



Candi R. Kaatz, Ph.D.
Licensed Marital & Family Therapist
Certified Sex Therapist
Certified Sex Addiction Therapist
Certified EMDR Therapist

2000 Warfield Dr.
 Nashville TN 37215

Intake

For couples counseling, each partner please complete separately.

CLIENT INFORMATION		
Full Name:	Relationship Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> Sep <input type="checkbox"/> W	
Name that you like to be called (nickname):		
Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Place of Birth
Occupation:		Birth Order
Employer/Company Name: Work Address:		
Home Address w/zip code: Ok to mail to this address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Email: Ok to email? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please note that email correspondence is not guaranteed to be confidential)	
Home Phone#:	Cell Phone#:	Work Phone#:
Ok to leave messages? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ok to leave messages? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ok to leave messages? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you previously attended therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind of therapy? Inpatient /Outpatient/ Other: _____	If yes, what was the length of treatment, and when were the dates attended? Length: Date(s):	If yes, why did you stop attending therapy?

BIOPSYCHOSOCIAL HISTORY			
Symptoms and Behaviors (Please be as specific as possible to any 'yes' responses)			
Mania/manic symptoms	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", circle severity: Low ← 1 2 3 4 5 6 7 8 9 10 → High
Depressed Mood	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", circle severity:

			Low ←1 2 3 4 5 6 7 8 9 10 →High
Appetite Disturbances	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Sleep Disturbances	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Change in Energy Level	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Decreased Concentration	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Worthless/Helpless Feelings	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Anxiety Symptoms/ Panic Attacks	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Bingeing/Purging	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Feelings of Guilt	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Obsessions/ Compulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", please describe:
Phobias	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", please describe:
Medical Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", please describe:
Hyperactivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", please describe:
Are you having suicidal thoughts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", do you have a plan about how you would commit suicide:
Do you have the means to carry out your plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", how would you do this?
Have you ever made a suicide attempt or been hospitalized for suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Describe: Date(s) of attempt(s):
Is there a history of suicide in your family of origin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If "Yes", please list who and what year:
Have you had a previous diagnosis by a therapist or psychiatrist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please list the diagnosis's and the years:
Prescription Medications (please list all currently taking or have taken, the length of time and what they are prescribed for: pain, illness, depression, etc.)			
1. 2. 3.			

4.

List anything other medications or comments that your therapist should be aware of regarding your physical or mental health:

Substance Use

Are you currently using alcohol, nicotine or other prescription or non-prescription drugs? Please list how much and how often you drink and/or take prescription or non-prescription drugs:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever felt you would like to cut down on your substance use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been arrested for a DUI, or drug use? Or do you have a past that involves using drugs or alcohol? Please briefly describe circumstances below:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Family & Relationship History (Use reverse side of this page if you need additional space)

	Age	Name	Living With You (Y/N)	Deceased (Y/N)
Spouse/Partner	_____	_____	_____	_____
Parent	_____	_____	_____	_____
Parent	_____	_____	_____	_____
Stepparent	_____	_____	_____	_____
Stepparent	_____	_____	_____	_____
Sibling	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Children/Step	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Are your parents divorced? Yes No Remarried? Yes No

Religion (if any) _____

Family of Origin (Circle Your Answer)

Have you experienced any abuse in your family or relationships?

None Emotional Physical Sexual Uncertain

In general, how happy were you growing up?

None Somewhat Mostly Extremely

How much is your family of origin a source of support for you?

None Somewhat Very Extremely

How much conflict in values do you experience with your parents?

None Somewhat Substantial

Legal Issues

Have you personally experienced legal problems? No Yes (describe)

Are you currently involved in a lawsuit? If so please describe:

Briefly describe concerns in your life and/or in your relationships that would be relevant for me to know. You may use the back of the form for more space if needed:

On a scale of one to ten, how motivated are you to resolve this issue? _____

Please list your therapy goals (list as many that apply & use the back if need be):

1.

