



Karen I. Maldonado, MSPC, LCMHC, LMHC  
130 Torrey Pines Pt., Naples, FL 34113

Dear Client,

Thank you for choosing TheraPeace, PLLC. **Please read all of this important information.** **Keep this one sheet for your information.**

1- Please complete all forms in full, sign, scan and email. I will also need an original signature that you can mail to me at 130 Torrey Pines Pt., Naples, FL 34113 but we can get started as soon as I have the email version.

2- I, Karen Maldonado, strive to offer the best counseling experience possible. Studies have shown that video-conferencing sessions are just as effective as the common face-to-face method of counseling. I also require that you would be alone for your sessions unless you are scheduled for a marital, family or group session. I do not see children for video-conferencing.

3- I also require an Emergency Management Plan for all my clients due to the fact that I am so far in distance from some and would have to know who to reach if my client is in distress requiring professional attention. Please enter on the intake forms the emergency contact person that will be available during all your session times that I could reach if this should happen.

4- Should you need to cancel an appointment with me, please do so at least 24 hours before you are scheduled by emailing me directly at [karen@thera-peace.com](mailto:karen@thera-peace.com). Otherwise you will be charged the regular fee for the missed appointment and will not be able to reschedule until the fee is received.

5- Payments are received one of these two ways:

- a) Checks – Payable to “TheraPeace, PLLC” and placed in the mail prior to your first session. Mail to:  
Karen Maldonado, 130 Torrey Pines Pt., Naples, FL 34113.
- b) Square – Your credit or debit card information will be entered into the Square App on my phone after each session (within 48 hours of the session).





Karen I. Maldonado, MSPC, LCMHC, LMHC

**CLIENT INTAKE FORM**

Client's Name \_\_\_\_\_

Military background? \_\_\_\_ yes \_\_\_\_ no If yes, when? \_\_\_\_\_

**Family Status: List name, birth date or age, sex, relationship of all children, and whether they live at home with you.**

Name	DOB/age	Sex	Relationship (step, foster, yours, adopted)	At home?
1.				YES NO
2.				YES NO
3.				YES NO
4.				YES NO

Presently married? \_\_\_\_ yes \_\_\_\_no If yes, how long?\_\_\_\_\_ presently separated? \_\_\_\_ yes \_\_\_\_ no

Divorced? If yes, when? \_\_\_\_\_

Name all who are coming for counseling? \_\_\_\_\_

Previous counseling? Y\_\_N\_\_ If yes, why? \_\_\_\_\_

Are you or another family member currently seeing a psychiatrist or another counselor? Y\_\_\_\_\_ N\_\_\_\_\_

If so, what family member? \_\_\_\_\_ If Yes, why? \_\_\_\_\_

**FAMILY MENTAL HEALTH HISTORY**

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member(s)
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Gambling/pornography/sex addiction	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Was abused/neglected (physical, sexual, emotional)	yes/no	

**GENERAL HEALTH & MENTAL HEALTH**

Have you ever had any thoughts or feelings of harming yourself? Y\_\_\_ N\_\_\_ If yes, when & explain why \_\_\_\_\_

Have you ever had thoughts or feelings of harming someone else? Y\_\_\_ N\_\_\_ If yes, when & explain why \_\_\_\_\_

Do you have any present &/or past problems with: gambling \_\_\_ pornography \_\_\_ sexual addiction \_\_\_ spending \_\_\_ none\_\_\_\_ If so, when? \_\_\_\_\_

Have you had any significant life stressors or losses in the last year? (Death of a loved one, job, home, etc.) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Last exam: \_\_\_\_\_ Are you currently taking any prescribed medication? \_\_\_ Yes \_\_\_ No Please list: \_\_\_\_\_

Have you received any type of mental health services in the past (counseling, psychiatric, hospitalization)? \_\_\_\_\_

