



Welcome! Let me take a minute to provide you with some professional information about myself. I am a Licensed Marriage and Family Therapist in Nevada (#01435) and California (#94047). My Master of Science is in Marriage & Family Therapy from Vanguard University and my undergraduate degree is from New York University. I provide mental health counseling for individuals, families, couples, adolescents and children. Please complete the following forms as the information you provide will be helpful in determining the best course of action for your current needs.

**Client Information**

Name \_\_\_\_\_ Date \_\_\_\_\_

Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_ Referred By/Website \_\_\_\_\_

Highest Level of Education \_\_\_\_\_ Occupation \_\_\_\_\_ Sliding scale/Income \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Number \_\_\_\_\_ Relationship \_\_\_\_\_

**Second Party Information (Spouse, Parent, Legal Guardian, Etc.)**

Name \_\_\_\_\_ Date \_\_\_\_\_

Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_ Referred By/Website \_\_\_\_\_

Highest Level of Education \_\_\_\_\_ Occupation \_\_\_\_\_ Sliding scale/Income \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Number \_\_\_\_\_ Relationship \_\_\_\_\_

**Payment Information (Credit Card)**

Name as it appears on card \_\_\_\_\_ Zip code (billing address) \_\_\_\_\_

Credit Card number \_\_\_\_\_ Exp Date \_\_\_\_ / \_\_\_\_ Vcode \_\_\_\_\_

Your card will automatically be billed for each session & for cancellation fees (without 24-hour notice). Sign to accept:

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Background Information on Immediate Family Members** (use back of sheet if space is needed)

Name	Relationship	Age	Living In Home Y/N		

Have you had any treatment with a Neurofeedback coach, psychiatrist or therapist in the past?  Yes  No

If yes, name of psychiatrist/therapist/practitioner \_\_\_\_\_ Was it helpful?  Yes  No

Current Prescriptions/Medications \_\_\_\_\_

Religious Affiliation/Church \_\_\_\_\_ Do you want spiritual/religious issues to be a part of your therapy?  
 Yes  No

Briefly explain why you are seeking counseling \_\_\_\_\_

Please describe any complaints associated with the problem \_\_\_\_\_

When did the problem start? \_\_\_\_\_ How long do you think it will take to resolve the problem(s)? \_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_

Are you currently at risk of harming yourself or someone else?  Yes  No  Unsure

Have you attempted to harm yourself in the past? (Please list dates) \_\_\_\_\_

Following is a list of common obstacles that often lead people to seek counseling. Please check all that apply:

- |   |  |  |                                     |
|---|--|--|-------------------------------------|
| <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Communication     | <input type="checkbox"/> Self Esteem         | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Addiction            | <input type="checkbox"/> Grief             | <input type="checkbox"/> Eating Problems     | <input type="checkbox"/> Insomnia   |
| <input type="checkbox"/> Alcohol              | <input type="checkbox"/> Drugs             | <input type="checkbox"/> Weight              | <input type="checkbox"/> Stress     |
| <input type="checkbox"/> Smoking              | <input type="checkbox"/> Gambling          | <input type="checkbox"/> Work Problems       | <input type="checkbox"/> Shyness    |
| <input type="checkbox"/> Relationships        | <input type="checkbox"/> Sexuality         | <input type="checkbox"/> Panic Attacks       | <input type="checkbox"/> Guilt      |
| <input type="checkbox"/> Phobia (Please List) | <input type="checkbox"/> Abuse             | <input type="checkbox"/> Trauma              | <input type="checkbox"/> Anger      |
| <input type="checkbox"/> Suicide Attempts     | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Self-Harm (Cutting) | <input type="checkbox"/> Pain       |
| <input type="checkbox"/> Low Motivation       | <input type="checkbox"/> Sexual Problems   | <input type="checkbox"/> Social Withdrawal   | <input type="checkbox"/> School     |

Is there a family history of any of the following? Please list family member in space provided (grandparent, father, sister, etc.)

