Dr. Laurie Patlin Suttenberg, DSW, LCSW-QS, DCSW

Florida Lic #SW13600; New Jersey Lic #44SC04307900; New York Lic #093887
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INTAKE FORM

Date: ______________________________________

Name: ____
(Last) (First)

Name of parent or guardian (if under 18 years):

____
(Last) (First)

Address: ___________________________________ City/State/Zip: ____

Email: _____________________________________ OK to email? Y N

Home Phone: ______________________________ OK to leave message? Y N

Cell Phone: _________________________________ OK to leave message? Y N

OK to send a text? Y N

Birth Date: ___________________________ Age: ____________ Gender: ____________________

Emergency Contact (name and phone number): ____

____

Single: ________Married: _______ Separated: ____Divorced: ________ Widowed: _______

If applicable:

Spouse/partner name and age: ____

Children('s) name /ages: ____

____

Occupation: ____

Employer: ____

What is your ethnic/cultural/religious background? ____

Who currently lives in your household? ____

____

Have you ever served in the military? Y N

Dates of service: ________________________________ Combat veteran? Y N

Branch: ____ Rank: ________________________________

Referred by: ____

Please describe the challenges or symptoms for which you are seeking services: __________________________

____

What issue/specific concern is the most important to address in therapy? _______________________________

____

What significant life changes or stressful events have you experienced recently? __________________________

____

What goals would you like to work toward in therapy? ____

____

Have you ever had therapy? Y N

Therapist's name and approximate length of treatment: ____

____

Are you currently seeing a psychiatrist? Y N

Psychiatrist name: ____

Are you currently taking medication for any reason? Y N
Please list medications and reason you are taking them (eg: Lexapro for depression): _______________________

____

When was your last medical exam? ____

Do you have any chronic illnesses? If yes, please list: ____

____

Do you have trouble sleeping? (check all that apply):

______No
______Yes, can't fall asleep
______Yes, can't stay asleep
______Yes, wake up too early
______Yes, sleep too much/trouble waking
______Yes, always sleepy/tired
______Other, please explain

Have you lost or gained weight in the past year? ______ lost ______ gained ______ lbs

Have you had any of the following experiences?	Before your 18th birthday	As an adult
parents divorced or separated		
grandparent died		
parent died		
sibling died		
other close person died		
moved more than once		
parent or daily caregiver was depressed		
parent or caregiver was heavily using alcohol/drugs		
confusing or unwanted sexual experience		
harsh physical discipline or physical abuse		
verbal or emotional abuse		
bullying		
parent served active duty/deployed away from home		
sibling with chronic illness or special needs		
poverty		
neighborhood violence		
severe conflict between parents or between parent and his/her partner		
failed or repeated a grade in school		

In the past 60 days, have you…?	**Yes**	**No**
smoked cigarettes		
used marijuana		
used alcohol		
used street drugs		
used prescription pain medicine		

What other information might you like me to know about why you are seeking therapy? ________________________

____

Dr. Laurie Patlin Suttenberg, DSW, LCSW-QS, DCSW

INFORMED CONSENT FOR TREATMENT

My choice to engage in treatment is voluntary, and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative process and effort between my therapist and me, I will work with my therapist in a collaborative manner to resolve my challenges for which I am seeking support.

I understand that during the course of my treatment I may discuss matters that are emotionally challenging, which might be a necessary part of the process.

I understand that records and information collected about me will be held or released in accordance with state and federal laws regarding confidentiality. I am aware and recognize that written, telephone, or personal inquiries about me will not be acknowledged by my therapist without my written consent. I must sign an authorization before any information is disclosed to anyone.

I understand that confidentiality cannot be maintained when:

1. A child or vulnerable adult is being neglected, exploited or physically or sexually abused.
2. Client is in danger of hurting self or others.
3. Court ordered or for a subpoena unopposed by client.

I understand I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken.

Social Media Policy:
I understand that social media is used to deliver services in this practice. Social media includes online communications to seek and share information, provide professional services, and send and receive information. Examples include emails and texting. I understand that social media may not protect my privacy and is considered public communication. The use of social media to provide services is only done with my approval.

Search Engines: Search engines are not used to seek information about me. A rare exception would be during a crisis when my therapist has reason to suspect that I may be in danger to myself or others and my therapist has exhausted other resources. Should this ever occur, this will be documented in my clinical record and discussed with me at my next session.

Texting: I understand that my therapist does not respond to mobile phone text messages (SMS).

Emails: I understand that my therapist does accept and respond to emails. I am aware that email communication may not be secure nor confidential. I understand that if an emergency occurs, I may email after following the emergency protocol listed below. I understand that emails received from me and sent to me by my therapist become a part of my clinical record.

Location-Based Services: There are privacy concerns related to location-based services on a mobile phone. I understand that if I have GPS tracking or a location-based device on my mobile phone, it may compromise my privacy and provide a clue that I am a therapy patient due to my regular check-ins.

Emergencies:
In the event of any emergencies, such as harm to self or others, clients are directed to the nearest emergency room and/or call 911 for help.

I understand that I am responsible for all fees related to my treatment. I agree to pay $_______ at each session that I attend with Dr. Suttenberg.

I have read and understand the above. My signature below indicates that I give my full and informed consent to receive services.

____ ____________________

Client/Legal Guardian Signature Printed Name Date

Dr. Laurie Patlin Suttenberg, DSW, LCSW-QS, DCSW

Teletherapy Sessions Consent Form

I, ____, would like to participate in psychotherapy sessions via video call service with Dr. Laurie Patlin Suttenberg, DSW, LCSW-QS (FL & NJ), DCSW.

