



MindWise Institute

Parenting, Child, Couples & Family Therapy, Clinical Neuropsychotherapy
and Rapid Resolution Therapy

Mary Bowles, MA, LMFT, RRT, MIAAN

FAMILY INTAKE FORM

Please provide the following information for my records. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself 10 minutes prior to your appointment to complete the form in the office. **For therapy purposes, a "minor child" is one who is younger than 15 years old.**

PLEASE NOTE: PARENTS MUST REMAIN IN THE BUILDING WITH CHILDREN UNDER THE AGE OF 15!

PARENT 1 NAME: _____
(Last) (First) (Middle Initial)

Birth Date: ____ / ____ / ____ **Age:** ____ **Gender:** Male Female **Marital Status:** _____

Physical Address: _____
(Street and Number) (City) (State) (Zip)

Mailing Address (if different): _____
(Street and Number) (City) (State) (Zip)

Home Phone: (____) _____ **Messages OK?** **Cell Phone:** (____) _____ **Voicemail Ok?** **Text OK?**

E-mail: _____ **May we email you?** Yes No **email might not be confidential**

On Prescribed meds? Yes No **Name/Dose:** _____ **Employer:** _____

PARENT 2 NAME: _____
(Last) (First) (Middle Initial)

Birth Date: ____ / ____ / ____ **Age:** ____ **Gender:** Male Female **Marital Status:** _____

On Prescribed meds? Yes No **Name/Dose:** _____ **Employer:** _____

CHILD 1 NAME: _____
(Last) (First) (Middle Initial)

Minor Child **Birth Date:** ____ / ____ / ____ **Age:** ____ **Gender:** Male Female **Marital Status:** _____

On Prescribed meds? Yes No **Name/Dose:** _____ **School:** _____

CHILD 2 NAME: _____
(Last) (First) (Middle Initial)

Minor Child **Birth Date:** ____ / ____ / ____ **Age:** ____ **Gender:** Male Female **Marital Status:** _____

On Prescribed meds? Yes No **Name/Dose:** _____ **School:** _____

Is there a parenting plan in place for your children? No Yes **Other parent (name/phone):** _____

Goals for therapy? _____

Referred by: Family/Friend Google Facebook www.MindWiseInstitute.com Psychology Today Other _____

HEALTH AND SOCIAL INFORMATION

Anyone in the family currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? Yes No
 If so, where? _____

FAMILY MENTAL HEALTH HISTORY: Check the box if anyone in your family (immediate family members or relatives) has experienced difficulties with the following, then list family member, e.g., Sibling, Parent, Uncle, etc.

Difficulty	Family Member(s)	Difficulty	Family Member(s)
<input type="checkbox"/> Depression:	_____	<input type="checkbox"/> Eating Disorders:	_____
<input type="checkbox"/> Bipolar Disorder:	_____	<input type="checkbox"/> Learning Disabilities:	_____
<input type="checkbox"/> Anxiety Disorders:	_____	<input type="checkbox"/> Suicide Attempts:	_____
<input type="checkbox"/> Schizophrenia:	_____	<input type="checkbox"/> Personality Disorders:	_____
<input type="checkbox"/> Alcohol/Drug Abuse:	_____	<input type="checkbox"/> Other:	_____

OUR AGREEMENT

All adults (age 15+) must INITIAL that you've read, understand, & agree to these aspects of therapy:

- I agree not to disclose the name or identity of any other client being seen by this therapist.
- I understand that my therapist may also be seeing a close friend or family member. If this happens my therapist will inform me and the other party without disclosing names or identities and offer a referral if desired.
- In couples/family counseling, if you tell me something another party does not know, and not knowing this could harm him or her or your relationship, I will not promise to keep it confidential.
- To ensure my confidentiality I understand my therapist won't approach me in public, but I know I can approach her.
- I understand my therapist is not on call 24 hours for crisis and if I cannot reach my therapist and I am in crisis I should call a crisis line such as Mind Springs:888-207-4004 or Aspen Hope:970-925-5858.
- I agree to pay \$140 (before 5pm)/\$180 (after 5pm/weekends) per session and all additional fees as listed in this disclosure.
- I agree to give 24 hours notice if I must cancel an appointment. I know I am responsible for the full session fee (\$140/\$180) if I do not give such notice, *even if* I am on the sliding scale.
- I understand that my therapist may confidentially consult about my case with other professionals, but only with those who are also required by law to maintain my confidentiality.
- I know my sessions may be recorded. I understand that the only purpose for recording my sessions will be to: 1) act as an aid in my therapy and/or 2) act as an aid for professional development. I know I am under no obligation to agree to this and I understand that refusal will not alter the services you receive. These files will be maintained according to Colorado Law 12.43.214(1)(d) CRS: Privileged Communications. Any questions/comments about this process are always welcome.
- I authorize my therapist to contact me during and after the termination of treatment to gather information for follow-up and research studies.
- I understand that I have a right to confidentiality unless I or other persons are believed to be in physical danger, the law requires me to tell others about it. Specifically:
- If my therapist suspects that I am threatening serious harm to another person.
 - If I seriously threaten or act in a way that is very likely to harm myself.
 - In an emergency where my life or health is in danger, and my therapist cannot get my consent, my therapist may give another professional some information to protect my life.
 - If my therapist believes or suspects that I am abusing a child, an elderly person, or a disabled person, my therapist **MUST** file a report with a state agency. To "abuse" means to neglect, hurt, or sexually molest another person. The therapist does not have any legal power or requirement to investigate the situation to find out all the facts. All that is required is suspicion. The state agency will investigate.

