ARCHER MANESS
Psychotherapy

New Client Intake Packet

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Welcome. Please complete this packet before your first appointment. You can type directly into the fields using Adobe Acrobat Reader (free) or Preview on a Mac, then save the file. Please bring it to your first session or email it to **Archer@archermaness.com**. Email is not fully secure; if you prefer, print it and bring a paper copy. Answer only what you are comfortable sharing; we will talk through everything together.

For clients under 18: a parent or legal guardian with authority to consent to the child's treatment should complete this packet and sign where indicated. Please answer the questionnaire about your child, and complete the Parent / Guardian Information section on page 1. Adolescents are welcome to help.

This packet includes: 1. Client Information 2. Background Questionnaire 3. Informed Consent & Confidentiality 4. Fees, Payment & Superbill Agreement 5. Authorization for Release of Information (optional)

1. CLIENT INFORMATION

Full legal name | Preferred name | Date of birth

Street address

City | State | ZIP

Cell phone | Other phone | Email

I give permission to:

☐ Leave voicemail messages ☐ Send text messages ☐ Email about scheduling

Emergency contact name | Relationship | Phone

Services requested (check all that apply):

☐ Individual therapy ☐ Couples therapy ☐ Family therapy ☐ Parent consultation / support
☐ Substance use concerns ☐ Substance use evaluation ☐ Child or adolescent therapy ☐ Not sure yet

Preferred format:

☐ In person ☐ Telehealth (video) ☐ Either

Other family members who may take part in sessions (names, ages, relationship)

How did you hear about this practice? | Referred by (name, if any)

For substance use evaluations only

Evaluation requested by:

☐ Myself ☐ Attorney ☐ Court
☐ Agency / DSS ☐ Employer / licensing board ☐ Other

Requesting person or agency | Case number, if any | Due date, if any

Parent / Guardian Information (complete if client is under 18)

Client's school | Grade | Pediatrician

Parent / guardian 1 name | Relationship | Phone | Email

Parent / guardian 1 address, if different from client

Parent / guardian 2 name | Relationship | Phone | Email

Parent / guardian 2 address, if different from client

Legal custody of the child:

- ☐ Parents married / living together
- ☐ Joint legal custody
- ☐ Sole legal custody (name below)
- ☐ Guardian / kinship caregiver
- ☐ Foster care / DSS custody
- ☐ Other (describe below)

Custody details: who holds legal custody, current schedule, and any court orders that affect decision-making

Is there a custody order, protective order, or other court order concerning this child? If yes, please bring a copy of the current order to the first appointment. ☐ Yes ☐ No

Is the other parent aware of and in agreement with this child beginning therapy? ☐ Yes ☐ No

2. BACKGROUND QUESTIONNAIRE

This information helps me understand you and use our first meeting well. Skip anything you would rather discuss in person. If you are completing this for a child, please answer about your child.

What brings you in at this time?

How long has this been a concern?

What prompted you to reach out now?

What would you like to be different as a result of our work together?

In the past month I have experienced (check all that apply):

- ☐ Anxiety or worry
- ☐ Changes in appetite
- ☐ Grief or loss
- ☐ Trouble concentrating
- ☐ Upsetting memories
- ☐ Sadness or depression
- ☐ Irritability or anger
- ☐ Stress at work or school
- ☐ Panic attacks
- ☐ Low energy or motivation
- ☐ Sleep problems
- ☐ Relationship conflict
- ☐ Parenting stress
- ☐ Loneliness or isolation
- ☐ Concerns about substance use

Other concerns

Safety

In the past month, have you had thoughts of harming yourself or ending your life? ☐ Yes ☐ No

In the past month, have you had thoughts of harming someone else? ☐ Yes ☐ No

If you are in crisis now, please do not wait for your appointment. Call 911, call or text 988, or call Region Ten Emergency Services at 434.972.1800 (24 hours).

