Client Information

Name: (F, MI, L)			Date:
Address:	City, State, Zip		SSN:
Client DOB:	Age:	Employer:	
Home Phone:	Work Phone:		Cell Phone:
Preferred Method of Contact ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ____________________			Is it ok to leave a message? ☐ Yes ☐ No

INSURANCE INFORMATION

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

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

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):	

Emergency Contact:	Relation to Client:	Phone Number:
Primary Care Physician		Phone Number:
Psychiatrist/Medication Management (If applicable)		Phone Number:

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 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:

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:

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.

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Goals of Therapy
There can be many goals for the therapy 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 therapy, they will be set by the clients according to what they want to work on in therapy. The therapist may make suggestions on how to reach that goal but you decide where you want to go.

Risks/Benefits of Therapy
Therapy is an intensely personal process that can bring unpleasant memories or emotions to the surface. There are no guarantees that therapy will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Therapy 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.

However, there are many benefits to therapy. Therapy 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 at a time we agree on, although 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, I ask that you provide me 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 for the session [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible 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 such 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.

Confidentiality and Group Therapy
The nature of group Therapy makes it difficult to maintain confidentiality. If you choose to participate in group therapy, be aware that your therapist cannot guarantee that other group members will maintain your confidentiality. However, your therapist will make ever effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in group confidential. Your therapist also has the right to remove any group member from the group should she discover that a group member has violated the confidentiality rule.

Record Keeping
Your therapist may keep records of your therapy sessions and a treatment plan which includes goals for your therapy. 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.

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, I reserve the right to use an attorney or collection agency to secure payment.

If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required. Fees are non-negotiable. To receive sliding scale fees, you must present proof of income through recent pay stubs or tax forms. Fees are subject to change at therapist's discretion.

Fee Schedule
90791 psychiatric diagnostic evaluation (Intake) – $220
90834 psychotherapy 45 minutes – $120
90837 psychotherapy 60 minutes – $175
90846 family psychotherapy without the patient present – $150
90847 family psychotherapy with the patient present - $175
90853 group therapy 90 to 120 minutes – $50

Sliding Scale
If you feel you would qualify for a sliding fee scale please inquire with the therapist for more information.

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.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information which will become part of the insurance company files. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover counseling fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services.

Client's Initials: _______________

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

Contacting Me

I am 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, but 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

Therapist may request client's email address. Client has the right to refuse to divulge email address. Therapist may use email addresses to periodically check in with clients who have ended therapy suddenly. Therapist may also use email addresses to send newsletters with valuable therapeutic information such as tips for depression or relaxation techniques. Therapist also has a blog and if this is appropriate for the client, therapist may send information through email about subscribing to the blog or information related to mental health and wellness. If at any time in between appointments a client uses email for correspondence with the therapist it is likely that no response will be received. Email is to be used for the purpose of scheduling and any other information will be processed in the next scheduled therapy session.

Payment Arrangement

Client pays: $____________________ Client Initials:________________

Therapist Initials:________________

Consent to Therapy

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):

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 ☐arly full remission ☐artial 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 ☐isexual ☐ther
☐Currently sexually active ☐exually satisfied ☐exually dissatisfied

Age of first sexual experience:

Trauma related to sex: Ye☐ No☐

Would you like therapy to focus on sexual issues or topics? ☐es ☐o

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

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):

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 ☐arly full remission ☐artial 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 ☐isexual ☐ther
☐Currently sexually active ☐exually satisfied ☐exually dissatisfied

Age of first sexual experience:

Trauma related to sex: Ye☐ No☐

Would you like therapy to focus on sexual issues or topics? ☐es ☐o

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?
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- ☐ 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:**