EMPOWERING THROUGH TRANSITION

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CONFIDENTIAL CLIENT INTAKE

GENERAL INFORMATION

Client #1:

Name_____ SS #:_____Date of Birth:____/____/____

Address:_____

City:_____ State:_____ Zip:_____

Phone/Cell:_____ Okay to text: ☐Yes ☐No

Email:_____

Emergency Contact:_____ Contact Phone:_____

Emergency Contact Relationship to you:_____

Client #2:

Name_____ SS #:_____Date of Birth:____/____/____

Address:_____

City:_____ State:_____ Zip:_____

Phone/Cell:_____ Okay to text: ☐Yes ☐No

Email:_____

Emergency Contact:_____ Contact Phone:_____

Emergency Contact Relationship to you:_____

FAMILY RELATIONSHIP INFORMATION

Present relationship status (check all that apply): ☐Married (yrs:___ mos:___) ☐Single (yrs:___ mos:___)
☐ New relationship (6 mos or less) ☐Partnered (yrs:___ mos:___) ☐Other:_____

If married, partnered or in a primary relationship, do you live with your significant other? ☐Yes ☐No

Others living in your household or outside (please specify which):

Name	Relationship	Age

EDUCATIONAL AND VOCATIONAL INFORMATION

Client #1:

Current Occupation:_____ Employer:_____

Higher grade completed and/or degree(s) obtained:_____ Annual HH income:_____

Client #2:

Current Occupation:_____ Employer:_____

Higher grade completed and/or degree(s) obtained:_____ Annual HH income:_____

MEDICAL INFORMATION

Client #1:

PrimaryTherapist:_____Phone:_____
Psychiatrist:_____Phone:_____
Medical Doctor:_____Phone:_____
Other Specialist:_____Phone:_____
Are you in recovery for addiction or compulsion? ☐Yes ☐No What program(s)?:_____
Are you currently sober? ☐Yes ☐No
List medications you are currently taking (including non-prescription and herbal remedies):_____
_____
Describe any current physical and/or psychiatric concerns that you have:_____
_____

Client #2:

PrimaryTherapist:_____Phone:_____
Psychiatrist:_____Phone:_____
Medical Doctor:_____Phone:_____
Other Specialist:_____Phone:_____
Are you in recovery for addiction or compulsion? ☐Yes ☐No What program(s)?:_____
Are you currently sober? ☐Yes ☐No
List medications you are currently taking (including non-prescription and herbal remedies):_____
_____
Describe any current physical and/or psychiatric concerns that you have:_____
_____

CONFIDENTIALITY

Under most circumstances, all communication between you and your therapist is confidential, unless permission is given by you to convey information to a third party. There are certain legal exceptions to this:

1. When there is a reasonable suspicion of child abuse, dependent-adult abuse or elder abuse;
2. When a client threatens violence to an identifiable victim;
3. When a client presents a danger to violence to others;
4. When a client is likely to harm him/herself unless protective measures are taken.

Disclosure may also be required in certain legal proceedings. *If you have concerns about the content of our sessions and any legal proceedings in which you are involved or expect to be involved (e.g., divorce, child custody cases), please let your therapist know.*

Before any disclosure is made, every reasonable effort will be made to appropriately resolve these issues or to notify clients.

ALL clients shall maintain the confidentiality of other clients and are not permitted to disclose any personal and/or identifying information about any other client. This boundary is critical for client safety

CONTACTING THERAPIST

Clients may email, text or leave a voicemail for the therapist at any time. Please be aware that the therapist may not be able to immediately retrieve messages. **If you have a life-threatening emergency, dial 911.**

APPOINTMENTS

Sessions are 45-50 minutes in length and begin at the scheduled appointment time. If you arrive late, your session will be shorter; if the therapist begins late, your session will be extended to make up the time. If you must cancel a session, please let the therapist know at least 24 hours in advance. **You will be responsible for the full fee of any session canceled with less than 24 hours notice.** Appointments must be canceled via text or voicemail, as mail is not checked regularly. For psychotherapy to be most effective, clients must not be under the influence of intoxicating substances.

FEES, BILLING AND PAYMENTS

All services are billed at the standard rate. Sliding-scale fees may be established based on ability to pay and therapist availability. Clients pay for services at the end of each session, unless other arrangements have been made. Please notify the therapist if any problems arise that affect your ability to make timely payments.

If document preparation is required (e.g. legal proceedings, insurance appeals), the therapist reserve the right to bill for services, plus fees for materials (copies, outside services, etc).

In order to prevent any misunderstandings about payment for services, please be advised of the following:

1. All services provided are billed directly to the client unless other arrangements have been made;
2. Clients are personally responsible for payment at time of service via credit card, cash, check or money order;
3. Statements can be provided for clients to submit for insurance reimbursement;
4. Clients are responsible for submitting all claims to their insurance providers;
5. If payment is not received when services are rendered, payment may be applied to the credit/debit card on file if no other payment arrangements have been made;
6. If client credit/debit card is invalid and client have made no other payment arrangements, client past due balance may be sent to an agency for collection.

If client commit to group therapy, the weekly fee for group sessions is due even if you do not attend.

Client is individually responsible for all incurred charges, even if client direct us to bill another person. If client direct charges to be billed to another person, client represent that he/she is authorized to give such direction. If client has directed charges to be billed to another person who fails to make payment, you will promptly pay on demand.

I have read, understand and agree to the information, guidelines and office policies stated above:

Client #1:

Signature_____ Date:_____

Printed Name:_____Date:_____

Client #2:

Signature_____ Date:_____

Printed Name:_____Date:_____

Please fill out the payment information (next page)

PAYMENT INFORMATION

Please provide a credit card authorization regardless ofyour payment method

Credit Card Authorization: I authorize the maintenance of valid credit card information to guarantee my chosen payment option.

Cardholder Name:_____

Billing Address:_____

City:_____ Sate:_____ Zip:_____

Circle Card Type: Visa MC Discover AmEx

Credit Card #_____Expiration Date:_____/_____

3 Digit CVV Code:_____

Cardholder Signature:_____ Date:_____

Payment is due when services are rendered. If payment is not made when services are rendered, or if client has an outstanding balance, then client credit card on file will be charged in the amount of the outstanding balance.

Monthly statements will be provided upon request. Clients are responsible for submitting all claims to their insurance provider.

Payment Guarantee: I understand that I am individually responsible for all incurred charges, even if I direct you to bill another person. If I direct charges to be billed to another person, I represent that I am authorized to give you such direction. If I have directed you to billed charges to another person who fails to make a payment promptly when due, I will promptly pay on demand. If I commit to group therapy, I understand that the weekly fee for group sessions is due even if I do not attend.

I understand there is a 24-hour cancellation policy for sessions and that I will be charged without providing 24 hours advance notice to cancel a session.

I have read, understand and agree to the information, authorization and guarantee stated above.

Client #1:

Signature_____ Date:_____

Printed Name:_____Date:_____

Client #2:

Signature_____ Date:_____

Printed Name:_____Date:_____