Any past surgeries or medical hospitalizations? why & when \_\_\_\_\_

Any problems with: eating \_\_\_ sleeping \_\_\_ chronic pain \_\_\_ weight changes \_\_\_ loss of consciousness \_\_\_ headaches \_\_\_

Describe any answers checked above: \_\_\_\_\_

Have you ever been sexually, physically, emotionally or mentally abused? \_\_\_ yes \_\_\_ no If yes, by who? \_\_\_\_\_

Have you ever experienced an abortion (pregnancy termination)? \_\_\_ yes \_\_\_no If yes, when? \_\_\_\_\_

Other medical problems: \_\_\_\_\_

**OTHER INFORMATION**

Do you consider yourself to be spiritual or religious? No \_\_\_\_\_ Yes\_\_\_ any specific denomination? \_\_\_\_\_

Would you like your counselor to pray with you before starting the sessions? No \_\_\_\_\_ Yes \_\_\_\_\_

What values are important to you? \_\_\_\_\_

What has brought you to counseling now? \_\_\_\_\_

What would you like to see change in your life? \_\_\_\_\_

What do you consider to be some of your strengths? \_\_\_\_\_ weaknesses? \_\_\_\_\_

**CONSENT FOR TREATMENT:**

I hereby give my consent to my counselor, Karen Maldonado, to provide an evaluation & treatment that we may mutually determine to be appropriate. I understand that services will be rendered in a professional manner, consistent with accepted ethical standards. I understand I will likely gain the most benefit from counseling if I am committed to the process and attend regularly. I understand that no promises have been made to me as to the results of therapy provided by this professional. If at any time during treatment I cannot wait for a return call from my counselor, I agree to contact my psychiatrist, family physician, or call 911.

Print Name \_\_\_\_\_ Client/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Karen I. Maldonado, M.S.P.C., L.C.M.H.C., L.M.H.C**



**Professional Disclosure Statement & Informed Consent**

130 Torrey Pines Pt., Naples, FL 34113

**Qualifications**

My highest degree is a Master of Science in Professional Counseling. I graduated in May 2009 and my degree conferred February of 2010 from Southeastern University in Lakeland, Florida. I am also a licensed minister with the Assemblies of God since June 2007 with license number 2730703. I am a Licensed Mental Health Counselor (MH#12666) with the State of Florida since June 19, 2014 which will expire in March 31, 2023. My North Carolina License as a Professional Counselor Associate (LPCA# A10715) was issued in June of 2014 and I continued to work under that license at The Counseling Center at Winston-Salem First until June 2015 when I obtained my licensure for Licensed Professional Counselor (LPC# 10715 converted to LCMHC with the same license number on January 1, 2020 due to the NC board's name changes within the profession). The Counseling Center, continued doing business as a dba of Christ Family Church, which officially opened its doors on January 4, 2016 where I practiced until November 2017. I now have my own telemental health practice due to the fact that I was moving to Florida and my clients from North Carolina wanted to continue therapy with me. I prepared myself to become a Distance Credentialed Counselor (DCC) through the Telehealth Certification Institute in 2017 where I successfully completed all the coursework required to help my clients via video-conferencing. I earned my Board Certified - Telemental Health Provider credential on May 31, 2018 which is the new distance counselor credential.

I have worked as a counselor for the past 16 years with my first counseling experience beginning in my practicum in August of 2008. I continued to work through my school internship (1000 hours) and then my Registered Counselor Internship through June of 2012 (1084 hours) at the same agency. This took place at Hope Counseling Centers in Lakeland, Florida where I received 75 hours of supervision. When I moved to North Carolina, I continued to complete my required Florida licensure hours (1500 total) toward my LMHC under the supervision of Jennifer B. Locklear, LPCS. I continued under board approved supervision of Ms. Locklear also to complete the requirements for licensure as a Licensed Professional Counselor in North Carolina which has been changed in name only to Licensed Clinical Mental Health Counselor.

