CLIENT INFORMATION

Name: (F, MI, L)	Client DOB:	Date:
Address:	City/Zipcode:	
SSN:	Employer:	Work Phone:
Home Phone:	Cell Phone:	Email:

Preferred Method of Contact ☐Home Phone ☐Work Phone ☐Cell Phone ☐Email	Is it ok to leave a message? ☐Yes ☐No	Emergency Contact: Name and Phone # Primary Care Physician:

INSURANCE INFORMATION

Subscriber Name (F,M,L):	Subscriber DOB:
Address (If different):	SSN:
Primary Insurance Company:	Employer:
Policy/ID# (On card)	Group#

By signing this form, I am stating that the information I have provided is accurate. I also authorize my therapist and their staff to release protected health information from my clinical record to any of the following entities as applicable for the billing for payment of services: EAP program, my health insurance company, and/or its designated managed care company. I also authorize my therapist to use software provided by Therapy Appointment and the clearinghouse Office Ally to submit claims and store recorders. I understand that this authorization continues indefinitely unless I revoke it in writing. However, if I revoke this authorization, I understand that any of the above entities retains the right to information in my clinical record prior to the revocation date.

Sign:	Date:

IF CLIENT IS NOT A MINOR SKIP THIS PAGE

Complete if client is a minor or someone else is responsible for payment.

Parent (s):	Phone
Parent (s):	Phone
Person responsible for payment of services:	Relation to Client:
Responsible party's address (if different than client):	

Parents of Minors

I authorize _____ to receive services including evaluations and treatment. I consent to services for the minor mentioned above and to allow the above insurance policy to be billed.	
Sign:	Date:
Sign:	Date:

Clients' Initials: _____

Informed Consent

Client-Therapist Service Agreement
Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. **We can discuss any questions you have when you sign them or at any time in the future.**

Goals of Counseling
There can be many goals for the counseling relationship. Some of these will be long term goals, such as, improving the quality of your life, learning to live with mindfulness and self-actualization. Others may be more immediate goals, such as, decreasing anxiety and depression symptoms, developing healthy relationships or changing behavior. Whatever the goals for counseling, they will be set by the clients according to what they want to work on in counseling. The therapist may make suggestions on how to reach that goal, but you decide where you want to go.

Risks/Benefits of Counseling
Counseling is an intensely personal process that can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.
There are many benefits to counseling. Counseling can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages.

Appointments
Appointments will ordinarily be 50-60 minutes in duration, once per week. Some sessions may be more or less frequent, as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, provide your therapist with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hour notice, you may be required to pay a cancelation fee of $50 for the session. It is important to note that insurance companies do not provide reimbursement for canceled sessions; thus, you will be responsible for the cancelation fee. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Confidentiality
Your therapist will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form before any information will be released. There are some limitations to confidentiality to which you need to be aware. Your therapist may consult with a supervisor or other professional therapist in order to give you the best service. In the event that your therapist consults with another therapist, no identifying information, such as your name, would be released. Therapists are required by law to release information when the client poses a risk to themselves or others, and in cases of abuse to children or the elderly. If your therapist receives a court order or subpoena, she may be required to release some information. In

such a case, your therapist will consult with other professionals and limit the release to only what is necessary by law. As a private therapy office your therapist does the best to protect you anonymity, but there may be times when there are other people sitting in the waiting room. If this makes you uncomfortable please talk with your therapist.

Record Keeping

Your therapist may keep records of your counseling sessions and a treatment plan which includes goals for your counseling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared, except with respect to the limits to confidentiality discussed in the Confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be kept for longer. Records will be kept either electronically, on a USB flash drive, or in a paper file and stored in a locked cabinet in the therapist's office. Your therapist uses Therapyappointment.com to manage electronic files and scheduling. This website is HIPPA compliant.

Professional Fees

You are responsible for paying at the time of your session, unless prior arrangements have been made. Payment must be made by check or cash. If you refuse to pay your debt, your therapist reserves the right to use an attorney or collection agency to secure payment. Additional time will be charged in 30 minute increments. If there is a returned check, the charge will be $35. A sliding fee scale is offered for services not covered by insurance. To receive sliding scale fees, you must discuss this arrangement with your therapist. Fees are subject to change at therapist's discretion.

