



2315 McDonald Ave., Suite 101, Missoula, MT 59801
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PATIENT INTAKE QUESTIONNAIRE

General Information:

Husband's Name _____

Birthdate _____ Social Security # _____

Wife's Name _____

Birthdate _____ Social Security # _____

Street Address _____

City _____ State _____ Zip _____

Home phone _____

Husband's Cell phone _____ Wife's Cell phone _____

If I am trying to return your joint call or need to reschedule an appointment, which is the best number to call? _____

May a voicemail or text message be left at the above numbers? _____

How many years have you been married? _____

Previous Marriages? _____

Who referred you to Elizabeth's practice? _____

Immediate Family Information:

List the persons with whom you are now living and their relationship to you (include ages of children) _____

List the names, ages and location of children who do not reside with you at this time?

Relationship History and Background:

(Please answer each question as completely and accurately as possible)

What are the things you like most about your relationship?

What are the things you most want to be different?

How often do you argue?

What do you most often argue about?

When you do argue, does someone end up leaving? Who? How long before they come back?

How long do you stay mad at each other?

Who is the first to attempt to make things better?

Do your arguments get physical?

HUSBAND'S QUESTIONNAIRE

Social Information:

Occupation _____ Education level _____

Employer _____ Work phone _____

Address _____

Length of employment at above _____

Where/are you a member of the armed services? ____ If so, when? _____ What branch?

If you are actively involved in a community of faith/church, please indicate which one?

Medical Information:

Describe any physical problems you have that require medication or physical care:

_____ Are

you currently under a physician's care? ____ No ____ Yes

Name of physician: _____ Date of last physical examination: _____

Are you currently under psychiatric care? ____ No ____ Yes

Name of psychiatrist _____

Please list any medications you are currently using.

Do you have a past history of substance abuse or addiction? ____ No ____ Yes

If yes, please describe any past treatment, length of sobriety and any current concerns with substance use? _____

Therapeutic History:

Have you had any prior counseling? _____ How helpful was your previous counseling? _____

Please explain any childhood history of abuse (physical, sexual, emotional or spiritual)?

_____ Is

there anything else that you believe might be important for your therapist to know at this time?

HUSBAND: Place a in the box to the right of each relationship category that best describes **how satisfied you feel**.

	Very Dissatisfied	Moderately Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Moderately Satisfied	Very Satisfied	Check 3 Areas you most want to Change
Degree of Closeness, Openness, Confiding and Sharing							
Expression of Affection and Caring							
Satisfaction of Sexual Intimacy							
Handling Conflicts and Arguments							
Expression of Anger, Criticism or Blame							
Handling Family Finances							
Handling of Parenting Responsibilities							
Degree of Respect or Admiration of Partner							
Satisfaction with Your Role in the Relationship							
Satisfaction with Your Partner's Role in the Relationship							

WIFE'S QUESTIONNAIRE

Social Information:

Occupation _____ Education level _____

Employer _____ Work phone _____

Address _____

Length of employment at above _____

Where/are you a member of the armed services? ____ If so, when? _____ What branch?

If you are actively involved in a community of faith/church, please indicate which one?

Medical Information:

Describe any physical problems you have that require medication or physical care:

Are you currently under a physician's care? ____ No ____ Yes

Name of physician: _____ Date of last physical examination: _____ Are you currently under psychiatric care? ____ No ____ Yes

Name of psychiatrist _____

Please list any medications you are currently using?

Do you have a past history of substance abuse or addiction? ____ No ____ Yes

If yes, please describe any past treatment, length of sobriety and any current concerns with substance use? _____

Therapeutic History:

Have you had any prior counseling? _____ How helpful was your previous counseling? _____

Please explain any childhood history of abuse (physical, sexual, emotional or spiritual)?

Is

there anything else that you believe might be important for your therapist to know at this time?

WIFE: Place a check in the box to the right of each relationship category that best describes **how satisfied you feel**.

	Very Dissatisfied	Moderately Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Moderately Satisfied	Very Satisfied	Check 3 Areas you most want to Change
Degree of Closeness, Openness, Confiding and Sharing							
Expression of Affection and Caring							
Satisfaction of Sexual Intimacy							
Handling Conflicts and Arguments							
Expression of Anger, Criticism or Blame							
Handling Family Finances							
Handling of Parenting Responsibilities							
Degree of Respect or Admiration of Partner							
Satisfaction with Your Role in the Relationship							
Satisfaction with Your Partner's Role in the Relationship							

**This is a strictly confidential client medical record.
Re-disclosure or transfer is expressly prohibited by law.**

Insurance Information (If you have a copy of your insurance card you may disregard this section.)

