TRINITY RELATIONSHIP CENTER
Larry Baumgartner, Licensed Marriage & Family Therapist
7747 Mitchell Blvd. Ste. B., Trinity, FL 34655
727-946-1346 | www.TrinityRelationshipCenter.com

NEW CLIENT INTAKE FORM

Demographic Information

Name (print clearly): ____________________________ Today's Date: __________________

Date of birth: ______________________ Gender: _________________

Street Address:____
City, State, Zip Code: ____
Alright to send mail? Y N

Phone: ____
Alright to text? Y N Alright to leave message? Y N

Email: ____
Alright to send appointment reminders or other non-sensitive info? Y N

Highest level of Education: ____

Occupation: ____

How did you hear about the Trinity Relationship Center?

Psychology Today Referral Social Media

Google Search (which words?) _____________________ Other __________________

Getting To Know You

What do you believe are your 3 best traits/characteristics?
1.________________________ 2.________________________ 3.________________

What are the 3 biggest concerns you have right now? Write them in order:
1. ____
2. ____
3. ____

What solutions/techniques have you tried to help with your concerns?

Have you been to counseling/therapy before? If so, when, with whom and when?
Share reasons attended and if it was helpful or not.

If you are seeking marriage or couples therapy, how would you define your relationship?

Married-how many years?
OR
Dating-how many years?

Let's Talk About Change

What do you expect from therapy? What are your expectations of me?

Looking into the future, how will you know that our work and time together will be beneficial?
What are some concrete changes you will see?

Do you see anything getting in the way of your goals?

How long do you think therapy should last for you to achieve your goals? Share a target date or number of sessions.

Medical & Wellness Information

What do you do for wellness (healthy food, exercise, other)?

Are you currently under a Physician/Psychiatrist care? If so, for what reason(s)?

What is the name, address and phone number of your Primary Care Doctor?

May I contact them for coordination of care? Y N
Please sign and date for authorization of communication.

_______________________________________ _______________

Client Signature Date

Are you taking any medications?
List:

Intimate Relationships

If you are currently in a relationship, describe what it is like.

How would you describe your communication with your partner?

How would you describe intimacy in your relationship?

If you are in a relationship:
Like: ____
Dislike: ____
Not enough of: ____
Too much of: ____
Ideal relationship: ____

____ ____________________

Client Signature Date

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Informed Consent

LIMITS OF CONFIDENTIALITY:
Contents of all therapy sessions are considered confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian.

Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the healthcare professional is required to report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide/self-harm, the healthcare professional must make reasonable attempts to protect the client and legal authorities will also be notified.

Risk Assessment:

Current Suicide ideation, intent or plan?	Y	N
Current self-harming behaviors?	Y	N
Current homicidal ideation, intent or plan?	Y	N
Current uncontrolled anger or abusive behavior toward others?	Y	N
Current alcohol or substance abuse?	Y	N
Flashbacks, hallucinations, nightmares or sleep walking?	Y	N

Abuse of Children and Vulnerable Adults (Dependent Adults and Elderly)
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or that Therapist is told that a child (or vulnerable adult) is in danger of abuse, the healthcare professional is required to report this information to the appropriate social service and/or legal authorities.

CONTACT & EMERGENCY PROCEDURES: If you see Larry Baumgartner, LMFT in the community, he will not be the first to acknowledge you. If you acknowledge him, a wave or smile will try to be returned. If you need to contact him between sessions, please leave a voicemail at 727-946-1346. Your call will be returned as soon as possible. Larry checks his messages on a regular basis unless he is out of town. If it is an emergency, please indicate it clearly in your message. If you need to talk to someone right away in case of emergency, please dial 911.

Please do not e-mail Larry content related to your therapy sessions, as e-mail is not completely secure or confidential. If you choose to communicate by e-mail, be aware that all e-mails are retained in the logs of both (client and therapist) Internet service providers. You should also know any e-mails with therapeutic content received from you will become part of your legal

record. If you are comfortable, text or e-mail may be used to arrange or modify appointments. Please no texting or email outside of appointment modification.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay in full their therapy session amount at time of service. Larry accepts cash, check, all major credit cards and Health Savings/Flexible Spending Account cards. There is a minimal fee when using a card for payment. If client decides they would like a receipt from services to submit for insurance purposes, please let Larry know before you meet for your first session. Please be aware that submitting a receipt for reimbursement carries a certain amount of risk. Not all issues/conditions/problems are reimbursed by insurance companies. It is your responsibility to verify the specifics of your out of network benefits coverage.