If you anticipate becoming involved in a court case, it is recommended that we discuss this fully before you waive your rights to confidentiality. If your case requires therapist participation, you will be expected to pay for the professional time required at the cost of $150 per hour. This would include travel, prep, and appearance time. Emails and phone calls with attorneys will be charged $75 per incident and there will be an additional charge of $150 to process a request for records for an attorney or to be released to court.

Insurance

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but **you are responsible for knowing your coverage and for letting me know if/when your coverage changes.** This includes knowing if you have a deductible that needs to be met before you have coverage. Your therapist uses a clearinghouse, Office Ally to assist in filing insurance claims.

You should also be aware that some insurance companies require you to authorize your therapist to provide them with a clinical diagnosis. Sometimes additional clinical information will need to be provided, which will become part of the insurance company files. By signing this Agreement, you agree that the therapist can provide requested information to your carrier if you plan to pay with insurance. **If insurance denies coverage or payment for any reason, you remain responsible for paying any outstanding balance.**

Clients' Initials: _____

Contacting Your Therapist
Your therapist is often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, be aware it may take a day or two for non-urgent matters. **If you feel you cannot wait for a return call or it is an emergency situation, go to your local hospital or call 911.**

Email is another option for contacting your therapist and at times may be the fastest way to reach me. Due to the nature of online technology there is always the possibility that unauthorized persons may attempt to discover your personal information. **I have taken every precaution to safeguard you information but cannot guarantee that unauthorized access to electronic communication could not occur.** Please be advised to take precautions with regard to authorized and unauthorized access to any technology used in communication with your therapist. Be aware of any friends, family members, significant others or co-workers who may have access to you computer, phone, or other technology. It is best to keep communications related only to scheduling purposes.

Payment Arrangement

Insurance: ☐ Yes ☐ No

Sliding Fee Arrangement

Client pays: $_____ Client Initials: _____

Therapist Initials: _____

Consent to Counseling
Your signature below indicates that you have read this Agreement and agree to its terms.

Name of Client(s): _____

Client Signature _____ Date_____
(Guardian if client is a minor)

Client Signature _____ Date_____

Intake Assessment Form

Name (First, Last): **DOB:** **Gender:** ☐ Male ☐ Female ☐ Transgender ☐ _____

Presenting Concerns

Who Referred you?

What occurred to cause you to seek counseling now?:

Living Conditions

☐ Rent ☐ Own ☐ Friend/Relative's Home ☐ Respite Care ☐ Jail/Prison ☐ Homeless
☐ Residential Care/Treatment Facility: ☐ Hospital ☐ Temporary Housing ☐ Residential Program ☐ Nursing

Are you at risk of losing your current housing? ☐ Yes ☐ No

Are you satisfied with you current housing? ☐ Yes ☐ No

Comments:

Family History

Pertinent Family Medical, Mental Health and Substance Use History:

Family Dynamics (Please include everyone who lives in your household and ages):

Personal History

Highest Level of Education: ☐ GED ☐ High School ☐ College ☐ Vocational Training ☐ Graduate Degree ☐ Other

Employment Status: ☐ Currently Employed at:
☐ Not Employed ☐ Other:

Military Service: ☐ N/A ☐ Active ☐ Veteran **Date of Discharge:**

Legal Status: Do you have a history or current involvement with the legal system? ☐ Yes ☐ No
Comments:

Religion/Spirituality and Cultural/Ethnic Information:

Friendships/Social/Peer Support Relationships, Pets, Community Supports:

Intake Assessment Form

Substance Use History

Substance use status: ☐ No history of abuse ☐ Active abuse ☐ Early full remission ☐ Partial remission ☐ Sustained full remission ☐ Sustained partial remission

Client Treatment history: ☐ Outpatient ☐ Inpatient ☐ 12-step program ☐ Stopped on own ☐ Other

Comments: (Please provide locations and dates of treatment)

Substances used: (Age of First Use, Amount of Current Use)

☐ Alcohol _____ _____
☐ Cocaine _____ _____
☐ Hallucinogens (e.g., LSD) _____ _____
☐ Marijuana or hashish _____ _____
☐ PCP _____ _____
☐ Other _____ _____
☐ Amphetamines/speed _____ _____
☐ Crack cocaine _____ _____
☐ Inhalants (e.g., glue, gas) _____ _____
☐ Opioids _____ _____
☐ Prescription _____ _____

Consequences of substance abuse:

Medical and Mental Health History

Medications you are currently taking:

Known Allergies:

Physical Health Concerns:

Primary Care Physicain:

Primary Psychiatrist:

Previous Mental Health Diagnosis:

Previous Mental Health Counseling/Treatment Experiences:

Did you find any of your previous treatments to be benefecial?

