RHYTHMIC HEART
MUSIC THERAPY

Welcome to Rhythmic Heart Music Therapy, LLC. We strive to serve the entire person we work with individualized services. In order to do that, we want you to get to know us, while we get to know you.

Music therapy services look different for every client or group. It can involve active music making, songwriting, discussion, listening, creation and more. Our music therapists specialize in creating individualized services, and will work to tell you the background and reason for interventions. Please be sure to read through the Client Rights and Responsibilities to learn more.

Thank you for choosing Rhythmic Heart Music Therapy, LLC services. In order to maintain a high level of service, confidentiality and privacy, please fill out the attached forms. This intake is for clients receiving individual sessions or group sessions.

In this intake packet you will find:

- Client Information and History
- Client Rights and Responsibilities
- Financial Policy
- Attendance Policy
- Consent to Treat
- Privacy and Confidentiality
- Notice of Privacy Practices

Please fill out all forms as complete and accurate as possible. The purpose of these forms is to collect background information to assist in forming individualized services. This information will also be reviewed during your assessment session.

If you have any questions or concerns, please contact Kathrine at klee@rhythmicheartmusictherapy.com

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Client Information and History

Client Full Name: _____ D.O.B: _____

Preferred Name: _____ Gender: _____

Guardian Name (if Client under 18): _____

Address: _____ City/State:_____ Zip: _____

Phone: _____ Type: _____ 2nd Phone: _____ Type:_____

Email: _____ Preferred method (circle): Phone Email

Guardian Contact (if applicable): _____

Emergency Contact: _____ Relation: _____

Emergency Contact Phone: _____

Reason for seeking Music Therapy Services:

_____

_____

_____

Referred to Rhythmic Heart Music Therapy, LLC by:

_____

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Primary Diagnosis: _____

Additional Diagnoses: _____

Date(s) you received each Diagnosis: _____

Do you agree with these diagnoses? Yes No Some:_____

Primary Physician: _____

Primary Therapist/Counselor: _____

Primary Dietitian: _____

Are you currently participating in other therapies? Yes No

If yes, please list:

_____

_____

Do you attend school? Yes No

If yes, list school and major/grade: _____

Current Occupation/Employer: _____

Have you participated in music therapy services before? Yes No

If yes, please describe:_____

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What is the current role of music in your life? Please check all that apply:

- ❑ I listen to music in the car
- ❑ I listen to music around my house
- ❑ I like to sing along to songs I know
- ❑ I only sing along when no one is around
- ❑ I have played these musical instruments _____
- ❑ I still play these musical instruments _____
- ❑ I use my music when I am feeling anxious or going through a hard time
- ❑ Other_____

What radio stations, songs, CDs, or artists do you usually listen to?

_____

_____

When do you like to listen to music?

_____

_____

If you have participated in Music Therapy service before, what did you find useful?

_____

_____

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General Questions

What do you view as your personal strengths?

_____

_____

What are your primary goals for music therapy?

_____

_____

Do you have any sensitivities, i.e. sounds, lights, space, etc? If yes, please describe

_____

Are you familiar with using virtual platforms, such as zoom? Yes No

Is there any additional information you would like us to know about you?

_____

_____

_____

_____

_____

_____

_____

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Client Rights and Responsibilities

Clients have the right to:

- Be informed at initial visit and as updated of:
  - Client Rights and Responsibilities
  - Privacy Practices
  - Financial and Attendance Policy
  - Consent to Treat
- A physically and emotionally safe therapeutic space
- Approve or refuse release of information to and from Rhythmic Heart Music Therapy with written authorization
- Terminate treatment by own choice, or by decision made with therapist
- Participate actively and fully in music therapy process

Clients have the responsibility to:

- Participate actively and fully in music therapy process
- Provide complete and accurate information to ensure proper treatment
- Pay bill for service in a timely manner
- Reschedule/Cancel session in timely manner per attendance policy
- Ask questions and engage in discussion to understand music therapy process
- Maintain respect and confidentiality of therapist and fellow clients

I acknowledge that I have read and understand these rights and responsibilities.

