Diane K. Schmidt Counseling Services
Diane K. Schmidt, LSCSW
8575 W. 110 Street, Suite 304
Overland Park, Kansas 66210
913.730.6778
diane@dkschmidtcounseling.com
www.dkschmidtcounseling.com
www.acckc.com

INTAKE FORM

Date: _____

Last Name: _____ First Name: _____

Birthdate: _____ Age: _____

Address: _____ City/State/Zip: _____

How long at this address: _____

Home Phone: _____ Cell Phone: _____

OK to leave message? □ Yes □ No Number Preferred: □ Home □ Cell

Email address: _____

Would you like a reminder message for appointments? □ Yes □ No If yes, what mode: □ email □ text □ phone call

□ Married □ Single □ Separated □ Divorced □Widowed □ Committed Relationship

Spouse's Name: _____ Birthdate: _____ Age: _____

Date of current marriage: _____

Previous marriage(s) for husband? How many? _____ Duration of each: _____

for wife? How many? _____ Duration of each: _____

Names and ages of children: _____

Names and ages of present household members: _____

_____

Are there any serious medical problems or physical disabilities in your immediate family (parents, siblings, children)?: _____

_____

Last Grade completed/degree(s)? You: _____ Spouse: _____

Your employer: _____ Phone: _____

Occupation: _____

Spouse's employer: _____ Phone: _____

Occupation: _____

Nearest relative not living with you: _____ Phone: _____

Whom may we thank for referring you? _____

INTAKE FORM

(continued)

Whom may we contact in case of an emergency who does not reside with you? _____

_____ Phone: _____

Briefly, how would you describe the situation or problem that brings you here: _____

_____

_____

Are you taking any medications? If yes, what, how much, and with what results: _____

_____

_____

Role of religion and/or spirituality in your life:

a. In childhood: _____
b. As an adult: _____

Present interests, hobbies, and activities: _____

_____

How is most of your free time occupied? _____

_____

What actions, if any, have you taken toward finding a solution? _____

_____

_____

Have you or any other family member ever received prior counseling or treatment? □ Yes □ No

If yes, whom and when? _____

What do you expect to accomplish from therapy, and how long do you expect therapy to last?

_____

_____

What is there about your present behavior that you would like to change? _____

_____

In a few words, what do you think therapy is all about: _____

_____

_____

I would like Christian principles incorporated into my therapy □ Yes □ No

If yes, does this include scripture? □ Yes □ No

If yes, does this include prayer? □ Yes □ No

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State of Kansas Physician Consult

I understand that when I describe symptoms that may be consistent with a mental disorder, these symptoms can have medical or biological origins and that my therapist must consult with my physician, unless I waive this requirement.

☐ No, I do not want my therapist to contact my physician and I waive this requirement. (Please sign below.)

_____ _____
Client Signature Date

☐ Yes, I request that my therapist consult with my physician regarding my mental health. (Please sign below.)

_____ _____
Client Signature Date

Physician's Name: _____

Address: _____

Phone: _____

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CLIENT INFORMATION FORM

QUALIFICATIONS

The therapist providing services is licensed in the State of Kansas as a Licensed Specialist Clinical Social Worker, License #4169.

She received her Master of Social Work degree from the University of Kansas.

SESSION FORMAT

Research has shown that the nature and severity of the client's presenting problems usually determine the length of therapy. Treatment can range from a few sessions to several months of therapy. The estimated length of a client's treatment will be determined in a collaborative discussion between client and therapist. Regular reviews of the client's progress and continuing need for therapy will be discussed with the client. Clients may leave therapy at any time, but the therapist asks that they agree to discuss the termination of therapy at a regular therapy session, rather than by phone.

She will incorporate Christian principles if so desired by the client. Emphasis is on relationship, not religion.

CONFIDENTIALITY

The information clients provide in therapy is confidential. The therapist will not reveal any information about clients or their issues, except for professional consultation, without the client's written consent. Any written records about treatment are also confidential. Because of the therapist's legal mandate to report some issues, confidentiality may be broken if a client is found to be a clear and imminent danger to self or others, if he/she reports current abuse of a child or dependent adult, or if the therapist receives a court order to release the client's records.

BENEFITS AND RISKS

Any time individuals seek therapy to work on difficulties within themselves or their personal relationships, there are benefits and risks involved. The benefits can include the ability to handle or cope with specific concerns and/or interpersonal relationships in a healthier way. Clients may also gain a greater understanding of personal, interpersonal, or family goals and values. This new understanding may lead to greater maturity and happiness as an individual, couple or as a family. There may also be other benefits that come as clients work at resolving specific concerns.

However, therapy can be challenging and uncomfortable at times. Remembering and resolving an unpleasant event may cause intense feelings of fear, anger, depression, and frustration. As clients work to resolve personal issues or issues between family members, marital partners, and

other persons, they may experience discomfort and an increase in conflict. There may also be changes in their relationships that they had not originally intended.

