Dr. Toni Warner-McIntyre, LCSW
(215) 437-3414
mail@authenticallymepsychotherapy.com
www.authenticallymepsychotherapy.com

ADOLESCENT INTAKE FORM
AUTHENTICALLY ME PSYCHOTHERAPY, LLC

(Please provide as much detail as possible, we will review this together during our first session)

Name: _____ **Today's Date:** _____

Age: ____ **Date of Birth:** _____ **Grade:** _____**Gender/Pronouns:** _____

Residential Address: _____

_____

Mailing Address (if different then residential address): _____

_____

Best E-mail: _____

Best Phone: _____

Emergency contact Name and Phone Number*(this would only be used in life threatening situations; providing this information does not give permission for private clinical information to be shared with this individual):*

_____

(Name) *(Phone Number)*

Parent/Guardian E-mail: _____
Okay to e-mail? Y N

Parent/Guardian Phone: _____
Okay to call? Y N Text? Y N Voice message? Y N

Permission for leaving messages for you/the client. Initial next to "Y" for Yes or "N" for No.
It's okay for Dr. Toni to contact me via:

Phone? Y_____ N_____ Leave A Voicemail? Y_____ N_____

E-mail? Y_____ N_____ Send a Text? Y_____ N_____

Sexual Orientation/ Who are you attracted to?_____

Current Relationship Status: _____

Partner(s): _____

*******ALL SIGNATURE PAGES NEED TO BE RETURNED PRIOR TO TREATMENT*******

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Please share any information you feel is important to share about your siblings/other kids/teens you may or may not currently live with (Ie. names, ages, disposition):

_____
_____
_____
_____
_____

What issue(s) brings you in today?

_____
_____
_____
_____
_____
_____

In the past 6 months, have you experienced any of the following (check off all applicable spaces):

_____ **Anxiety**
_____ **Crying spells**
_____**Depression**
_____**Hopelessness**
_____**Excessive Energy**
_____**Fatigue**
_____**Guilt**
_____**Hallucinations**
_____**Impulsivity**
_____**Irritability**
_____**Loss of interest**
_____**Panic attacks**
_____**Issues sleeping**
_____**Other. Describe:**

Share more information about above checked off areas here:

_____
_____
_____
_____

Are there certain persons, places or things you have been avoiding that are impacting your daily functioning? If yes, please explain _____
_____

Is there currently, or has there ever been, an important person in your life that regularly puts you down? If yes, please explain_____
_____

Previous therapy/treatment (please describe what type and if it was/wasn't helpful):

_____
_____

What has helped to manage the current issues?

_____
_____
_____
_____

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What makes the current issues worse?

_____
_____
_____
_____

What are your strengths and interests? _____
_____
_____

What makes you feel happy? _____
_____
_____

Are you sexually active? Y N **Does your parent/legal guardian know? Y N**

Religious/Spiritual Affiliation (also share if your religion/spiritual beliefs are different from your family's):

_____
_____
_____
_____

Any head, neck or jaw pain or head/neck injuries (*concussions, ear pain, TMJ, etc***.):**

_____
_____

Medical conditions (share if you're being treated for any):

_____
_____

Current Medications or Supplements (share if you are taking them regularly):

_____
_____

Medications in past: _____
*(reason for discontinuing):*_____

Any previous mental health diagnosis: _____
_____
_____

Do you often crave or dislike physical touch or body pressure? _____
_____
_____

Are there certain sounds, smells or textures that bother you or comfort you? _____
_____
_____

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Would you like me to be able to connect with other professionals, to more holistically support you? Communication would only be done with your knowledge and consent. Please identify which other professionals you'd like me to communicate with:

PCP: _____ ***#:*** _____

OBGYN: _____ ***#:*** _____

Dentist: _____ ***#:*** _____

School: _____ ***#:*** _____

Court/JPO: _____ ***#:*** _____

Lawyer: _____ ***#:*** _____

Therapist: _____ ***#:*** _____

Psychiatrist: _____ ***#:*** _____

Specialist: _____ ***#:*** _____

Specialist: _____ ***#:*** _____

Other: _____ ***#:*** _____

Eating difficulties and/or eating habits: _____
_____

How often do you drink water? _____ **Caffeine?**_____ **Alcohol?** _____

Describe your physical movement routine? (i.e. sit at desk all day, work out weekly, daily walks)_____
_____

Describe your overall health: _____
_____
_____
_____

Sleeping difficulties and/or sleeping habits: _____
_____
_____

Sexuality-related challenges (i.e. heightened arousal, inability to engage sexually, fear of sexual engagement):
_____
_____
_____

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How would you describe your social life? What are your friendships like?

How would you describe what your experience is/has been like at school?

Are there any challenges at school that you'd like to share?

Describe what your relationships have been like with your current and/or past partners?

What is your relationship like with your parents/guardians/care givers?

Any family issues you want me to know about up front?

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Have you experienced neglect, abuse or trauma?

_____
_____
_____
_____
_____

How receptive are you to trying different tools and techniques for helping your presenting issues get better?

_____
_____
_____
_____

Are you engaging in any risk taking behaviors (i.e. stealing, putting self in dangerous situations on purpose):

_____
_____

Do you sometimes or often *(circle one)* **lose chunks of time** *(describe):* _____

_____

Do you sometimes or often *(circle one)* **dissociate or feel separate from body** (describe): _____

_____

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)
Please Circle yes or no.

		List Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____
Bipolar Disorder	yes / no	_____
Other	yes / no	_____

History of suicide attempt or ideation: _____

_____

Currently suicidal: _____

_____

******If you are actively struggling with wanting to kill yourself, please stop completing this form and immediately reach out to 9-1-1 or a trusted adult that can take you to a crisis center to receive the necessary acute care to become stabilized. Authentically Me Psychotherapy, LLC is not a crisis center and cannot provide acute care.******

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History of self-harm: _____

_____

Currently self-harming: _____

_____

If you answered yes to any suicide or self-harm questions, are you willing to commit to a goal of safety with and for yourself, during our time together, while we work on strengthening your ability to create and maintain relationships with yourself and others that feel safe, trusting and comforting?

YES or NO *(circle one)*

What are your primary goals in coming to therapy at this time? In other words, how would you know that treatment has been helpful for you? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How did you discover Me and Authentically Me Psychotherapy, LLC:

_____

Anything else you want to share before we start working together?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

YOU HAVE TAKEN A COURAGEOUS STEP BY CHOOSING THERAPY.
YOU ARE ALREADY ON YOUR WAY TO PROGRESS!

Please complete the following documents prior to the session. They are legally required in order for us to work together.

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PACKET OF REQUIRED INTAKE DOCUMENTS

Below are the documents required for clinicians in PA to provide to clients prior to providing services. We will also review these documents together during the initial session, so that any questions or concerns can be answered. After reviewing each document, sign the lines highlighted in yellow to indicate understanding and agreement. If you have any questions about any of these documents, don't hesitate to send an email to mail@authenticallymepsychotherapy.com to ask.

You can send your signed documents back to me via the SPRUCE app, which is HIPPA compliant. If you'd prefer to send them via email, you may do that but please know that it is not as secure. If you'd like to mail your documents in physically, you can mail them to:

Dr. Toni Warner 654 North West End Blvd #1025
Quakertown, PA 18951
United States

Be sure to keep a copy of these for your records.

By signing below I'm indicating that I have reviewed each document and I both understand and agree to the contents of each document provided:

HIPPA
Client Signature:_____
Date:_____
Parent/Guardian Signature:_____
Date:_____

Informed Consent
Client Signature:_____
Date:_____
Parent/Guardian Signature:_____
Date:_____

Telehealth Consent
Client Signature:_____
Date:_____
Parent/Guardian Signature:_____
Date:_____

Good Faith Estimate
Client Signature:_____
Date:_____
Parent/Guardian Signature:_____
Date:_____

For the initial session, there are signatures required on each document included in this packet, in addition to the signatures above.