Client Signature:_____ Date: _____

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Financial Policy

I, _____, understand that all sessions, individual or group, will be invoiced on the day of service and all payments will be due within 5 days of the invoice. I understand that I am responsible for making full payments in a timely manner.
I acknowledge that I have read and understand this financial Policy.

Responsible Party Name:_____Initials: _____ Date:_____

Attendance Policy

In order to maintain a high level of service, we require a twenty four (24) hour notice for cancelation of sessions, individual or group. If notice is not given, the client will be charged 80% the rate of the missed session. We understand that emergency situations arise that are out of our control and are willing to accommodate such circumstances on a case by case basis.
I acknowledge that I have read and understand this attendance policy.

Initials: _____ Date:_____

Consent to Treat

I, _____, consent for music therapy services provided by Rhythmic Heart Music Therapy, LLC for _____(myself or client's name). I understand that there is always physical risk involved in any activity involving my body, however, the physical risk associated with music therapy is inherently low. I understand that music therapy can involve growth in personal awareness involving tough emotions, personal growth, and insight, yet am accepting of this necessity in the process. I understand that

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Rhythmic Heart Music Therapy practices in the guidelines set by the American Music Therapy Association and the State of Idaho. I am choosing to participate and take an active role in the music therapy process, and will ask for clarification or make comments as necessary.

I acknowledge that I have read and understand this consent to treat statement.

Initials:_____ Date:_____

Privacy and Confidentiality

At Rhythmic Heart Music Therapy, LLC, we gather information in a number of ways, including this intake form, as well as during sessions. When participating in individual or group sessions, it is all our responsibility and obligation to maintain confidentiality with anything discussed during sessions. This information will be kept confidential and not disclosed to anyone else. As privacy and confidentiality are of the utmost importance, we will not share any of your personal information unless the following conditions occur:

1. You or someone else is in danger
2. Therapist is required due to court, or legal requirements
3. You sign and authorize release of information in written form to be shared with a specific party or person

See the attached Notice of Privacy Practices for more information about how your medical information can be used and disclosed and how you can get access to this information.

I acknowledge that I have received a copy of the Notice of Privacy Practices, and that I have read and understand these privacy practices.

Responsible Party Signature: _____ Date:_____

Printed Name: _____

Relation to Client: _____

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PRIVACY PRACTICES

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.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 C.F.R. Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. **Uses And Disclosures We May Make Without Written Authorization**. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

· To avoid a serious threat to your health or safety or the health or safety of others.

· As required by state or federal law such as reporting abuse, neglect or certain other events.

· As allowed by workers compensation laws for use in workers compensation proceedings.

· For certain public health activities such as reporting certain diseases.

· For certain public health oversight activities such as audits, investigations, or licensure actions.

· In response to a court order, warrant or subpoena in judicial or administrative proceedings.

· For certain specialized government functions such as the military or correctional institutions.

· For research purposes if certain conditions are satisfied.

· In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.

· To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. **Disclosures We May Make Unless You Object**. Unless you instruct us otherwise, we may disclose your information as described below.

· To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.

3. **Uses and Disclosures With Your Written Authorization**. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes, and for most marketing purposes, including as found in the Media/Information Release attached as part of the Rhythmic Heart Music Therapy intake packet. You may revoke your authorization by submitting a written Revocation of Authorization to Rhythmic Heart Music Therapy, LLC. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. **Your Rights Concerning Your Protected Health Information**. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

· You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

· We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your email address. You may request that we contact you by

alternative means or at alternative locations. We will accommodate reasonable requests.

· You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.

· You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.

· You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.

· You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. **Changes To This Notice**. We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice on our website. You may obtain a copy of the operative Notice from Kathrine Lee.

6. **Complaints**. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying Kathrine Lee. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. **Contact Information**. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact: Kathrine Lee; Phone: 208-918-2854; Address: PO BOX 45026, Boise, ID 83711; E-mail: klee@rhythmicheartmusictherapy.com

8. **Effective Date**. This Notice is effective October 28, 2020.