BodyWise Psychotherapy

Counseling that Moves You

Susana Potter, LMHC, R-DMT

Confidential Information

Date: ____/_____/_____

Last Name: _____Middle _____First Name: _____

Address

_____City_____ST_____

Zip_____

Phone:

Home: _____ Cell: _____

Email:

_____

DOB: _____ Age: _____

SSN: _____-_____-_____

Sex: ☐ Male ☐ Female ☐ I prefer not to answer

Gender: ☐ Woman ☐ Man ☐ Non-Binary ☐ No Label

Preferred Pronoun(s): ☐ She/her ☐ He/him ☐ They/them

☐ Other _____

Marital Status	Employment	Student
☐ Single	☐ Working	☐ Part time
☐ Married	☐ Full time	☐ Full time
☐ Divorced	☐ Part time	☐ Not a student

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☐ Separated	☐ Not working	
☐ Partner	☐ Retired	

Emergency Contact Information:

Last Name: _____ First Name: _____
Phone:_____ Relationship_____

How were you referred to us? (Thank you for taking the time to complete this!)

☐ Friend	☐ Website name:
☐ Internet	☐ Other Please explain:

Confidential Information (Psychosocial Assessment)

Name of Medical Doctor
_____Ph_____
Name of Psychiatrist
_____Ph_____

Have you been to therapy before? ☐ Yes ☐ No
When _____ Duration _____
With whom? _____
Was it helpful? ☐ yes ☐ No Are you taking medication? ☐ Yes ☐ No
If yes, please list medications:
_____
_____

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Have you ever considered or attempted suicide? ☐ No ☐ Yes
When_____

Reason for today's visit:

_____
_____
_____
_____
_____

Medical History: Please list any significant conditions, surgeries, hospitalizations etc.:

_____
_____
_____
_____

Psychiatric History: Have you ever received Psychiatric/Psychological Testing and/or been in inpatient or outpatient counseling?

_____
_____
_____

Family History: Please share a general description of childhood significant events (birth parents, siblings, family history of substance abuse):

_____
_____
_____
_____
_____
_____

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Strengths and Assets: Please share any activities, talents, hobbies, religious or spiritual practices:

_____

_____

_____

Legal Issues: Please share any current or pending legal issues:

_____

_____

Financial Issues: Please share any significant and current financial issues:

_____

_____

Confidential Information

Sometimes we like to follow-up with clients by letter, phone or email after our work together has stopped. Please check yes or no if you agree to be contacted.

☐ Yes ☐ No

By signing below, I acknowledge that all information given is accurate, I received a copy of the Notice of Privacy Practices to read over. I was given a chance to have answered, any questions I may have about it.

Signature _____ Date_____

Patient / Legal Guardian

Signature_____ Date_____

Therapist

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Agreement and Consent

Please read carefully to be sure you have a complete understanding of the following statements.

- Sessions are 45- 50 minutes at $250.00 (unless otherwise negotiated).
- We accept cash, checks, or credit cards. Checks are to made payable to: **Susana Potter**

* Fees are due by the end of each session. For information on packages speak with your therapist.

- Should you have an emergency after hours call 911 or go to the nearest hospital for help.
- You may also call Dade County Crisis Hotline at (305) 358-HELP, in Broward (954) 467-6333.
- If you are late for your appointment it will end at the scheduled time. In instances that the therapist is late you will be allowed your full session time.
- **48 hour notice is required for cancelation of appointments.**
- **Missed appointments or cancellations of less than 48 hours will be billed as a regular session.**
- Emergencies are of course excused. If you are not able to make your appointment you may have the option of either a phone, Skype, or Facetime session. Discuss this with your therapist about which of these are available at the time.
- Appointments are set and canceled with your therapist. If you are unable to reach your therapist, you may leave a message (786) 402-7078.

What is discussed as a part of therapy is kept confidential with the following exceptions:

- If you are determined to be a danger to yourself or others.
- If you are suspected of child or elder abuse.
- If your records are subpoenaed by the courts.
- If you authorize in writing the release of information to others

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Intake session fee $_____
Subsequent sessions fee $_____
Late cancelation / no show fee $_____

In the occasion that your records are subpoenaed by the courts and your therapist is required to testify or provide records, there is a $200 fee for travel time as well as a $200 fee per hour that your therapist is present at court.

Patient or Legal Guardian Signature:
_____Date: _____

Therapist signature:_____ Date: _____

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Credit Card Authorization

I _____, hereby authorize BodyWise Psychotherapy to charge the following credit card for all payments due them. I am financially responsible for myself and/or:

_____ .

This agreement will be in effect until services have been paid in full or by the request of myself in writing.

Card information:

Card Type: ☐ Visa ☐ Mastercard ☐ American express

Billing Zip Code _____ **CVV** _____

Name on Card

_____

Credit Card #

_____

Expiration Date

_____

Card holder's signature

_____