(615) 964-7113
hopeinhealinginc@gmail.com

NICK GOWEN, LPC-MHSP (TEMP)
in affiliation with HOPE IN HEALING, INC.

607 W. DUE WEST AVE.
MADISON, TN 37115

INTAKE INFORMATION

Client _____ **Birth Date** _____ **Phone** _____

Address _____

Gender _____ **Preferred Pronouns** _____

E-mail _____

If the client is a **dependent/minor**, please provide the address and phone information of the client's parent/guardian:

_____

Name **Address** **Phone**

GENERAL MENTAL HEALTH INFORMATION

What brings you to counseling?

_____

How long have you been experiencing this issue?

_____

What would you like to get out of counseling?

_____

Have you received mental health services in the past? If yes, whom did you see and when?

_____

Are you currently taking any prescribed medications for mental health? If so, please list them below.

_____

Would you or someone you know say that you are having a problem with alcohol or illegal drugs? If yes, please provide a brief summary below.

_____

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STATEMENT OF INFORMED CONSENT

Psychotherapy Treatment _____ (initials)
I (client[s] name) _____ agree and give consent for psychotherapy and treatment by Nick Gowen, LPC-MHSP (temp.), in affiliation with Hope In Healing, Inc. I understand that there are certain risks involved, such as being willing to disclose personal information and be open and honest with the counselor. I understand that I have entered this therapeutic relationship voluntarily and may terminate treatment at any time. However, there may be risks involved in terminating treatment early. The scope and nature of this treatment has been explained to me, and I understand that there are no guarantees for treatment outcomes. I agree to hold harmless and indemnify the counselor and/or his staff from any damages, suits, claims, or liabilities arising from this therapeutic relationship.

Confidentiality _____ (initials)
I understand that confidentiality will always be maintained within the legal requirements of the State of Tennessee and ethical guidelines according to the American Counseling Association Code of Ethics. I understand that confidentiality will NOT be maintained if I threaten or give reason to believe that I will harm myself or others, if a court orders the counselor to provide documents, or if child or elder abuse is suspected. Client(s) involved in couples or family therapy are encouraged to maintain a “no secrets” policy and address issues openly and honestly during the sessions. I understand that Hope In Healing, Inc., cannot guarantee that other clients will abide by confidentiality expectations.

Privacy of Information (HIPAA) _____ (initials)
I have been given a copy of the Health Insurance Portability and Accountability Act (HIPAA) Patient Notification of Privacy Rights, which describes how client records and information are handled.

Credentials and Supervision _____ (initials)
The counselor is licensed by the State of Tennessee as a Licensed Professional Counselor-Mental Health Service Provider (temp.) and is under clinical supervision. I understand that the counselor will participate in clinical supervision, and cases will be discussed anonymously with other counselor professionals solely for the purpose of gaining additional perspective, input, and treatment.

Appointments _____ (initials)
The length of sessions is 50 minutes. Clients should arrive on time for scheduled appointments. If the client is late for the session, then the session time will be cut short based on the allotted time for the session. If the client is more than 15 minutes late for a scheduled appointment, then the appointment will be considered as a “no show” and will need to be rescheduled. “No shows” for appointments are subject to a fee according to the PAYMENT, NO-SHOW, AND LATE CANCELLATION POLICY. Cancellation need to be made 24 hours prior to schedule appointments, except in the case of emergencies. Cancellations made within 24 hours are subject to a fee according to the PAYMENT, NO-SHOW, AND LATE CANCELLATION POLICY.

DISCRIMINATION AND GRIEVANCE POLICY

Our office does not discriminate based on sex; gender; sexual orientation; race or ethnicity; national origin; age; economic, marital, veteran or HIV/AIDS status; disability; religion; or political beliefs.

We hope that you will discuss any dissatisfaction with the counselor's services with the counselor. All staff are committed to trying to resolve your concerns. Any staff member can tell you how to file a grievance and provide contact information for Tennessee's counselor licensure board.

OFFICE POLICIES

Clients are expected to treat Hope In Healing, Inc. staff and counselors with respect and dignity. Failure to do so may result in the termination of the client-counselor relationship. Hope In Healing, Inc. does not have the capacity to provide childcare. We do not allow children in sessions unless they are a client in the session. Children may not be left unattended in the office.

EMERGENCIES AND URGENT NEEDS

Nick Gowen, LPC-MHSP (temp.), in affiliation with Hope in Healing, Inc., does not provide 24-hour or emergency mental health services. Should you or someone close to you require such services, contact 911 for emergency assistance OR the Tennessee Statewide Crisis Line at (855) 274-7471.

An emergency contact is required to offer counseling services. This contact will only be used if we believe you or someone else is in immediate danger or if you become ill and unable to continue or depart therapy without assistance.

_____

Emergency Contact **Relationship to Client**

_____

Address **Phone Number**

PAYMENT, NO-SHOW, AND LATE CANCELLATION POLICY

1. I understand that **I am financially responsible** to Hope In Healing, Inc. for all charges incurred for services rendered. **I agree to pay the fee of $80 (first session) and $65 (recurring sessions) prior to attending scheduled sessions** using the following payment method:
   Credit/Debit ___ Check ___ Cash ___

2. I understand that I will be charged **a late cancellation fee of $25.00** if I fail to give at least a **24-hour cancellation notice** prior to my appointment. I understand that I will be charged a **no-show fee of $60.00** if I fail to show for my appointment.

INFORMED CONSENT ACKNOWLEDGMENT

I have read, understand, and agree to the Statement of Informed Consent.

Client Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

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INFORMED CONSENT ADDENDUM FOR VIDEO SESSIONS

Nick Gowen, LPC-MHSP (temp.), in affiliation with Hope in Healing, Inc., may offer video chat psychotherapy sessions under certain circumstances. The counselor does NOT provide psychotherapy services over text or email.

CONFIDENTIALITY ISSUES

No method of technological communication can completely guarantee confidentiality. With any technology, there is always a small risk of outside interference (e.g., “hacking") and therefore loss of confidentiality. However, the counselor has taken efforts to provide confidentiality by using a HIPAA-compliant psychotherapy system. The counselor does not record sessions, and the client is asked to do the same.

You are encouraged to use a private wireless connection during your session and have updated virus protection on your device.

At the time of your video session, please be in a quiet place where you will not be distracted or interrupted and your session will not be overheard. Consider using another device to play white noise for increased privacy.

Smart device technology such as Siri, Google Now, and Alexa that are physically close to you during a session may be listening to your session, thereby violating confidentiality. It is recommended that smart devices are unplugged or turned off before your session.

BENEFITS AND RISKS OF VIDEO SESSIONS

Video sessions may allow the counselor and client to meet at times when in-person meetings are not practical. However, there may be less nonverbal communication than during in-person meetings. There is also the risk of disconnected or interrupted services. The session will be resumed unless technology issues prevent the session from continuing.

INFORMED CONSENT ADDENDUM ACKNOWLEDGMENT

I have read, understand, and agree to the Informed Consent Addendum for Video Sessions. I consent to using video chat for psychotherapy and understand that I can withdraw my consent at any time.

Client Signature: _____ Date: _____

Counselor Signature: _____ Date: _____