Lisa B. Therapy

CLINICAL MENTAL HEALTH COUNSELING

Lisa B. Therapy | 503 Wando Park Blvd. Suite 205P Mt Pleasant, SC 29464
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Client Intake Form

Client Information

Name(s):

Address:

City: State: Zip Code:

Date of Birth: Age:

Phone #: Email:

Is it ok to leave messages and send text messages to this phone number? ☐ Yes ☐ No

Is it ok to contact you via email? ☐ Yes ☐ No

Emergency Contact Name: Phone #:

Referred by:

RACE:

☐ White ☐ Black/African American ☐ Asian ☐ Latinx/Hispanic ☐ Native American ☐ Multi-racial

BIRTH SEX: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to disclose

GENDER: ☐ Female ☐ Male ☐ Non-binary ☐ Transgender ☐ Prefer not to disclose

Family Information

MARITAL STATUS:

☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

Spouse/Partner: Age: Lives with you? ☐ Yes ☐ No

How satisfied are you with your relationship?

☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied ☐ Very Unsatisfied

Do you have children? ☐ Yes ☐ No Children's names & ages: _____

Spiritual / Faith Information

Do you identify with any spiritual or religious belief? ☐ Yes ☐ No ☐ Prefer not to disclose

If yes, please describe: _____

Would you like these beliefs included in your care if relevant? ☐ Yes ☐ No ☐ Unsure

Family History

Who were you raised by:

How many siblings do you have:

Please describe your relationship with your parents/caregivers:

Please describe names, ages, and relationships with your siblings:

Circumstances from your childhood that you'd like to elaborate on:

Support System

Do you have a support system? ☐ Yes ☐ No

Who?:

Current living situation?

Is your home environment safe? ☐ Yes ☐ No

If no, explain:

Employment/Education Status

Employer/School:

Occupation/Years in School:

Status (check all that apply:

- ☐ Disabled
- ☐ Employed Part Time
- ☐ Unemployed
- ☐ Employed Full Time
- ☐ Retired
- ☐ Student

What is your highest level of education completed?

- ☐ Less Than High School
- ☐ Associates Degree
- ☐ Bachelor's Degree
- ☐ High School/GED
- ☐ Some College
- ☐ Post Graduate Degree

Mental Health History

Have you experienced any of the following in the past 90 days? Please check all that apply:

- ☐ ADHD
- ☐ Anger/Rage
- ☐ Anxiety
- ☐ Death in Family
- ☐ Depression
- ☐ Hallucinations
- ☐ Hospitalization
- ☐ Obsessive/Intrusive Thoughts
- ☐ Mood Swings
- ☐ Panic/Phobia
- ☐ Paranoia/Delusions
- ☐ Poor Sleep Patterns
- ☐ Racing Thoughts
- ☐ Self Injury
- ☐ Suicide Attempt
- ☐ Thoughts of Harming Others
- ☐ Violence
- ☐ Weight Gain/Loss

Have you experienced abuse? ☐ Yes ☐ No

If yes please explain:

Have you ever been admitted to the hospital for mental health reasons? ☐ Yes ☐ No

If yes please explain:

Is there any family history of mental health problems or suicide (attempts)? ☐ Yes ☐ No

If yes please explain:

Have you had therapy in the past? ☐ Yes ☐ No If yes, was it helpful? ☐ Yes ☐ No

Previous therapist: Dates seen:

Medical History

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list:

Do you currently have any medical problems? ☐ Yes ☐ No

If yes, please list all symptoms and treatments you are undergoing:

Do you experience physical pain that causes mental health issues? ☐ Yes ☐ No

Physician: Phone Number:

Permission to contact physician if necessary? ☐ Yes ☐ No

Stressors

What stressors are you dealing with or have you dealt with in the past? Please check all that apply:

- ☐ Physical/Sexual Abuse
- ☐ Serious Illness
- ☐ Death
- ☐ Debilitating Injuries/Disabilities
- ☐ Divorce
- ☐ Financial Crisis/Unemployment
- ☐ Frequent Relocations
- ☐ Legal Problems
- ☐
- ☐
- ☐
- ☐

How long have you been dealing with these?