2.

3.

Thank you for taking time to read and complete these questions. This information will be helpful in your therapy process. Your signature is required on the last page before I can begin our work together. Please discuss any questions you may have with me prior to signing.

Emergency Contact Information

In the event of an emergency, please provide a contact person:

Name _____

Relationship _____ Phone _____



- **I understand that I am financially responsible for charges and fees incurred. And I agree to honor the 24 hour cancellation policy.**
- **I understand limits of confidentiality and all mandated reporting by Dr. Kaatz.**
- **I agree to respect the boundaries of contact between sessions and understand email and text is not an appropriate form of processing what is best discussed in session.**
- **I understand that emailing, texting and cell phone are not guaranteed as confidential.**
- **I have answered all questions in full, truthfully and to the best of my knowledge.**
- **I have had all questions about this document answered and sign willingly.**
- **I authorize Dr. Kaatz to provide psychotherapeutic treatment for me.**

Client's name (printed): _____

Client's signature: _____ Date: _____



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Informed Consent

It takes courage to reach out for support and to move forward in your healing journey. These forms contain information about my professional counseling services and business policies. It is important that you review the following information before beginning your first session. Please feel free to ask any questions you may have about these policies; I will be happy to discuss them with you. Prior to your first session, please email these forms to me or bring these completed forms with you to your first session.

Therapy Services – Risks and Benefits

My role as a therapist is to assist clients with issues regarding relationships, addictions, and issues such as depression, anxiety, grief, and other challenges that impact you emotionally. Counseling often involves discussing difficult aspects of your life. During our work together you may experience uncomfortable feelings such as sadness, guilt, shame, anger, or frustration. As a result of what comes out of your therapeutic work and the decisions you make, important relationships may be impacted or may end. Your journey in therapy may also lead to healthier relationships. Counseling often helps an individual find solutions to problems with family and friends, life challenges, as well as a reduction in feelings of distress, anxiety and depression. If you ever have any concerns about your therapy process, I encourage you to discuss this with me during your sessions so that we can collaborate together as you move forward.

Termination of Therapy

You may terminate therapy at any point. When our work comes to a close, I ask that you schedule at least one final session in order to review the work you have done. Occasionally clients return to therapy to process new challenges. If you decide to return in the future, please know that I have an open door policy and welcome the possibility of working together again.

Length of Therapy

Therapy is a process that is unique to each client and the challenges they are presenting with. Some presenting issues can be worked on very effectively in a fairly short period of time (10-20 sessions). Other challenges may take much longer. It can be difficult to predict exactly how long therapy will last and this is best discussed in the first

few sessions. We will put together a treatment plan and goals that you will be working toward. If you have questions regarding the length of treatment, please feel free to discuss this at the start and/or at any point during therapy.

Confidentiality

Therapy is best experienced in an atmosphere of trust. Thus, all therapy services are strictly confidential and I cannot reveal information to anyone without your written permission. There are exceptions to confidentiality where disclosure is required by law (see below). There may be occasions where I may consult with other therapists in order to discuss aspects of your sessions to best support your process. When doing so, please understand that your name will not be used and I will change significant identifying details in order to protect your confidentiality. Your confidentiality is very important to me. Should you request that I speak with another professional or person (i.e. doctors, former therapists, teachers, family, friends or anyone else outside the therapy room), you must first provide your signed written consent in order to do so and only after I determine if this is in the best interest of supporting your therapeutic process and progress.

Confidential Electronic Data Storage and Email Transmission

Your confidentiality as a client is of utmost importance. To support and secure your clinical information, I have set up a system in order to securely store and protect your information in a confidential and protected capacity. All client protected health information is protected under the Health Insurance and Portability Act of 1996 and in particular 45 C.F.R, Part 164, Subpart C under HIPPA.

