Andrews & Associates, Inc.
Clinical Intake and Informed Consent

Person One

Name					
Address	City	State	ZIP	Gender	Social Security Number
Home/Cell Phone	Business Phone	Date of Birth		Age	Education
Occupation	Place of Employment				
In case of emergency, contact (please give name, address, and telephone number)					
Marital Status ☐ Never Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Married/Dmstc.Part. (How long? _____)					
Medications					

Person Two

Name					
Address	City	State	ZIP	Gender	Social Security Number
Home/Cell Phone	Business Phone	Date of Birth		Age	Education
Occupation	Place of Employment				
In case of emergency, contact (please give name, address, and telephone number)					
Marital Status ☐ Never Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Married/Dmstc.Part. (How long? _____)					
Medications					

Immediate Family Members

Name	Age	Relationship	Grade/Occupation	Live at home?(Y/N)

Please continue on next page.

We want you to know as much as possible about your therapy and the policies and procedures involved in providing your treatment. Please take a few moments to read the following information, ask any questions that you may have, and sign at the end.

Referral Information

If you were referred by another professional (physician, clergy, therapist, etc.) please write their name and address here.

Name	May we have your permission to notify the referring professional that you have participated in your first session of therapy? ☐ Yes ☐ No
Address	
City, State ZIP	If you wish us to have additional contact with this professional, please complete a separate authorization.

Fees

Regular psychotherapy services are provided at fees based on the number of minutes in the session. The standard therapy "hour" is 45 minutes and our rate for this service (90834) is currently $125. A $30 discount ($95 resulting fee) for this service is available if you pay at the time of service. Other lengths of sessions have different fee and a different fee may apply to intake sessions. If you anticipate needing related services, such as extensive report writing or testimony in court, please ask for a list of fees for these special services. Fees are subject to change.

Therapy appointments not attended but not cancelled or rescheduled at least 24 hours in advance will be billed at the regular session rate.

Fees for services are due at the time the services are rendered, unless payment arrangements are made in advance. Unpaid balances on billed amounts are subject to a charge of 1.5% each month (18% each year). In certain cases billing will be made to your insurance company (upon your written authorization); however, the person responsible for payment for the services will still be responsible for amounts not paid by insurance. Unpaid accounts may be referred to an outside agency for collection and the "Responsible Party" will be responsible for reimbursing collection, attorney, and court costs.

Checks returned unpaid will incur an additional charge of $35 for each occurence.

By your signature on the last page, you acknowledge you have read this fee policy and agree to it.

Confidentiality

See our "Notice of Privacy Practices" for details (also available on our web site).

Data may be collected from you or about your treatment to be used for professional research purposes. The purpose of this research is to increase the quality of service you and other clients receive. Information from any one client would be combined with information from other clients; for example, the number of sessions received by clients seeking marital therapy. In all cases, information that could identify any specific client is never used in research.

Your therapist may have occasion to use case information as examples when writing or speaking about therapy or related topics in a public or educational setting. In most cases such examples are actually a compilation of the therapist's experience and not information about a specific case. In any event, information that could identify any client specifically is never used in this context.

By your signature on the last page you indicate that you have read this Confidentiality Policy and the accompanying Notice of Privacy Practices and that you agree to it.

Termination

Completing therapy is a decision best reached in consultation with your therapist. However, should you stop attending sessions without consulting with your therapist, we will, after 30 days past your last appointment or missed appointment (whichever is later) assume the issues you brought to treatment are resolved and we will close your file.

Please continue to the next page.

Informed Consent

"I understand that treatment at Andrews & Associates, Inc. will involve discussing relationship, emotional, behavioral, and/or cognitive issues that may at times be distressing. However, I understand that this process is intended to help me personally and with relationships. I also understand that I may leave therapy at any time, although I understand that this is best accomplished in consultation with my therapist."

Services Are Being Provided By:

- ☐ Emmett L. "Rusty" Andrews, PhD, a licensed clinical marriage and family therapist in Kansas whose clinical doctorate is in marriage and family therapy, not in medicine. *
- ☐ John Fajen, PhD, a licensed psychologist in Kansas whose clinical doctorate is in psychology, not in medicine. *
- ☐ Yvonne Amanor-Boadu, PhD, a licensed clinical marriage and family therapist in Kansas whose clinical doctorate is in marriage and family therapy, not in medicine.*
- ☐ Cory Richards, MS, a licensed marriage and family therapist in Kansas. †
- ☐ Kathryn Thompson, MSFT, a licensed clinical marriage and family therapist in Kansas.
- ☐ Jennifer Brown, MS, a licensed marriage and family therapist in Kansas. †
- ☐ Kristy Archuleta, PhD, a licensed marriage and family therapist in Kansas under the supervision of Nancy O'Conner, LCMFT, who can be reached at Campus Creek Complex, Kansas State University, Manhattan, KS 66506 (785) 532-6984. *
- ☐ Stephanie Wick, PhD, a licensed clinical marriage and family therapist in Kansas whose clinical doctorate is in marriage and family therapy, not in medicine.*

* While he/she does not prescribe medicine, if you so direct she/he will consult with your physician regarding medical issues. Kansas law may require this consultation, which you have a right to waive.

† Practicing under the supervision of Emmett L. "Rusty" Andrews, PhD, LCMFT, and Yvonne Boadu, PhD, LCMFT, who can be reached by contacting this office (1019 Poyntz Ave., Suite C, Manhattan, KS 66502 (785-539-5455).

Method of Contact: From time to time we may need to contact you regarding your treatment. For instance, we may need to contact you regarding billing, appointment reminders, etc. We always retain the right to contact you by postal mail, but we ask your preferences regarding additional methods of contact you prefer.

Alternative contact methods (including leaving voice mail messages, where applicable):

☐ Cell Phone # ☐ Text	☐ Land Phone #
☐ Other Phone #	☐ Other (please specify):
☐ E-mail:	

Please consider that Andrews & Associates, Inc. cannot guarantee the privacy of any method of communication, including, but not limited to, voice mail or e-mail.

Please continue to the next page.

Signatures

"I have read the above policies and agree to them. I also give my consent to participate in therapy at Andrews & Associates, Inc."

Print Name	Signature	Date
Print Name	Signature	Date
Print Name	Signature	Date
Print Name	Signature	Date

Responsible Party

Person responsible for payment for services provided please sign here:

Signature	Date

Consent for Treatment of Minors

If any participant in therapy is under 18 years of age, that person's parent or legal guardian must complete this section.

I certify that I am legally authorized to give permission for

Print name of minor	Social Security Number	Date of birth
Print name of minor	Social Security Number	Date of birth

to receive therapy services and that I give my permission for such treatment to be provided to the above-named minor(s) by Andrews & Associates, Inc."

Print name of parent or legal guardian	
Signature	Date
Street Address	
City, State and ZIP Code	
Telephone Number	
Signature of Witness	