What effect do these have on your life? ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe

Habits & Lifestyle

Do you regularly drink alcohol? ☐ Yes ☐ No

If yes, how often:

Are you dealing with any addictions? ☐ Yes ☐ No

If yes, please explain:

How often do you engage in recreational drug use?

☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily

Do you consider your alcohol/drug use a problem? ☐ Yes ☐ No ☐ Unsure

Do you exercise regularly? ☐ Yes ☐ No If yes, please describe what you do and how often:

Do you have hobbies? ☐ Yes ☐ No If yes, what are they and how often do you do them?

Goals

Why are you seeking treatment at this time?

What would you like to change?

What gives you hope, purpose, and meaning?

What do you hope to gain from therapy?

Legal

Have you or are you dealing with any of the following legal issues? Please check all that apply:

- ☐ Custody/Divorce
- ☐ Fraud
- ☐ Substance Abuse
- ☐ Driving Offenses
- ☐ Immigration
- ☐ Violence

Have you ever been imprisoned? ☐ Yes ☐ No

If yes, please explain:

Are you court ordered for services? ☐ Yes ☐ No

Are you assigned to a probation officer or case worker? ☐ Yes ☐ No

If yes, please list them here:

Name: Phone Number:

Will you require progress reports for legal authorities? ☐ Yes ☐ No

Attorney Involvement

Are you currently involved in a legal case related to your treatment? □ Yes □ No

If yes: Name of Attorney/Law Firm: _____

Phone Number: _____

Case Type (e.g., personal injury, civil suit, custody, criminal, etc.): _____

Is your treatment related to this legal matter? □ Yes □ No

Is your attorney's office financially responsible for payment of services? □ Yes □ No
If yes, please note:

- I understand that my therapy services are being paid for by a third party (legal office/attorney).
- I understand that clinical notes, records, summaries, and treatment documentation may be requested and disclosed to the paying legal entity as part of the legal process.
- I understand that I remain personally financially responsible for all therapy fees in the event that the attorney, law firm, insurance carrier, or third party does not pay, delays payment, denies payment, or disputes coverage.

Legal Records Disclosure Acknowledgment

By signinging below, I acknowledge and understand that:
• My therapy records, clinical notes, treatment summaries, and documentation may be released to my attorney or their legal representatives upon request.
• These records may be used in legal proceedings, litigation, insurance claims, or court processes.
• Confidentiality protections may be limited due to legal involvement and court-mandated disclosures.

_____ _____ _____

Name Printed Signature Date

Lisa B. Therapy
CLINICAL MENTAL HEALTH COUNSELING

Informed Consent for Therapy

This informed consent document is intended to provide general information about the counseling services provided by Lisa B. Therapy. This is a legal document; please read it carefully before signing.

Lisa Buscemi is a Licensed Clinical Mental Health Counselor Associate (LPCA). She may discuss certain cases with supervisors and peers for guidance, in which case the identity of individuals remains anonymous.

MENTAL HEALTH SERVICES

Lisa B. Therapy recognizes that it may not be easy to seek help from a mental health professional. It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Due to the varying nature and severity of problems and the individuality of each client, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result

NATURE OF THERAPY & RISKS

It is important to understand that there are both benefits and risks associated with participation in therapy. Therapy may improve the ability to relate to others, provide a clearer understanding of self, values, and goals, and an ability to deal with everyday stress. However, clients often learn things about themselves that they don't like. Often growth cannot occur until past issues are experienced and confronted, often causing distressing feelings such as sadness and anxiety. Therapy can lead to unanticipated feelings and change, which might have an unexpected impact on you, and your relationships.

CONFIDENTIALITY

Discussions between you and your therapist are confidential. No information will be released without your written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; criminal prosecutions; child custody cases, suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, or disclose. If you have any questions regarding confidentiality, you should bring them to the attention of your therapist when you and the therapist discuss this matter further. You have the right to review your records at any time. Psychotherapy notes are excluded from this provision.

