Michael D. Lynch, LMFT

101 Cambridge St. Suite 365
Burlington, MA 01803
(617) 334-7727

MEN'S CENTER MCNE NEW ENGLAND

Initial Intake (Individual Adolescent 11-18)

Name_____ Date of Birth_____

Parent(s)/Legal Guardian(s)_____

Address _____ City_____ State _____

Telephone _____ Alternate Telephone _____

E-mail address _____

Age _____ Sex _____ Identified Gender _____ Preferred Pronoun _____

Relationship Status_____ Length of Current Relationship _____ LGBTQ?_____

Emergency Contact

Name _____ Relationship to client _____

Address _____ Phone # _____

Cultural Information (Optional)

Race/Ethnicity _____ Primary Language Spoken at Home _____

Do you find your culture to be a source of strength or identity? _____

Do you consider yourself spiritual or religious? Describe: _____

_____

Financial/Employment

Current Job (if employed) _____ Satisfied with job? _____

Current Employer _____ Length of time on this job _____

Financially I am… _____

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Medical Information

Name of Primary Care Physician _____

Address _____ Phone # _____

List ALL allergies _____

List ALL medications and dosages below:

Medication	Dose/Frequency	Condition Used For

Have you ever been hospitalized? When? What for? _____

_____

Please provide additional information on any serious or chronic illnesses or major injuries including when they occurred or began in the space below.

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Family Relationships / Living Situation

List People Living in Your Household:

First Name	Age	Relationship to You	First 3 Words That Come to Mind to Describe Them

Are there other significant people in your life who you do not live with? Describe them below.

Educational/Developmental Information

Current Grade_____ Current School (if enrolled) _____

Highest Grade Completed _____ Preferred Subject(s) _____

Any diagnosed learning disabilities? _____

Any developmental delays in early childhood? _____

Reason for Seeking Treatment

Briefly describe what you are seeking treatment for and why now?

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Previous Treatment

Have you ever had therapy in the past? When? For what issues? With whom? Did you find it effective? Please describe briefly:

Addiction and Substance Use

Have you had any issues with drugs or alcohol or other addictive behaviors such as gambling, sex, food, exercise, internet/video games? Please describe which substances/behaviors, when this began and the last time the substance was used or behavior was engaged in.

Trauma History

If you have experienced any trauma in your life, especially in childhood, please describe briefly:

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Electronic Communication Policy

Michael D. Lynch, LMFT (Men's Center New England, LLC) utilizes E-voice for business communication. This service routes calls and texts to him at specified times and/or when available. Men's Center New England has an e-mail account through Gmail which has been provided to me. By signing below, I confirm that I understand and agree to the following:

- I understand that this number is not to be used for emergency purposes. Should I need urgent help I agree to call 9-1-1 or go to my nearest emergency room.
- I understand that messages may take some time to return.
- I agree to utilize voicemail, e-mail and text messaging only for non-clinical matters such as scheduling. Texts or e-mails containing clinical information will be printed and saved as part of my clinical record.
- I understand that no electronic communication can be 100% secure from hacking. I understand that any electronic communication could be intercepted, altered or forwarded without detection, stored electronically by 3rd parties, and could be used in court if my clinical record was ever court ordered. Additionally, I understand that text messaging rates may apply depending on my carrier.
- I understand that E-voice records voicemails in a digital file and sends them to menscenternewengland@gmail.com in order to communicate with Michael D. Lynch, LMFT in a timely fashion. These files will be deleted within 30 days.
- Michael Lynch, LMFT cannot guarantee but will use reasonable means to maintain security and confidentiality of all electronic communication.
- I allow Michael Lynch, LMFT to leave voicemail messages on the number I have provided _____ (initial to agree) and to send text messages to the number I have provided regarding appointment times and other non-clinical matters _____(initial to agree)
- Michael Lynch, LMFT can discontinue the use of text messages and e-mail if these policies are not adhered to.

Name of client (Print) _____ Date_____

Signature _____

Signature of parent/legal guardian_____

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Confidentiality Policy

Confidentiality and privileged communication are the cornerstone of any therapeutic process and are the right of all clients. However, there are limits to such communication as mandated by state law. It is very important that you and those seeking therapy services understand and agree to the following limitations. In the interest of transparency, informed consent, and education I have included reference to the actual laws below. This will be explained to you verbally upon intake and you can be provided a signed copy of this informed consent form.

- *Duty to Protect:* Massachusetts law (MG.L. c.123, section 36B) is very specific about licensed mental health professionals and our duty to warn or protect identifiable potential victims of our clients. Any disclosure of intent to harm another will be treated seriously and confidentiality will be breached to be acted on accordingly with law enforcement and directly with the person/property threatened.