Health

Primary care provider

Phone

Current medications (including dose) and any significant medical conditions

Have you received counseling or psychiatric care before? ☐ Yes ☐ No

If yes: with whom, when, and what was or was not helpful

Have you ever been hospitalized for mental health or substance use? ☐ Yes ☐ No

If yes: when and where

Alcohol and substance use

Please describe your current alcohol use pattern (how often, typical amount, and any recent changes)

Other substances used currently or in the past (including cannabis and prescription medications not taken as prescribed)

Has anyone expressed concern about your alcohol or drug use? ☐ Yes ☐ No

For children and adolescents

Developmental history: pregnancy and birth, early milestones, and any early separations from caregivers, moves, or placements

School: how is your child doing academically and socially? Any IEP, 504 plan, or school concerns?

Your child's strengths and interests, and what helps when they are upset

Relationships and daily life

Relationship status:

☐ Single ☐ Dating ☐ Partnered / living together ☐ Married
☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Who lives in your household? (names, ages, and relationship to you)

Occupation / employer or school

Highest level of education

Important people and supports in your life

Is there anything else you would like me to know before we meet?

3. INFORMED CONSENT & CONFIDENTIALITY

Welcome. Beginning therapy is an act of courage and of hope, and I want you to know what to expect as we begin our work together.

Our work together. I think of therapy as a relationship: a secure base from which to explore what is hard, and a safe haven to return to when things feel overwhelming. Whether I am meeting with you individually, as a couple, or with your family, we will set goals together, move at a pace that feels manageable, and check in along the way about what is helping. Therapy often brings real relief and change, and it can also stir up difficult feelings for a time. That is a normal part of the process, and I welcome you to talk with me about it. You are always free to ask questions, or to end our work at any time.

Your privacy. What you share with me stays between us, and I will not release information without your written permission. There are a few important exceptions required by Virginia and federal law: if I have reason to suspect that a child, an elderly person, or an incapacitated adult is being abused or neglected; if someone is at serious and imminent risk of harm; or if a court orders records released. Whenever possible, I will talk with you first. I occasionally consult with trusted colleagues, without identifying information, to be sure I am offering you my best care.

Children, teens, and families. When I work with a young person, a parent or legal guardian with authority to consent signs these forms. If parents are separated, I ask for a copy of the current custody order and generally seek both parents' involvement. Virginia law gives parents access to their child's records unless a court limits it, and yet young people do their best work when they feel safe to speak freely. Together we will agree at the start about what I share with parents: generally, how things are going and anything that affects safety. In couples and family sessions, I do not hold secrets that would get in the way of our work. As a treating therapist, I do not make custody or visitation recommendations.

Evaluations. A substance use evaluation is different from therapy. The findings are summarized in a written report that is released only with your signed authorization or by court order, and an evaluation does not by itself begin a therapy relationship.

Telehealth. Video sessions use a secure platform. Please join from a private space in Virginia and let me know where you are at the start of each session. If we are disconnected, I will call you.

Staying in touch. Email and text are not fully secure, so I use them mainly for scheduling, and I usually respond within one to two business days. I am not able to provide emergency services. If you are in crisis, please call 911, call or text 988, or call Region Ten Emergency Services at 434.972.1800.

Records. I keep records of our work as required by law, and you may ask to review or receive a copy. My Notice of Privacy Practices is available at any time on request.

INITIALS — I have read and understand this information, have had the chance to ask questions, and consent to services with Archer K. Maness, M.Ed., LPC.

INITIALS — I have been offered a copy of the Notice of Privacy Practices.

INITIALS — **For clients under 18:** I am the child's parent or legal guardian with authority to consent, and I have shared any court orders affecting custody or decision-making.

Client signature (typing your full name serves as your electronic signature)	Printed name	Date

Parent / legal guardian signature (REQUIRED if client is under 18)	Printed name and relationship to client	Date

4. FEES, PAYMENT & SUPERBILL AGREEMENT

Fee schedule

Current fees for all services, including therapy sessions, evaluations, and court-related services, are listed in the separate **Archer Maness Psychotherapy Fee Schedule** provided with this packet. Fees are reviewed annually, and you will receive at least 30 days written notice of any change.