_____ Alcoholism	_____ Drug Use	_____ Depression	_____ Anxiety
_____ Suicide	_____ Attempted Suicide	_____ Medical Problems	_____ Psychosis
_____ OCD	_____ Eating Disorder	_____ Domestic Violence	_____ Abuse

In the past 2 weeks have you engaged in any of the following?

<input type="checkbox"/> Alcohol	Frequency _____	Your strengths _____
<input type="checkbox"/> Marijuana	Frequency _____	Your weakness _____
<input type="checkbox"/> Drugs	Frequency _____	Your pets & names _____
<input type="checkbox"/> Other _____	Frequency _____	Your hobbies _____

Explain how you cope with stress \_\_\_\_\_

What do you like to do with your free time? \_\_\_\_\_

Are you currently in a romantic relationship?  yes, for how long? \_\_\_\_\_

On a scale of 1-10, how would you rate your relationship?  List any areas you would like to improve: \_\_\_\_\_

What stressful life events have you experienced recently? \_\_\_\_\_

Is there anything else you feel is important for me to know about you? \_\_\_\_\_

**Client Rights**

1. You have the right to receive information concerning the methods of therapy employed, the techniques used, the duration of therapy and the fee structure for services provided. If services are not appropriate, referrals to other qualified professionals will be provided.
2. You have the right to refuse or terminate treatment at any time.
3. You have the right to seek a second opinion, if needed I can provide you with the names of other qualified professionals.
4. You have the right to know that in a professional psychotherapeutic relationship sexual intimacy between therapist and client is never appropriate.
5. Therapy is a professional relationship. It is extremely important that you and I both believe the relationship is the right fit in order to provide you with the greatest benefit possible. Because I value and appreciate your commitment to therapy, if at any time I believe you would more greatly benefit from seeking the services of another professional, I will inform you immediately and provide referrals.

\_\_\_\_\_ Initials

**Confidentiality**

The therapeutic relationship is confidential and protected by ethical standards of practice and Nevada statutes. Any information obtained in the therapeutic setting cannot be released without your prior written consent except in the following situations according to Nevada State Regulations:

- a. Cases of suspected child or elder abuse or neglect.
- b. Cases of potential harm to self or others or a need for immediate hospitalization – medical/mental health concerns
- c. Cases of legal claims or defense required by state or federal law or court ordered by a judge.
- d. Cases under investigation by a board of examiners as part of an investigation or hearing.
- e. If you are under the age of 18 in the State of Nevada, parents have access to information in regard to their child’s medical records.
- f. HWG’s clinical director and administration have access to information for administrative purposes.

It is my policy to maintain confidentiality throughout the therapeutic process; therefore, I will not acknowledge clients in a public area unless first approached by client.

\_\_\_\_\_ Initials

**Fees, Missed Appointments and Cancellation Policies**

All sessions are 50 minutes long. The charge per session is \$250 or a sliding scale fee of \$\_\_\_\_\_, which is due at the time of service. Fees for in-person sessions can be paid with cash, check or major debit/credit card. Fees for teletherapy can be paid with major debit/credit card. We value your time and ask you to value ours. For the initial session, a \$50 fee will be charged if cancellation is not given to Kana within 24-hours of the session start time. After the initial session, Kana allows one (1) free missed session per year without the 24-hour notice. Please give a 24-hour cancellation notice to avoid being charged a session fee for subsequent missed appointments. Returned checks will incur a \$30 fee per occurrence.

\_\_\_\_\_ Initials

**Emergencies**

*I understand that Kana Nootenboom is not a 24-hour crisis intervention provider. If I am faced with a mental health emergency, I agree to call 911 or go to my local emergency room.*

\_\_\_\_\_ Initials

**Insurance Billing**

I understand that Kana Nootenboom does not accept insurance. If you have PPO insurance a superbill (receipt) will be given at the end of the month which you can submit to your insurance for possible reimbursement or going towards your out of network deductible.

