

# ISI Therapeutic Family Services, LLC

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## INTAKE PACKET

### ***DECLARATION OF PRACTICE AND PROCEDURES***

I am grateful to have the opportunity to offer services to you and hope this form will assist your decision in pursuing counseling.

***Qualifications.*** I hold a Masters degree in Marriage and Family Counseling (MA) from New Orleans Baptist Theological Seminary. I hold license #LMFT259 as a Licensed Marriage & Family Therapist in the State of Alabama. I am a Clinical Member of the American Association of Christian Counselors. I have served as Minister to Students at Union Grove Baptist Church located in Opelika, AL, East Tallassee Baptist Church, Tallassee, AL, and Fowler's Spring Baptist Church in Blountsville, AL. I have further served as Minister to Families at Union Grove Baptist Church. I am currently on Sabbatical from church-employed services. Clinical experience includes individual counseling, couples counseling, family counseling, including adolescent and children's issues. During this time I directed the Lee County CHINS Intervention Program specifically targeting truant, runaway and ungovernable youth. I also facilitate both personal growth and grief/support groups in both pastoral and hospice settings. Current areas of clinical focus include post-divorce adjustment, custody evaluation, grief/loss and anger management/impulse control. I have worked closely with Dr. Daniel Mejer, M.D., Child Psychiatrist and Dr. Rohini Reddy, M.D., Adult Psychiatrists within a collaborative structure to provide the highest level and standard of care to each patient.

***Areas of Expertise.*** I provide therapy for individuals, couples, families and groups dealing with a wide range of therapeutic issues. My training and experience provide me with abilities to assist with concern areas including family issues, marital difficulties, depression and anxiety, grief and loss, stress, behavior problems in children and adolescents, post-traumatic stress, pre-marital and divorce issues, and spiritual/religious matters. In dealing with grief and loss, I have participated in and facilitated Hospice support groups. I have lead and co-facilitated adolescent groups. I have facilitated Parent skill training groups. I am not a medical physician and cannot prescribe or provide any medication. If medical treatment is indicated, the client will be encouraged to seek such attention. I will work closely with a psychiatrist or other physician if medication is warranted.

***The Counseling Relationship.*** Each person who seeks counseling comes with unique experiences and concerns. The relationship of counselor to counselee will be characterized by professional dignity, expertise, warmth, and acceptance. Therapy is a learning process and a process of change that seeks for the persons involved to better understand themselves and others as well as the interactions that occur between the participants and significant others. Equally important is to achieve enhanced functioning as an individual, couple, or family so that healthy interactions are established and greater satisfaction is attained. My therapeutic approach is eclectic, depending on the type of problem being addressed. While I am systemic in nature, I gravitate toward cognitive-behavioral therapy, solution-focused brief therapy,

family systems, and structural family therapy. My approach is straightforward and based upon the counselee's goals. Techniques may involve visualizations and/or material drawn from spiritual disciplines. In addition, the holistic nature of my views concerning mental health recognizes a person's spirituality as a vital component and the central organizing principle around which lasting mental health and strong relationships may be achieved. Initially in the therapeutic process, we will explore the background of focal issues. Although it may be a painful process at times, success is dependent on client honesty. My hope early in therapy is to instill trust within the client/therapist relationship. Once this foundation has been adequately established, we will develop specific goals and a plan by which these goals will be achieved. We will jointly assess objective achievement on a regular basis to determine if significant change in the treatment plan needs to be made. Termination of therapy will result when the client and therapist agree the goals have been achieved, at the client's request, or when another therapist might better meet the needs of the client.