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Notice of Privacy Rights & Responsibilities:
Health Insurance Portability Accountability Act (HIPAA)

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient 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 patient 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-patient 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 patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient 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 patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us 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 to use or disclose 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 patient'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 Pennsylvania Abuse Hotline. Once such a report is filed, I may be required to provide additional information.

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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 Pennsylvania Abuse Hotline. 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 patient, to other individuals, or to society, I may be 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 patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** I may use and disclose your health information internally (within Authentically Me Psychotherapy, LLC) in the course of your treatment. If I wish to provide information outside of our 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.

Patient's Rights:

- ***Right to Treatment –*** You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***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 sure you request well in advance; allow 30 days 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. I will make a determination of how to proceed and if I decide not to make the requested changes, 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.

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- ***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 copy as promptly as possible..

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 Pennsylvania 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 Printed Name (Required for Treatment) Date

_____ _____
Client Signature (Required for Treatment) Date

The below parent/guardian signatures are optional for clients aged 14 and older

_____ _____
Legal Guardian Printed Name Date

_____
Legal Guardian Signature

_____ _____
Printed Name Date

_____
Legal Guardian Signature

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Adolescent Informed Consent Form

Welcome to Authentically Me Psychotherapy, LLC. This document contains important information about my psychotherapy services, business policies, therapist expectations and client rights and expectations. Please read this carefully and jot down any questions you might have so that we can discuss them when we meet. When you sign this document, it will represent an agreement between us.

Therapy is a unique and individualized experience. My approach as a psychotherapist is tailored to meet your needs, build upon your strengths, and operate from my clinical skillset and framework. If ever there is a time when you are unhappy with the services you are receiving, it is of the utmost importance that you share this with me during session. We will need to discuss this challenge and assess whether it is part of the therapeutic process or if it indicates that our therapist-client fit is not optimal.

What can I expect?

The purpose of meeting with a psychotherapist is to get help with navigating life stressors that are making it difficult to lead a socially, emotionally, mentally and behaviorally well-functioning and fulfilling life on a regular basis. We will also learn how to manage barriers that are preventing you from achieving success in important areas of your life. As a teen, you may be here because of others who have expressed concern, such as a parent/care-giver or teacher, or you may be here because you realized yourself, that it would be helpful to speak with a psychotherapist. These are all valid reasons for meeting.

During our sessions we will talk about your strengths and the areas that are challenging for you. We will identify realistic treatment goals and we will work towards them together. I will bring my authentic self as a therapist and it is important that you bring your authentic self to therapy sessions as well. It is okay to feel uncomfortable; just be honest about how you feel so that we can work through everything together. Your thoughts and your feelings matter. Sometimes you will want to talk about things that you don't want your parents/guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

Risks & Benefits

Psychotherapy can have benefits and risks. Part of therapy includes getting in touch with your body sensations, your internal feelings, and your troubling thoughts. This means that there will be times that you may experience discomfort, sadness, guilt, or a variety of other feelings. Learning to move through these challenging feelings without being overcome by them, is often an integral part of therapeutic work. Psychotherapy has also been shown to have benefits for people who work through it. Depending on your social system, there may be people who express support for you participating in therapy, and there may be those who disapprove. The decision to engage in therapy is an incredibly personal one. Therapy can lead to more functional relational interactions, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees as to what you will experience.

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Crisis Protocol

Authentically Me Psychotherapy, LLC is not a crisis center. If there is an emergency, please call 9-1-1 or ask a responsible and trusted support person to take you to the nearest emergency room or call 9-1-1 on your behalf. If crises are a part of what has happened in your system both recently, and on an on-going basis, then we will create an individualized crisis response plan together as part of your treatment.