I have received the Fee Schedule effective: _____

_____ INITIALS

Payment. Payment is due in full at the time of service. I accept cash, checks, credit cards, and electronic payment. Fees may be adjusted with at least 30 days written notice.

_____ INITIALS

No insurance billing. I understand that Archer Maness Psychotherapy does not accept insurance and does not bill insurance companies. I am responsible for the full fee for all services.

_____ INITIALS

Superbills. On request, I will receive a superbill (a detailed statement of services) that I may submit to my insurance company for possible out-of-network reimbursement. I understand that submitting the superbill is my responsibility, that reimbursement is not guaranteed and depends entirely on my plan, that a superbill includes a diagnosis code, and that my payment responsibility does not depend on whether or how much my insurance reimburses.

_____ INITIALS

Cancellations and missed appointments. Appointments cancelled with less than 24 hours notice, or missed without notice, will be charged the full session fee.

_____ INITIALS

Legal involvement. Therapy is not a forensic evaluation. If I am asked or required to participate in legal proceedings on your behalf (records, letters, attorney consultation, depositions, or court testimony), those services are billed at the hourly rates in the current Fee Schedule, including preparation and travel, and are due regardless of who requests them.

_____ INITIALS

Good Faith Estimate. Because I am not using insurance, I have the right to receive a Good Faith Estimate of expected charges under the No Surprises Act. I may request one at any time before or during services. More information: www.cms.gov/nosurprises.

Superbill request (optional):

☐ Please provide a superbill each month ☐ Please provide a superbill on request only

I have read and agree to the fees, payment, and billing policies above.

Responsible party, if not the client (for minors, the parent or guardian responsible for payment) _____ Phone / email _____

Client signature (typing your full name serves as your electronic signature) _____ Printed name _____ Date _____

Parent / legal guardian signature (REQUIRED if client is under 18) _____ Printed name and relationship to client _____ Date _____

5. AUTHORIZATION FOR RELEASE OF INFORMATION

Complete this form if you would like me to share information with, or receive information from, other people or organizations, such as a physician, another therapist, a school, an attorney, or a court. List up to four below. Unless noted, the information and purpose checked apply to each party listed.

Client name | Date of birth

I authorize Archer K. Maness, M.Ed., LPC, to release information to (R), obtain information from (O), or exchange information with (E) each party below, as checked:

	Person or organization	Role / relationship	Phone	Fax	R	O	E
1					☐	☐	☐
	Address		Email				
2					☐	☐	☐
	Address		Email				
3					☐	☐	☐
	Address		Email				
4					☐	☐	☐
	Address		Email				

Information to be disclosed (check all that apply):

- ☐ Dates of attendance
- ☐ Assessment and recommendations
- ☐ Verbal consultation
- ☐ Evaluation report and results
- ☐ Diagnosis
- ☐ Records received from others
- ☐ Treatment summary / progress
- ☐ Substance use information
- ☐ Other (describe below)

Other information, limits, or notes

Purpose of disclosure:

- ☐ Coordination of care
- ☐ Requested by referral source
- ☐ Legal / court proceedings
- ☐ Other (describe below)
- ☐ At my request

Other purpose | Expires on (date or event); if blank, one year from signing

I understand that: (1) I may revoke this authorization at any time by giving written notice, except to the extent that action has already been taken in reliance on it; (2) my treatment, payment, or eligibility for services will not be conditioned on signing this form, except where the purpose of an evaluation is to provide a report to the requesting party; (3) information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations; and (4) I have the right to receive a copy of this authorization. If the client is under 18, a parent or legal guardian must sign; adolescents are encouraged to sign as well.

Client signature (typing your full name serves as your electronic signature) | Printed name | Date

Parent / legal guardian signature (REQUIRED if client is under 18) | Printed name and relationship to client | Date