The therapist will discuss with clients the benefits and risks involved in their particular situations. The therapist encourages ongoing discussions of client's concerns as therapy progresses. Clients are encouraged to discuss with the therapist any concerns they may have as they progress through therapy.

You will be expected to relate not only problems and concerns, but successes and enjoyable experiences as well. At times you may be given homework assignments such as reading, keeping a journal, monitoring your own behavior, practicing a new behavior, etc.

It is important that you regularly and promptly attend scheduled sessions.

PHONE CONTACT AND EMERGENCY POLICY

Clients may contact the therapist at 913.730.6778. A phone voicemail system is available to take messages when the therapist is unavailable. Messages will be returned as soon as possible. The therapist cannot be available for 24-hour emergency care and clients cannot assume the therapist will be available at all times. In case of an emergency and the inability to reach the therapist, the client can contact one of the following crisis hotlines:

Kansas Crisis Hotline, Domestic Violence	**1-888-END ABUSE (1-888-363-2287)**
National Domestic Violence Hotline	**1-800-799-7233**
Johnson County Mental Health Emergency Services	**913-268-0156**
Child Abuse	**1-800-922-5330**
Rape Crisis Line, MOCSA	**816-531-0233 or 913-642-0233**
Suicide	**800-273-8255 or Text GO to 741741**
Battered Women's Shelter	**913-262-2868**
Emergency	**911**

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FINANCIAL POLICY

It is my desire to provide you with excellent professional counseling. My fee is set in accordance with the fair market of professional psychological treatment in the Kansas City Metropolitan area. Fees are based upon 50-minute sessions.

Payment is required at the time service is rendered. I accept cash, checks, debit or credit cards. (There will be a $30.00 charge for returned checks.) If you would like to keep your debit or credit card on file, I will provide a pre-authorization form to be completed.

Clients who carry Health Care Insurance should remember that professional services are rendered and charged to the client and not to the insurance company. Diane K. Schmidt Counseling Services does not file insurance claims.

You will receive the documentation required in order to submit your claim to your insurance company, your health savings account (HSA) or your employer's flexible benefits/cafeteria plan (FSA). This will include the provider's name and credentials, the date of service, the type of service, the cost and diagnostic code.

In the event that you are unable to keep a scheduled appointment, **a 24-hour notice is required**, except, of course, in an emergency situation. If I do not receive a **24-hour notice you will be charged and liable for the full visit fee.** This fee will need to be paid at the next appointment or will be charged to your debit or credit card if a pre-authorization form was completed.

If you have any questions regarding my policy or other matters, please feel free to call me at 913.730.6778.

I have read and understand the above policies; therefore, by signing below I agree that I am responsible for all applicable charges.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

Diane K. Schmidt Counseling Services
Diane K. Schmidt, LSCSW

INFORMED CONSENT & THERAPY CONTRACT

It is important that you are fully informed about the services you will receive. By signing below, you are saying:

1. I understand that my therapist is licensed by the State of Kansas as a Licensed Specialist Clinical Social Worker, LSCSW #4169.

2. I understand that the therapist is bound by the Code of Ethics set forth by the National Association of Social Workers, and I can request a copy of these ethics at any time.

3. I understand the confidentiality policies detailed in the **"Client Information Form",** including the circumstances in which Kansas Law may permit or mandate limits to confidentiality.

4. I understand that there are risks and benefits associated with therapy and I have discussed those with my therapist to my satisfaction. I also understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

5. I understand that I may leave therapy at any time and agree to discuss the termination of therapy at a regular therapy session, rather than by phone or text.

6. I understand that, under Kansas Law, my therapist is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to symptoms of a mental disorder. In order to complete such a consultation, my therapist will request that I complete a Release of Information form. I also understand that I may waive this consultation, in writing, and that my therapist will discuss this process with me at any time if I so request.

7. I understand the appointment and financial policies and agree to pay the current full fee for therapy at the end of each session, which is approximately fifty minutes in length.

8. I have received the client information form that informs me of my rights and other pertinent information, and the information has been explained to me and any questions answered by my therapist.

My signature below indicates that I give my full and informed consent to receive therapy services with Diane K. Schmidt of Diane K. Schmidt Counseling Services.

Signature _____ Date _____

Signature _____ Date _____

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Right to Receive a Good Faith Estimate

You have the right to receive a "Good Faith Estimate" per the **No Surprises Act** enacted January 1, 2022, explaining what your mental health care will cost. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, an estimate will be provided for the cost of services. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist.

You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

You have a right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges).

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in the Good Faith Estimate that will be provided to you via IVY Pay, if paying by credit card, which is the HIPAA compliant payment platform used for credit card processing. If paying by cash or check, one will be provided separately.

Please inform you have read this form and know that you can request a Good Faith Estimate by signing and returning.

I would like to receive a Good Faith Estimate: ☐ Yes ☐ No

_____ _____

Client Signature Date