

**Sunflower Therapy**

Rita DeLoach McGaw, M.S.  
KS LCMFT 2753, CA LMFT 119310  
Overland Park, KS 66212  
805-620-8419

**Individual or Couples Therapy Intake Form**

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

M  F  Trans\*  Other \_\_\_\_\_ (fill in the blank)

Prefer not to disclose

Age: \_\_\_\_ DOB: \_\_/\_\_/\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Ok to send mail?  Yes  No

Primary Care Doctor \_\_\_\_\_ Date last seen \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Date last seen \_\_\_\_\_

Please list any medications prescribed:

\_\_\_\_\_

List any head injuries or major illnesses; past or present:

\_\_\_\_\_

List any previous mental health diagnoses:

\_\_\_\_\_

**In Case of Emergency Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Please circle all that may apply to you or your family:

Divorce--Legal Separation---Custody of Minor Issues--Restraining Orders--Current Litigation  
Issues--Probation/Parole

I, (print name) \_\_\_\_\_, agree to be legally responsible for any charges  
that incur during therapy with Rita DeLoach McGaw, LCMFT. \_\_\_\_\_ (initial here)

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

## **Therapeutic Contract**

Rita DeLoach McGaw

KS LCMFT 2753, CA LMFT 119310

**Probable Length of Services:** Although some clients elect to pursue long-term in depth treatment, many issues can be resolved within 6-24 sessions. Of course, the success of any treatment depends on the identified goals, ability, motivation, willingness and engagement of the person being treated. For this reason, I can make no guarantees about treatment length or success.

**Risk of Services:** As with any change in your life, you should be aware that outcomes of therapy can be unpredictable. However, it has been my experience that the majority of engaged clients improve their situations through therapy. Therapy is intended to induce change in your life, and when change occurs it may disrupt your accustomed manner of living and/or your relationships with others. You should also know that positive change takes work and you may be asked to try things that are challenging for you. Some individuals will reach their goals fairly quickly and without much discomfort; while others need additional time and feel more stress through the process. The experience of each individual is impossible to predict as each person has their own unique strengths and needs. Therapy can also provoke feelings of affection and/or conflict toward the therapist which, if needed, will be addressed in session.

**My Therapeutic Approach:** I believe each person already embodies the resiliency to get them through difficult times; I am here to help highlight and strengthen your skills and resiliencies so you can overcome any challenges you may be facing. I “meet you where you are;” meaning I take the lead from you regarding what goals you want to accomplish while in therapy and honor your level of comfort with the process.

I utilize the following therapeutic approaches:

1. **Cognitive/DBT Therapy:** A collaborative approach where thoughts, beliefs and reactions are identified and any thoughts that are causing clients difficulty in their lives are explored and reframed.
2. **Behavioral Therapy:** Used to address dangerous or destructive behaviors (aggression, opposition, threats, running away, self-harm, eating disorders etc.) in children and teens or adults. This approach focuses directly on the behaviors and uses techniques such as emotion

regulation skill building, role play, or in-the-moment coaching to decrease unwanted behaviors.

3. Empowerment & Person-Centered Therapy: Emphasizes the importance of a safe and positive relationship between therapist and client(s), and assists clients in identifying their choices, individual values, unique strengths/resiliencies and self-responsibility in their lives.

**Your Rights:** Treatment is entirely voluntary, and you have the right to terminate treatment at any time. I have the right to terminate therapy with you under the following conditions:

1. If I believe that therapy is no longer beneficial to you.
2. If I believe that you will be better served by another professional
3. If you have not paid for at least two sessions, unless special arrangements have been made
4. When you have failed to show up for two consecutive therapy sessions without a 24-hour notice
5. You are seeing another therapist, and participating in treatment with me would jeopardize our relationship and work with that

therapist. (If you are seeing another therapist I will require that you sign a consent form to release information so I can communicate with the other therapist).

If for any reason our services terminate, I will provide you with the names of other qualified professionals.

**Limits of Confidentiality:** All information that you disclose to me within our sessions is confidential and will not be revealed to anyone without your written permission (or your parents' permission if you are under 18), except for the following reasons:

1. Where there is a reasonable suspicion of child abuse, dependent adult abuse or elder adult abuse.
2. If you reveal to me that an alleged perpetrator is in contact with minors and there is a reasonable suspicion that he or she may still be abusing minors.
3. Where there is a reasonable suspicion that you may present a danger of violence to others.
4. Where there is a reasonable suspicion that you are likely to harm yourself unless protective measures are taken.

**In all of the above cases, the psychotherapist is either allowed or required by law to break confidentiality in order to protect you, or someone you might endanger from harm.**

5. I can release all or portions of your records to any person or entity you specify. I will inform you whether or not I think releasing that information to that agency or person might be harmful to you.

6. If a court of law issues a subpoena or an order, I am required by law to comply with the subpoena or order.

Records: Your clinical file will consist of (a) legal forms such as this document, (b) a record of visits and payments, and (c) clinical progress

notes (these progress notes will contain enough information about your treatment to justify it, should such justification ever become an

issue).

\*You have the right to view your records at any time. I have the right to provide you with the complete records or a summary of their content. In all cases therapy never includes sexual contact or conduct between therapist and client.

### **Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET

ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND SIGN THE LAST PAGE.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal law that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronic, on paper, or orally, are kept properly confidential. HIPAA gives you,

the client, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

Each time you meet with your psychotherapist, a record is made which may contain your symptoms, diagnoses, treatment, a plan for future treatment, and billing-related information.

Usually, less information is recorded if you are not using insurance to pay for treatment. This notice applies to all of the records of your care.

**Psychotherapist Responsibilities:** Therapist is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. I am required to abide by the terms of this notice and notify you if I make changes to this notice, which may be at any time.

**How I May Use and Disclose Medical Information About You:**

**Treatment:** I may use and disclose medical information about you to provide, coordinate, and manage your treatment or services. I may disclose medical information about you to doctors, other therapists, or others who are involved in your treatment only with your written authorization. For example, if a referral is made to another health care provider. I may provide oral information and copies of various reports that should assist her or him in treating you.

**Payment:** I may use and disclose medical information about you in order to obtain reimbursement for services, to confirm insurance coverage, for billing or collection activities, and for utilization review. An example of this would be sending a bill for your sessions to your insurance company.

**Health Care Operations:** I may use and disclose, as needed, your health information in order to support my business activities, licensing, legal advice, and customer service. For example, I may call you by name in the waiting area. Additionally, there are other business professionals using the offices and you may encounter them upon arrival and departure from our sessions.

**Other Uses and Disclosures:** I may use and disclose your health information in an emergency situation to prevent harm to yourself or others. An example would be mandated reporting of abuse to children, the elderly, a disabled person, or when a judge orders the release of information. Only the minimum amount of information relevant to your health care will be disclosed. I may create and distribute de-identified health information by removing all references to individually identifiable details. I may contact you to provide appointment reminders, or to offer information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

**Your Rights:** You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the

Privacy Officer (Rita DeLoach McGaw, MFT):

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to inspect and copy your protected health information.
3. The right to amend your protected health information.
4. The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint to me or with the federal government at the address below, about violations of the provisions of this notice or the policies and procedures of my practice. I will not retaliate against you for filing a complaint.

Department of Health & Human Services, Office of Civil Rights

200 Independence Avenue S.W. Washington, D.C. 20201.

1-877-696-6775 or (202) 619-0257

If you have any questions about this notice, please contact:

Rita DeLoach McGaw, LCMFT. 805-620-8419

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature, \_\_\_\_\_,