Intake Form

Type of Counseling:

- ☐ Individual
- ☐ Couples
- ☐ Pre-Marital
- ☐ Family
- ☐ Groups
- ☐ Evaluation

Name:

Last, First, Middle Initial

Address:

(Number & Street Name) (City) (State) (Zip)

Contact Information

Home: (______) - __________- _________ May we leave a voice message? ☐Yes ☐No

Cell/ other: (______) - __________- _____ May we leave a voice message? ☐Yes ☐No

Email: __________________________@__________.com May we email you? ☐Yes ☐No

Emergency Contact Name: _________________ Relationship: __________________

Phone Number: (_____) - ______- _________

Birthdate (Please spell out): Month___________________ Day_________ Year____________

Social Security Number (SSN): ____-____-_____ Age: _______

School Name: ____

Highest Level of Education: ____

Gender assigned at birth: ☐ Male ☐ Female

Current gender identity: ☐Male ☐Female ☐Transgender

☐Do not identify as female, male, or transgender

Marital Status: ☐Never Married ☐Domestic Partnership ☐Married ☐Separated ☐Divorced ☐Widowed

Race/ Ethnicity: ____

Please list any children/ age: ____

Legal Issues:____

Name of Parent/ Guardian (if client is under 18yrs):

____

How did you hear about us? ☐Internet ☐Referral ☐Other: __________________

Insurance

Insurance: _______________________ Policy Holder: ___________________________

Policy Number: ___________________ Group Number: __________________________

EAP Name: ______________________ Authorization: ____________________________

Effective Date of Insurance: _____________ Phone Number: (____) - ______- ______

General Health Information:

1. Are you currently taking any prescription medication? ☐Yes ☐No
   Please List: ____
2. How would you rate your current physical health?
   ☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

   Please list any specific health problems you are currently experiencing:

   ____
3. How would you rate your current sleeping habits?
   ☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

   Please list any specific sleep problems you are currently experiencing:

   ____
4. How many times a week do you generally exercise?
   ☐0-1 ☐2-3 ☐4-5 ☐6-7 ☐7 or more
   What type of exercise do you participate in? _____________
5. Please list any difficulties you experience with your appetite or eating patterns:

   ____

Mental Health Information

1. Have you previously received any type of mental health services (such as psychotherapy, psychiatric services, etc.)? ☐No ☐Yes

   If yes, please list previous therapist/ practitioner: _______________________

2. Have you ever been prescribed psychiatric medication? ☐Yes ☐No

   If yes, please list and provide dates: ___________________________________

3. Are you currently experiencing overwhelming sadness, grief or depression?

   ☐No ☐Yes If yes, for approximately how long? ______________________

4. Are you currently experiencing anxiety panic attacks or have any phobias?

   ☐No ☐Yes

   If yes, approximately when did you begin experiencing this? ___________________

5. Are you experiencing any chronic pain? ☐No ☐Yes

   If yes, please describe. ____

6. Do you drink alcohol? ☐No ☐Yes

   How often: ☐Once a week ☐twice a week ☐Three or more times a week

7. How often do you engage in recreational drug use?

   ☐Daily ☐Weekly ☐Monthly ☐Infrequently ☐Never

8. Are you currently in a romantic relationship: ☐No ☐Yes

   If yes, for how long? ____

   On a scale of 1 - 10, how would you rate your relationship? _______________

9. What significant life challenges or stressful events have you experienced recently?

   ____

   ____

   ____

   ____

   ____

   ____

Family Mental Health History

In the section blow identify if there is a family history for any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please Circle One	List Family Member
Alcohol/ Substance Abuse	Yes - No	
Anxiety	Yes - No	
Depression	Yes - No	
Eating Disorder	Yes - No	
Obesity	Yes - No	
Obsessive Compulsive Behavior	Yes - No	
Schizophrenia	Yes - No	
Suicide Attempts	Yes - No	

Additional Information

1. Are you currently employed? ☐No ☐Yes

If yes, what is your current employment situation? ______________________________

Do you enjoy your work? ☐No ☐Yes

Is there anything stressful about your current employment situation?