Legal Exceptions to Confidentiality

I take confidentiality very seriously. Your information is confidential, with the exception of information relating to child abuse, or suspected child abuse, elder abuse, dependent adult abuse, intent to harm self or others, or unless mandated by a court of law. Legally, therapists are mandated reporters of abuse or intent to harm another. If you are suicidal or homicidal, I will take all reasonable steps to prevent harm to you or another.

No Secrets Policy

Please note that with couples and family therapy I practice a no-secrets policy when conducting couples or family therapy. On occasion an individual session may be scheduled to assist in the overall therapy process of all concerned if all parties agree. Any information given in individual sessions will not be held in confidence or secret in couples and/or family sessions.

I will encourage a person holding a secret to share the secret in the following session and will support the client in doing so. I also reserve the right to share or disclose information revealed by one partner or family member in an individual session to the other partner or family members as deemed appropriate or necessary to support the treatment progress and goals. If you are seeking couples therapy, or family therapy, please have each member to fill out and sign an intake form.

Therapy Sessions

Standard sessions are 50-minutes in length. Therapy can be conducted in office or via teletherapy (phone) if you are away on business or ill. The fee is the same for in-office or teletherapy. It is understandable that occasionally you may be late. If you are late to your session, please understand that the session will not extend past your 50-minutes.

Longer sessions are available by request and have a fee of two 50-minute sessions.

Health Care/Managed Care Insurance Policy

In order for me to be reimbursed by an insurance company, you must be given a mental health diagnosis which is submitted to the insurance carrier.

This information once filed becomes part of your medical records and may impact confidentiality. I have no control over how the information gathered will be utilized by the insurance company or representative. You are responsible to contact your insurance company prior to our first session to determine what your deductible or copy is for behavioral and mental health. You are to be prepared to pay this amount each session.

Fees

The fee for services is \$185 per 50-minute session. This fee is the same for in office, teletherapy (phone sessions), or couples therapy. On occasion clients will ask for an extended session for 90 or 110 minutes. The fee is doubled for an extended session.

If you utilize insurance, your fee is as determined by your insurance company. Your insurance company requires payment at each session for me to be in cooperation and agreement with providing services. Insurance does NOT cover sessions over 50 minutes.

Groups sessions are \$75 for each 90-minute group session.

Session Payments

Therapy sessions are paid via Visa, MasterCard, debit card or FSA.

Appointments/Cancellations

Contact me via telephone if you need to reach me the same day as your appointment. Note that cell phones cannot be guaranteed as confidential. I understand that occasionally circumstances beyond your control may arise which would prevent you from keeping your appointment. However, this does not release you from responsibility of paying for a short-notice cancellation.

Client Cancellation Procedures and Fees

Short-Notice Cancellation: All appointment cancellations made less than 24 hours before the scheduled appointment will be charged \$185. Please note that insurance companies do not pay for this fee. This includes if you have a business or work-related cancellation.

No-Show: If you do not show up for a scheduled appointment, you will be charged \$185.

Group Therapy: Group therapy runs in 12-week modules. Each client is responsible for their commitment to the group for the full module. All 12 groups are to be paid whether or not the client attends as the spot in group is saved for that particular client. A client may be asked to leave group if more than 2 sessions are missed per module, as it will impact the group flow and bonding.

Therapist Availability between Sessions

I am available to take a brief 5-minute phone call or to answer a short 1 paragraph email regarding your therapy appointment times or therapy homework one time between sessions without incurring a fee.

Holiday, Weekend and Evening Contact

I will make every effort to return a call, email or text message of a non-emergency message within 24 hours during a scheduled work week. If a call, text or email arrives during a holiday, weekend or evening, I will return the non-emergency client contact during the first working day following the holiday, weekend or evening. If you are facing a life-threatening emergency, please call 911 immediately.

There will be a half session fee for phone calls and sessions that are in excess of 10 minutes.