Therapist availability during a crisis can't be guaranteed. Any client is able to sign a release for their therapist to speak with another professional, in the event of a crisis, should the client want the therapist to collaborate with crisis staff at the hospital. If you contact me during a crisis and you refuse to contact 9-1-1 or notify a trusted adult who is able to help you immediately, I will be required to contact 9-1-1 and, if possible, a safe adult, in order to ensure to your safety.

Session Expectations

Payments, Late Cancellations & No Shows

If we mutually agree to work together, I will explain if and why I recommended either a 50-minute ($200) session, a 90 minute ($370 session), or a 2 hour session ($400) and how often. It is most commonly necessary to begin treatment at least once per week, and sessions can be tapered from there based on clinical assessment. For new clients, it is required that once per week sessions are held for at least the first month, to properly assess clinical necessity and treatment direction.

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide more than 24 hours advance notice of cancellation. Appointments canceled with 24 or less (including no shows) hour notice will be charged the full session fee. Extenuating circumstances will be discussed, as needed. Notice of cancellation prior to 24 hours before your scheduled session, may be sent via text or call to (215) 437-3414, or via e-mail to mail@authenticallymepsychotherapy.com

Inactivity

If you have not scheduled a session for 45 consecutive days, you will be considered an inactive client; new intake paperwork will have to be completed at your next session, should you choose to schedule again at a later date. A credit card is required to be on file for all clients. This card will be charged after each session, and will be used to cover you for any no shows or less than 24-hour, late cancellations.

Fees

Rates are as follows: 50-minute ($200) session, a 90 minute ($370 session), or a 2 hour session ($400). If we meet more than the usual time, an additional fee will be charged accordingly. If you are late to session, I can't guarantee availability for moving the session time back. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 15-20 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me.

Legal Matters

If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. There is a copying fee of $1.00 per page for records requests.

authentically me
PSYCHOTHERAPY, LLC

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A Virtual Therapy Practice
(215) 437-3414
mail@authenticallymepsychotherapy.com
www.authenticallymepsychotherapy.com

Payment Expectations

All session fees are due at the time of service and a credit card is required to be held on file, regardless of how you choose to regularly pay for sessions. Credit cards will only be charged at your request or upon a no show or late cancellation. Payment schedules for other professional services will be agreed to when such services are requested. In circumstances of unusual financial hardship, there are times when I am able to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 50 days and arrangements for payment have not been agreed upon, legal means may be used to secure the payment. I make every attempt to avoid legal matters unless and until they have been deemed necessary. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information released regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

Unpaid Sessions & Financial Issues

If two unpaid sessions are accumulated, another session will not be scheduled until the two unpaid sessions are either paid in full, or for extenuating circumstances, have been placed on a payment plan discussed with the therapist, and the first payment has been made. When finances prohibit treatment participation, I can provide you with the information of other qualified therapists who I believe may be a good fit for you, who are able to offer lower fee sessions. The payment plan account must be in good standing in order to continue with session scheduling. A credit card is required to be on file for all clients.

Sliding Scale, Payment Plans & Open Path

I offer a limited number of sliding scale spots in my practice, and generally only using the Open Path Collaborative. If you are struggling with a financial hardship, please speak with me so that we can discuss if a payment plan is able to be set up, or if a sliding scale is available. If a practical financial resolution is not able to be reached, I will provide you with a therapist in the area who I believe to be a good fit for your presenting issues who is able to provide services at a lower fee. I may also recommend you to Open Path, if you are interested. I can't guarantee that my sliding scale slots will be available at any given time, as they may already be filled by other clients in need. Sliding scale need will be assessed for every 6-12 months, to ensure need.

Confidentiality

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are a few times when I can't keep our conversations private, and it is important that this is made very clear. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality can't be maintained when:

>You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself. I will work with you so we can do this together, if this is at all possible.