*I understand that I am responsible for contacting my insurance company for information about my insurance company.*

\_\_\_\_\_ Initials

**Security**

I understand that there are cameras facing the front and back doors to the center for surveillance for client and staff protection.

\_\_\_\_\_ Initials

**Documents and Letters**

I understand there is an hourly fee of \$75, with a minimum charge of one hour per request, for documents or letters that I require from my therapist. Your therapist requires 10 business days’ notice with a prepayment of fee. Prepayments are non-refundable and are valid for one (1) calendar year from date of payment.

\_\_\_\_\_ Initials

**Court Appearances**

I understand that my Therapist will not appear in court unless mandated by the court. If a therapist has to appear in court, they will be compensated for the court appearance, travel time, and preparation time which will be agreed upon ahead of time.

\_\_\_\_\_ Initials

**Teletherapy and/or Electronic Communications**

Though I do my best to protect your confidentiality of electronic messages, please note that I cannot guarantee confidentiality under circumstances that include use of Internet (Doxy.Me, VSee, Skype, Facetime, etc), cellular phone or text messages.

*I understand that using this medium of teletherapy is not entirely secure. I will not hold Healing with Grace Counseling Center nor my therapist responsible should there be a breach in security on the Internet or phone. I understand that I am responsible for information security on my computer.*

\_\_\_\_\_ Initials

*I understand if I am experiencing an emergency, suicidal or considering harming someone I should go immediately to a mental health hospital or call 911 for emergencies or 211 national help line. I understand teletherapy services are not appropriate treatment modality for everyone and should not continue if my therapist and I feel it is counter-productive. My therapist will suggest other options if needed. I understand that fees and cancellation policy is the same in teletherapy as in-person therapy. I authorize Kana Nootenboom to send email and or text messages regarding appointments.*

\_\_\_\_\_ Initials

***I have read and fully understand the nature and limits of the above statements and agree to participate in counseling under these conditions.***

Signature \_\_\_\_\_ Date \_\_\_\_\_



## **INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS**

This informed consent document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

### **DECISION TO MEET FACE-TO-FACE**

We have agreed to meet in-person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision as long as it is feasible and clinically appropriate.

### **RISKS OF OPTING FOR IN-PERSON SERVICES**

By coming to the office, you are assuming the risk of exposure to COVID-19 (or other public health risks). This risk may increase if you travel by public transportation, cab, or ridesharing services.

### **YOUR RESPONSIBILITY TO MINIMIZE EXPOSURE**

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, our families, other therapists/practitioners in the office and other clients) safe from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting/returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- I will only keep my in-person appointment if I am symptom free.
- I will take my temperature before coming to each appointment. If it is elevated (100 m Fahrenheit or more), or if I have other symptoms of COVID-19, I agree to cancel the appointment or proceed using telehealth. If I cancel for this reason, my therapist or practitioner will not charge me the normal cancellation fee.
- I will wait in my car or outside Healing with Grace Counseling Center until no earlier than 5 minutes before our appointment time, unless your therapist/practitioner instructs you otherwise.
- I will wash my hands or use alcohol-based hand sanitizer when I enter the lobby of Healing with Grace Counseling Center.
- I will adhere to safe distancing precautions that are set up in the lobby and therapy rooms. For example, I will not move the furniture from its current layout.
- I will keep a distance of 6 feet from others and there will be no physical contact (e.g. no shaking hands) with me or other people present in the office.

- I will try not to touch my face or eyes with my hands. If I do, I will immediately wash or sanitize my hands.
- If I bring my child, I will make sure that they follow all of these sanitation and distancing protocols.
- I will take preventative steps in-between appointments to minimize my exposure to COVID-19.
- If I have a job that exposes me to other people who are infected, I will immediately tell my therapist/practitioner.
- If I commute or partake in other responsibilities or activities that put myself in close contact with others (beyond my immediate family), I will let my therapist/practitioner know.
- If I travel out of the state of Nevada, I will let my therapist/practitioner know.
- If a resident in my home tests positive for COVID-19, I will immediately tell my therapist/practitioner and we will begin or resume treatment via telehealth.