Would you like us to request previous records?: ☐Yes ☐No

Sexual and Relationship History

Describe any significant issues from the past or currently in you intimiate relationships:

Sexual Orientation: ☐Heterosexual ☐Homosexual ☐Bisexual ☐Other
☐Currently sexually active ☐Sexually satisfied ☐Sexually dissatisfied

Age of first sexual experience:

Trauma related to sex: ☐ Yes ☐ No

Would you like therapy to focus on sexual issues or topics? ☐Yes ☐No

Comments:

Intake Assessment Form

Symptom Check List – Please check any that apply to you.

- ☐ Aggressive Behaviors
- ☐ Agitation
- ☐ Irritability
- ☐ Panic Attacks
- ☐ Phobias
- ☐ Have recurrent or persistent thoughts that bother you.
- ☐ Excessive anxiety/worry for over 6 months, more days than not.
- ☐ Difficulty controlling the worry, sleep disturbance, or restlessness.
- ☐ Re-experience in your mind bad things that have happened to you.
- ☐ Depressed Mood
- ☐ Hopelessness
- ☐ Mood Swings
- ☐ Social Isolation
- ☐ Grief
- ☐ Poor Grooming
- ☐ Appetite Disturbance
- ☐ Feel depressed most of the day, nearly every day.
- ☐ Changes in sleep
- ☐ Elevated Mood
- ☐ Withdrawal
- ☐ Feeling inadequate
- ☐ Have less interest/pleasure in doing things you usually enjoy doing.
- ☐ Feel fatigued nearly every day.
- ☐ Feel worthless or excessively guilt most of the time.
- ☐ Have a difficult time thinking/concentrating, or feel indecisive a lot.
- ☐ Have any beliefs that other people would think are strange.
- ☐ Ever wanted to hurt or kill yourself.
- ☐ Currently feel suicidal.
- ☐ Ever made, or currently have, a suicide plan.
- ☐ Ever attempted suicide
- ☐ Delusions
- ☐ Ever experience any of the following, lasting for one week: feelings of grandiosity, decreased need for sleep, pressured speech, racing thoughts, distractible, agitated, increase in pleasure-seeking activities, increase in libido.
- ☐ Seen or heard things that other people didn't see or hear.
- ☐ Frequently aggressive towards people or animals
- ☐ Bingeing/Purging
- ☐ Anorexia
- ☐ Often destroy property?
- ☐ Often set fires?
- ☐ Often lose your temper?
- ☐ Often feel angry or resentful?
- ☐ Often argue with adults or authority figures?
- ☐ Often refuse to comply with rules?
- ☐ Often blame other people for your mistakes?
- ☐ Ever been diagnosed with ADHD?
- ☐ Often make careless mistakes?
- ☐ Often don't finish assignments.
- ☐ Often distracted when listening to people.
- ☐ Have trouble organizing tasks?
- ☐ Avoid things that take you a long time?
- ☐ Easily distracted by stuff going on around you?
- ☐ Often forgetful
- ☐ Poor Memory
- ☐ Often fidget
- ☐ Often feel restless
- ☐ Often "on the go," can't sit still long
- ☐ Often talk too much
- ☐ Have trouble waiting your turn
- ☐ Often blurt out the answers to questions
- ☐ Interrupt a lot.
- ☐ Physical Trauma Perpetrator
- ☐ Physical Trauma Victim
- ☐ Sexual Trauma Perpetrator
- ☐ Sexual Trauma Victim
- ☐ Sexually Acting out
- ☐ Sexual Dysfunction
- ☐ Substance Abuse
- ☐ Self-Injury
- ☐ Emotional Trauma Perpetrator
- ☐ Emotional Trauma Victim

Any other information that you feel is important:

Signature: _____ **Therapist Signature_____**

Date: **Date:**

Intake Assessment Form