

# INTAKE FORM

Eastwind Healing Center:  
221 E. College Street Suite 211

Gabe Bodzin, LISW  
Iowa City, Iowa 52240

(319) 337-3313 Scheduling and Front Desk

(319) 337-0686– Fax

[www.eastwindhealing.com](http://www.eastwindhealing.com)

An association of sole practitioners (not in partnership)

Today's Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Occupation: \_\_\_\_\_

Email: \_\_\_\_\_

Marital Status: M S W D

What medications or drugs are you taking?

Family Physician:

Emergency Contact & Phone:

\*\*\*\*\*

Insurance Company: \_\_\_\_\_ Policy#: \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_

Holder's Birth Date (if not client): \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

\*\*\*\*\*

Signing below gives us permission to submit relevant information to your insurance company, and allows payment to be sent directly to Gabe Bodzin. This signature also indicates that you understand that the practitioner you are seeing is a sole practitioner, not in partnership.

\_\_\_\_\_  
SIGNATURE HERE

\_\_\_\_\_  
Date

Signing below indicates that you have been given the opportunity to read and have a copy of our HIPAA practices.

\_\_\_\_\_  
SIGNATURE HERE

\_\_\_\_\_  
Date

# INTAKE FORM

## Informed Consent to Psychotherapy for Gabe Bodzin, LISW

The following material is provided to inform and clarify the rights and responsibilities of both the therapy client and therapist. Please feel free to ask me if you have any questions, and I will do my best to answer them. It is important that you read and understand the information below so that you can be an informed consumer of my services and we can work together with clarity in support of your goals and well-being.

### **Confidentiality**

Confidentiality is a central component to the therapeutic relationship, and with the exception of certain circumstances described below, you have the right to confidentiality. I will not disclose the content of our discussions and interactions with anyone, including that you are in therapy with me, without your prior written permission. Under certain legal provisions, I may legally communicate with another health care provider or member of your family without your prior consent, but I will only do so in the case of an emergency. As a general rule, even when I do have prior authorization to speak with another party via a written release of information I will only disclose information that we have discussed beforehand and that you have consented for me to share.

Under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA) you have certain rights and protections. This law insures the confidentiality of all electronic transmission of information about you. When information regarding you is transmitted electronically, as with electronic billing for insurance or faxing information, it will be done with safeguards pursuant to HIPAA regulations. If you choose to communicate with me by email during our work together, please understand that email is not completely confidential. Emails are retained in the logs of Internet service providers (ISP), are often not encrypted, and in theory could be read by ISP administrators.

### **Limits of Confidentiality**

If I have good reason to believe that you are in imminent danger of harming yourself or another person, I am legally and ethically required to take necessary action to prevent harm, including - but not limited to - informing friends or family members, contacting police or calling paramedics/ambulance.

If you provide me with information that leads me to have a reasonable suspicion that a child, vulnerable and dependent adult, or developmentally disabled person is being abused or neglected, I must inform the appropriate state protective services. Neglect and abuse in this case also include situations in which you have expressed that you are under the influence of illegal substances while caring for a child, vulnerable and dependent adult(s), or developmentally disabled person.

The competent and ethical practice of psychotherapy requires that I consult periodically with other licensed mental health professionals. Should I consult with a colleague, I will omit any extraneous identifying information so that your anonymity is carefully preserved.

### **Couples Therapy**

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In the case that you and your partner engage in couples therapy with me, and as a part of that process you decide that individual sessions will be a part of this process, anything said in the individual sessions will be considered a part of the couples therapy and can be discussed in the joint sessions. Therefore, do not disclose to me anything that you wish to be kept secret from your partner.

## Record Keeping

I keep brief records of our sessions, including interventions used in sessions, topics discussed, and your reports of how you feel you are doing. You have the right to a copy of your file at any time. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else.

## Diagnosis

If a third party, such as an insurance company, is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that help us to understand the symptoms that a client describes but are not an attempt to describe the cause of the symptoms or diagnosis. The diagnoses used come from a book titled *The DSM-IV* (soon to be *DSM-V*) and if I do use one, I will discuss it with you. I do not feel a diagnosis defines an individual, but instead seeks to provide some descriptive categories to provide a language that we can use to *begin* a conversation in therapy. The cause of any given symptoms or diagnosis is not something I will seek to impose upon you, but something I hope to support you in discovering for yourself in a manner that is safe and empowering.

## Other Rights and Collaborative Nature of Therapy

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing. Your input into therapy is both welcome and can be an important and central part of the process. My approach to therapy is both collaborative and strengths-based. We work together to support your goals and honor your inner strengths and resources that you can bring to your life and to your life-challenges. If at any time you feel I am not a good fit for you, please feel free to terminate therapy with me. Also, should that be the case, I am available to help you find another therapist who might be a better fit.

## Conflicts of Interest, Insurance Changes, and Financial Hardship

In certain circumstances, it may be necessary that I will be ethically required to terminate therapy with you, if and when I become aware of a conflict of interest. While rare, this does happen, and can be more frequent in smaller communities. When this happens, it can also be the case that I am unable to share with you the nature of the conflict of interest because doing so would also be a breach of confidentiality for another party. In the event that this should happen, I will be available to help you find another therapist. Also, if there is a change in insurance or you are experiencing financial hardship such that funding for my

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services is no longer available or difficult, this may necessitate ending our therapy relationship. If this is the case, I will to the best of my ability work with you to find a solution to the problem and help you to have access to appropriate services.

## **Fees for Therapy and Sliding Scale**

My fee for a 50 minute therapy session is \$120.00 and this amount and/or co-pay are payable on the day of the session. I offer a sliding scale for uninsured individuals whose income makes paying the full fee prohibitive to participate in therapy. Sliding scale arrangements are made on an individual basis. Please contact me for information.

## **No Shows, Cancellations, and Lateness**

You are responsible for coming to your session on time and at the time we have scheduled. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four hours notice, you are still responsible to pay for that session at the rate 50% the normal fee, and must pay this in full before or at our next regularly scheduled meeting.

## **Contacting Me**

I will respond to emails sent to [gabebodzin@middlepaththerapy.com](mailto:gabebodzin@middlepaththerapy.com) within 24 hours of being received, unless I am out for illness or vacation. You may also call the Eastwind receptionist and leave a message for me to call you back, which I will do between sessions as time allows, or at the end of the business day. For the sake of my schedule and seeing other clients, I will try to limit phone calls to less than 10 minutes, and work to address your concerns in that time. Every effort will be made to assist you, especially during crisis.

However, there may be times when contacting you won't be possible. For emergencies in which you feel a threat to your safety for any reason, please call the Crisis Center at 319.351.0140, dial 911, or go to a local emergency room.

## **Client Consent to Psychotherapy**

I have read this statement, had sufficient time to consider it carefully, have asked any questions that I needed to, and understand it.

Name (print)\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_