**Counseling Background**

I continue to serve clients needing marital, family, grief or group counseling, and individuals struggling with mood, personality and adjustment disorders. The groups I have worked with encompass marital groups, women's intimacy-in-marriage groups, couples' intimacy-in-marriage groups, women in marital separation and female victims of sexual abuse groups. I have worked with children in the past ages 3 through adolescent years however it is my opinion that face-to-face counseling is best for children so I do not see minors now. Sessions are always focused on how to benefit the client. I will serve members of the community looking for a Christian Counselor. I will see any individual for at least one session, but if I believe that any issues are beyond my expertise, I will explain these issues and offer you referrals to an appropriate professional that may better serve your needs.

My theoretical orientation is mainly cognitive behavioral. Cognitive Behavioral Therapy (CBT) clearly separates your thinking from your emotions and behaviors. CBT allows you to see that you can have control over your thoughts and actions when trying to cope and it offers power in establishing stability. CBT explores how the mistaken irrational thoughts can lead to miserable feelings and behaviors. The goal in my approach is to bring you to the point that you no longer need counseling and can manage to work through issues on your own. If at any time during our counseling relationship you feel the process is not successful, you may end the relationship at any time. If you encounter an emergency outside of our session times please call **911**.

**Fee Schedule and Length of Session**

The designated fee for my services to individuals and couples is \$75.00 per 50 minute video-conferencing session through VSee, a software which is HIPAA-compliant. Please remember to give at least 24 hours' notice if canceling your appointment.

I accept credit card payments through the Square where I will enter your information after each session. I can also accept payment by check prior to your session date if you would like to pay in advance by mailing to 130 Torrey Pines Pt., Naples, FL 34113. I do not accept insurance, however if you would like to attempt to submit paperwork on your own to your insurance company to be reimbursed, I will gladly sign and include your diagnosis if one applies.

### **Use of Diagnosis**

Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most will require a diagnosis of a mental-health condition and indicate that you must have an “illness” before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records. I also use diagnosis in order to ascertain how to best treat my clients.

### **Confidentiality & the Counseling Relationship**

All of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our counseling relationship, with the following exceptions: (a) Occasionally, I may choose to sharpen my competency as a licensed clinical mental health counselor so I will continue to remain under the supervision of a licensed professional counselor supervisor:

Jennifer B. Locklear, MS/EdS, NCC, LPCS, LCAS, ACS, CSI, ICAADC  
P.O. Box 471, Lewisville, NC 27023  
(336) 945-0137 Jennifer@lewisvillefamilycounseling.com

Ms. Locklear will review some of my work and discuss in individual supervision (b) you direct me in writing to disclose information to someone else, (c) it is suspected you are a danger to yourself or others (including child or elder abuse), or (d) I am ordered by a court to disclose information (*a subpoena is not a court order*), or (e) your employer has sent you and requires limited amounts of information including attendance to sessions.

I believe confidentiality is of utmost importance for my clients, however, if I am seeing you with your partner or spouse I do not keep secrets from either party so if you so not want your partner/spouse to know something you plan to share with me then I would not be a good fit for you.P

Although our session may be very intimate psychologically, it is important for you to realize that we have a professional relationship. Our contact will be limited to the sessions you arrange with me. It is vital for you to know that if I see you in public, I will protect your confidentiality by greeting you only if you greet me first.

### **Complaints**

Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the organization below should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (<http://www.counseling.org/Resources/aca-code-ethics.pdf>).

North Carolina Board of Licensed Clinical Mental Health Counselors  
PO Box 77819  
Greensboro, NC 27417  
Phone: 844.622.3572 Fax: 336.217-9450  
E-mail: Complaints@ncblcmhc.org

**Acceptance of Terms:** by signing below you are acknowledging that you have read, understood and agree with the conditions outlined. We agree to these terms and will abide by these guidelines.

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Counselor: \_\_\_\_\_ Date: \_\_\_\_\_