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> You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and if at all possible, I must inform the person who you intend to harm. If the situation permits, I will work with you first, so we can communicate with your caregivers and any other required entity, together.

>You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed. I will always strive to work out a joint method of communication with others, if it is in your best interest and is at all possible.

>You tell me you are being abused-physically, sexually or emotionally-or that you have had undocumented abuse in the past. In this situation, I am required by law to report the abuse to Pennsylvania ChildLine.

>You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

<u>Online Communication</u>
Clinical consultation will not be provided electronically. No clinical treatment will be provided via email or any other internet-based application, unless a telehealth session has been scheduled and informed consent for telehealth has been discussed and signed. No correspondence with any former, current or potential clients will occur via any personal social media page of the therapist. Should a client choose to follow an organization- based social media page, the client agrees to maintain therapeutic boundaries that would otherwise expected to be maintained in any out of office interaction with the therapist.

<u>Interactions in Public Spaces</u>

In public, I will not acknowledge that I know you, unless you first acknowledge me. If you do acknowledge me in public, I will respond with a brief greeting and will not hold any detailed conversation nor discuss any personal information with you.

Should you choose to hold any outdoor therapy sessions, you agree to shift personal conversations to general discussion or to pause discussion entirely, if there is any awareness of anyone else in the public arena that could hear our conversation. I will do the same. We will review this protocol prior to going outdoors, as a reminder for both client and therapist.

<u>Communicating with parent(s)/guardian(s) for adolescents:</u>

I will not tell your parent/guardian specific things you share with me, as long as it is not listed in the above exception section. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and

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immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent/guardian. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing _____, would you tell their parents?"

There may be times when I encourage and support you in sharing important information with your parent/guardian yourself. The ultimate decision will be yours, but we will talk through these important conversations together, when needed. When I do meet with your parents/guardians, I may describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

If your parent/guardian is paying the session fee, I will communicate with them, as needed, about fees. A credit card is required to be kept on file for all clients.

Communicating with other adults:

School: I will not share any information with your school unless I have your permission and permission from your parent/guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. It may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, we will discuss it first.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

Open Communication: Allergies, Sensitives, Medical Issues, Etc.

A variety of interventions may be used throughout treatment. Some interventions require materials, like essential oils, vibration headphones, bilateral music/sounds, coloring, writing, fidgets, weighted object (like weighted blankets), etc. This is not an exhaustive list. It is your responsibility to inform me of any allergies, sensitivities, medical conditions, or other condition/situation that may cause these types of interventions to cause you an adverse reaction. You may choose not to use any intervention that I present to you.

SIGNATURE OF TEEN REQUIRED IN ORDER FOR TREATMENT TO TAKE PLACE.

Sign next page.

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Adolescent Informed Consent Form Signature Page

and Parent Agreement to Respect Privacy

Adolescent therapy client:

Signing below indicates that you have reviewed the policies described above and that you both agree to and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Signature of Teen _____
Date_____

Parent/Legal Guardian:

In the state of PA, teens 14 years of age and older must consent to treatment and can also refuse to share treatment information, as well as refuse participating in treatment. However, an important part of therapy for minors often is to include their support systems, as appropriate. Therefore, by checking below, you are supporting your teens growth and healing journey, giving them space and confidence to open up and build necessary trust and rapport within the therapeutic relationship.

_____ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

_____ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent/legal guardian Signature: _____
Date_____

Parent/legal guardian Signature: _____
Date_____

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Telehealth Consent

Authentically Me Psychotherapy has transitioned fully to telehealth services, with the exception of walk and talk therapy if and when clinically appropriate and feasible. Telehealth services have allowed for clinical support to become available to those who do not live within reasonable driving distance in PA, and has also served as helpful for clients during times of inclement weather, illness, last minute work or family changes, etc. We are honored to be able to provide this service and will continue to do our best to provide only the highest quality clinical support on HIPPA-compliant systems.

