The Couples Center, PLLC
Comprehensive Services For Married and Unmarried Partners

Susan Lager, LICSW, BCD
Ph: 603-431-7131

INTAKE

Date_____

Name(1)_____
Address_____
_____
Home phone#_____
Work_____Cell_____
Email_____
May I notify you about future services?
Yes_____ No_____

Soc.Sec.#_____
Birthdate_____Age_____

M.Status:M__ Yrs___ Single__Sep__D__

Occupation_____
Employer_____
Time employed_____

Insurance Co_____
Policy type (HMO, PPO)_____
Subscriber_____
ID#_____
Group#_____
Deductible_____ Copay_____

Children? Yes_____ No_____
Names:
1._____ Age_____
2._____ Age_____
3._____ Age_____
4._____ Age_____
Others in home_____
_____
(relationship)_____

(initials)_____(date)_____

Name(2)_____
Address_____
_____
Home phone#_____
Work_____Cell_____
Email_____
May I notify you about future services?
Yes_____ No_____

Soc.Sec.#_____
Birthdate_____Age_____

M. Status: M__ Yrs___ Single__ Sep__Div__

Occupation_____
Employer_____
Time employed_____

Insurance Co_____
Policy type (HMO, PPO)_____
Subscriber_____
ID#_____
Group#_____
Deductible_____ Copay_____

Children? Yes_____ No_____
Names:
1._____ Age_____
2._____ Age_____
3._____ Age_____
4._____ Age_____
Others in home_____
_____
(relationship)_____

(initials)_____(date)_____

Medical History(1)_____

Hospitalizations_____

Current Issues_____

Meds_____

Prescriber_____
Phone#_____
PCP_____

Previous therapy and date(s):

Current therapy and therapist:

Phone#_____

Person who referred you to me:

Phone#_____
May I contact them?_____

May I contact above health providers?
Yes_____ No_____

(initials)_____(date)_____

Medical History(2)_____

Hospitalizations_____

Current Issues_____

Meds_____

Prescriber_____
Phone#_____
PCP_____

Previous therapy and date(s):

Current therapy and therapist:

Phone#_____

Person who referred you to me:

Phone#_____
May I contact them?_____

May I contact above health providers?
Yes_____ No_____

(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
	Maine, LCSW # LC20850
	Massachusetts, LICSW #105981
	Rhode Island, LICSW # LSW03488
	Florida, Telehealth # TPSW1299
Certification -	American Board of Examiners in Clinical Social Work, "Board Certified Diplomate," (BCD) #14332

Professional Associations

National Association of Sociat 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)_____

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.

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 al 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**

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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 _____