PRIMARY INSURANCE: _____

Group No.: _____ Ins. I.D. Number: _____

Policy Holder: _____

Relationship to Patient: _____ Birthdate: _____

Effective Date: _____ Employer: _____

City & State: _____

SECONDARY INSURANCE: _____

Group No.: _____ Ins. I.D. Number: _____

Policy Holder: _____

Relationship to Patient: _____ Birthdate: _____

Effective Date: _____ Employer: _____

City & State: _____

Please see the next page for consent and assignment of benefits.

INFORMATION AND CONSENT TO TREATMENT

Thank you for entrusting your therapeutic care to Elizabeth Kennard, MSW, SWLC. Elizabeth provides client centered, confidential, psychotherapeutic counseling to individuals. She will help individuals look at many aspects of their life; physical, emotional, mental, relational, and spiritual using professional clinical training. Elizabeth promotes inner healing and wholeness according to the needs of each person, and believes in the dignity, value and worth of each individual life. She believes there is hope even in the most challenging life circumstances.

Elizabeth is a Social Worker Licensure Candidate, practicing under the supervision of Jennifer Walrod, LCSW. As such, billing will be processed under Jennifer Walrod, LCSW and this may reflect on your billing receipts.

I acknowledge that I have received, have read (or have had read to me), and understand the privacy policy and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in behavioral health treatment with Elizabeth Kennard, MSW, SWLC.

- I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest.
- I agree to play an active role in this process.
- I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.
- I have the right and responsibility to choose a therapist and treatment modality that best suits my needs and purposes.
- Once sessions begin, the duration and termination of therapy is something that should be a joint decision. Thoughts and feelings around wanting to stop therapy are important and encourage you to raise these concerns in counseling sessions.
- I am aware that I may stop my treatment with Elizabeth Kennard, MSW, SWLC, at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered).
- Records maintained by Elizabeth Kennard, MSW, SWLC, PLLC are considered medical records and protected health information. She places a high value on confidentiality and will make every effort to ensure your privacy. Consultation with individuals or organizations regarding your treatment will require your written consent. There are, however, some exceptions and limitations to confidentiality as required by law. These specific situations are:
 1. Any known or reasonably suspected cases of child abuse or neglect.
 2. Any known or suspected intentions of harming oneself (suicide).
 3. Any known or suspected intentions of harming others.
 4. When written consent is given by the client to release information.
 5. When charges are brought against a counselor in response to a subpoena from a court of law or administrative agency.

Husband's Signature _____

Wife's Signature _____

INSURANCE BILLING, SESSION FEES, AND FINANCIAL POLICY

- I understand that fees for couples' sessions are 60 min, \$175. After the initial intake visit, Elizabeth will meet with each spouse individually for additional assessment. The individual appointments are 60 min, \$125. Most couples need weekly sessions for upwards of a year to get the most benefit from Emotionally Focused Couples Therapy.
- If you choose to bill insurance, Elizabeth will bill one partner's insurance for the first 45 minutes and the second partner for the remaining 45 minutes. If insurance is billed, you are responsible for co-pay amounts at the time of services. These fees also apply to the preparation of assessment reports, court appearances, consultations, or meetings you have authorized as part of your therapeutic process. If payment for the services I receive is not made, Elizabeth, though reluctantly, may stop my treatment. Please contact your insurance company prior to treatment to understand any copay or deductible you may be responsible for.
- I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged the full amount for that appointment.
- Elizabeth Kennard, MSW, SWLC, PLLC requires a card be kept on file for co-pays, late cancellation fees, or missed appointment fees.

“NO SECRETS” POLICY FOR COUPLES THERAPY

During the course of work with a couple, Elizabeth may see an individual for one or more sessions. If you are involved in one or more of such sessions, please understand that generally these sessions are confidential in the sense that she will not release any confidential information to a third party without your consent. However, Elizabeth may need to share information learned in an individual session with the other partner, if she is to effectively serve the unit being treated. She will use her best judgment as to whether, when, and to what extent she will make disclosures to the treatment unit, and will also, if appropriate, first give the individual the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be confidential you might want to consult with an individual therapist.