- *Child Abuse:* Massachusetts state law (M.G.L. c.119 section 51A) mandates the reporting of incidence or suspected incidence of child abuse to the Department of Children and Families. In cases of reported or suspected child abuse Men's Center New England (Michael Lynch, LMFT) will report to DCF within 24-hours.

- *Disabled Adult and Elder Abuse:* Massachusetts state law (M.G.L. c.19A section 14 and 15 & M.G.L. c.19C section 1, 10, and 11) also provides protections for the disabled and elders. Should abuse be disclosed about either of these protected populations confidentiality will be breached and appropriate reporting will be made.

- *Suicide & Self-harm Ideation:* I am not required to make a notification if you express a desire to hurt yourself unless your intent to do so puts others at risk. However, I retain the option to notify family members, emergency services or law enforcement if you are unable or unwilling to seek help for yourself. Expressions of hopelessness in-and-of themselves would not necessarily trigger any action and I would not want to shame or stigmatize thoughts in this realm. In fact, I welcome them as part of your experience of being to be processed in our therapeutic context. But I will assess for plans and means to act upon these thoughts and take whatever steps are needed to protect you so that the work in these areas of hopelessness can continue.

- *Outside Consultation:* If you want me to consult with another healthcare provider, school, or any other appropriate party a Release of Information must be signed in advance, stating the purpose of the consultation, and the duration of the ROI.

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Confidentiality Policy (cont.)

- *Family and Couples Therapy:* Family members and couples may be seen at times individually or conjointly. Information shared during these sessions or in related settings (e.g. telephone calls) is considered part of the overall family or couple therapy process and is not confidential from the other participating family members or partners. I will use my discretion in handling these matters. This is simply a "no secrets" policy to respect the trust of all participants. It is important that you understand this policy before treatment begins. Healthy relationships are built on openness and truth. A separate couples therapy agreement may be signed to clarify the rules and policies around that particular service

- **Under no circumstances will I testify or participate in legal proceedings without a court order.** Client records must be court ordered, not only subpoenaed by an attorney. With the exception of attendance letters confirming treatment dates - should you request one - I recommend you never make your mental health or treatment part of a legal proceeding.

Please be sure you have read the above very carefully. If you are not sure you fully understand any of the above limitations to confidentiality, please ask before you sign.

I the undersigned, have read and fully understand the limits of my/our confidentiality. I further agree to abide by the policy set out above. I have had a chance to ask my therapist for additional clarification regarding the limits of confidentiality.

Signature: _____ Date: _____

I am the parent/legal guardian signing for minor (name) _____

Signature: _____ Date: _____

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General Policies/Procedures & Consent for Treatment

Cancelation Policy: 24-hour notice is required for cancellation except in emergencies. The full session fee will be charged if inadequate notice is given. A pattern of cancellations or no-shows could result in termination of services. We will always discuss options and work to identify and remove the barrier preventing full engagement in therapy but I will not hold time that another person could be utilizing. Please be mindful when canceling that it is not only my time not being used, but members of your community on my waiting list who could be using that time.

Fees: My standard fee for a 50-minute individual, couple or family session is $160 ($200 for 90-minute intake sessions). Consultations (with schools, attorneys, family, etc.) and phone calls will be charged at $40 per 15-minute increment. Full payment is due at the beginning of each session by cash (exact change only), check, or Venmo electronic transfer. All checks should be made payable to **Men's Center New England** or **Michael Lynch, LMFT.** Returned checks will incur a $15 fee payable at the beginning of the following session. Clients are responsible for protecting their confidentiality by setting Venmo transactions to private and using **the session date only** as the reason for the transaction. Exceptions due to pre-payment and reduced rate agreements will be noted in a signed contract addendum to this informed consent agreement.

Consent to Treatment: Men's Center New England, LLC is a practice of Michael Lynch, LMFT (licensed in Massachusetts #1768) equipped by training and education to provide psychotherapeutic services to enable individuals, couples, groups and families to achieve more satisfying relationships, personal, psychological, spiritual and emotional growth, and physical wellbeing.

My signature below verifies that I, or my minor child, are entering into a therapeutic process with Michael Lynch, LMFT under my own free will. The scope of services, policies and procedures including fee & payment, communication, cancellation, license information, confidentiality and legal obligations have all been explained to me and that I agree to and understand its contents.

Name (Print) _____ Date _____

Signature _____

Name of Parent/Guardian signing for minor (Print) _____

Signature _____ Date _____