of Client _____
Date _____ Signature of Parent / Guardian _____