In any of these situations, the therapist would reveal only the information that is needed to protect the client or the other person. The therapist would not tell everything the client told her/him.

I understand that my therapist's solitary role is as a therapist and **IS NOT** to make recommendations to a court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in any litigation. By signing this disclosure statement, I agree not to call my therapist as a witness in litigation. I understand the fee for any court appearances, including expert witness testimony, reports, and correspondence, responding to subpoenas and/or conferrals with my own or another party's lawyer, and/or any other court preparation is **\$360 per hour** beginning with a **retainer of \$1440** to cover the first 4 hours.

Choose (one):

I DO NOT have any pending court cases I intend to request this therapist testify or report to.

OR

I DO have a pending court case and have disclosed this to my therapist and we have discussed it.

By signing below, as a client or guardian of a client, I am stating I have received or read and fully understand my agreement with **MindWise Institute/Mary Bowles, MA, LMFT, RRT, MIAAN**. My signature below indicates that I have read and discussed those points I did not understand and have had my questions, if any, fully answered. *It is also my understanding that any of the points mentioned above can be discussed and may be open to change.* If at any time during the treatment I have questions about any of the subjects discussed in this disclosure, I can talk with my therapist about them and she will do her best to answer them. I agree no specific promises have been made to me by this therapist about the results of treatment, effectiveness of the procedures used, or the number of sessions necessary for therapy to be effective.

CONSENT TO TREATMENT

I have received and/or read the **Mandatory Disclosure Statement, Private Practice Policies,** and the **HIPAA Notice of Privacy Practices** and I understand my rights as a client (or the client's responsible party). I am consenting to treatment being appropriately informed of my rights. My signature below indicates that I have discussed all points I did not understand in this mandatory disclosure statement and I have had my questions, if any, fully answered.

> _____ <i>Printed name of Parent 1</i>	> _____ <i>Clients Date of Birth</i>
> _____ <i>Signature of client</i>	> _____ <i>Date</i>

> _____ <i>Printed name of Parent 2</i>	> _____ <i>Clients Date of Birth</i>
> _____ <i>Signature of client</i>	> _____ <i>Date</i>

> _____ <i>Printed name of Child 1</i>	> _____ <i>Clients Date of Birth</i>
> _____ <i>Signature of client (or legal Guardian)</i>	> _____ <i>Date</i>
<input type="checkbox"/> Check this box if a parenting plan exists for this child. (Be prepared to provide a copy)	

> _____ <i>Printed name of Child 2</i>	> _____ <i>Clients Date of Birth</i>
> _____ <i>Signature of client (or legal Guardian)</i>	> _____ <i>Date</i>
<input type="checkbox"/> Check this box if a parenting plan exists for this child. (Be prepared to provide a copy)	

The following MUST be completed by one family member for each family...

CREDIT/DEBIT CARD INFORMATION & AUTHORIZATION FOR PAYMENT

> I authorize **Mary Bowles, MA, LMFT, RRT, MIAAN/MindWise Institute.** to charge the card listed below when I miss my scheduled appointment and did not cancel within 24 hours. I understand this includes any appointment I fail to pay for at time of service, or for any outstanding balance owed due to my insurance company, EAP, Crime Victims Compensation Fund, etc. not covering services. I also agree to have my credit/debit card charged the replacement cost for any items I borrow (books, DVD's, etc.) from MindWise Institute that I might borrow and fail to return within 2 weeks from the date the item was borrowed or that I return damaged.

Type of Card: MASTERCARD VISA DISCOVER

> Name (as on Card): _____ > Expiration Date: ____/____

> Credit Card #: _____ - _____ - _____ - _____ > CVV#: _____

Complete Billing Address for THIS Card:

> _____

Street

> _____

City

State

Zip

> _____

Authorized Card Holder Signature

_____ *Date*