Ineligible Clients
Clients that are not or have not recently been safe with themselves (on-going or recent suicidal ideation, attempt or other related activity), are not able to receive telehealth services, for purposes of their own safety. By signing a telehealth consent, you are confirming that you do not have and have not recently had, any active suicidal intentions, attempts or on-going desire to act upon ideation of killing yourself.

1. I have requested and have chosen to engage in telehealth psychotherapy sessions or consultations with Dr. Toni.
2. I am aware that video conferencing technology will be used, and psychotherapy sessions/consultations will not be exactly the same as a direct, in-office, in-person psychotherapy session/consultation with Dr. Toni.
3. I understand there are potential risks to using technology for psychotherapy sessions, including interruptions, unauthorized access and technical difficulties. I agree to be in a private location, away from interruptions and out of hearing range from others, while I am participating in telehealth psychotherapy sessions/consultations.
4. I understand that I or Dr. Toni can choose to discontinue telehealth psychotherapy sessions/consultations if it is felt that the videoconferencing connections and/or conditions are not adequate for the situation.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. My personal health information will be confidentially maintained.
6. I have had the alternatives to a telehealth psychotherapy sessions/consultation explained to me.
7. I understand that the full fee of each session is charged at each session, and all of the rights and responsibilities presented within my informed consent and HIPPA documentation remain valid and intact with regard to payments, as well as every other rights and responsibilities section.
8. I have had the opportunity to ask questions about telehealth and am aware that I may continue to ask questions at any time, as they arise.

My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. I have read or had this form read and/or had this form explained to me; I fully understand its contents including the risks and benefits of the procedure(s); I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

By signing this form, I certify that: I have read or had this form read and/or had the Telehealth Form and Policy explained to me; I fully understand its contents including the risks and benefits of the procedure(s); I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

PATIENT SIGNATURE _____ **DATE** _____

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GOOD FAITH ESTIMATE DOCUMENT

As of January 2022, the No Surprises Act was put into place by the federal government for all healthcare providers to ensure clients do not receive “surprise billing.” Essentially, this is the law wanting to make sure that all clients are clear about what services are being charged for, why and how much, before they receive services rather than after.

To prevent “surprise billing” this new law states that providers need to give a Good Faith Estimate of cost for services rendered.

Since it is unethical to provide a specified amount of sessions upfront for the nature of clinical work provided at Authentically Me Psychotherapy (as there are too many variables that are unable to be accounted for in order to give specifics with good faith), a premeditated list of session amounts is not able to be created. Psychotherapy services can be clinically appropriate anywhere from months to years, and that can’t be predetermined. Furthermore, each client has a right to decide how long they would like to participate in mental health care, and could therefore start and/or stop services whenever they choose.

Therefore, attached you will find a fee schedule for the services typically offered and I’ll continue to collaborate with you on a regular basis to determine how many sessions are clinically appropriate. It is a Federal requirement that I have each client sign this form to begin/resume treatment. Please sign and date before your next appointment and return the signed document on or before your next appointment. If you have any questions, please don’t hesitate to ask.

Warmly,

Dr. Toni Warner-McIntyre, LCSW, MSW, MeD

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SURPRISE BILLING PROTECTION FORM

Authentically Me Psychotherapy is a private pay psychotherapy practice; this psychotherapy practice is not in network with any insurances and does not work with insurances directly in any capacity. All payments are due in full, upon receipt of service. To receive reimbursement for services rendered, clients must speak directly with their insurance provider.

Getting care from this provider or facility could cost you more than using an in network provider. To determine if psychotherapy services are covered by your insurance plan, you'll need to contact your health plan/insurance directly, for more information. If you do not have insurance, you may be entitled to other services with a different, potentially lower fee structure than what is offered at Authentically Me Psychotherapy, LLC with Dr. Toni Warner-McIntyre, LCSW, MSW, MED.