Email Policy

Please do not email content related to your therapy sessions, letters to read, blogs, or videos, as email is not completely secure or confidential. If you choose to communicate by email, be aware that all emails are retained in the logs of your and my Internet service providers.

Physical Contact

Sexual contact is never acceptable in the therapeutic relationship. Romantic or sexual talk, flirting, or sexual innuendos and sexual jokes are also unacceptable in the therapeutic relationship. If you should express a sexual comment or joke while in session directed to me, I will explore this comment professionally and in a non-shaming way within a therapeutic non-sexual relationship.

Illness Policy

If you are experiencing any stage of illness, please let Dr. Kaatz know in order to conduct the session through video therapy until fully recovered and not experiencing any signs of illness, fever, rash, or contagious symptoms.

If ill, either reschedule your session by the 24-hour cancellation time period or conduct your therapy session via telehealth. If married, cancel the session by 24 hours if you or your spouse is ill. Do not bring in sick family members or children to the office setting if they are experiencing any stage of illness or flu.

If in group therapy, forgo attending group if feeling ill or are recovering at any stage from the flu virus.

Please recognize that the session fee will apply to all sessions that are not cancelled by 24 hours prior to your scheduled session.

Video Therapy Sessions

Technology will not be the same as an in-person session but is beneficial. To have the best results for these sessions, you need to be in a quiet place with limited interruptions when in session. There are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. You can discontinue the video therapy session if it is perceived that the technical connections are not adequate for the session.

Inclement Weather Policy

In the event of inclement weather, I will offer telephone sessions at the same time of the designated appointment. I will contact you as soon as possible to confirm the appointment via telephone.



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Acknowledgement of Receipt of Privacy Practice Notice

By signing below, I hereby acknowledge receiving and reviewing the Dr. Kaatz's Notice of Privacy Practices and Limits of Confidentiality.

Client's Name (print)

Signature of Client

Date

Signature of Client

Date



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Client Credit Card Authorization Form

Please note that the information on this form will be securely entered and stored in a HIPAA compliant online virtual terminal that is password protected for your safety. Once your information has been entered to the secured terminal, these paper forms will be shredded and destroyed immediately to protect your information. While all secure methods to protect your information are in place, and I take your safety seriously, no one can 100% guarantee that any online system cannot be breached, thus you are accepting responsibility and risk in allowing me to store your information for therapy charges.

I authorize Dr. Kaatz to keep my signature and card information on a virtual terminal file that is password protected and HIPAA compliant in order to charge therapy session fees (individual, group, workshops, couples, family or other), and any fees related to therapy related materials (workbooks, DVD's, CD's, and other materials, and/or fees), or for any appointments that are not cancelled 24 hours before the scheduled appointment time to be charged to my credit, charge, or debit card as filled out below for therapy services provided to:

(Therapy Client's Name: Please Print)

I understand that this authorization is valid until canceled in writing. I understand that though this information is secured in an online protected client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised. I understand that charges for ongoing services or materials will normally be posted to my credit/debit/flex card account at the time of my appointment.

Additionally, I agree that the card listed below may be charged in order to settle any outstanding balances accrued by the above listed client upon termination of therapy

services including any materials (i.e. books, CD's, DVD's) that I have not returned within one week of completion of my therapy services. I understand that if a charge back fee is incurred or a retrieval fee of is incurred I am responsible for these fees.

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Dr. Kaatz for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Dr. Kaatz and those attempts have failed.

Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by Dr. Kaatz.

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Cardholder Name (print): _____

Signature _____

Relationship to client: _____

Billing Address: _____

Zip Code: _____

Card Type (**circle one**): 1. Visa 2. Mastercard 3. AMEX

Acct. Number: _____ - _____ - _____ - _____

Exp. Date: _____ Security Code: _____

I understand that my therapy sessions will be charged via this form and not by swiping my card on the evening of my session unless cancelled 24 hours in advance:

Cardholder Signature: _____ Date: _____