CLINICAL DOCUMENTATION TECHNOLOGY CONSENT

Lisa B. Therapy may use secure, HIPAA-compliant clinical documentation software that assists with audio recording sessions and generating clinical notes for documentation, treatment planning, and record-keeping.

□ I consent to the use of clinical documentation software
□ I do NOT consent to the use of clinical documentation software

TELEHEALTH CONSENT

I consent to participate in therapy services via telehealth if clinically appropriate. □ Yes □ No

_____	_____	_____
Name Printed	Signature	Date

COMMUNICATION

By signing the Informed Consent for Therapy document, you are consenting for Lisa B. Therapy to communicate with you by phone, e-mail, and at the address provided on your client intake form. You agree to notify us if you need to opt out of any form of communication

AFTER-HOURS CONCERNS AND EMERGENCIES

As a general rule, it is our belief that important issues are better addressed within regularly scheduled sessions. However, you may contact your therapist in between sessions. You may leave a message for your therapist at any time on her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Emails and text messages become part of your client record and subject to the same laws and restrictions governing your file. Texting is not a secure form of communication, therefore texting of personal information is always discouraged. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance or call 211 from a landline (or 744-HELP from a cell phone) for access to the local Hotline help and referral service

EMERGENCY SAFETY ACKNOWLEDGEMENT

I understand emergency services may be contacted in a crisis situation to ensure safety.

□ Acknowledge

FEES AND INSURANCE

- The fee for individual therapy sessions is $125 per session and is approximately 50 minutes in length and the fee for conjoint (marital/family) therapy sessions is $145 per session and approximately 50 minutes in length unless
- otherwise discussed. Once licensed, Lisa B. Therapy will have a fee change that will be presented. The fee and time allotted for group therapy sessions will be discussed prior to scheduling. Fees are payable at the time that services
- are rendered. If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.
- Lisa B. Therapy is not in network with insurance companies at this time but can provide you with a superbill monthly you to to submit to your insurance provider for possible reimbursement. It is your responsibility to check with you insurance provider to determine if this is an option.

RELATIONSHIP / SOCIAL MEDIA / ONLINE PRIVACY

The relationship you have with your therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that your therapist not have any other type of relationship with you. It is not appropriate to share gifts, barter, or trade services with your therapist or befriend her on social media. Lisa B. Therapy will not establish connections or engage with clients through social media in any way.

CONSENT TO TREAT

By signing the Informed Consent for Counseling and Psychotherapy, you voluntarily agree to receive mental health assessment, care, treatment, or services and authorize Lisa B. Therapy to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services and that you may stop such care, treatment, or services at any time. By signing you, you understand that Lisa Buscemi is currently enrolled in school to become a Clinical Mental Health Counselor, she is pre-licensed and under the supervision of Helen Wheeler, LPCS. By signing the Informed Consent for Counseling and Psychotherapy document you acknowledge that you have both read and understood all the terms and information contained herein. You also agree that you have had the opportunity to ask questions and seek clarification of anything that remains unclear and that those questions have been answered satisfactorily.

Your signature below indicates that you have read this agreement for services carefully and understand its contents.

Name Printed	Signature	Date

Lisa B. Therapy

CLINICAL MENTAL HEALTH COUNSELING

Payment Information & Authorization

Payment Information

Amount: ☐ Cash ☐ Check ☐ Credit Card

Credit Card Authorization

Please complete all of the fields below if you plan on paying by credit card. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled. There are no refunds once services are rendered.

Name on Card: Zip Code:

Card Number: Exp: CVC Code:

Card Type: ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover ☐ Other

Cancellation and No Show Policy

Your appointment is very important. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least 24 hours notice prior to your scheduled appointment time for cancellations or rescheduling of appointments. Please notify us by e-mail if your cancellation is outside of our normal business hours or if you're unable to reach us by phone. Please remember that it is your responsibility to remember your appointment dates and times in order to prevent any missed appointments which result in a cancellation fee. Not receiving an electronic notification of your appointments from us is not sufficient reason to miss an appointment if the original confirmation notification was received timely. It is mutually understood that if a cancellation is due to circumstances beyond any of our control, such as power outage, unfortunate incidence, illness, or weather that requires you or us to have to cancel or be closed during regular business hours, we will reschedule your existing appointment and no discount or rescheduling fee will apply.