____

2. Do you consider yourself to be spiritual or religious? ☐No ☐Yes

   If yes, please describe your faith or belief: ______________________________

3. What do you consider to be your strength? ______________________________

   ____

4. What do you consider to be your weakness? ______________________________

   ____

5. What would you like to accomplish out of your time in therapy? ____________

____

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without written consent of the client or legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicided, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abuses a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse the mental health professional is required to report this information to the appropriate social service and / or legal authorities.

Prenatal Exposure to Controlled Substance

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/ Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Insurance Providers (when applicable):

Insurance companies and other third party payers are given information that thy request regarding services to clients. Information that may be requested includes, but not limited to: types of services, dates/ times of service, diagnosis, treatment plans, descriptions of impairment, progress of therapy, case noes, and summaries.

I agree to the above limits of confidentially and understand there meaning and ramifications.

Client Signature Date

Client's Parent/ Guardian Signature (if client is under 18) Date

Consent for Treatment

It is our goal to make your experience her an informed and positive one. Please review and complete the following information. If you have any questions, please feel free to discuss them with us.

It is the responsibility of all client of Transitions Counseling and Mentoring Services to be aware of all fees due for services under private pay or through health insurance. Payments are due at the **beginning** of each session. We cannot continue to schedule sessions if payments have not been made on prior sessions. There will be a $30.00 service charge on returned checks (NSF). _________ **Clients Initials.**

Counseling Rates for Private Pay (per 50-min sessions):

Service	Fee
Diagnostic Intake	$175.00
Individual Counseling	$125.00
Couples Counseling	$160.00
Family Counseling	$185.00
Group Counseling	Varies
Returned Check fee	$30.00
Missed Appointment fee	$50.00

Health Insurance Coverage

Please bring a copy of your medical insurance card to each appointment. As a courtesy, **Transitions Counseling and Mentoring Services will verify your benefits with your insurance company. However, this is not a guarantee of payment. If prior authorization or approval is needed for mental health services, it is the clients'' responsibility to contact the insurance agency**. It is also your responsibility to understand your coverage, including co-pays, co-insurance, and deductibles. This includes understanding which services are covered and what services are not covered. It is also your responsibility to let us know if there has been a change in your insurance coverage or changes in employment. We will be glad to file your insurance for you. You are responsible for your deductibles and co-payments. _________ **Clients Initials.**

Financial Responsibility

You are responsible for payments of fees (co-pay, co-insurance, deductibles, non-covered services) for Transitions Counseling and Mentoring Services. If we provide services that are not covered by your

medical insurance or EAP, you are responsible for the payment of these services. Payment of fees are due prior to the start if an appointment. _________ **Clients Initials.**

The person who signs below is agreeing to be the "financial guarantor," which means this person agrees to pay any of these fees. If we determine there is a balance on your account (ex. Session fees, Missed Appointment, Returned Check, etc.), we will send you a statement. We ask that your complete payment in 30 days If the fees are not pain in 30 days, we will send your account to a collection agency where you will be responsible for all collection fees, court costs, and legal fees. _________ **Clients Initials.**

Training and Clinical Supervision

- Transitions Counseling and Mentoring Services is a training center for Master's and Doctoral Level Counseling, Social Work, and Psychology interns. All counselors at Transitions Counseling and Mentoring Services are under the supervision of licensed mental health professionals.
- In order to ensure that counselors receive the best possible training, and that clients are well served, some session will be video or audio taped. Tapes are viewed by Transitions Counseling and Mentoring Services clinical supervisors only, and are erased in a timely manner. You must agree to be taped to receive counseling services at Transitions Counseling and Mentoring Services.
- Counselors are generally on a time limited contract with Transitions Counseling and Mentoring Services. Therefore, it is possible that your counselor may leave Transitions Counseling and Mentoring Services prior to the end of your therapy. If this occurs, we will take reasonable steps to ensure a smooth transition. _________ **Clients Initials.**

Child Care Release

Transitions Counseling and Mentoring Services does not provide childcare and is not responsible for children or adolescents left unsupervised in the waiting room. Minors must be picked up following their appointments on time. If you must leave your child in the waiting room during a session, it is your responsibility to provide appropriate supervision for that child. Children under the age of 10 may not be left without supervision in the waiting room. _________ **Clients Initials.**