***Client Responsibilities.*** Your commitment to the counseling process indicates that you agree to make a good faith effort at personal growth and to engage in the counseling process as an important priority at this time in your life. You agree to complete assignments given or discuss any reasons for resistance. Your welfare is most important in professional counseling. As a result of Alabama State Law regarding Licensed Marriage and Family Therapists, Section 34-17A-22 (If both parties to a marriage have obtained marriage and family therapy by a licensed marriage and family therapist, the therapist shall not be competent to testify in an alimony or divorce action concerning information acquired in the course of the therapeutic relationship. This section does not apply to custody actions.) Due to the inherent conflict of interests on the part of the therapist who is working with a couple, an individual seeking help in resolving relationship problems with a spouse also ***agrees to restrain from subpoenaing this therapist for testimony in the event that court proceedings develop at a later date. If this therapist is subpoenaed, the fee for testimony is \$400 .00 the moment the therapist arrives at location of trial. The fee is NOT waived if case is continued, cancelled, or delayed in anyway. Payment for testimony is expected prior to trial.*** Clients coming from another therapist must first terminate with the previous therapist. Clients must make their own decisions regarding such things as deciding to marry, separate, divorce, reconcile and how to set up custody and visitation. That is, I will help you think through the possibilities and consequences of decisions, but my Code of Ethics does not allow me to advise you to make a specific decision.

***Physical Health.*** Physical health can be an important factor in the emotional well-being of an individual. If you have not had a physical examination in the last year, it is recommended that you do so. Also, please provide me with a list of current medication your taking.

***Potential Counseling Risks.*** In Counseling there is the potential that personal discoveries will result in emotional discomforts such as anxiety, sadness, or anger. Although this is a natural reaction, these discoveries may also lead to difficult changes in interpersonal relationships. Please do not hesitate to discuss your concerns related to counseling risks.

***Fees and Length of Therapy.*** A detailed explanation of the fee scale is included on the fee schedule. Pay special attention to information regarding client payment, insurance payment, and appointments. According to the annual gross income of \_\_\_\_\_, the client agrees to pay \_\_\_\_\_ (according to the sliding fee scale on the fee schedule) for each 45-60 minute session.

Appointments are usually scheduled one time a week for 45-60 minutes. The entire therapy process may take on the average of ten to twelve sessions. New appointments are typically set at the close of each session. I have afternoon, and evening appointments available Monday through Friday.

***Code of Conduct.*** I am required by state law and my own personal convictions to adhere to the Alabama Code of Conduct for Licensed Marriage and Family Therapists. A copy of these codes is located at the following website: [www.alamft.org](http://www.alamft.org).

***Confidentiality.*** All of our sessions will remain strictly and absolutely confidential except for the following circumstances in accordance with state law: (1) The Client signs a written release of information indicating informed consent to such release. Verbal authorization will not be sufficient except in emergency situations; (2) The client expresses serious or life threatening intent to harm himself/herself or someone else; (3) there is evidence or reasonable suspicion of abuse/neglect against a minor child, elder person (65 or older), or disabled person; or (4) a court order is received directing the disclosure of information. Certain types of litigation (such as child custody suits) may lead to the court-ordered release of information without your consent.

If you use third party insurers, such as health insurance policies, HMO or PPO plans, or EAP programs, you must sign a release of information and all information will be disclosed. In group therapy, therapist is not responsible for the actions of group members; however, all members are expected to keep all information absolutely confidential and will share no identifying information about any group member.

When working with couples, families, or groups, I cannot disclose any information outside of the treatment context without a written authorization from all individuals competent to sign such authorization. For example, I cannot release any information about either or both spouses I have seen for marital therapy to an attorney without signed authorizations from both spouses.

When working with a family or couple, information shared by individuals in sessions where other family members are not present must be held in confidence (except for the mandated exceptions already noted) unless all individuals involved sign written waivers at the outset of therapy. Clients may refuse to sign such a waiver but should be advised that maintaining confidentiality for individual sessions during couple or family therapy could impede or even prevent a positive outcome to therapy.

***Emergency Situations.*** Since I provide outpatient diagnostic and psychotherapy services only, I cannot guarantee around-the-clock availability. Phone calls made after hours will be handled by my voice mail system and returned the following day. Therefore, if you should experience an emotional or behavioral crisis, and I cannot be reached immediately by telephone, you can contact a local medical or psychiatric hospital or call 911. East Alabama Medical Center is located at 2000 Pepperell Parkway, Opelika, AL 36801.

**Professional Services Contract:** \_\_\_\_\_ (name of client) commissions Chad Smith, MA, LMFT for marriage and family therapy and/or psychotherapy. The named client understands that Chad Smith, MA, LMFT offers no guarantee of cure or length of therapy, but is obligated to maintain a reasonable standard of care for a LMFT. The client agrees to pay fees in full at the time of session and understands that failure to do so may result in the suspension of therapy until the balance is paid. We, the undersigned client and therapist, fully understand the terms of service outlined in this document and agree to honor them with full knowledge of all that they may entail.