By signing this document, you agree to the above precautions. Your therapist/practitioner and/or Healing with Grace Counseling Center may change the above precautions if additional local, state, federal orders or guidelines are published. If that happens, I will notify you of any changes.

#### **MY COMMITMENT TO MINIMIZE EXPOSURE**

Healing with Grace Counseling Center has taken steps to reduce the risk of spreading COVID-19 within the office. Please let me know if you have questions about these efforts.

#### **IF YOU OR I ARE SICK**

I am committed to keeping you, me, other therapists and practitioners in the office and all of our families safe from the spread of this virus. If you show up for an appointment and I, or other therapists/practitioners in the office believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I or other therapists/practitioners in the office test positive for COVID-19, I will notify you so that you can take appropriate precautions.

#### **YOUR CONFIDENTIALITY IN THE CASE OF INFECTION**

If you have tested positive for the COVID-19, we may be required to notify local health authorities that you have been in the office. We may also be required to notify local health authorities that you have been in the office if another person who has entered the office has tested positive. If we must report this, we will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. We will also inform you of our report.

Since there are multiple therapists and practitioners in the office, this information may be shared with the other therapists and practitioners to ensure their safety, the safety of their clients, and the safety of their families.

By initialing here, you agree with these limits to confidentiality for in-person sessions during Covid-19 Public Health Crisis: \_\_\_\_\_

**INFORMED CONSENT**

This agreement supplements the general informed consent that we agreed to at the start of our work together.

By signing below, you agree to all of the above conditions.

\_\_\_\_\_  
Written Name of Client

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date



### RELEASE OF LIABILITY FOR COUNSELING SERVICES

**FOR AND IN CONSIDERATION OF** the receipt of information and counseling services from Kana Nootenboom (name of therapist/practitioner) provided at ***Healing with Grace Counseling Center*** located at 2637 W. Horizon Ridge Suite 100, Henderson, NV 89052 (referred to as HWGCC hereafter), the undersigned, being legally competent and fully authorized and empowered to do so, **does hereby RELEASE, ACQUIT, AND FOREVER DISCHARGE HWGCC, ITS CLINICAL DIRECTOR AND ALL PARTICIPATING COUNSELORS AND INDEPENDENT CONTRACTORS CONNECTED WITH HWGCC,** from any and all actions, courses of action, claims, demands, injuries, damages, costs, loss of service, expenses and compensation, on account of any and all known and unknown contracting of coronavirus, COVID-19 and/or any other virus/diseases related to the aforementioned “coronavirus” to any person or property resulting from or arising out of or related to counseling services and administrative services provided by HWGCC, its clinical director and/or independent contractors in any way affecting the undersigned parties from this date forward. The undersigned understands that by choosing to meet in-person for therapy at HWGCC’s offices, when an alternative, free HIPAA compliant option for teletherapy has been offered to them, the undersigned understands that they are increasing their contact with others outside of their immediate household and increasing their risk of contracting COVID-19.

It is further understood and agreed that this waiver and release constitutes an admission and acknowledgment by this undersigned that they have received no warranty, guarantee, or promise that they are safe from contracting coronavirus and/or COVID-19 at HWGCC, the clinical director, its independent contractors or any other persons associated with HWGCC.

**This release contains the entire agreement between the parties hereto, and the terms of this waiver and release are contractual and not mere recital.** The undersigned further states they have carefully read the foregoing release, know the contents thereof, are fully competent, and sign the same as their own free act and deed.

\_\_\_\_\_  
Client’s full written name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client’s signature

\_\_\_\_\_  
Date