Cancellations and Missed Appointments

Transitions Counseling and Mentoring Services is a very busy counseling office, so we require 24 – hour notice for cancelations and reschedule so that your appointment tie could be available for another cline in need. If you do not cancel or reschedule 24 hours before and appointment, a fee of $ 50.00 will be assessed to your account. Clients are responsible for all cancelation/no-show fees. Insurance companies will not reimburse for missed appointments. Fees MUST be paid before your next session is scheduled. _________ **Clients Initials.**

Court Appearance, Letter, and Other Paperwork:

Court appearances are billed at $200 per hour with a minimum charge of eight (8) hours, for a total of one thousand and six hundred ($1,600) dollars. Since the client-therapist relationship is built on trust with the foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, testify whether factual or in an expert

nature, in court or deposition. The therapist askes that clients only request court appearances in extreme cases. In the event that it is necessary for the therapist to testify before any court, arbitrator, or other hearing officer to testify at a deposition, weather the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the therapist for his or her services, including transportation, preparation, and necessary expenditures at the rate of two hundred ($200) dollars per hour, rounded to the nearest half hour. These expenditures included but are not limited to copies, parking, meals and the like. The client agrees to pay the $1,600 two weeks prior to the appearance, presentation of records, or testimony requested

_________ **Clients Initials.**

End of Treatment

In addition to your right to confidentiality, you have the right to end your counseling at any time, for whatever reason and without any obligation, with the exception of payment of fees for services already provided. You have the right to question any aspect of your treatment with your counselor. You also have the right to expect that your counselor will maintain profession and ethical boundaries by not entering into other personal, financial, or professional relationships with you.

_________ **Clients Initials.**

Transitions Counseling and Mentoring Services reserves the right to discontinue counseling at any time including, if we do not believe you will make progress on your mental health condition because of no-shows, or late cancelations. We may consider you an inactive client with us if: (1.) sixty (60) days have passed, (2.) You do not have any scheduled appointments with us, and (3.) We have not heard from you. You will receive a letter stating that your file has become in-active. You may contact us to set up an appointment to become active again. Although we make an effort to remind you about upcoming appointments by text message and email, you are responsible for remembering and attending your appointments.

_________ **Clients Initials.**

Your signature below indicates that you have read and understand this information and have received a copy of this consent form and give permission to Transitions Counseling and Mentoring Services to provide counseling services and that this contract is binding for all future sessions you may have with this entity.

I, ____________________________ agrees to all the terms and conditions of this contract.
(Printed name of client or representative)

____

Client Signature (Client's Parent/ Guardian if under 18) **Today's Date**

Transitions Counseling and Mentoring Services

AUTHORIZATION OF USE OR DISCLOSURE OF PROTECTED HEALTH INFROMATION

(Page 1 of 2)

1. Client's name: ____
   First name Middle Name Last Name
2. Date of Birth _____/______/_______
   MM / DD / YYYY
3. Date authorization initiated: _____/______/_______
   MM / DD / YYYY
4. Authorization initiated by: ____
5. Information to be Released: ____
   i. For Psychotherapy Notes, (you must not use it as an authorization for any other type of protected health information.)
6. Purpose of Disclosure: The reason I am authorizing release is:
   ____
7. Person(s) Authorized to Make the Disclosure:
   ____
8. Person (s) Authorized to Receive the Disclosure:
   ____
9. This Authorization will expire on ____/____/____ or upon the happening of the following event:

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law and the used/ disclosure is to be made to conform to my directions. The information that is used and/ or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by stat laws that limit the used and/ or disclosure of my confidential protected health information.

Signature of the Patient: ____

Signature of Personal Representative: ____

Relationship to Patient if Personal Representative: ____

Date of signature: __________________

Transitions Counseling and Mentoring Services

PATEIENT RIGHTS AND HIPPA AUTHORIZATION
(Page 2 of 2)

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPPA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, provider has the right to decided not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to terms of this authorization, this office has no control over how it will be sued by the recipient. You need to be aware that at this point your information may no longer be protected by HIPPA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. **Special instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.** HIPPA provided special protection to certain medical records known as "Psychotherapy Notes". All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health processional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPPA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b)

counseling sessions start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow the release of Psychotherapy Notes.