THE PROCESS OF THERAPY: Participation in therapy can result in benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits; however, requires effort on your part. Psychotherapy requires active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. During therapy remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Larry may challenge some of your assumptions, perceptions or propose different ways of looking at, thinking about, or handling situations in which can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

RECORDKEEPING: Your records are maintained in a web-based system. What this means is your records are stored online in a secure, encrypted, HIPAA compliant system that is backed up to ensure records are not lost due to technical problems. This system provides certain benefits to a client including credit card payment, online scheduling, and automated text and/or e-mail reminders. As with any record keeping method, every foreseeable precaution has been taken to protect privacy, but there are no guarantees.

SOCIAL MEDIA POLICY: Larry does not accept personal ‘friend’, ‘follow’ or contact requests from current or former clients on any social networking site (Facebook, Instagram, LinkedIn, etc.). It may blur the boundaries of the therapeutic relationship.
Larry has many social media business pages through the Trinity Relationship Center. You may follow or like them at any time. Larry will not indicate that you are or were a client of his in replying to comments or questions on the Trinity Relationship Center social media pages.

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CANCELLED/NO-SHOW APPOINTMENTS:
Client understands that, except in the event of an extreme emergency, Larry will charge your credit card on file a fee of $50.00 (fifty dollars) for either not showing up or cancelling your appointment within 24 hours of your scheduled session. To avoid this fee, Larry will need to be notified via phone (text or call) or email more than 24 hours in advance of scheduled appointment.

Please print clearly information below.
Visa, Mastercard, Discover or American Express (circle which one using)

____
Name on Card

______________ ______________ ______________
Credit Card Number Expiration Date CVV Code

____
Signature approving a charge in event of above

Larry will notify you once the card has been charged. If you are here for marriage or couples counseling, only one of your cards will be charged.

I acknowledge reading the above information.

______________________ ______________________
Client Signature Today's Date

______________________ ______________________
Address City, State, Zip Code

______________________ ______________________
Phone Number Date of Birth

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Practice's Notice of Privacy Act

This notice describes how the medical information about you may be used, disclosed and how you can get access to it.

Please review it carefully.

As your professional therapist, I care about your privacy and strive to protect the confidentiality of your medical information in my practice. Federal legislation requires this notice of privacy practices. You have the right to have confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information.

Who Will Follow This Notice:

Any healthcare professional authorized to enter information into your medical records, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, sites and locations of this practice may share information with each other for treatment purposes of healthcare operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish this task will be shared.

How We May Use and Disclose Medical Information About You:

The following categories describe different ways that I may use and disclose medical information without your specific request or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category has been listed.

For treatment-we may use your medical information to provide you with medical treatment services. Example: in treating you for a specific condition we may need to know if you have other conditions that may affect your treatment.

For payment-we may use and disclose your medical information so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: we may need to send your protected health information such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For healthcare operations-we may use and disclose your medical information for healthcare operations to ensure that you receive quality care. Example: we may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Your Consent or Authorization:

As required during an investigation by law enforcement agencies
To avert a serious threat to public health or safety
As required by military command authorization for their medical records
To worker's compensation or similar programs for processing claims
In response to a legal proceeding

To a coroner or medical examiner for identification of body
If an inmate, to the correctional institution or a law enforcement official
As required by the Food and Drug Administration (FDA)

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and disclosures of Protected Health Information Requiring Written Authorization:

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosure we have already made with your permission and that we are required to maintain records of the care we have provided you.

Larry Baumgartner, Licensed Marriage & Family Therapist MT3602
Trinity Relationship Center, LLC

I HEREBY ACKNOWLEDGE THAT I HAVE REVIEWED THIS PRACTICE'S NOTICE OF PRIVACY ACT, MY CLIENT RIGHTS AND RESPONSIBILITIES AND CONSENT TO THERAPY.