I am aware that Dr. Suttenberg has worked to maximize all aspects of confidentiality with regard to my Teletherapy. I agree that my therapist, Dr. Laurie Patlin Suttenberg, should not be held responsible in the event that any outside party passes the internet security and discovers personal or confidential information.

I understand that if I am experiencing an emergency, seriously considering harming myself (suicide), or considering harming someone else that I should immediately go to a mental health hospital or facility, call 911 for help, or call 211 for a national help line.

I understand that although I may desire therapy sessions via Teletherapy, they may not be appropriate for my treatment and must be agreed upon between my therapist and myself.

Client Printed Name: ____

Client/Guardian Signature: ____

Date:____________________

Teletherapy Services Agreement and Informed Consent

As a client using Teletherapy services, you agree to the following:

1. Your Teletherapy sessions are confidential. Any personal information you choose to share with your therapist will be held in the strictest confidence the same as if you were seen in an office. Information will not be released to anyone without your prior approval, or when required to do so by law. Therapists are required to notify authorities if we suspect a client is about to physically harm someone; or if they are abusing, or about to abuse, children, the elderly, or the disabled.

2. Dr. Suttenberg uses HIPAA-compliant Zoom to conduct Teletherapy sessions. There is no need to download software or create an account. Just use a browser on a computer or device (tablet or smartphone) with a camera and microphone. Before the first session, Dr. Suttenberg will send you an invite with a "Join Zoom Meeting" link so you may join your private Teletherapy session. If you are unable to connect or are disconnected during a session due to a technical breakdown, please try to reconnect. If reconnection is not possible, please call Dr. Suttenberg to schedule a new session time.

3. Teletherapy services are not an appropriate treatment modality for everyone and remote treatment via video-chat methods should not continue if counter-productive. Should your therapist believe this treatment modality is not in your best interest, your therapist will explain this to you and suggest alternative options better suited to your needs.

4. You are responsible for information security on your computer. If you decide to keep copies of our e-mails or communication on your computer, it is your responsibility to keep that information secure. It is possible, although unlikely, to intercept e-mails or other forms of information in transit. If you are concerned about that possibility, please consider the option to encrypt our e-mails. Even if someone were to intercept an encrypted e-mail, they would not be able to read the encoded message.

5. The cancellation policy for Teletherapy services is outlined under "CANCELLATION POLICY AND AUTHORIZATION FOR CREDIT CARD USE". You will be billed at your full fee rate if you miss an appointment without providing at least 24 hours notice.

6. Payment Information. Payment for Teletherapy sessions is to be made via Zelle or credit card at the beginning of each session.

Client Printed Name: ____

Client/Guardian Signature: ____

Date:____________________

Dr. Laurie Patlin Suttenberg, DSW, LCSW-QS, DCSW

CANCELLATION POLICY AND AUTHORIZATION FOR CREDIT CARD USE

Your Teletherapy session time is reserved for you. Should you need to cancel, please give Dr. Suttenberg at least 24 hours notice; she is rarely able to fill a cancelled session unless she has at least 24 hours in advance. If you are unable to provide at least 24 hours notice when you cancel, your credit card on file will be charged the full fee for your Teletherapy session.

_______________________________________ _______________________

Client/Legal Guardian Signature Date

____

Printed Name

Please provide the following credit card information, which will be charged **only** in the event that a 24-hour notice is not provided.

Name on card: _______________________________________

Credit card type: _____ Visa _____ MasterCard ____ Discover _____ AmEx

Credit card number: _______________________________________

Expiration date: _______________________________________

Card security number: ________

Billing address Zip code: ________

I authorize Dr. Laurie Patlin Suttenberg to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

_______________________________________ _______________________

Cardholder Signature Date

____

Printed Name

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HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA)
CLIENT RIGHTS & THERAPIST DUTIES

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a client and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-client privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a client files a complaint or lawsuit against me,I may disclose relevant information regarding that client in order to defend myself.
4. If a client files a worker’s compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the client's employer, the insurance carrier or an authorized qualified rehabilitation provider.

I may disclose the minimum necessary health information to my business associates that perform functions on my behalf or provide me with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed using or disclosing any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a client's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the appropriate state authorities. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the appropriate state authorities. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the client, to other individuals, or to society, I am required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the client.

CLIENT RIGHTS AND THERAPIST DUTIES
Use and Disclosure of Protected Health Information:

For Treatment - I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of my practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.

For Payment - I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
For Operations - I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Client's Rights:

Right to Confidentiality - You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
Right to Amend - If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
Right to a copy of this notice - If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
Right to an Accounting -You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
Right to choose someone to act for you - If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
Right to Choose - You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
Right to Terminate -You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
Right to Release Information with Written Consent - With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of New Jersey Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

____ _____________________
Client/Legal Guardian Signature Date

____
Printed Name

____ _____________________
Dr. Laurie Patlin Suttenberg Date

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AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Dr. Laurie Patlin Suttenberg to other individuals or agencies. Such requests should be referred to the original individual or agency.

I ____ authorize Dr. Laurie Patlin Suttenberg to: release to_____, obtain from _____,

____
(name of agency/individual)

the following information pertaining to myself:

_____ Treatment summary
_____ Diagnosis
_____ Psychiatric evaluation/medication history
_____ Other (specify) _______________________________
_____ History/intake
_____ Psychological test results
_____ Dates of treatment attendance

for the purpose of:
_____ Evaluation/assessment and/or coordinating treatment efforts

_____ Other (specify) _______________________________

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event:__________________________________.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

____ ____________________
Client/Legal Guardian Signature Date

____
Printed Name

____ ____________________
Dr. Laurie Patlin Suttenberg Date