Client's Signature: \_\_\_\_\_ Date:

Client's Signature: \_\_\_\_\_ Date:

Client's Signature: \_\_\_\_\_ Date:

Client's Signature: \_\_\_\_\_ Date:

Therapist's Signature: \_\_\_\_\_ Date:

**Parental authorization for minor client:**

I, \_\_\_\_\_, give permissions for \_\_\_\_\_

*Signature of Parent or Guardian*

*Therapist Name*

To conduct therapy with my \_\_\_\_\_, \_\_\_\_\_

*(Relationship)*

*Name of Minor*

***Please complete the entire packet prior to your first appointment.***

Client Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone numbers: Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Marital/Relationship Status: \_\_\_\_\_ Significant Other's Name: \_\_\_\_\_ how long: \_\_\_\_\_

***If Client is under 18, please complete the following section:***

Client's School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Parent/Legal Guardian's Name(s):

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

Custody Status/Relationship to Client: \_\_\_\_\_

Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone numbers: Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Marital/Relationship Status: \_\_\_\_\_ Significant Other's Name: \_\_\_\_\_

Please complete the following with regard to any children (including adult & stepchildren):

Name	Age	DOB	Gender	Location

Who else lives with you & what is their relationship? \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

Who referred you to Chad Smith, M.A., LMFT? \_\_\_\_\_

## **FEE SCHEDULE FOR SERVICES**

**The standard rate for services is \$125.00 per hour for therapy.**

Other fees that you may incur for services rendered by ISI Therapeutic Family Services, L.L.C. include, but are not limited to the following:

Letters drafted:	\$30 minimum
Phone calls with attorneys or other 3 <sup>rd</sup> parties:	<15 min - \$30 15-30 min \$60
Consultations including IEP's, attorneys, other counselors, etc:	\$60 per hour

Client Signature \_\_\_\_\_

It is the policy of ISI Therapeutic Family Services, L.L.C. to accommodate clients relative to income, whereas the standard fee of \$125.00 is prohibitive to self-paying clients, a discount may be considered based on gross household income.

To be completed at initial appointment

Qualifies for Discount Based on Income: Y or N

Discounted Fee per Session: \$ \_\_\_\_\_

Client Signature \_\_\_\_\_

Therapist Signature \_\_\_\_\_

## **INSURANCE**

**Please See Insurance Packet on website: [isitherapy.com](http://isitherapy.com)**

***Court fee schedule***

The fee for testimony and time missed with scheduled clients and contract work with other entities is stated below. Please read very carefully, as any outstanding balances are adjudicated through Lee county, or county whereas adjudication takes place, small claims court:

**Therapist presents to court at stated time per subpoena, fee is \$400.00.**

**This fee remains the same in cases where therapist is never called to testify, or case continues to next day.**

**\* Please inform your attorney that failure to notify therapist of any change of time or date will result in charge listed above.**

Please note carefully this fee schedule as it is non- negotiable.

By your signature below, you state your understanding of this fee schedule and agree to pay all costs incurred should this therapist be subpoenaed.

I understand the fee schedule and my signature is evidence of my agreement:

X\_\_\_\_\_ Client of ISI TFS, L.L.C.

X\_\_\_\_\_ Chad Smith, M.A., LMFT

Licensed Marriage and Family Therapist

Client Initials X \_\_\_\_\_

## ***Cancellation Policy***

Any cancellation made less than 24 hours will require a cancellation fee of \$60.00. This policy enables clients to obtain appointments on an as needed basis. Emergency circumstances will most certainly be considered.

We most certainly appreciate your kind understanding. Your signature below acknowledges your understanding and agreement with the policy.

X \_\_\_\_\_ Client of ISITFS, L.L.C.

Chad Smith M.A., LMFT

Licensed Marriage and Family Therapist

**Please either save the forms to your computer and email them to [isitherapy@gmail.com](mailto:isitherapy@gmail.com) & [sarahisitherapy@gmail.com](mailto:sarahisitherapy@gmail.com) or print the forms & bring them to your 1st appointment.**