______________________________ ______________
Client Signature Date

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Rights & Responsibilities

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies or third parties, and for health care operations such as quality reviews.

I have been informed that I may review this practice's Notice of Privacy Act before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at this practice.

I understand that I have a right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction(s), they must follow the restriction(s).

I also understand that I may revoke this consent at any time by making a request in writing, except for any information already used for disclosure.

____ ______________________
Client Signature Date

Emergency Contact

It is necessary for Larry Baumgartner, LMFT at Trinity Relationship Center to have someone to contact on your behalf in case of an emergency. Who should I contact?

Full Name: _______________________________________
Relationship: _________________________ Phone Number: ____________________

Please sign below to allow Larry Baumgartner, LMFT/Trinity Relationship Center, LLC to contact above person in case of an emergency.

____________________________________ ___________________________
Client Signature Date

Telehealth Informed Consent

I, ________________________________, consent to engaging in telehealth with Larry Baumgartner LMFT/Trinity Relationship Center, LLC as a part of the therapy process. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning and therapy. Telehealth will occur primarily through audio, video or telephone communications.

I understand I have the following rights with respect to telehealth:

1. I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefit to which I would otherwise be eligible.
2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentially including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth intersection to other entities shall not occur without my written consent.
3. I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Larry Baumgartner LMFT/Trinity Relationship Center LLC that the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.
   In addition, I understand that telehealth-based services and care may not be as complete as in-person services. I understand that if Larry believes that is the case, he will recommend those types of services moving forward. I also understand that there are potential risks and benefits associated with any form of mental health/relationship treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.
4. I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that Telehealth by SimplePractice is the technology service Larry will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in.
5. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
6. Though Larry and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare

services or advice including, but not limited to, emergency or urgent medical services.

7. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
8. I do not assume that Larry has access to any or all the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up to date.
9. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

I have read and have had the opportunity to ask questions.
That I fully understand its contents including the risks and benefits of telehealth.

____ ________________________
Client Signature Date

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Authorization For Release of Information

Provider Name: Larry Baumgartner, Licensed Marriage & Family Therapist of Trinity Relationship Center

I,____,

With date of birth of
____,

hereby give Larry Baumgartner, Licensed Marriage & Family Therapist the authority to release the below specified information and release the above name organization/individual from all legal liabilities that may arise from this situation.

____
Information to be released

____
Purpose of Disclosure

____
Person authorized to receive disclosure

____
Method of Disclosure

____
Today's date

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary, and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing. Consent for this organization/name shall expire in 1 year or unless noted by client.

____________________________________ _______________________
Client Signature Date

____________________________________ _______________________
Larry Baumgartner, LMFT Signature Date

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

This document contains important information about our decision (yours and mine) to start or resume in-person counseling services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you any questions. When you sign this document, it will be an official agreement between you and the Trinity Relationship Center, LLC/Licensed Marriage & Family Therapist Larry Baumgartner.

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, however, 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 or begin telehealth for everyone's well-bring.

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 appropriate.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk).

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, met, our families, and other patients) safer from exposure, sickness and possible death. If you do not adhere to safeguards, it may result in our starting/returning to a telehealth arrangement.

Initial each to indicate that you understand and agree to these actions:
____You will keep your in-person appointment if you are symptom free.
____If you have an elevated temperature of 100 degrees Fahrenheit or more, or other symptoms of the coronavirus, you agree to telehealth services.
____You will take steps between appointments to minimize your exposure to COVID-19.
____If you have a job that exposes you to other people who are infected, you will immediately let me know and we will then begin/resume telehealth services only.
____If a resident of your home tests positive for the infection, you will immediately let me know and we will then begin/resume telehealth services only.

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

If You or I Are Sick
You understand that I am committed to keeping you, me and all of our families safe from the spread of this virus. If you show up for an appointment and I believe that you have a fever or other symptoms, or believe you have been exposed, you will leave the office immediately and we can follow up with services by telehealth.

If I am sick, I will contact you before your appointment to schedule telehealth services.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I 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. By signing this form, you are agreeing that I may do so without an additional signed release.

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

Your signature below shows that you agreed to these terms and conditions.

____________________________________ _____________________
Client Date

____________________________________ _____________________
Larry Baumgartner, LMFT Date

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