You are not required to sign this form if you do not understand or do not agree with any of its contents. You have the right to choose which clinical professional you want to work with, and you are not required to continue working with this practice if you want to choose to receive psychotherapy services elsewhere.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with another one. At Authentically Me Psychotherapy, monthly superbills can be provided to individuals who request to receive them. Furthermore, the payment processor used by this practice is set-up to provide you with receipts usable for reimbursement; this can be set-up for you upon your request and at no additional charge. You have the right to submit these receipts of paid services (aka "superbills") to your insurance, to see if they will directly reimburse you in accordance with your out-of-network plan.

Enclosed you will find the most up to date rate information for services rendered by Authentically Me Psychotherapy and by Dr. Toni Warner-McIntyre, LCSW, MSW, MED. All of the information contained here, was also discussed with you at the time of intake and is written within your Notice of Privacy Practices and Informed Consent documents (which were reviewed and signed prior to treatment).

It's recommended that you retain a copy of this document for your records.

By signing, I am indicating that I understand I might pay more for out-of-network care with this provider than with another one. I am freely choosing to work with Dr. Toni Warner-McIntyre, LCSW, MSW, MED. Furthermore, I understand that I am responsible for the full fee (unless otherwise indicated through a sliding scale written agreement), and will be billed in full for each session, at the time of session.

Breakdown of Fees and Total Cost Estimate below:

Dr. Toni Warner-McIntyre will discuss clinical assessment and recommendations for continued treatment throughout the course of services rendered. It is your ethical right to determine your goals for treatment and how long you would like to remain in therapy unless you are pursuing mandatory treatment.

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By signing below I indicate that I understand and agree to what is reviewed here in the Good Faith Estimate:

_____ _____
Client Printed Name (Required for Treatment) **Date**

_____
Client Signature (Required for Treatment)

_____ _____
Legal Guardian Printed Name **Date**

_____
Legal Guardian Signature

_____ _____
Printed Name Date

_____
Legal Guardian Signature

The amounts reflected in the graph on the following page are estimates; it isn't an offer or contract of services. This estimate shows the full estimated costs of items or services listed. It doesn't include any information about what your health plan may or may not reimburse you for directly.

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TOTAL ESTIMATE: Each session is billed per session at the above rate structure unless otherwise indicated due to financial hardship based upon express written and discussed information for specific individuals in financial duress/need. Frequency of sessions and length of treatment will be an on-going clinical discussion included as part of your treatment/services rendered.

Dates of Service	Service Code (CPT Code)	Service Description	Fee For Service, Billed Per Session	Sliding Scale
Per 50 minute session	90791	Initial Consultation	$200	*Full sliding scale fee*
Per 50 minute session	90834	Individual Psychotherapy	$200	*Full sliding scale fee*
Per 90 minute session	99354	Individual Psychotherapy	$370	*Full sliding scale fee X1.5*
Per 2 hr session	90837 99354	Individual Psychotherapy	$400	*Full sliding scale fee X2*
Per 15 minutes	90831	Telephone Consultation	$50	.25 of *Full sliding scale fee*
Requests for printed documents/Record Requests			$1 per printed page	$1 per printed page
Missed/late cancels appointment	Charged at the full rate, in accordance with the codes indicated above.			*Full sliding scale fee*
*Other Professional Services	Charged at % of full rate, billed in 15 min. increments in accordance with the codes indicated above.			*Same for all clients*

**Other professional services include report writing, telephone conversations lasting 15 minutes or longer, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service client may request of clinician.*

HAVE ADDITIONAL QUESTIONS?

For questions about your rights? Contact the Pennsylvania Secretary of State at 717-787-6458. For questions about this notice and estimate email mail@authenticallymepsychotherapy.com.

For insurance questions, call your health plan. Your plan may have better information about how much of these services are reimbursable. Prior authorization or other care management limitations: Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage. More information about your rights and protections: Visit https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprisebilling-providers-facilities-health.pdf for more information about your rights under federal law.