The “no secrets” policy is intended to allow Elizabeth to continue to treat the couple by preventing a conflict of interest where an individual’s interests may not be consistent with the interests of the couple being treated. If she is not free to exercise clinical judgment regarding the need to bring this information to the family or the couple during their therapy, she might be placed in a situation where treatment of the couple or the family will need to be terminated. This policy is intended to prevent the need for such a termination.

We, _____ (couple), acknowledge by our individual signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with Elizabeth Kennard and that we enter couple/family therapy in agreement with this policy.

Husband’s Signature _____

Wife’s Signature _____

CONSENT FOR VIDEO RECORDING AND CONSULTATION

In order to provide the best possible therapy treatment to you, it is common for Elizabeth Kennard, MSW, SWLC to video record her sessions with couples for the purpose of her own personal review as well as consultation with an advanced practitioner. This practice of recording has been shown to provide the best outcomes for couples and is considered best practice. Video recordings are not part of your medical record and will be permanently deleted after review.

By signing below, I give my consent to allow my therapy sessions with Elizabeth Kennard, MSW, SWLC to be observed through video recordings by an EFT supervisor, therapist, team of therapists, or therapist-in training. Because of the lack of supervisor-level EFT therapists in Montana, I consent to have this consultation occur via a tele-health, HIPAA compliant platform.

I understand that any supervisor, therapist, or therapist-in-training who observes my therapy session is under the same confidentiality requirements as my therapist. Furthermore, I understand that if by chance any supervisor, therapist, or therapist-in-training knows me socially, he/she will immediately leave the supervision session and will not observe, seek, or be given any information about my case. I also understand that the purpose of allowing observation of my therapy sessions is to enhance the effectiveness of the therapy treatment I am receiving. I understand that I may withdraw this consent at any time and that I will be notified if any live observation or recording is going to occur before my session.

Husband's Signature _____

Wife's Signature _____

PRIVACY POLICY AND ASSIGNMENT OF BENEFITS

The **HIPAA Notice of Privacy Practices and Authorization to Disclose Limited Mental Health Information** provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I acknowledge receipt of this document and my signature below indicates that I understand and consent to treatment under these conditions.

I acknowledge and authorize Elizabeth Kennard, MSW, SWLC, PLLC to use and disclose my individual identifiable health information for the purpose of providing treatment to me, receiving payment from responsible parties for behavioral health care services rendered and / or engaging in behavioral health care operations. My signature below allows Elizabeth Kennard, MSW, SWLC, PLLC to receive all benefits which are or shall become payable from any third-party payer. I authorize and direct all third-party payers to pay all benefits directly to Elizabeth Kennard, MSW, SWLC, PLLC.

I understand that I have the right to request a restriction on the use or disclosure of my Health information. I further understand that I have the right to revoke this consent, in writing. I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices from Elizabeth Kennard, MSW, SWLC, PLLC which provides a description of the uses and disclosures of protected health information.

With my signature I acknowledge I have read and understand the nature of counseling services, my rights, responsibilities, HIPAA Notice of Privacy Practices and hereby consent to treatment with Elizabeth Kennard, MSW, SWLC, PLLC.

Husband's Signature _____

Printed Name _____ Date _____

Wife's Signature _____

Printed Name _____ Date _____

PLEASE SUBMIT PAYMENT AT TIME OF SERVICE

Credit Card Authorization Form

Elizabeth Kennard, PLLC requires a card be kept on file for co-pays, late cancellation fees, or missed appointment fees. Clients must call to cancel an appointment at least 24 hours before the time of the appointment. Cancellations with less notice and missed appointments will be charged the full amount.

Please complete all fields. You may cancel this authorization at any time by contacting Elizabeth Kennard, PLLC. This authorization will remain in effect until canceled.

Credit Card Information
Card Type <ul style="list-style-type: none">● Master Card● Visa● Discover● AMEX● Other _____
Credit Card Number _____
Expiration Date _____ CVV _____
Cardholder ZIP Code _____

I, _____, authorize Elizabeth Kennard, PLLC to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transitions on my account.

Customer Signature

Date