ALL NO-SHOWS AND ANY APPOINTMENTS CANCELLED, RESCHEDULED, OR CHANGED WITHOUT 24 HOURS' NOTICE WILL BE BILLED TO YOUR ACCOUNT IN THE AMOUNT WE WOULD HAVE COLLECTED IF THE SERVICE HAD BEEN PROVIDED AS SCHEDULED.

LATE ARRIVAL POLICY: All appointments begin and end on time in order to maintain our schedule. If the therapy does not start on time due to client tardiness, the therapy time will be reduced accordingly and you will still be required to pay full price. If a client is more than 15 minutes late, the appointment will be considered a cancellation.

By signing below, I authorize Lisa B. Therapy to charge the credit card above after each session and for agreed-upon purchases and fees. I understand that my information will be saved for future transactions on my account. I have read and understood the cancellation and refund policy and agree to abide by the above conditions.

Name Printed	Signature	Date

Lisa B. Therapy

CLINICAL MENTAL HEALTH COUNSELING

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This document may be updated without notice so please review it each time you visit us. A copy of this statement is always available upon request.

All information revealed by you in a counseling or therapy sessions and most information placed in your counseling/therapy file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper, or oral]) is considered "protected health information" by HIPAA. As such, your protected health information cannot be distributed to anyone else without your express informed and voluntary written consent or authorization. The exceptions to this are defined immediately below. Additional information regarding your rights as a client can be found in your counselor's/therapist's Professional Disclosure Statement and Consent for treatment.

Use of disclosure of the following protected health information does not require your consent or authorization:

1. Uses and disclosures required by law- like files subpoenaed by a judge.
2. Uses and disclosures about victims of abuse, neglect, or domestic violence – like the duties to warn as explained in your counselor's/therapist's disclosure statement.
3. Uses and disclosures for health and oversight activities- like correcting records of correcting records already disclosed.
4. Uses and disclosures for judicial and administrative proceedings- like a case where you are claiming malpractice or breech of ethics.
5. Uses and disclosures for research purposes- like using client information in research; always maintaining confidentiality.
6. Uses and disclosures for law enforcement purposes- like when you claim mental health issues as a defense in a civil or criminal case.
7. Use and disclosures to avert serious threat to health or safety- like calling Probate Court for a commitment hearing.
8. Uses and disclosures for Worker's Compensation- like the basic information obtained in counseling/therapy as a result of your Worker's Compensation claim.

I have read (or had read to me) the information above as it concerns my private information. I sign to acknowledge that.

–

_____	_____	_____
Name Printed	Signature	Date

Lisa B. Therapy
CLINICAL MENTAL HEALTH COUNSELING

Legal Authorization & Release of Information

I hereby authorize Lisa B. Therapy to release, disclose, and provide copies of my mental health records, clinical notes, treatment summaries, billing records, and related documentation to:

Attorney/Law Firm Name: _____
Contact Person: _____
Phone: _____ Fax: _____
Email: _____
Purpose of Disclosure: □ Legal proceedings
□ Insurance claim
□ Civil litigation
□ Attorney review
□ Court-related documentation
□ Other: _____

This authorization includes disclosure of records related to mental health treatment, diagnoses, treatment plans, progress notes, and clinical documentation. This consent is voluntary and may be revoked in writing at any time, except to the extent that action has already been taken in reliance on this authorization.

Client Name (printed): _____

Signature: _____ Date: _____

Legal issues (check all that apply):
□ Custody/Divorce □ Driving Offenses □ Fraud □ Immigration □ Substance Abuse □ Violence
Ever been imprisoned? □ Yes □ No
Court ordered for services? □ Yes □ No
Assigned probation officer/case worker? □ Yes □ No
Name/Phone: _____
Progress reports required for legal authorities? □ Yes □ No